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Implications of a Family Systems Orientation for Preventing Psychiatric Hospitalization

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IMPLICATIONS OF A FAMILY SYSTEMS ORIENTATION
FOR PREVENTING
PSYCHIATRIC HOSPITALIZATION

by

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ABSTRACT

IMPLICATIONS OF A FAMILY SYSTEMS ORIENTATION
FOR PREVENTING
PSYCHIATRIC HOSPITALIZATION

James Howard Bullock
Virginia Consortium For Professional Psychology, 1987
Director: Dr. Glenn Shean, W&M

The present study evaluated the implications of a family systems approach for preventing psychiatric hospitalization by comparing the behavior of field clinicians who professed a systems view versus clinicians who held more traditional nonsystems views. The focus of the investigation was the clinical assessments and decisions of 31 clinicians who worked at five Virginia public mental health centers as they prescreened (ie., evaluated need for inpatient treatment) 171 candidates for hospitalization. Q-technique was employed to determine theoretical orientation.

It was hypothesized that clinicians who held a systems view would be more likely than nonsystems therapists to evaluate and attempt to organize clients' social context and to contact and organize the input of relevant professional helpers. They were expected to be less likely to involve physicians, use medical or psychodiagnostic procedures, or refer clients to sheltered treatment/support facilities. Most importantly, they were expected to recommend hospitalization less often and emphasize aspects of clients'

social context in their decision-making. If hospitalized, their clients were expected to have shorter stays.

The results indicated that clinician behavior, clinician decision-making, and client disposition all reflected elements of systems and nonsystems views. While systems therapists placed greater emphasis on approaches that were consistent with their point of view, they also employed methods and were influenced by factors (eg., symptom severity, diagnosis) that were inconsistent with professed orientation. Further, they hospitalized clients no less frequently than nonsystems therapists and their clients spent the same amount of time in the hospital during the 30 days following prescreening. The results are discussed in terms of the exportability of the method outside the training institute.

DEDICATION

To my wife Denise, for her love, support and endurance.

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I'd like to thank Glenn Shean, my dissertation chair, for his support and sensitive supervision during the last year of this project. I'd also like to thank my friend Michael O'Connor. His support during the times when I was most discouraged helped to keep the process and the goal in perspective. Most of all, I'd like to thank my wife Denise without whose love and support this project would not have been possible. She worked with me, suffered with me, and stayed with me through the most difficult times. She helped to inspire the hope that made all of this possible.

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Introduction

The practice of hospitalizing people whose behavior deviates from community standards began during the late 18th and early 19th centuries (Leahey, 1980; Zilboorg, 1969). In accordance with the emerging scientific and mechanical spirit of that era, behavior was thought to reflect natural biological processes. Deviant behavior was viewed in terms of a disruption of normal biological functioning and its treatment fell to the physician. Hospitalization ensured that "the mentally sick [received] all the consideration that is due to suffering humanity" (Pinel, cited in Zilboorg, p. 324).

Psychiatric hospitals continue to be a preferred context within which to treat deviant behavior. In this country, for instance, more than 70% of mental health expenditures support inpatient psychiatric treatment (Kiesler, 1982b). Furthermore, both the absolute number of people hospitalized and the rate of psychiatric hospitalization are increasing (Gelman et al., 1986; Kiesler, 1982b; Kiesler et al., 1983; Kiesler, 1984; Mosher, 1983). This growing reliance on psychiatric hospitalization continues despite strong criticism of the practice throughout this century (Beers, 1908; Goffman, 1961; Langsley and Kaplan, 1968; Langsley, Flomenhaft and

Machotka, 1969; Szasz, 1960) and despite government policy implemented with the passage of the Community Mental Health Centers Act in 1963 supporting deinstitutionalization and outpatient treatment.

Among the most vocal critics of psychiatric hospitalization are therapists who profess a family-systems orientation to the treatment of deviant behavior. Their approach, rooted in cybernetics and systems theory, views behavior disorder as primarily a phenomenon of social systems. Assessment and intervention by systems-oriented therapists focus on transactions between people, not on internal psychological or physiological states. "The intrinsic characteristics of individuals-- their personality traits, biological predispositions, unconscious conflicts, social skills, etc.--are secondary to the ongoing communicational patterns in which problems are embedded" (Rohrbaugh and Eron, 1982, p. 251). Hospitalization, because it tends to be correlated with paradigms which focus on individual pathology, is considered at best to be an irrelevant treatment and at worst to be a form of social control that perpetuates the very problems it is intended to alleviate (Haley, 1980). Preventing hospitalization (ie., maintaining the individual in his/her natural social context which itself becomes the unit of treatment) is an explicit goal of family systems approaches (Colapinto, 1982; Madanes, 1981; Rohrbaugh, 1983; Tavantzis, Tavantzis, Brown and Rohrbaugh, 1982).

Unfortunately, despite the importance placed by family-systems therapists on preventing hospitalization, there is little systematic evidence that systems-oriented diversion/treatment methods work or even that they are routinely practiced by field clinicians who identify themselves with the approach (Pinsof, 1981). In fact, the only research with direct relevance is Haley's (1980) series of apparently successful (but largely uncontrolled) case studies where a primary goal was to prevent the hospitalization of young adults. Unfortunately, the data obtained in these studies is at best only suggestive since, as Haley himself noted, the procedures and criteria for establishing outcome failed to meet minimum methodological standards. Furthermore, since the case studies were conducted within the confines of Haley's training program, the question of whether his methods have been--or could be--successfully exported outside the training institute (Gurman and Kniskern, 1981; Kniskern and Gurman, 1979) remains unanswered. Whether and how the behavior of systems therapists in the field is related to their theoretical perspective has simply not been examined.

The present study evaluated the implications of a systems view for preventing psychiatric hospitalization by comparing the assessment and decision-making behavior of clinicians in the field who professed (and/or who work in clinics that professed) systems versus more traditional nonsystems views. Five Virginia public mental health

centers, two of which were staffed exclusively by clinicians who endorsed a family-systems orientation and three agencies that were staffed by clinicians who espoused more traditional orientations, participated in the study. The focus of the investigation was the clinical assessments and decisions of clinicians at each center as they prescreened (ie., evaluated the need for inpatient treatment) candidates for hospitalization. It was anticipated that centers staffed by clinicians who endorsed a systems view of problems would differ significantly on a number of specific criteria (to be outlined later in this section) from those who professed one or more of the nonsystems models.

Paradigm and Practice

Unfortunately, the notion that clinician behavior varies predictably as a function of theoretical orientation (whether systems or nonsystems-oriented) lacks convincing empirical support. Despite growing concern in the literature regarding the issue of "correspondence between professed orientation and actual behavior" (Orlinsky and Howard, 1978, p. 290), there has been little systematic investigation of the relationship between theory and practice (Pinsof, 1981). "Extremely important and lacking have been data showing that therapists' beliefs are matched by their behaviors" (Sundland, 1977, p. 215).

What evidence there is comes from studies that compared different orientations within systems or nonsystems paradigms on the basis of clinician reports of in-session

behavior. For instance, Green and Kolevzon (1982) asked members of the American Association for Marriage and Family Therapy and the American Family Therapist Association, to describe their theoretical orientation (based on assessment of assumptions about therapy process and goals) and their in-session style. The results suggested clear divergence in belief systems, ie., beliefs about therapy process and outcome, of therapists who endorsed different family therapy models, but little difference in in-session behavior. For example, therapists who differentiated themselves as structural/strategic (Minuchin, Haley), communications (Satir) or systems (Bowen) therapists were indistinguishable in terms of inclination to organize, plan and direct sessions. They also were indistinguishable in terms of their tendency to improvise, provoke or confront while in session.

Similarly, Rohrbaugh (1982) obtained evidence of similarity in intervention style despite clear conceptual differences when he sampled a small group of highly experienced family therapists representing brief problem-focused (Fisch, Weakland and Segal, 1982), structural (Minuchin, 1974), strategic (Haley, 1976,1980; Madanes, 1981) and systems (Palazzoli-Selvini, Boscolo, Cecchin and Prata, 1980; Hoffman, 1981) models. Rohrbaugh concluded that "in practice, the four approaches are closely related -- enough so to be considered variations of a common clinical . . . paradigm (p. 11).

In contrast, Kolevzon and Green's (1983) findings suggest clear differences in the behavior of therapists who endorsed different theories of family therapy. Like Rohrbaugh's project, their study evaluated highly experienced therapists. Unlike Rohrbaugh, however, the authors concluded that "intensively trained practitioners hold . . . mutually exclusive belief systems and behaviorally antithetical dimensions of interventive style" (pp. 188-189).

These equivocal findings for family therapists are paralleled for therapists practicing from traditional nonsystems viewpoints. For instance, Lieberman, Yalom and Miles (1973), studying group therapists, and Fischer, Paveza, Kickertz, Hubbard and Grayston (1975), studying therapists representing different individual approaches, were unable to conclude that clinicians representing different models behaved differently. Sloane, Staples, Cristol, Yorkston and Whipple (1975), on the other hand, did find similarities and differences reflective of theoretical orientation in the behavior of analytic and behavioral therapists. However, they also found significant points of similarity and difference that were inconsistent with theoretical orientation (eg., behavioral therapists were indistinguishable from analytic therapists regarding their use of "interpretation").

In sum, despite notions that theory will "influence the kind of data [the clinician] will focus attention on . . .

[and] what he will say and do" (Fisch, Weakland and Segal, 1982, p. 5), differences in the practice of clinicians who profess different orientations within systems or nonsystems paradigms have not been convincingly demonstrated. Further, despite efforts by Haley and others to differentiate systems-oriented methods of practice from that of more traditional clinicians, there is no research at all that examines differences in clinical behavior between the two paradigms. This study evaluated the implications of systems and nonsystems views of behavior disorder for psychiatric hospitalization practices. It focused on the actual behavior of clinicians representing systems and nonsystems paradigms. Specifically, the prescreening practices, ie., routine assessment of need for psychiatric hospitalization, at five Virginia public mental health centers characterized by different theoretical orientations were examined and compared by directly assessing clinicians' in-session behavior on a case-by-case basis.

Individual and Family-Systems Theories Compared

Rohrbaugh and Eron (1982) propose that at least four models of therapy define the systems paradigm: (1) Haley (1976, 1980) and Madanes' (1981) strategic therapy; (2) the brief therapy model associated with the Palo Alto Mental Research Institute (Fisch, Weakland and Segal, 1982; Watzlawick, Weakland and Fisch, 1974); (3) Minuchin's structural family therapy (Minuchin, 1974) and (4) the systems therapy associated with the Center for Family

Studies in Milan, Italy and applied in this country at the Ackerman Institute in New York (Palazzoli-Selvini, Boscolo, Cecchin and Prata, 1978, 1980; Hoffman, 1981). These models of family therapy share an intellectual and philosophical heritage based on cybernetics and systems theory. Their roots can be traced directly to the pioneering work of Bateson and his associates during the early 1950's and 1960's, and to the work at the Mental Research Institute of Jackson and his colleagues during the late 1950's and 1960's (Gurman and Kniskern, 1981; Hoffman, 1981). Although distinct, the models share basic assumptions and are more similar to one another than to traditional theories of pathology and treatment which focus on the individual. For present purposes, therefore, they will be classified together as a single paradigm comprised of "systems-oriented" models of family therapy.

Similarly, the differences between the various biomedical, behavioral, analytic, and experiential theories will not be emphasized. Instead, these theories will be classified together on the basis of their focus on individuals rather than social systems. This grouping of nonsystems theories includes ones that attach importance to family assessment or intervention (eg., the psychoeducational and stress vulnerability models described by Beels and McFarlane, 1982; Brown, Birley and Wing, 1972; Rohrbaugh, 1983; and others) but which continue to identify problems with individuals. Thus, the classification of

systems and nonsystems paradigms is based not on whether but on how the family is relevant to problems and their resolution. Models that have in common a systems view of problem maintenance will be compared with models that do not.

At least three related assumptions distinguish systems models from other viewpoints. First, "the central concept of the new epistemology is the concept of circularity" (Hoffman, 1981, p. 5). Traditional linear causal notions about mental illness or psychological disorder which characterize most individually-oriented models are rejected. According to systems theorists, the traditional view results when one's focus is arbitrarily confined to the individual.

If one saw the same person with his or her family, in the context of current relationships, . . . one would see many circular causal loops that played back and forth, with the behavior of the afflicted person only part of a larger, recursive dance (Hoffman, 1981, p. 6).

Some therapists, in fact, suggest that problem behavior plays an integral, ie., system stabilizing, role vis-a-vis relationships among family members. "Problems, regardless of their origin, are maintained in ongoing cycles of interaction and [are] inextricably interwoven with their social context (Rohrbaugh and Eron, 1982, p. 248).

A second area of difference between systems and nonsystems paradigms concerns the locus and nature of

pathology. In the former, characteristics of individuals are secondary to current interactional patterns and regulatory processes of the social system to which they belong. "Symptoms" are said to reflect a dysfunctional structure in the relationships among family members. The problem unit and the object of intervention is the social system which serves as the context for problem behavior. Not surprisingly, little attention is accorded to questions regarding the biology and psychology of individuals. "The wisest strategy for a therapist is to assume that there is no organic basis for mad behavior and to proceed as if the problem is a social one" (Haley, 1980, p. 12). "Bizarre behavior . . . is an adaptive response to the current social situation; theories of organic defects or early childhood traumas are abandoned as undemonstrated, if not unprovable (Haley, 1981, p. 211).

A final area of difference between the paradigms concerns assumptions about the role of therapists in resolving or maintaining problems. As it is understood by systems theorists, the problem unit encompasses the therapist, ie., the therapist includes him or herself (as well as other professionals, community agencies or personnel, family acquaintances etc.) as part of the ecology within which problem behavior occurs. This belief stems from the notion that problems can reflect organizational confusion in the system of professional helpers or in other social systems that surround problem behavior.

The therapist is not an agent and the client is not a subject. Both are part of a larger field in which therapist, family, and any number of other elements act and react upon each other in unpredictable ways, because each action and reaction continually changes the nature of the field in which the elements of the new therapeutic system reside.

This emphasis on understanding how broader social systems interact with and/or perpetuate problems clearly distinguishes the systems view from traditional models which, at most, consider only the possibility of mutual causal relationships between therapist and client.

When translated into clinical practice, these areas of difference generate much disagreement among proponents of individual and systems-oriented paradigms. For instance, assessment and diagnosis of individuals occupies a central role in many nonsystems models. Activities related to the historical investigation and identification of the cause of deviant behavior take on great importance; emphasis is placed on the cataloging of signs and symptoms and on tests designed to elucidate the individual's pathology.

For instance, in his widely cited clinical psychology text, Korchin (1976) defines the discipline in terms of its "unique concern with the human problems of "persons in particular" (p. 3). "Clinical intervention includes efforts to (1) understand the state of the person [ie., the

assessment process] and (2) alter the personality and functioning of the person". (p. 12).

Spitzer (American Psychiatric Association [APA], 1980) provides another example. He opens the introduction to the third edition of the Diagnostic and Statistical Manual of Mental Disorders, by asserting "the importance of diagnosis for both clinical practice and research" (p. 1). It is inferred that there are "behavioral, psychological or biological dysfunctions" of individuals that are characterized by "painful symptoms or impairments" (p. 6). "The definitions of the disorders generally consist of descriptions of the clinical features [ie., signs and symptoms] of the disorders" (p. 7).

Systems-oriented clinicians, in contrast, are interested in understanding ongoing social interactional patterns. The assessment goal is to understand the manner in which relationships between persons in the system, including the therapist and other professionals, depend on and function to maintain problem behavior. "The qualitative shift in the conceptual framework that characterizes the interpersonal systems approach . . . requires that one utilize the transactions between individuals rather than the characteristics of each given individual as primary data" (Sluzki, 1978, p. 366). Assessment ". . . specifies not just the people involved, but the patterns, rules, and relationships that govern their behavior" (Rohrbaugh and Eron, 1982, p. 257). Little or no interest is expressed in

diagnosis. In fact, diagnostic classification of the individual is often considered to be harmful because it reinforces among all family members--including the symptom bearer--the perception that there is a "problem individual".

Treatment goals and methods show similar disparity between systems and nonsystems paradigms. The goal of individually-oriented treatment is to modify or manage the individual's problem. Generally, treatment methods focus on the individual. Little if any consideration is given to the social context except in the sense that it may serve as a distracting or stress inducing influence (American Psychiatric Association [APA], 1980).

At the core of psychotherapy is a unique relationship between the clinician and the patient within which there is communication which can relieve distress and set conditions for relearning and personal growth (Korchin, 1976, p. 281).

The goal of systems-oriented treatment, on the other hand, is to modify the social context so that problem behavior is no longer adaptive or functional. Treatment methods are typically geared toward changing or interrupting current problem-maintaining interactions or changing the structure of relationships within the interpersonal system and may or may not involve the symptomatic individual directly. Treatments which ignore the social context or which remove or attempt to insulate individuals from their

social context (eg., hospitalization) are rejected as irrelevant or, possibly, harmful.

In view of these differences in clinical goals and techniques, it is not surprising that the topic of psychiatric hospitalization is a focus of controversy between the two paradigms. For the nonsystems-oriented clinician, hospitalization is often viewed as a haven within which to protect and insulate the individual from distracting or stressful external influences while providing the opportunity to focus or intensify assessment or treatment (Haley, 1981; Kiesler, 1982a; Zinn, 1979).

From a systems viewpoint, however, psychiatric hospitalization is likely to inhibit problem resolution and may even make matters worse. Colapinto (1982), for instance, argues that hospitalization "hinders efforts to restructure the family because of the unnatural isolation of a key member" (p.122) and because removing the individual artificially reduces stress in the family system which could serve as a source of energy for family change. Also, like Haley (1980) and Madanes (1981), Colapinto maintains that hospitalization confirms the family's perception that the problem resides within a single individual. This exerts a stabilizing influence on the deviant family system, further limiting the probability of system change. Preventing hospitalization, therefore, is a prime goal of systems-oriented clinicians.

Hospitalization: Effectiveness and Alternatives

Despite severe criticism of psychiatric hospitalization practices in this country throughout this century (eg. Beers, 1908; Goffman, 1961; Langsley and Kaplan, 1968; Szasz, 1960), until recently there have been few systematic attempts to evaluate its efficacy (Kiesler, 1980, 1982a). For the most part, however, these recent studies echo the themes set by earlier writers. For example, Kiesler (1982b) reviewed studies in which severely disturbed patients were randomly assigned to carefully specified hospital or alternative treatments. Without exception, non-hospital treatments enjoyed equivalent or superior clinical effectiveness and on the average were 40% cheaper. Moreover, there was clear evidence of a self-perpetuating effect of hospitalization. "People who were randomly assigned to a mental hospital were more likely, after discharge, to be readmitted to the hospital than people who were randomly assigned to an alternative mode of care were ever to be admitted to mental hospitals" (Kiesler, 1982b, p. 1326). Straw (1982) and Braun et al. (1981) reached similar conclusions even though studies included in their reviews were less rigorously controlled, ie., they did not exclude studies without random assignment. Together these reviews clearly suggest that the majority of patients "could be treated in alternative settings more effectively and less expensively" (Kiesler, 1982a, p. 358). Hospital treatment of severe psychiatric disorder may be less effective, more

costly and more likely to perpetuate problems than a wide variety of alternate non-hospital treatments.

Hypotheses

The present study focused on mental health clinics and clinicians who embraced a family-systems approach, comparing them with nonsystems-oriented clinics and clinicians to determine (1) whether differences in conceptual orientation influenced how the need for psychiatric hospitalization was evaluated in actual practice, and (2) whether family-oriented clinicians (or clinics) operating within unspecified but presumably randomly distributed organizational and systems constraints were in fact more likely to prevent hospitalization at the time of prescreening and in the weeks that followed.

The strategic systems model of Haley (1980) and Madanes (1981) which deals extensively with psychiatric hospitalization was used to supplement the discussion above in deriving predictions regarding the behavior of systems-oriented clinicians. Hypotheses focused on the prescreening behavior, ie., the evaluation and decision making behavior, of clinicians working within the Virginia public mental health system.

Hypothesis I. Family-systems clinics/clinicians will recommend hospitalization less often and their clients will experience fewer hospital days during the month following prescreening.

(I)t is evident that . . . change does not occur with institutionalization but rather with normal behavior in the community. Therapeutic change therefore occurs most rapidly when the family is encouraged to push the child into normal activities immediately--that is when action in the family happens (Haley, 1980, p. 33).

When dealing with severely disordered behavior, systems approaches adopt as a primary goal the prevention of hospitalization. Hospitalization is said to maintain problems by stabilizing the deviant family system within which the problem occurs. Haley argues, for example, that a individual can stabilize a family by developing "some form of incapacitating problem [eg. a psychiatric symptom] . . . so that he or she continues to need the parents" (1980, p. 31). In turn, the "parents can use an official institution to restrain their offspring, so that he or she does not become independent and self-supporting" (Haley, 1980, p. 31).

Madanes (1981) adds that hospitalization can reinforce existing organizational confusion/incongruity within a family which, in turn, will reinforce deviant behavior. She explains that problem behavior often exists in a context where family members are dominated by the need to help and care for a problem person and are in a superior position to the helpless, incompetent person. Hospitalization ensures that the problem person is contained and cared for and

allows the family to escape the domination associated with a caretaking role, but it does nothing to remedy the incongruous structure of family relationships. In fact, because of the social stigma associated with hospitalization, the problem family member often is defined as even more helpless which, paradoxically, contributes to his or her power and, thus, to symptom maintenance. As a result, the prevention of hospitalization or rehospitalization is said to be a critical first step in changing a deviant family system.

Hypothesis II. Family-systems clinics/clinicians will more often (a) investigate the client's immediate interpersonal network, (b) contact and engage other family members (or significant others) in treatment, and (c) organize and direct them vis-a-vis supervising the client and managing the crisis in the natural environment.

Preventing hospitalization depends on understanding and organizing the individual's interpersonal context, including the immediate family, relevant members of the extended family, and non-relatives whose interactions with the family bear on the expression of the problem behavior. The primary goal is to define the problem as one that can be solved by family members without recourse to hospitalization. Assessment and treatment activities, accordingly, should focus on identifying, contacting,

organizing and charging the members of the interpersonal network with solving the problem.

Hypothesis III. Family-systems clinics/clinicians will more often contact other professional helpers involved with the client and organize their participation in a coordinated treatment plan.

Preventing hospitalization also involves identifying and organizing the professionals and agencies within the community that have relevance for the problem behavior. This is done to clarify the lines of professional responsibility as well as to gain strategic control of treatments available to the family. This point is given particular emphasis in Haley's (1980) model. He believes that the professional network may even display the same organizational confusion as the family system with the result that problems are reinforced rather than resolved.

Hypothesis IV. Family-systems clinics/clinicians will less often utilize medical or psychodiagnostic procedures that focus on the individual.

A systems approach orients the therapist to current relationships and repetitive sequences or patterns of interaction among family members, mental health professionals, representatives of community agencies etc. There is no place in the model for traditional diagnostic techniques such as physical evaluation, laboratory testing,

psychological testing, mental status examination or the gathering of individual or family medical or psychiatric history. No interest is expressed in the problem individual's past or in speculation regarding etiology or pathophysiology. Instead, assessment is geared toward the identification of aspects of the current interpersonal context that can be brought to bear on the solution of the problem. In Haley's words, "the wisest strategy for a therapist is to assume that there is no organic basis for a mad behavior and to proceed as if the problem is a social one" (1980, p. 12).

Hypothesis V. Family-systems clinics/clinicians should less often report the use of physician contacts, medication and sheltered treatment/support alternatives.

The problem person's immediate return to his or her normal activities and routines without the influence of medication, day hospitalization or other restraining or sheltering (ie. stabilizing) treatments is recommended. Therapeutic change is thought to occur not with hospitalization or other restraining treatments, but with returning the client to his or her normal situation in the community. "Everyone should expect the problem person to become normal and not excuse failure. Going to work or school immediately should be expected, with no delay for day hospitalization or long-term therapy" (Haley, 1980, p. 45. This allows the family to reestablish itself at the point

which preceded the eruption of problem behavior and sets the stage for resolving the organizational difficulty in a more adaptive manner.

Hypothesis VI. Symptom severity and hospitalization history will be less highly correlated with decision to admit for systems-oriented therapists than for other therapists.

Since systems therapists view disordered behavior as a phenomenon of social systems rather than of individuals, characteristics of the individual such as severity of symptoms and previous hospitalization should be less relevant in their assessment and treatment activities. These variables should also be less predictive of whether systems therapists recommend hospitalization. In contrast, research concerned with the decision-making behavior of nonsystems-oriented clinicians clearly shows that they are more likely to recommend hospitalization as symptoms worsen and when there is a history of psychiatric hospitalization (Dean, Lee, Pickering, and Klinger, 1978; Feigelson, Davis, Mackinnon, Shands and Schwartz, 1978; Man and Elequin, 1971; Mendel and Rapport, 1969; Streiner, Goodman and Woodward, 1975).

Method

Overview of the Project

In conjunction with an ongoing program evaluation project (Bullock and Rohrbaugh, 1984), clinicians' prescreening behavior was studied at five Virginia community mental health centers, two of which endorsed a family-systems treatment philosophy. Clinicians at each of the participating centers completed a supplementary Prescreening Survey form whenever they evaluated a client for possible hospitalization. Aspects of clinician assessment and decision-making behavior sampled in the survey served as dependent variables.

After all of the prescreening data had been collected, participating clinicians at each clinic were asked to complete a Clinician Q-Sort designed to evaluate conceptual orientation. By correlating and factor analyzing these Q-sorts, it was possible to define idealized points of view (Q-factors) with which participating clinicians (and hopefully clinics) could be identified. Conceptual orientation was then examined in relation to dependent measures from the Prescreening Survey, namely diversion outcome and aspects of clinician's assessment and decision-making behavior.

It was hypothesized that a family-systems orientation would be associated with fewer recommendations for hospitalization and that clients seen by family therapists would have fewer hospital days in the month following prescreening. Family-oriented clinicians also were expected to behave differently than nonsystems clinicians when conducting prescreening evaluations. Specifically, clinicians and clinics espousing a systems orientation were thought to be more likely to (1) investigate the client's interpersonal network and direct members of the network to provide support and supervision, (2) encourage the immediate reinvolvement of the client in his or her normal daily routines and responsibilities, (3) investigate relationships between the client and other helpers and agencies in the community, and, contact those helpers and attempt to coordinate their activities related to the treatment of the client. In addition, they were expected to be less likely to (1) use traditional diagnostic procedures focusing on the individual's current or past medical or psychological status and (2) encourage the use of medication, partial hospitalization or other sheltered treatment/support alternatives. It is also hypothesized that case variables such as symptom severity and prior hospitalization would influence the assessment and decision-making behavior of systems and nonsystems clinicians in different ways. Specifically, nonsystems clinicians should be more likely to hospitalize clients with previous hospitalizations or with

more severe symptoms while the behavior of systems-oriented clinicians should remain unchanged by these variables.

Subjects: Clinics, Clinicians and Clients

The subjects included 31 clinicians and 171 clients involved in pre-admission screening activities between April 1 and June 30, 1984, at five Virginia community mental health centers: Colonial Community Mental Health Center (Williamsburg); Prince William County Community Mental Health Center (Manassas); Gloucester Counseling Center (Gloucester); Warsaw Counseling Center (Warsaw) and the Saluda Counseling Center (Saluda).

The Gloucester, Saluda and Warsaw centers employed 16 clinicians to serve a population of 54,000 in a 10 county catchment area in rural southeastern Virginia. The Prince William Mental Health Center in Manassas serves rural and suburban areas of Northern Virginia. Seventy five clinical staff delivered services to 185,000 people. The Colonial Mental Health Center in Williamsburg employed a clinical staff of 27. The center serves a primarily rural catchment area of 85,000 people.

Although the assessment behavior and conceptual orientation of therapists were of primary interest in this study, the unit of observation was the cases which the clinicians evaluated. In other words, the N for most statistical analyses was based on the number of cases evaluated during the study period, rather than the number of participating clinicians.

As noted earlier, two of the mental health centers (Prince William and Gloucester) were selected for the study because they endorsed a strong family-oriented treatment philosophy. The directors of these two clinics were themselves recognized authorities on family therapy in the public sector as evidenced by the fact that both were invited speakers on the topic at the March 1984 Family Therapy Network Symposium. In addition, virtually all of the clinicians working at these two clinics had been trained either in Haley (1976, 1980) and Madanes' (1981) strategic family therapy approach or in Minuchin's (1974) structural approach as taught by Marriane Walters at the Family Therapy Practice Center in Washington, D.C.

The other three clinics (Warsaw, Saluda, and Williamsburg) were more eclectic in orientation. They were more typical of public mental health centers in that no single conceptual viewpoint was advocated to the exclusion of others.

Instruments and Measures

Prescreening Survey.

The Prescreening Survey (Bullock and Rohrbaugh, 1984; see Appendix A) is a single page questionnaire composed of four sections: (I) Background Information (II) Assessment (III) Disposition and (IV) One Month Followup. Items in section I cover general demographic information and the identified patient's current living arrangements, social supports, legal history and medical/psychiatric history. Section II deals with aspects of the clinical assessment. Section III assesses the clinician's decision-making and initial intervention. Section IV summarizes service utilization in the month following prescreening.

The main use of the Prescreening Survey was to operationalize the dependent variables, ie. whether or not the identified patient is hospitalized and how, specifically, clinicians approached the task of evaluating the need for hospitalization and/or prevented it. The items of primary interest for each of the six hypotheses are listed below.

Hypothesis I: Family-systems clinics/clinicians will recommend hospitalization less often and their clients will have fewer hospital days during the month following prescreening.

Family-systems therapists should less often recommend hospitalization (item 52) and more often report that the client returned home after the prescreening (item 53). In

addition, clients of family-systems therapists should spend less time in the hospital (item 68) during the 30 day period immediately following prescreening.

Hypothesis II: Family-systems clinicians will more often (a) investigate the client's immediate interpersonal network, (b) contact and engage other family members (or significant others) in treatment, and (c) organize and direct them vis-a-vis supervising the client and managing the crisis in the natural environment.

Systems therapists should more often contact the client's relatives or friends during the assessment (items 44 and 45) and evaluate the capacity of these significant others to provide custodial supervision and support (item 47). They will more often encourage the participation of significant others in treatment (item 43) and, in doing so, will more often give specific instructions about how to supervise the client (item 57).

Hypothesis III: Family-systems therapists will more often contact other professional helpers involved with the client and organize their participation in a coordinated treatment plan.

Family-systems therapists should more often indicate that they contacted other helping agencies or professionals (items 44 and 45). They should more often encourage the participation of these helpers (item 43) and, in doing so, give specific management suggestions (item 58).

Hypothesis IV: Family-systems therapists will less often utilize medical or psychodiagnostic procedures that focus on the individual.

Family-systems therapists should report less frequent use of physical exams, lab work, medical history, mental status exam, psychodiagnostic testing and social history(item 50).

Hypothesis V: Family-systems therapists should less often report the use of physician contacts, medication, and sheltered treatment/support alternatives.

Family-systems therapists should less often consult physicians or psychiatrists (items 40 and 41). In addition, they should report fewer medication consults(item 50), less frequent prescription or adjustment of medication(item 60) and less frequent use of restrictive or sheltered specialized care alternatives such as partial hospitalization (item 65).

Hypothesis VI. Symptom severity and hospitalization history will be less highly correlated with decision to admit for systems-oriented therapists than for other therapists.

Family-systems therapists assessment and decision-making behavior should be less strongly related to rated severity of symptoms (item 48) and history of psychiatric hospitalization (items 21 and 23) than the behavior of nonsystems therapists.

Therapist Q-Sort.

Therapist conceptual orientation was operationalized via a two-way structured Q-sort (Brown, 1980; Kerlinger, 1973; Rohrbaugh, 1982) composed of 44 items reflecting common assumptions of systems and nonsystems models regarding (1) the nature of psychiatric problems, (2) general approaches to assessment, (3) intervention and (4) specific beliefs about psychiatric hospitalization (see Appendix C). The statements representing these eight content domains (ie., two levels of orientation by four levels of content) were selected from published sources; interviews conducted with staff members at participating clinics and with recognized systems therapists, and from other instruments used to study therapist's orientation, such as Rohrbaugh's (1982) Q-sort for strategic, structural and systems family therapists and Kolevzon and Green's (1983) questionnaire on therapists' belief and action systems.

The Q-sort task required the sorting of items into categories according to how well they represent the therapist's views regarding clinical practice. Clinicians were asked to arrange items into nine categories along a continuum from "most disagree" (category 1) to "most agree" (category 9) with, respectively, 3, 4, 5, 6, 8, 6, 5, 4, and 3 items in each category (see Appendix D for Q-sort instructions). The arrangement of items within categories was irrelevant.

Therapists recorded item ranks on the Q-sort answer form (Appendix E). The Q-sort answer form also requested information about the clinician's age, sex, professional discipline, years of experience, and professed theoretical orientation.

Procedure

Data collection proceeded in two phases. The first phase involved the Prescreening Survey, which clinicians at participating CMHC's completed within 48 hours of each prescreening evaluation conducted during the study period. The Prescreening Survey was attached as a supplement to VA DMH Form #224 (Appendix B) which clinicians routinely completed subsequent to each pre-admission screening. Thus, except for additional paperwork, the study required little change in how prescreening evaluations were normally conducted.

Surveys were completed whenever a client, relative or referring source suggested that hospitalization may be indicated or whenever the clinician recognized a need to evaluate suicidal or homicidal potential. Administrators adopted these guidelines for the purposes of this study in order to promote uniformity among clinics regarding the definition of a prescreening. It is important to note, however, that these guidelines still allowed considerable latitude as to when and how prescreening was defined. There likely was variation among the clinics with respect to decisions about when to complete the survey.

The Prescreening Survey includes a brief follow-up section designed to obtain information about the client's status in the month following prescreening evaluation. Follow-ups were conducted in somewhat different ways at different clinics. At the Williamsburg, Warsaw, Saluda and Gloucester clinics, followup information was compiled by case managers. At the Prince William clinic this task was performed by the Program Evaluator.

The second phase of data collection concerned the evaluation of conceptual orientation. After the prescreening data had been collected, clinicians were asked to complete the Clinician Q-sort. The Q-sort was administered in group sessions at each clinic.

Results

Overview of Analyses

Data analysis proceeded in several phases. First, the independent variable of conceptual orientation was defined via Q-methodology. Second, analyses of clinician and client demographic characteristics provided information about the comparability of cases evaluated at the five clinics. Third, hypotheses I through V were tested by directly comparing the hospitalization rates and assessment behaviors of clinicians affiliated with different clinics and/or conceptual orientations. Hypothesis VI was tested by correlating client outcome variables and selected case variables within each orientation. Finally, stepwise multiple regression analyses were employed to further clarify the relationship between case variables and clinician decision-making.

Clinicians, Clinics and Conceptual Orientation.

The Q-sorts of the 31 participating clinicians at the five clinics were correlated and factor analyzed. Factors were extracted using SPSS algorithm PA1 with unities in the diagonal of the correlation matrix (Nie et al., 1975). Factors with eigenvalues greater than 1.0 were rotated to a varimax solution.

The factor structure that emerged included seven factors which accounted for 75% of the total variance. All of the clinicians from Gloucester had a factor loading of at least .30 on factor I as did all the clinicians at Warsaw and all the clinicians at Manassas except one. Clinicians from the other clinics were scattered among the other factors.

With only one exception, clinicians from clinics that endorsed a systems orientation prior to the study loaded on a single factor while clinicians from the other clinics almost never loaded on that factor. Subjecting clinician loadings on Factor I to a one-way analysis of variance yielded a significant main effect for clinics, $F(4,26) = 17.83$, $p < .001$. As shown in table 1, a posteriori comparisons utilizing the Least Significant Difference (LSD) test revealed that factor loadings for Gloucester, Warsaw and Manassas clinicians were significantly higher on Factor I than those for Williamsburg or Saluda clinicians. No other clinic comparisons reached significance.

Insert Table 1 about here

Table 2 presents the factor loadings for each of the participating clinicians. The factors that emerged can be thought of as idealized points of view held in common by the clinicians associated with them. Defining these points of

view involved first merging or averaging the Q-sorts associated with each factor. The result was one Q-sort for each factor with factor scores determining the degree to which each Q-sort item represented the factor (Brown, 1980). The items that attained the highest and lowest factor scores on each factor were then examined to define the beliefs and methods most highly endorsed or most strongly rejected. For the purposes of this analysis, the five items that attained the highest and lowest factor scores on each factor were examined. These items appear in Appendix F.

Insert Table 2 about here

All five statements with the highest factor scores on Factor I had been classified as "systems-oriented" items in the structured Q-sort. Four of them explicitly mention the family or the social system (items 3, 14, 19, and 44). Two offer highly critical beliefs about hospitalization (items 3 and 44). The other two concern approaches to assessment and treatment that focus on the organizational context of problem behavior (items 14, 19). The fifth item (item 12) concerns reframing, an intervention technique strongly identified with the strategic systems therapies.

All items with the lowest factor scores on Factor I represented a non-systems point of view in the structured Q-sort. Three focus on beliefs about psychiatric

hospitalization (items 1,30 and 37) and two concern assessment and intervention (items 8 and 33). The items dealing with hospitalization strongly support the practice by suggesting that it can provide an opportunity to learn more effective interpersonal functioning or that it is effective in promoting intensive involvement in treatment. The assessment item and the intervention item reflect traditional individually-oriented practices. The former deals with functional analysis, an assessment technique identified with the behavior therapies. The latter defines psychotherapy in terms of personal insight and emotional learning. All of these least preferred or lowest ranked items, regardless of content area, contain explicit references to practices or clinical phenomena associated with individuals.

When the items given highest and lowest priority on Factor I are examined together, the negative evaluation of hospitalization practices is underscored. Of the ten items, five concern hospitalization (items 1, 3, 30, 37, and 44). All were endorsed in a critical direction, ie., negative statements achieved very high factor scores while positive statements achieved very low factor scores. Thus, relative preference was given to items which suggested that hospitalization perpetuates problem behavior or deviant family structure. Comparatively, items which suggest that hospitalization is useful in promoting therapeutic

engagement, personal insight or enhanced interpersonal functioning were rejected.

The items with the highest and lowest factor scores on Factor II define a very different orientation. Highly ranked factor II items identify a medical or illness based view of deviant behavior (item 11) and underscore the importance of matching treatment modality (which may include hospitalization and medication) to patient disturbance via careful diagnosis (items 2, 10 and 21) and an understanding of client contact with other agencies or professionals (item 18). In contrast, items with the lowest factor scores on Factor II were ones that suggest an interactional definition of problems or problem maintenance (items 3, 22, 32, 39 and 42). This factor appears to be defined then by its rejection of a social/interactional locus of problem behavior and by its endorsement of diagnostic themes and a broad array of individually-oriented treatments.

Factor III items with the highest factor scores emphasize the importance of emotional awareness and experiential learning (items 5, 33 and 40) as well as the precise delineation of personality functioning or of the contingencies surrounding the behavior of individuals (items 8 and 23). Unexpectedly, three of the five items with the lowest factor scores on factor III were non-systems items (items 1, 2 and 11). However, the low priority accorded these items does not seem to reflect an endorsement of a systems view. Instead, the items focus on biological or

medical conceptualizations of deviant behavior. Together with the highly weighted items, they suggest a point of view defined by its endorsement of the emotional and experiential and by its rejection of both systems-oriented and medical/biological notions.

Although factors II and III both reflect strong individually-oriented perspectives, they appear to differ in regard to the acceptability of medical/biological (eg., diagnosis, mental illness, medication) notions. Factor II includes such formulations (and other individually-oriented ideas as well) while Factor III rejects them in favor of a focus on the experiential and emotional.

Like factors II and III, factor IV endorses a focus on individuals and eschews interactional formulations of deviant behavior. Here, however, the biological underpinnings of deviant behavior are given priority (as contrasted with the emotional and experiential in factor III and the broader range of individually-oriented notions contained in Factor II). Thus, deviant behavior is understood as illness and priority is given to biological modes of treatment (high factor scores on items 9, 11, 31; low factor score on item 28).

Accounting together for just over 10% of the variance, factors V, VI and VII do not lend themselves to interpretation. Though many of the items with high and low factor scores suggest a non-systems view, incompatible items were often grouped with them. For instance, item 36 (In

evaluating a psychiatric problem, characteristics of the patient are less important than the interactional patterns in which the problem is embedded.) was represented along with item 38 (The goal of clinical assessment is to construct a working image or model of the client from which intervention strategies can be developed.) in factor V. Similarly, item 28 (The wisest strategy for a therapist is to assume that there is no organic basis for mad behavior and to proceed as if the problem is a social one.) was grouped together with item 4 (Effective treatment involves correcting behavioral, psychological and/or biological dysfunctions of the individual.) for factor VI.

Clearly, clinicians at three of the five clinics expressed a point of view that rejects the practice of psychiatric hospitalization and endorses ideas and approaches identified with the systems therapies. Clinicians from the other two clinics, in contrast, scattered among a variety of non-systems factors but almost never loaded on the systems-oriented factor. These relationships were clear enough so that it made sense to think of orientations of clinics rather than of clinicians, ie., the Gloucester, Warsaw and Manassas clinics were thought of as systems or family-oriented clinics while the Saluda and Williamsburg clinics appeared to endorse a non-systems orientation. To examine this idea further, averaged Q-sorts for each clinic were computed. These

Q-sorts were then intercorrelated and factor analyzed, yielding the matrix of factor loadings displayed in Table 3.

Insert Table 3 about here

The factor structure includes only two factors which together account for more than 85% of the total variance. The clinics that appeared to share a family orientation in the factor analysis of clinician Q-sorts all loaded highly (.90 or higher) on Factor I. The other clinics loaded highly on Factor II.

The factors were examined in several ways. As above, the five items that attained the highest (and lowest) factor scores were used to define the general themes and issues underlying the factors (see Appendix G). Second, items were grouped according to their original designation in the two-way structured Q-sort, ie., two levels of orientation (systems and non-systems) by four levels of content (nature of psychiatric problems, approaches to assessment, ideas about intervention, beliefs about hospitalization). Item factor scores on each factor were then subjected to analysis of variance procedures. Finally, items upon which the greatest consensus occurred and items that most differentiated the factors were selected to compare and contrast the points of view represented.

All of the items with high factor scores on Factor I were systems-oriented items while all items with low factor scores were non-systems items. The converse was true of items on factor II, ie., all items with high factor scores were non-systems items while all but one of the items with low factor scores were systems items.

There was considerable overlap between Factor I in this analysis and the family-oriented factor in the analysis of clinician sorts. More than half the items, ie., three with the highest factor scores on factor I (items 12, 14 and 19) and three with the lowest factor scores (items 1, 30 and 37) also appeared in the item sample which earlier defined the family-oriented factor.

All five items (four of which explicitly mention the family) with the highest factor scores on Factor I were systems-oriented items. Three (items 19, 14 and 13) refer to an interactional definition of problems, ie., that problems (and the key to their solution) reside in the relationships that surround an individual. Accordingly, symptoms are presumed to have a meaning or function in the family system. And, knowledge of the organizational structure is viewed as fundamental to treatment. Two items (items 12 and 15) acknowledge a strategic perspective involving reframing and the utilization of client language consistent with the systems notion that reality is more created than discovered. Accordingly, the idea of couching interventions in language compatible with that of the client

(or family) and redefining the meaning of events or behavior was strongly endorsed.

Low ranked items provided a uniformly negative evaluation of psychiatric hospitalization. Four of the five items (items 1, 20, 30, and 37) explicitly mention hospitalization; the fifth (item 31) deals with the relationship between deviant behavior and biological dysfunction. Accordingly, the ideas that severe disturbance warrants hospitalization or even that hospitalization affords the opportunity for intensive engagement in treatment were clearly rejected. The same was true for the notion that medical aspects of psychological problems warrant greater emphasis.

Factor II takes an equally strong individual view. Eight of the ten items selected to represent this factor also appeared in the item sample for non-systems factors identified in the earlier analysis (high factor score items 5, 8, 10 and 33; low factor score items 1, 3, 28 and 34).

Careful diagnosis (items 8 and 10), active client participation (item 5) and experiential and emotional learning (item 33) were strongly endorsed as was hospitalization when symptoms are severe (item 16). Work with individuals was given exclusive focus; family-related issues received no mention at all.

As with Factor I, the majority of lowest ranked items concerned psychiatric hospitalization (items 1, 3, 6 and 34). They were ones which suggest that hospitals stabilize

deviant family systems and function to perpetuate problems. Exception also was taken to the notion that a clinician should assume that there is no organic basis for mad behavior (item 28, the lowest ranked item on this factor).

In sum, items ranked highly on factor I reflect beliefs commonly identified with systems-oriented approaches; low ranked items were ones that were included in the Q-sort because of their association with more traditional approaches. Exactly the reverse was true for item rankings on factor II.

Figure 1 displays the relationships between item ranking and orientation when all 44 Q-sort items are considered. The pattern remains quite consistent, ie., systems-oriented items are ranked high on Factor I and low on Factor II while non-systems items are ranked low on Factor I and high on Factor II.

Insert Figure 1 about here

The relationships between factors, orientations and item content domains was further investigated by subjecting factor scores to a 24.2 Split-Plot Factorial analysis of variance (Kirk, 1968). Factor served as the between blocks variable; content area within each orientation served as the within block variable, ie., four content domains within each orientation. Table 4 presents the analysis of variance

summary table. Of primary interest in view of the item content analyses above was the significant interaction between factor and orientation, $F(1,32) = 140.17$, $p < .01$. The interactions between orientation and content, $F(3,32) = 2.04$, $p > .05$, factor and content, $F(3,32) = .17$, $p > .05$, and between orientation, content and factor, $F(3,32) = .22$, $p > .05$, did not reach significance.

Insert Table 4 about here

Figure 2 presents a graphic representation of the interaction between orientation and factor. A posteriori comparisons utilized Tukey's HSD procedure. Systems-oriented items were rated significantly higher on Factor I than on Factor II $q = 10.91$, $p < .05$. The reverse was true for non-systems items, i.e., non-systems items were rated significantly lower on Factor I than on Factor II, $q = 10.64$, $p < .05$. Comparison between systems and non-systems items on each factor required the pooling of estimates of error variance and the calculation of an approximate critical value of Tukey's statistic, $q'_{.05} = 2.88$. According to this procedure, systems-oriented items were rated significantly higher than non-systems items on Factor I, $q = 8.19$, $p < .05$, and significantly lower than non-systems items on Factor II, $q = 4.02$, $p < .05$.

Insert Figure 2 about here

To understand better the points of convergence and divergence between the two perspectives, factor score differences were calculated for each of the 44 Q-sort items representing the two factors. The five items which generated the greatest consensus (ie., the smallest factor score differences) and the greatest disagreement (ie., the greatest factor score differences) were examined (These items appear in Table 5). This approach differs from the earlier interpretive strategy in that the items selected were not necessarily ones that were accorded high (or low) priority on the factors. Instead, the focus was on agreement or disagreement, ie., small or large absolute differences between item rankings on the two factors.

Insert Table 5 about here

Four of the five consensus items (39, 41, 22, and 18) were endorsed from both points of view, ie., the items received positive factor scores on each factor (This reflects item rankings at the midpoint of 5 or higher on the original Q-Sort distribution where category 1 was defined as "Least Agree" and 9 was "Most Agree"). Thus, the beliefs

that behavior--maladaptive and adaptive--is often learned, that therapeutic change results from change in problematic interpersonal interactions, and that understanding client contact with other agencies and professionals is valuable were shared by the two perspectives. Also, stressful family surroundings are thought to have an adverse effect (ie., cause relapse) in many psychiatric conditions.

One consensus item (item 17) had negative factor scores on both factors and thus was rejected from both perspectives. The item proposes that psychiatric hospitalization be viewed as an opportunity for patients and families to rest and recover when they've reached a point of extreme frustration and exhaustion.

Instead of reflecting differing levels of agreement or disagreement, difference items identified areas of extreme divergence between the points of view. In every case, items that received positive factor scores on one factor were matched with negative factor scores on the other factor. For instance, though it did not place highly on factor I (averaged Q-sort rank = 5), the idea that therapists should assume there is no organic basis for deviant behavior (item 28) was the lowest ranked of the 44 items on factor II. Similarly, interactional formulations of deviant behavior were endorsed on factor I but were rejected on Factor II. Thus the notion that hospitalization may stabilize deviant family structure and perpetuate problems (item 3) received a high positive factor score on factor I and an extreme

negative score on factor II. The same was true of the statement (item 42) that pathology exists in the relationships between people, not within individuals.

Conversely, the notion that careful diagnosis facilitates the matching of client and treatment modality (item 10) was endorsed on factor II and rejected on factor I. And, the idea that hospitalization is necessary to change severely regressed or dangerous behavior (item 16) ranked high on factor II and low on factor I.

In sum, the two clinic orientations agree on the importance of understanding the client and his or her social and treatment context. Also, both view good and bad behavior as learned and agree that change occurs with change in the way people behave toward one another. The idea that hospitalization serves only as respite for clients and families is rejected.

The greatest disagreement between the orientations occurred in response to interactional (as opposed to individually-based (eg., organic) formulations of deviant behavior and to the use of hospitalization when deviant behavior becomes severe. The clinics associated with Factor I tended to conceptualize problems in terms of difficulty in the relationships between people while the other clinics focused on difficulty within people.

Clients and Clinicians.

As shown in Table 6, 31 clinicians participated in the study. They ranged in age from 28 to 57 with an overall

mean age of 36 years. Roughly 65% of clinicians were women. Nursing, counseling, social work and psychology disciplines were represented with the majority, ie., more than 70%, of clinicians trained to the Masters level. The overall mean time of employment was just over four years. The mean number of years of clinical experience was over seven years.

Insert Table 6 about here

Analyses of clinician demographic data revealed no significant differences between the clinics with respect to number of years of clinical experience, $F(4,26) = .71$, $p > .05$, clinician sex, $F(4,26) = 1.45$, $p > .05$, or academic discipline, $\chi^2(12) = 19.48$, $p > .05$. Clear differences were apparent, however, as regards clinician age, $F(4,26) = 4.85$, $p < .05$, number of years employed at the clinic, $F(4,26) = 4.27$, $p < .05$, and educational level, $F(4,26) = 8.71$, $p < .001$.

A posteriori comparisons utilized the least significant difference (LSD) test from the Statistical Package for the Social Sciences (Nie, 1975). Williamsburg clinicians tended to be older, employed longer and were less highly educated than their colleagues at the other four centers. No other clinic differences were significant. These data are summarized in Tables 7, 8, and 9.

Insert Tables 7, 8 and 9 about here

As shown in Table 10, prescreening data were collected on 171 clients. The mean ages ranged from 34 at the Gloucester clinic to 44 at the Warsaw Clinic. The overall mean age was 36. Just over half of the clients prescreened were married. More than two thirds were white. More than half had less than a high school education. Only about a fourth were employed at the time of prescreening.

Insert Table 10 about here

For the most part, client demographics were comparable across the clinics. No differences were apparent as regards client age, $F(4,165) = 1.61$, $p > .05$, sex, $\chi^2(4) = 6.85$, $p > .05$, education, $\chi^2(12) = 18.55$, $p > .05$, marital status, $\chi^2(16) = 15.04$, $p > .05$, employment status, $\chi^2(8) = 6.10$, $p > .05$, number of weeks hospitalized in the year prior to prescreening, $F(4, 120) = .76$, $p > .554$, or number of hospitalizations over the last five years, $F(4,166) = .78$, $p > .05$.

The race of clients prescreened did differ between the clinics, $\chi^2(8) = 20.10$, $p < .05$. Roughly equal numbers of white and nonwhite clients were seen at the Williamsburg and Saluda clinics. In contrast, white clients outnumbered

nonwhites by a margin of at least three to one at the other three clinics.

Severity of symptoms also differed among the five clinics, $F(4, 165) = 4.14, p < .05$. Table 11 shows that Manassas and Gloucester clients displayed more severe symptoms than clients at Saluda or Williamsburg.

Insert Table 11 about here

The Prescreening Data.

Prescreening surveys were completed during the months of April, May, June, July and August of 1984. The Gloucester, Saluda, Warsaw, Williamsburg and Manassas clinics provided data on 71, 15, 11, 39 and 35 cases respectively.

Interviews with staff and administrators at the conclusion of the study indicated excellent (near 100%) sampling for the Gloucester, Williamsburg and Saluda clinics. In contrast, compliance at the Manassas and Warsaw clinics was extremely poor. Prescreening forms (many with items or sections omitted) were returned on less than half of clients evaluated for hospitalization at Manassas. The clinic research specialist who monitored the implementation of study procedures reported considerable reluctance among clinicians to participate in the study, an uneven pattern of form completion and an apparent inclination to complete forms only when hospitalization had been recommended.

Though they were more thorough in filling out forms, Warsaw clinicians also tended to complete forms only when hospitalization had been recommended, yielding an apparent hospitalization rate in excess of 90%.

Since non-compliance clearly was not random at the Warsaw and Manassas clinics, it is impossible to know the extent to which data from the two clinics are representative of cases screened and, by extension, of clinician behavior across the range of clients and clinical situations. Moreover, diversion rates for the two clinics are meaningless, ie., therapists minimized the diversion rate by completing forms only in cases where hospitalization was recommended.

For these reasons, prescreening data from the Manassas and Warsaw clinics will be excluded from all subsequent analyses. Testing of the main hypotheses will be based only on prescreening data obtained from the Gloucester, Williamsburg and Saluda clinics (Summary data from all clinics can be found in Appendix H). Prescreening data generated at the Gloucester clinic will be contrasted with combined data from the Williamsburg and Saluda clinics, reflecting, respectively, the systems and nonsystems clinic orientations as defined in the Q-factor analysis above.

Before proceeding on to the testing of the main hypotheses, however, it should be noted that the pattern of differences in client characteristics remains about the same when data from the Warsaw and Manassas clinics are excluded.

Comparing Gloucester clients to clients at the Saluda and Williamsburg clinics yields no differences with respect to client age, $F = 1.41$, $p > .05$, sex, $F = 1.03$, $p > .05$, marital status, $\chi^2 = 2.24$, $p > .05$, education, $\chi^2 = 7.67$, $p > .05$, employment status, $\chi^2 = .86$, $p > .05$, or five year hospitalization history, $F = 1.07$, $p > .05$.

Clinic differences on race and ratings of symptom severity remain. Gloucester clinicians saw significantly fewer non-white clients than did Saluda and Williamsburg, $\chi^2(1) = 5.70$, $p < .05$. Gloucester clinicians also rated the severity of presenting symptoms higher than did clinicians at Saluda and Williamsburg, $\chi^2(3) = 10.58$, $p < .05$.

The relationships between clinician characteristics change somewhat when data from Manassas and Warsaw is excluded. Previously, clinicians differed in terms of age, number of years employed at the clinic and educational level. Now, Gloucester clinicians show no differences from their colleagues at Saluda/Williamsburg on these variables, ie., age, $t(14) = .35$, $p > .05$, number of years employed at the clinic, $t(14) = .73$, $p > .05$ and educational level, $\chi^2(3) = 4.92$, $p > .05$. As before no differences are apparent with respect to clinician sex, $\chi^2(1) = 2.19$, $p > .05$, academic discipline, $\chi^2(3) = 4.14$, $p > .05$ or number of years of clinical experience, $t(14) = .20$, $p > .05$. In sum, clinician demographics show no significant differences between the Gloucester and Williamsburg/Saluda clinics.

Test of Main Hypotheses

Hypothesis I: Family-systems clinics/clinicians will recommend hospitalization less often and their clients will have fewer hospital days during the month following prescreening.

No support was obtained for this hypothesis. Clinics did not differ in terms of frequency of recommendations for hospitalization, $\chi^2 (1) = 1.80, p > .05$, actual hospitalizations following prescreening, $\chi^2 (1) = 2.08, p > .05$, frequency with which clients returned home after the prescreening, $\chi^2 (1) = 1.11, p > .05$, or number of days spent in the hospital in the month following prescreening, $F (1,70) = 1.04, p > .05$.

Pearson product-moment correlations computed between all prescreening variables and the two disposition variables, ie., "hospitalization recommended" (hosprec) and "hospitalization occurred" (hsptlzd) do not suggest a straightforward relationship between theoretical orientation and the kinds of case or client variables emphasized by clinicians. Correlations were computed for all prescreenings combined and then for the Gloucester and Saluda/Williamsburg clinics independently.

Looking first at correlations computed on all prescreenings (ie., across all three clinics) there is no correlation between either disposition variable and client age, $r_{\text{age.hosprec}} = .09, p > .05$, $r_{\text{age.hsptlzd}} = .04, p > .05$; sex, $r_{\text{sex.hosprec}} = -.05, p > .05$, $r_{\text{sex.hsptlzd}} = -.05, p > .05$; marital status, $r_{\text{mar.hosprec}} = -.07, p > .05$,

$r_{\text{mar.hsptlzd}} = -.04, p > .05$; race, $r_{\text{race.hosprec}} = -.06, p > .05$, $r_{\text{race.hsptlzd}} = -.02, p > .05$; or history for previous hospitalization, $r_{\text{prevhosp.hosprec}} = .12, p > .05$, $r_{\text{prevhosp.hsptlzd}} = .09, p > .05$.

However, disposition was related to symptom severity, $r_{\text{sev.hosprec}} = .16, p < .05$, $r_{\text{sev.hsptlzd}} = .23, p < .05$; availability of a relative to supervise the client, $r_{\text{avail.hosprec}} = -.27, p < .05$, $r_{\text{avail.hsptlzd}} = -.21, p < .05$; and dangerousness to self, $r_{\text{dang.hosprec}} = .24, p < .05$, $r_{\text{dang.hsptlzd}} = .21, p < .05$. Further, though not correlated with actual hospitalization, client education was inversely related to recommendation for hospitalization, $r_{\text{ed.hosprec}} = -.20, p < .05$. And, current client employment was inversely related to actual hospitalization, $r_{\text{emp.hsptlzd}} = -.18, p < .05$, but not to recommendation for hospitalization.

These relationships increase but remain largely unchanged in direction when only the disposition of Gloucester clients is examined. Symptom severity, $r_{\text{sev.hosprec}} = .3007, p < .05$, $r_{\text{sev.hsptlzd}} = .38, p < .001$; availability of a relative to supervise the client, $r_{\text{avail.hosprec}} = -.43, p < .001$, $r_{\text{avail.hsptlzd}} = -.45, p < .001$; and dangerousness to self, $r_{\text{dang.hosprec}} = .33, p < .01$, $r_{\text{dang.hsptlzd}} = .40, p < .01$ all retain strong relationships with case disposition. Additionally, client race, $r_{\text{race.hosprec}} = .25, p < .05$, diagnosis of schizophrenia, $r_{\text{schiz.hosprec}} = .32, p < .01$, $r_{\text{schiz.hsptlzd}}$

= .49, $p < .001$, recent bizarre behavior, $r_{\text{biz.hsptlzd}} = .33$, $p < .01$, previous hospitalization, $r_{\text{prevhosp.hosprec}} = .29$, $p < .05$, $r_{\text{prevhosp.hsptlzd}} = .24$, $p < .05$, and contact with police during the prescreening process, $r_{\text{police.hosprec}} = .30$, $p < .05$, $r_{\text{police.hsptlzd}} = .35$, $p < .01$ showed significant correlations. Of these, only the inverse relationship between availability of a relative and hospitalization makes sense from a systems perspective. The remaining variables have more to do with the clinical management of a case (ie., dangerousness to self, contact with police) or with selected client variables (ie., symptom severity, education, employment, past hospitalization) and as such reflect an individual rather than a systems focus.

Comparatively, correlations computed from the Williamsburg/Saluda data present a straightforward picture. Even so, both systems-oriented and nonsystems-oriented variables appear to be important. Of the relationships noted above, only symptom severity was significantly correlated with case disposition, $r_{\text{sev.hosprec}} = .67$, $p < .0001$, $r_{\text{sev.hsptlzd}} = .58$, $p < .0001$. Additionally, though not assessed via the same case variable as above, ie., relative available to supervise, clients' interpersonal context was important. Hospital recommendation and actual hospitalization were less likely when relatives accompanied the client to the prescreening interview, $r_{\text{accompany.hosprec}} = -.33$, $p < .05$, $r_{\text{accompany.hsptlzd}} = -.31$, $p < .05$ or when instructions were give to relatives as to how to manage

the client, $r_{\text{instruct.hosprec}} = -.50, p < .001,$
 $r_{\text{instruct.hspt1zd}} = -.54, p < .001.$

In sum, regardless of theoretical orientation, clinician decision-making appears to have taken into account both systems and nonsystems-oriented case and client variables. Gloucester clinicians who uniformly represented a strong systems orientation relied on symptom severity, dangerousness, race, and hospitalization history in addition to the availability of relatives. In addition to symptom severity, Williamsburg/Saluda clinicians attached importance to the availability of relatives and to the giving of instructions on how to contain clients during the crisis.

Hypothesis II: Family-systems clinicians will more often (a) investigate the client's immediate interpersonal network, (b) contact, assess and engage other family members (or significant others) in treatment, and (c) organize and direct them vis-a-vis supervising the client and managing the crisis in the natural environment.

Gloucester clinicians more often investigated clients' "interpersonal support alternatives", $\chi^2(1) = 17.31, p < .0001,$ and evaluated family hierarchies, $\chi^2(1) = 9.95, p < .01$ than did their nonsystems-oriented colleagues at Williamsburg/Saluda. In addition, though there was no difference in availability of family members to supervise the client, $\chi^2 = 1.09, p > .05,$ Gloucester clinicians more frequently asked relatives, friends or other professionals

to participate in the evaluation, $\chi^2(1) = 17.83, p < .0001$. Relatives more often accompanied the client to the prescreening, $\chi^2(1) = 7.19, p < .01$ and they tended to be rated as more cooperative, $\chi^2(1) = 11.91, p < .001$. In dealing with family or friends, Gloucester clinicians were more likely to give specific instructions about how to manage the client, $\chi^2(1) = 19.70, p < .0001$. Finally, Gloucester clinicians contacted a larger number of people during the course of an evaluation than did Williamsburg/Saluda clinicians, $t(90) = 2.42, p < .05$.

Hypothesis III: Family-systems therapists will more often contact other professional helpers involved with the client and organize their participation in a coordinated treatment plan.

Generally speaking, the frequency of contact with other helping professionals was low for both Gloucester and Saluda/Williamsburg clinicians. The most contact occurred with non-physician medical agency staff who were involved in about one quarter of prescreenings. Social service agencies and private physicians were contacted in less than 10 percent of cases. Clergy were contacted less than one percent of the time.

The only significant clinic difference in frequency of contact with other professionals concerned law enforcement personnel. Gloucester clinicians indicated that they had contacted the police or sheriff in nearly half of

prescreenings as compared to less than 20 percent for Williamsburg/Saluda clinicians, $\chi^2 = 6.12$, $p < .05$ (item 45.9). Importantly, however, when they did make contact with other professionals, Gloucester clinicians more often reported that they gave suggestions about how to manage the case, $\chi^2(1) = 4.89$, $p < .05$ (item 58).

Hypothesis IV: Family-systems therapists will less often utilize medical or psychodiagnostic procedures that focus on the individual.

No support was obtained for this hypothesis. Some individually-oriented evaluation techniques were rarely used; others were used with many or most clients. For instance, virtually no clinicians requested or performed psychodiagnostic testing or neurological examination. On the other hand, medical histories were taken on one quarter of clients. Further, the vast majority of clients (nearly 70% at Williamsburg/Saluda and 80% at Gloucester) received a mental status examination during the prescreening process. Table 12 summarizes clinic comparisons related to the use of medical and other individually-oriented assessment procedures.

Insert Table 12 about here

Hypothesis V: Family-systems therapists should less often report the use of physician contacts, medication, and sheltered treatment/support alternatives.

Data show a striking difference in use of physician services. Williamsburg/Saluda clinicians reported that a psychiatrist or other physician had direct contact with clients more than twice as often as Gloucester clinicians, $\chi^2(1) = 8.81, p < .01$. Forty-three percent of Williamsburg/Saluda clients were seen by an M.D. while only about 17 percent of Gloucester clients received direct physician contact.

Similarly, consultation with physicians during the prescreening process occurred significantly more often for Williamsburg/Saluda clients than for Gloucester clients, $\chi^2(1) = 4.94, p < .05$. M.D. consults occurred in less than one third of Gloucester cases while more than half of Williamsburg/Saluda clients received this service.

The differences in utilization of physician services are not attributable to differences in requests for medication evaluations, $\chi^2(1) = 1.18, p > .05$, or in the use/adjustment of medication to better manage clients, $\chi^2(1) = .53, p > .05$. In fact, Gloucester clinicians used the service with a larger percentage of their clients than did clinicians at the two nonsystems clinics.

No clinic differences were evident as regards the placement of clients not hospitalized as a result of the prescreening evaluation. Virtually no clients were placed

in group homes, transitional living situations, foster care homes or specialized care facilities. The greatest percentage went to jail or went to live with relatives or friends. Table 13 summarizes these data.

Insert Table 13 about here

Hypothesis VI: Symptom severity and hospitalization history will be less highly correlated with decision to admit for systems-oriented therapists than for other therapists.

Data are equivocal as regards this hypothesis. As predicted, the correlation between symptom severity and recommendation to admit was significantly smaller for clients prescreened at Gloucester ($r_{\text{sev.hosprec}} = .30$, $p < .05$) as compared to Williamsburg/Saluda ($r_{\text{sev.hosprec}} = .65$, $p < .001$), $t(119) = 2.98$, $p < .01$. However, the predicted pattern was reversed for hospitalization history. Recommendation to admit was uncorrelated with hospitalization history for non-systems clinicians, $r_{\text{prevhosp.hosprec}} = -.11$, $p > .05$, but was significantly correlated for systems-oriented clinicians, $r_{\text{prevhosp.hosprec}} = .29$, $p < .05$. As in the case of symptom severity, the difference between the two correlations was statistically significant, $t(119) = 1.99$, $p < .05$.

Theoretical Orientation and Client Disposition

In an attempt to further specify the variables

associated with clinician decision-making, stepwise multiple regression analyses were performed on data produced by systems and nonsystems clinicians. Predictor variables included all client and case variables sampled in the prescreening survey. Criterion variables included the two measures of client disposition (hospitalization recommended and actual hospitalization). Variables accounting for less than five percent of unique variance in the criterion were not selected as useful predictors.

Four client/case variables were identified as useful predictors of recommendation to hospitalize among systems-oriented clinicians. Together the four variables accounted for 45.5% of criterion variance. Table 14 presents the Pearson correlations, usefulness index, and tests of significance for these predictors. It can be seen that availability of a relative to supervise the client accounted for 17.0% of the variance, validating the importance of the interpersonal context for these clinicians. Interestingly, however, the remaining variables concerned aspects of individuals. Symptom severity accounted for 13.7% of the variance. Dangerousness to self and client race each accounted for 7.4% of the variance. In effect then, while interpersonal context was important, actual decision-making had more to do with individuals than with systems. Nonwhites, persons with more severe symptoms, and persons judged dangerous to themselves were more likely

to be recommended for hospitalization. Together these three variables accounted for 28.5% of criterion variance.

Insert Table 14 about here

A second set of four case/client variables was identified in the prediction of actual hospitalization (This analysis is summarized in Table 15). Together, they accounted for 55.5% of criterion variance. As above, the availability of relatives to supervise the client was an important predictor of hospitalization, accounting for 13.1% of the variance. However, variables reflecting characteristics of individuals were far more important in clinician decision-making. Diagnosis of schizophrenia was the best predictor, accounting for 23.6% of criterion variance. Dangerousness to self accounted for 12.9% of the variance. Symptom severity accounted for 6.0%. Clearly, as in the example above, individually-oriented case/client variables figured prominently in the actual hospitalization of clients seen by systems-oriented clinicians.

In sum, while systems-oriented clinicians clearly attended to aspects of the client's interpersonal context, they gave relatively more weight to characteristics of individuals. Thus, while relatives' supervision of clients was an important predictor of disposition, factors relating to the individual accounted for more than 28% of the

variance in "hospitalization recommended" and more than 42% of the variance in actual hospitalization.

Insert Table 15 about here

Stepwise regression analyses also were performed on data generated by individually-oriented clinicians. With "hospitalization recommended" as the criterion, regression analysis yielded four predictor variables which together accounted for more than 68% of the variance. Symptom severity emerged as the best predictor, accounting for 43.2% of the variance. Medical/biological factors then took precedence with diagnosis of an "organic" condition accounting for 10.2% of the variance and observation of a "medical condition requiring ongoing treatment" accounting for 7.6% of the variance. Finally, 7.4% of the variance was determined by whether the client was accompanied to the prescreening interview by a relative. Persons with organic conditions and persons not accompanied by a relative were more likely to be recommended for hospitalization. Persons with a medical condition requiring ongoing treatment were less likely to be hospitalized. These results are summarized in Table 16.

Insert Table 16 about here

Symptom severity, diagnosis of organicity and the giving of instructions to relatives on how to manage clients emerged as the best predictors of actual hospitalization for individually-oriented clinicians. Together, these three variables accounted for 54.1% of the variability. As above, the best predictor was symptom severity with 33.0% of the variance. "Instructions" accounted for 11.47% of the variance with hospitalization being less likely when guidance was given. An additional 9.7% of criterion variance can be explained by the diagnosis of an organic condition. These results are summarized in Table 17.

Insert Table 17 about here

As in the case of systems-oriented clinicians, judgements about hospitalization and actual hospitalization were mediated in large part by characteristics of individuals. Sixty one percent of the variability in "hospitalization recommended" can be explained in terms of factors related to the individual. And, fully 40% of the variance in "actual hospitalization" is accounted for by only two variables -- symptom severity and the diagnosis of organicity. Though important, variables related to clients' interpersonal context assumed a comparatively minor role.

In sum, contrary to study predictions both systems and nonsystems-oriented clinicians attended to their clients

interpersonal context and to characteristics of the clients themselves. Though systems clinicians emphasized contextual issues somewhat more than their nonsystems colleagues, it was clear that both clinician groups placed great weight on diagnostic variables and on variables that carried implications for immediate client containment such as dangerousness and severity of presenting symptomatology.

Discussion

This study focused on three sets of issues: 1.) the measurement of theoretical orientation via Q-technique; 2.) the relationship between the points of view that emerged in the Q-sort study and actual clinician behavior in field settings; and 3.) the relationship between clinicians' behavior and client disposition (Clinician decision-making and actual hospitalization are considered outcome variables only in the narrowest sense. The focus here was on the relationship between theory and practice, not on the relative effectiveness of systems versus nonsystems approaches). This section will summarize and interpret the findings in each of these areas and discuss various conceptual and methodological limitations of the study.

Paradigms

"One may ask therapists to label themselves, but over half will disavow any systematic, organized, articulated theory held in common with others" (Sundland, 1977, p. 190), preferring instead to characterize their work as eclectic. This fact, along with the paucity of research on concordance issues, made it crucial that the approach to measuring orientation in this study tap clinician's attributions in a way that avoided the usual nominal designations by school and that would afford maximum freedom to define a point of

view that would contain implications for "specifiable classes of actual therapist behavior with patients" (Sundland, 1977, p. 215).

Q-technique deals fundamentally with individuals' subjectivity. "If value preferences are at issue, the most sensible and straightforward strategy is to ask a person to provide a synthetic picture of what his value preferences are, and one crude way of doing this is to instruct him to model his preferences in a Q-sort" (Brown, 1980, p. 53). Though the method has obvious limitations (associated in large part with the representativeness and breadth with which Q statements sample relevant content domains) the method permits subjects to express their own point of view instead of responding within a structure or point of view imposed upon them. The task allows subjects to combine Q statements in new and unique ways, permitting the emergence of unanticipated behavior. If factors or idealized points of view do emerge, they are unencumbered by the investigator's preconceived notions. Instead, they reflect patterns of similarity between respondents; in effect, factors are nothing more than clusters of persons who have ranked Q statements in a similar fashion. The structured Q-sort designed for this study contained "best guess" items intended to represent systems and nonsystems notions about the nature of problems, assessment and intervention, and specific beliefs about psychiatric hospitalization. As such, it allowed clinicians to select among a range of

philosophical notions as well as specific ideas and techniques that could later be compared with actual in-session behavior.

As mentioned above, a major limitation of the technique concerns the adequacy with which Q-statements sample a particular content domain. Two approaches, random and structured Q-sorts, are possible. In the first, statements presumably relevant to a particular dimension or variable are selected. The only criterion for inclusion is that they relate to a single broad dimension; the hope is that the items are representative of a theoretically infinite population of items describing the dimension. The structured Q-sort, in contrast, is built from items reflecting one or more variables relevant to a particular theory or hypothesis, ie., domains "are partitioned in one or more ways" (Kerlinger, 1973 p. 588). This added precision provides a way of tailoring items to the situation at hand (in this case ideas related to hospitalization and to specific methods of practice), defining items so as to be theoretically important and ensuring that they more adequately represent content domains. For these reasons and in order to facilitate the description of points of view from a common framework, the structured method was used in this study. The remainder of this section will compare and contrast the points of view that emerged.

Factor I, the systems view, tended to be defined pragmatically in terms of specific applications or

techniques. The ideas endorsed suggested a way of working that is planful and strategic, that assumes an active, directive stance in working with clients, and that values an assessment of the social context in which problem behavior occurs in preference to the assessment of individuals.

Beliefs about the nature of problems emphasized the idea that problem behavior exists in relationship systems, not in individuals. Similarly, the problem unit was seen as involving at least two people.

Hospitalization was portrayed in a strongly negative light. It was seen as a way of stabilizing deviant family systems so as to actually perpetuate problem behavior. It was not viewed as a useful treatment, even for "severely disturbed" individuals "displaying high levels of symptomatic behavior".

In sum, the systems view that emerged in this study marked the importance of an interactional/organizational view of problems and problem resolution. The method was portrayed as active, strategic, and directive and it thoroughly rejected hospitalization as a treatment alternative even in the most severe circumstances.

Technical issues also were emphasized in items most strongly endorsed by nonsystems therapists. However, their view of intervention emphasized emotional and experiential variables; therapy was defined in terms of an opportunity for increased emotional awareness and self-knowledge. Further, treatment was described as a process which requires

the active cooperation and participation of the client. Ideas about assessment stressed the careful diagnosis of individuals' pathology. Problems were seen as residing within individuals and an historical notion of problem development was introduced, ie., problems were identified with "stressful or unresolved earlier experiences". With severe disturbance, hospitalization was seen as an appropriate treatment alternative.

Comparing the two models, nonsystems therapy as defined in this study was concerned with therapist/client relationship and experiential issues and it emphasized active client participation. These therapists looked to the client to cooperate and involve themselves in the interpersonal exchange. Systems therapists, in contrast, ignored the notion of an evolving client/therapist relationship and instead concerned themselves with how to efficiently move clients via reframing, careful joining with the system, and use of the appropriate language. Assessment reflected these different emphases; systems therapists identified with issues of organizational structure while nonsystems therapists looked to the individual and his or her background. Accordingly, problems were seen as residing within relationships or individuals for systems and nonsystems therapists respectively. Hospitalization was an acceptable alternative under appropriate circumstances for nonsystems therapists. Systems therapists rejected hospitalization under any circumstances.

Looking only at ideas strongly endorsed (or ranked lowest) by the two groups of therapists is somewhat misleading in that there were areas of substantial agreement. For instance, the models agreed on the importance of careful assessment of clients' social and treatment context, particularly as regards the involvement of other therapists and agencies. A pragmatic view of change and the nature of problems was suggested in the endorsement of notions that good and bad behavior is learned and can be modified via changes in the way people organize their behavior toward one another. Finally, as regards hospitalization, both models rejected the view that it should provide only respite for clients and families when they've reached a point of frustration and exhaustion.

In sum, the orientations that emerged in this study closely parallel ideas put forth by major proponents of family-systems and traditional individually-oriented theories of therapy as defined elsewhere in this study. The positions were unambiguous and internally consistent and the lines of division were clear, ie., virtually all clinicians within a particular clinic loaded only on one of the two factors, setting the stage for clinic as opposed to clinician comparisons. Though similarities existed between the models, different techniques and different areas of focus were consistently endorsed, reflecting fundamental differences in beliefs about the nature of problems and the relevant breadth of context in which to view them. If

Fisch, Weakland and Segal (1982) are correct in their assertion that theory will "influence the kind of data [the clinician] will focus attention on . . . [and] what he will say and do" (p. 5), then these clinicians should indeed have done different things as they prescreened clients for psychiatric hospitalization.

A final technical note concerns an issue of confounding between the independent variable of conceptual orientation (with its focus on--and direct assessment of--beliefs about hospitalization) and the dependent assessment of decision-making regarding hospitalization. The focus of the study was on concordance between theory and practice; the primary purpose was to determine in a field setting whether or not systems therapists actually do what they say they do--in this case, prevent hospitalization. Accordingly, the focus on hospitalization in the Q-sort was unavoidable. However, to minimize experimental demand characteristics, the Q-sort measure of theoretical orientation was administered after prescreenings had been completed.

Paradigms and Practices

As compared to nonsystems therapists, systems therapists (a) contacted more people, (b) more often asked for and received family members' participation and rated them as more cooperative, (c) more often evaluated the interpersonal context of the identified client as regards its organizational characteristics and available support alternatives, and (d) more often gave instructions on how to

manage clients. Further, when other professional helpers were contacted during the course of a prescreening, systems therapists more often gave suggestions on how to manage the case. All of these behaviors are fully consistent with a systems approach. Together, they suggest an active, directive therapeutic stance that emphasized the social context in which problem behavior occurred.

These same therapists also regularly conducted certain individually-oriented assessments commonly associated with medical/psychiatric models. Specifically, they conducted mental status exams (82% of cases), social and family histories (41% of cases), client and family medical histories (24% of cases) and requested medication consultations (21% of cases). These behaviors are fundamentally inconsistent with a systems view as they focus on historical information or on information concerning individuals.

No differences were apparent between clinician groups in the use of certain other medical and psychodiagnostic procedures. Psychological and neurological testing, lab work and physical examinations were almost never used, presumably because they would have limited relevance in a crisis situation.

Differences also were not apparent in the use of sheltered treatment/support alternatives such as group homes, foster homes or other specialized care facilities. As in the case of specialized diagnostic and physical exams,

neither group of clinicians made use of these sorts of placements with any regularity and so the lack of difference is largely uninterpretable. It should be noted that these types of placement alternatives were essentially non-existent in both catchment areas (The only exception was an extremely limited number of supervised apartments in Williamsburg.).

Clearly, in many respects, systems therapists behaved in accordance with their point of view and with study predictions. However, they also used methods traditionally associated with medical/psychiatric models. They regularly employed methods that involved physicians (medication consult) and that were aimed at identifying etiological variables (family and social history, medical history) and clarifying diagnostic issues (mental status exam). In view of the frequency with which these practices were employed, it is fair to say that systems therapists adopted a dual focus, combining family systems issues with a clear focus on individual pathology.

One would expect that requests for medication consultation would virtually never occur among systems therapists. Haley comments, for instance, that "medical theories and the medications that have followed from them have not solved the problem. The organic theory was obviously a disaster and has become a heavy burden to psychiatry" (1980, p. 12). Further, the Q-sort description that systems therapists provided of themselves in this study

ranked the notion that medications play an important treatment role thirty-fourth among the 44 items. Nevertheless, systems-oriented clinicians reported medication consults in more than one fifth of cases (Though the difference was not statistically significant, systems clinicians actually reported these requests for a greater percentage of clients than did nonsystems clinicians.). This was true despite the fact that there were significantly fewer direct physician contacts or consults (of an unspecified nature) for clients prescreened by systems clinicians, a fact that suggests a particular emphasis on medication.

One possible explanation for these data concerns a belief among some systems therapists that the issue of medication can be used strategically to promote rather than inhibit change. Accordingly, considerable effort is often devoted to gaining control over decisions to prescribe, adjust or terminate medication in order to support client compliance or, in fact, to prevent attributions of underlying disease (Haley, 1980; J. Mazza, personal communication, January 1984). Thus, these data may reflect efforts to weave the use of medications into a strategic plan, not the belief that medication is an effective treatment alternative by itself.

Social and family histories, medical histories and mental status exams are much harder to explain.

Systems-oriented assessment and treatment emphasize current

transactions between individuals, not the individuals themselves or problem antecedents. Problem behavior is typically thought of in terms of its stabilizing or protective function with respect to the social situation that surrounds and perpetuates it. In contrast, the investigation of family history, client social development, and client or family medical history suggests acknowledgement of the relevance of early experience or biological predisposition in the expression of deviant behavior and as such is antithetical to the systems view. "The past and past causes of the problem, are ignored, not explored. The focus is on what to do now" (Haley, 1980, p. 45).

Even more puzzling is use of the mental status exam in over 80% of cases. The mental status exam is a practice designed to identify or clarify diagnostic information. As the name implies, the procedure emphasizes individual pathology; it focuses on client orientation, language, structure and content of thought, psychomotor and neurovegetative functioning, etc. This manner of assessment clearly deviates from a systems approach, including the approach defined by therapists in this study. For instance, the most highly ranked Q-item by systems therapists in this study marked the organizational determinants of problem behavior. Other highly ranked ideas identified the problem unit as consisting of at least two people (ranked ninth of the 44 statements) and suggested that pathology exists in

relationship systems, not within individuals (ranked eleventh of the 44 items). All of these notions are fundamentally inconsistent with the intent of the mental status exam. Haley (1980), in fact, specifically warns therapists not to be distracted by bizarre speech, delusion, disorientation or obsession. Instead, such behaviors are portrayed as aspects of communicational deviance that function to stabilize and protect a family system. The prospect of change is lessened to the extent that the therapist focuses on such behavior.

In sum, over and above a clear theoretical and technical focus on organization and interaction, it appears that systems therapists in this study attended directly to the very ideas that Haley suggests will prevent or handicap change. They explored etiology, symptomatology, and, arguably, recommended chemical treatment. Given this dual emphasis in the methods used to evaluate clients and, in turn, the disparate bits of information that would be generated, it is reasonable to question the actual basis of clinician decision-making. How did the different styles of assessment combine to determine client outcome?

Paradigms and Client Disposition

Despite clear differences in prescreening behavior, the hospitalization decision-making of systems-oriented clinicians was indistinguishable from that of their individually-oriented colleagues. Clients returned home, psychiatric hospitalization was recommended and clients were

actually hospitalized at the same rate for both clinician groups.

Perhaps not surprisingly in view of the discussion above, the variables that were highly predictive of decision-making and disposition of clients seen by systems therapists included characteristics of the social context and of individual clients. On the one hand, the availability of relatives to supervise clients during the crisis was an extremely important factor; when relatives were available, systems therapists were less likely to recommend hospitalization and clients were less likely to be hospitalized. Further, as noted above, these therapists more frequently contacted relatives to arrange their participation in the prescreening evaluation. These results identify a clear emphasis on clients' social context as regards both the conduct of and the decision-making around prescreening.

On the other hand, symptom severity, client dangerousness, race and primary diagnosis of schizophrenia also were strongly associated with outcome (Race was an important factor in clinician decision-making; primary diagnosis was important as regards actual hospitalization.). Diagnostic variables actually took precedence over social context in the analysis of factors predictive of actual hospitalization. Together these individually-oriented factors suggest that decision-making and actual disposition depended to a large degree on practical issues related to

client containment and protection, ie., as symptoms worsened or became more bizarre, hospitalization became more likely. One might even speculate that factors relevant to the social context were important within a range of symptom expression and that once the range was exceeded and clients behaved in an extremely bizarre or dangerous fashion, social context issues became less important. Support for this notion is available in a study conducted by Dean, Lee, Pickering and Klinger (1978) who found that ". . . differences in rates of admission for patients where social supports were known compared to unknown were greatest where symptomatology was moderate" (p. 22).

Though interactional variables were much less important, the same general themes were evident among nonsystems clinicians. The involvement of relatives was important. To the extent that relatives accompanied the client, recommendations for hospitalization were less likely. Further, actual hospitalization was less likely when relatives were instructed as to how to manage the client. Despite this, however, individual factors such as symptom severity, diagnosis of organicity and medical issues took precedence in clinician decision-making and actual hospitalization.

Overall, these results closely parallel results from numerous studies that have examined correlates of hospitalization decision-making in widely differing settings among clinicians that represented the full spectrum of

disciplines, orientations and experience levels (Feigelson, Mackinnon, Shands, and Schwartz, 1978; Mendel and Rapport, 1969; Mezzich, Evanczuk, Mathias, and Coffman, 1984; Streiner, Goodman, and Woodward, 1975). Though none of these earlier studies specifically contrasted the behavior of systems and nonsystems clinicians, all marked the importance of social support alternatives, eg., the availability of relatives to assist in the crisis, along with client-focused variables such as symptom severity and dangerousness. Viewed in this context, the decisions of systems-oriented clinicians in this study differed very little from that of other clinicians with widely varying orientations, disciplines and work settings.

This study did not address the question of therapeutic outcome for clients prescreened by systems versus nonsystems clinicians. The outcome measures employed here were narrow in scope, pertaining only to decision-making and very short term client disposition. Accordingly, no conclusions can be drawn regarding the relative effectiveness or therapeutic efficacy of systems versus nonsystems approaches to prescreening. Interestingly, however, recent Virginia Department of Mental Health and Mental Retardation statistics concerning state psychiatric hospital bed utilization rates contain highly suggestive trends as regards relative effectiveness. These trends are not inconsistent with results obtained here in that diversion seems no more likely in systems-oriented clinics.

Applying bed utilization rate statistics to this discussion involved comparing data from catchment areas served by the Gloucester, Saluda and Williamsburg clinics. Unfortunately, the smallest unit by which the State reports these data is catchment area. This severely limits data applicability since one of the catchment areas represented in the study contained clinics that loaded on different factors. Accordingly, figures for the Mid-Peninsula/Northern Neck catchment area which includes the Gloucester (systems-oriented), Warsaw (systems-oriented) and Saluda (individually-oriented) clinics were compared with data from the Colonial Mental Health Center in Williamsburg (individually-oriented). In view of the primarily rural nature of both catchment areas (with few residential or other community support resources), it was anticipated that their statistics would be roughly comparable unless of course diversion efforts are indeed more successful at the Gloucester (and possibly the Warsaw) clinic.

Using 1984 population figures, there were 125 bed days per 1000 population in the Mid-Peninsula/Northern Neck catchment area for fiscal year 1984-85 (Tremaine, 1985). This compares with 109 bed days in Williamsburg. Fiscal year 1985-86 showed 128 bed days in Mid-Peninsula as compared to 120 in Williamsburg (Tremaine, 1986a). Finally, July through October 1986 statistics showed 30 bed days per 1000 population for Mid-Peninsula while Williamsburg showed 26 (Tremaine, 1986b). Though many unidentified factors may

have influenced these data, this trend does not suggest more successful diversion efforts at the Gloucester Clinic as compared to Williamsburg (Location of hospitalization is probably not a factor since a smaller percentage of Gloucester clients were placed in the state system as compared to Williamsburg). Over a period of more than two years (including the time during which this study was conducted), there were consistently fewer inpatient bed days per 1000 population for the Williamsburg catchment area where clinicians did not endorse a strong theory-based commitment to diversion.

Limitations and Implications

The purpose of this study was to evaluate the implications of a systems view for preventing psychiatric hospitalization by examining the behavior of field clinicians who endorsed the point of view. Data obtained in the study suggested that the systems view was in large part implemented in the field, ie., theory and technique were successfully exported outside the training institute. In addition, however, systems clinicians employed certain individually-oriented techniques to evaluate clients. They relied extensively on diagnostic and other individually-oriented variables in their decision-making. And, they diverted no fewer clients from hospitalization than their nonsystems colleagues, Unfortunately, the study provides few clues as to why individually-oriented methods

were used and allows for limited inferences regarding clinician decision-making.

Regarding the inconsistency between practice and theory, Green and Kolevzon (1982) advanced the notion that the family therapy movement remains in an early stage in the sequential building and disseminating of theoretical and technical skill. They suggested that belief systems are more readily available and are more easily acquired than technical skill, and hypothesized that incongruity between belief and practice reflects an inevitable lag in the communication of intervention technique. These notions do not seem applicable to the present research. Gloucester therapists had received extensive practical and theoretical preparation and routinely worked to refine their skills via live supervision (Dorgan, personal communication, Fall 1984). Further, the methods employed were not unclear in their implications for a systems view; they were fundamentally inconsistent with the view that these therapists had professed.

Given the clear choice of both approaches despite claims to the contrary (ie., by way of Q-sort rankings), it makes sense to consider that there may be issues unrelated to theory that encouraged systems therapists to use all the tools at their disposal. A major limitation of the present research was in not anticipating the need to investigate deviation from expected methods of practice by evaluating

the full context within which clinician and client behavior occurred.

The underlying spirit of this study reflected a systems approach in that it was anticipated that the context within which clinicians worked would influence in a dynamic way their beliefs and methods and the behavior of their clients. Measures were designed and implemented in a way so as to preserve as much as possible the ecological integrity of the systems that were to be evaluated. Unfortunately, the study failed to recognize the importance of larger systems within which "clinics" and "catchment areas" were embedded. The complex economic, legal, and political influences on clinician behavior were largely ignored. That such factors were important is evident in the responses of clinicians to an open-ended question concerning these influences contained in the Q-sort questionnaire. State Department of Mental Health and Mental Retardation policy regarding hospitalization practices by disability area, liability issues, civil commitment law and procedures surrounding the issuing of temporary detention orders, concerns regarding personal safety, and the client or family's financial situation are only a few of the sources of influence identified by clinicians in the study. Though, obviously, it was important to define manageable boundaries to the study, future research in the area would do well to attend to the broader context.

A number of additional methodological inadequacies became apparent as the study progressed. Two related issues are of major concern. First, there was no assessment of clinic decision-making practices regarding hospitalization. It is not unusual for clinics to formally (or informally) adopt policies requiring consultation with senior staff and/or physicians at some point during the prescreening process. This consultation could be brief and informal or it could involve the sharing or actual transfer of decision-making authority, with the line clinician then implementing the decision of others. As these practices were not assessed for each clinician, it is not certain that decisions to recommend hospitalization rested solely with the clinicians who completed the prescreening form.

Another problem concerns ambiguity in the definition of prescreening. Surveys were to have been completed whenever a client, relative or referring source suggested that hospitalization may be indicated or whenever the clinician recognized a need to evaluate suicidal or homicidal potential. Considerable decision-making latitude was available under this guideline and there was no independent check to ensure that prescreenings were defined comparably across clinicians or clinics. This significantly limits generalizations that can be drawn from the study, particularly as regards the relative effectiveness of diversion efforts by the two clinician groups. To the degree that clinicians theoretical orientation, work

setting, previous knowledge of the client or family, or other nonrandom factor influenced how prescreenings were defined, diversion rates become uninterpretable.

What conclusions can be drawn from the present study? Most importantly, the study bears on the exportability of systems-oriented methods outside the training institute. In addressing the issue of generalizability from the "parent setting" Gurman and Kniskern (1981) emphasize the importance of "setting effects . . . given the charisma that has characterized so many leaders in the family therapy movement, and the cultism that has so often characterized their followers" (p. 757). Therapists in this study who professed a systems approach provided a model of their orientation that was fully consistent with the approach and that contained implications for specific, quantifiable in-session behaviors. However, actual practice reflected the model only in part. Clinicians' behavior contained elements that were inconsistent with the systems view; these elements challenge the completeness or accuracy of translation to this field setting. Unfortunately, the study fell short in terms of allowing for closer examination of the reasons for this dual focus in assessment behavior. Future research in this area would do well to limit the scope of study to the issue of exportability of method. Accurate definition and understanding of the process by which the method is implemented in the field setting will in turn provide a better foundation for the study of outcome or

relative effectiveness. Such definition in this case would have helped in understanding the unanticipated use of individually-oriented assessment methods such as the mental status exam. Clearly, the use of this sort of procedure could have reflected a variety of issues unrelated to theoretical orientation (or the mixing of models) or clinic policy. For example, liability concerns, concerns regarding uniformity of practice, hospital admission requirements or the requirements of certain magistrates or special justices in issuing temporary detention orders all could have influenced clinicians' behavior toward the use of these methods.

A second, related implication concerns factors that appear to have guided clinician decision-making. Though, again, the study does not help in explaining why systems clinicians attended to issues such as symptom severity, dangerousness, race or diagnosis, it is clear that these variables were highly predictive of decision-making (and of what actually happened to clients). That these variables should not have played a role is obvious. Their importance further challenges the accuracy of translation of the systems model to this field setting and underscores the importance in future research of defining and evaluating the relevance of the broader context within which such decision-making occurs.

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Appendix A

PRESCREENING SURVEY

I. General

1. Age ____
2. Sex:
1. __male 2. __female
3. Education:
1. __less than H.S. 3. __some college
2. __H.S. grad 4. __college grad
4. Marital Status
1. __never married 4. __divorced
2. __married 5. __widowed
3. __separated
5. Racial/Ethnic Group
1. __Black 3. __White
2. __Hispanic 4. __other
6. Is client employed?
1. __part-time (occupation: _____)
2. __full-time (occupation: _____)
3. __not at all
7. Has client ever worked full-time for
six months or more?
1. __no 2. __yes
8. Is client a student?
1. __no 2. __yes
9. Is client currently receiving:
1. __SSI
2. __other public financial
assistance
10. Does the client: (check all that apply)
1. __own home 3. __have private
2. __own car health insurance

II. Living Arrangements and Social Supports

11. With whom does the client live?(check all
that apply)
1. __alone 5. __with child
2. __with parent 6. __w/ other relative

3. with sibling 7. w/ non-relative
 4. with spouse
12. Is client in a supervised living situation?
 1. no 2. yes
13. Are there are close relatives within 50 miles?
 1. no 2. yes 3. don't know
14. Frequency of contact w/ relatives
 1. daily 5. less than annual
 2. weekly 6. no contact
 3. monthly 7. N/A
 4. annually 8. don't know
15. Does client have weekly contact with close friends?
 1. no 2. yes 3. don't know
16. Does client participate regularly in any community organization or religious group?
 1. no 2. yes 3. don't know

III. Legal History

17. Are criminal charges pending against client?
 1. no 2. yes 3. don't know
18. Is client currently on probation/parole?
 1. no 2. yes 3. don't know
19. Has client ever been declared legally incompetent?
 1. no 2. yes 3. don't know

IV. Medical/Psychiatric History

20. Does client have a medical condition which requires ongoing treatment?
 1. no 2. yes 3. don't know
21. Number of psychiatric hospitalizations?
 1. in past year _____
 2. in past 5 years _____
22. Total weeks hospitalized in past year. _____
23. Age at first hospitalization? _____
24. Has client ever been treated for a drug or alcohol problem?
 1. no 2. yes 3. don't know

25. Does client have a drug or alcohol problem now? —
 1. __no 2. __yes
26. Did the client receive outpt. mental health or substance abuse services in the month prior to prescreening? —
 1. __no 2. __yes
27. If not, has the client ever received outpt. mental health or substance abuse services? —
 1. __no 2. __yes
28. Has the client been seen previously at this clinic? —
 1. __no 2. __yes
29. Prior to the current episode did the client have a history of: (check all that apply) —
 1. __suicidal behavior —
 2. __assaultive or homicidal behavior —
30. Did the client take psychotropic medicine in the month prior to prescreening? —
 1. __no 2. __yes
31. If yes, were meds taken reliably? —
 1. __no 2. __yes 3. __don't know
32. What community agencies/helpers were involved with the client in the three months prior to prescreening? (check all that apply) —
 1. __social service agency —
 2. __medical agency —
 3. __physician in private practice —
 4. __law enforcement agency —
 5. __clergy —
 6. __other (_____) —

Part B. Assessment

33. Who requested the prescreening?(check all that apply) —
 1. __family member —
 2. __friend, neighbor —
 3. __client —
 4. __medical agency —
 5. __mental health professional/agency —
 6. __law enforcement agency —
 7. __social service agency —
 8. __clergy —
 9. __other(_____) —
34. When was the prescreening requested? — —

1. ____ / ____ / ____
month day year --
2. hour of day _____ am/pm --
35. When did the evaluation begin? --
1. ____ / ____ / ____
month day year --
2. hour of day _____ am/pm --
36. Who recommended that the client be
hospitalized? (check all that apply) --
1. __relative --
2. __medical agency/M.D. --
3. __social services --
4. __clergy --
5. __attorney --
6. __other(_____) --
37. Total time devoted to prescreening? --
1. __less than 1 hr. 3. __2 to 3 hrs
2. __1 to 2 hrs 4. __more than 3 hrs
38. Where did the prescreening take place?(check all
that apply) --
1. __mental health center --
2. __hospital --
3. __sheriff's dept./jail --
4. __clients's residence --
5. __other(_____) --
39. Did police have contact with the client at
any point during the prescreening process? --
1. __no 2. __yes
40. Did a psychiatrist or other physician
see the client? --
1. __no 2. __yes
41. If not, was a psychiatrist or other
physician consulted? --
1. __no 2. __yes
42. Who accompanied the client to the pre-
screening interview?(check all that apply) --
1. __parent --
2. __spouse --
3. __child --
4. __other relative --
5. __friend/neighbor --
6. __agency staff person or helper --
7. __no one --
8. __other(_____) --
43. Were relatives, friends or other professionals

- asked to participate in the evaluation? —
 1. no 2. yes
44. How many people other than the client
 (eg. relatives, police, other professional
 helpers etc.) did you contact about the case —
 during the prescreening process? _____ —
45. Who was contacted?(check all that apply) —
 1. client's parent —
 2. client's spouse —
 3. client's child —
 4. other relative —
 5. friend —
 6. social service staff —
 7. medical agency staff —
 8. private physician —
 9. law enforcement personnel —
 10. clergy —
 11. other(_____) —
46. What was the relatives' attitude toward
 prescreening? (check all that apply) —
 1. cooperative —
 2. disinterested —
 3. resistant —
 4. wanted to have client hospitalized —
 5. wanted to prevent client's hosp. —
 6. N/A —
 7. don't know —
47. Were relatives or friends available to
 supervise the client during the crisis? —
 1. no 3. N/A
 2. yes 4. don't know
48. How severe were the client's presenting
 symptoms? —
 1. not present
 2. mild
 3. moderate
 4. severe
 5. extremely severe
49. In the week prior to prescreening did the
 client: (check all that apply) —
 1. have trouble at work or school? —
 2. cause complaints from household —
 members?
 3. cause community complaints? —
 4. destroy property? —
 5. display apathetic behavior? —
 6. present danger to self? —
 7. present danger to others? —

8. abuse alcohol?
9. abuse other drugs?
10. steal property?
11. behave in a bizarre or unusual fashion
12. disturb other with inappropriate sexual behavior?
13. other(_____)
50. In the course of the evaluation did you perform or request: (check all that apply)
1. a physical exam?
2. lab work(eg. drug screen, med. level, DST)?
3. client or family medical history?
4. neurological exam?
5. medication consult?
6. evaluation of family hierarchy?
7. genogram?
8. mental status exam?
9. diagnostic psychological or neuropsychological testing?
10. social and family history?
11. investigation of interpersonal support alternatives?

51. What is the client's primary diagnosis?

Part C. Disposition

52. Was hospitalization recommended?
1. no 2. yes
53. To what living situation did the client go when the prescreening was completed?
1. hospital 3. other
2. own residence (_____)
54. If hospitalized, was client admitted voluntarily?
1. no 2. yes
55. Was a commitment hearing held?
1. no 2. yes
56. If yes, where did the hearing take place?
1. hospital 3. other
2. community (_____)
57. Were specific instructions given to relatives or friends about how to manage the client?
1. no 2. yes
58. Were suggestions made to other helpers or

- professionals about how to manage the case? —
 1. __no 2. __yes
59. If client had not been hospitalized would he
 have gone to jail? —
 1. __no 2. __yes
60. Was medication prescribed or adjusted? —
 1. __no 2. __yes
61. If liability was not an issue in this case
 would you have recommended against hospital-
 ization? —
 1. __no 2. __yes
62. Was hospitalization related to drug/alcohol
 use? —
 1. __no 2. __yes
63. If yes, why? (check all that apply)
 1. __severe w/drawal symptoms —
 2. __no supervision from family or others —
 3. __repeated failures with outpt. tx —
 4. __client's request for hospitalization —
 5. __family's request for hospitalization —
64. If not hospitalized, were alternate living
 arrangements made in connection with the
 prescreening? —
 1. __no 2. __yes
65. If yes, where was client to be placed?
 1. __group home —
 2. __jail —
 3. __transitional living situation —
 4. __foster care —
 5. __with relative or friend —
 6. __specialized care facility —
 (_____
 7. __other(_____) —

ONE MONTH FOLLOWUP

THIS SECTION SHOULD BE COMPLETED ONE MONTH
 AFTER THE DATE OF THE INTIIAL PRESSCREENING

66. Was the client hospitalized at any time
 during the followup period? —
 1. __no 2. __yes
 (date:_____)
67. If yes, where was he/she hospitalized? —
 1. __state hospital
 2. __private psychiatric hosp.

- (_____)
 3. __general hospital
 4. __other(_____)

68. Total number of days client was hospitalized during the followup period? _____ _
 69. If client was not hospitalized following the first evaluation, were additional prescreenings conducted during the followup period? _
 1. __no 2. __yes

IF CLIENT HAS REMAINED HOSPITALIZED FROM THE TIME OF THE FIRST PRESCREENING, PLEASE STOP HERE

70. In the month following prescreening, did the client receive outpt. mental health or drug/alcohol services? _
 1. __no 2. __yes
 71. If yes, total number of visits? _____ _
 72. Total number of hours? _____ _
 73. Is outpatient treatment ongoing or recommended? _
 1. __no 2. __yes
 74. Was the client arrested during the followup period? _
 1. __no 2. __yes

This individual presents an imminent danger to himself or others as a result of his mental/cognitive state? No _____ Yes _____

This individual is substantially unable to care for himself as a result of his mental/cognitive state? No _____ Yes _____

This individual is in need of institutional treatment or training? No _____ Yes _____

Is there a less restrictive alternative to institutional confinement and treatment/training? No _____ Yes _____ If so, what?

Is this individual willing or capable of seeking his own admission? No _____ Yes _____

PREDISCHARGE PLANNING: Goals which should be achieved prior to discharge to the community: _____

Nearest Community Aftercare Program: _____

Names and addresses of community support people who can assist in pre-discharge planning, case management, or provide additional admission data:

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

Probable post-discharge needs/problem areas (check appropriate services):

- Housing Counseling/Therapy Educational Legal
- Nutritional Physical Health Vocational/Employment Leisure Time Activities
- Medication Transportation Financial Independent Living Skills
- _____ Other

AUTHORIZATION:

Source of Information: _____

Relationship of Applicant: _____

I hereby authorize _____ (Name of CMHC) to submit prescreening admission data to _____ Hospital.

Date

Signature of Applicant or Petitioner

Date

Signature and Title of Screener

Community Services Board or Community Clinic

APPENDIX C
Q-Sort Items
Assessment

Non-systems

10. Careful diagnosis maximizes the possibility of matching the patient and his disturbance to the most appropriate treatment.
38. The goal of clinical assessment is to construct a working image or model of the client from which intervention strategies can be developed.
23. Knowledge of the client's personality functioning, skills, and deficits is important in developing a treatment strategy.
2. Accurate diagnosis is the cornerstone of effective treatment.
8. A functional analysis identifying the antecedents and consequents of deviant behavior is critical to an appropriate treatment strategy.

Systems

13. One should study family coalitions and apparent power

balances or imbalances in relation to symptomatic behavior.

19. It is important to understand the function served by the client's symptom in the family system.
27. The main goal of assessment is to understand how a client's symptoms are connected to present patterns of family functioning.
36. In evaluating a psychiatric problem, characteristics of the patient are less important than the interactional patterns in which the problem is embedded.
18. It is important to understand how other agencies or therapists are involved with a case.

Intervention/Change

Nonsystems

9. Medications play an important role in the therapeutic management of psychiatric illness.
33. Psychotherapy increases the individual's self-knowledge, emotional awareness and capacity for effective life decisions.
4. Effective treatment involves correcting behavioral, psychological and/or biological dysfunctions of the individual.

5. Because change depends on experiential and emotional learning, the patient's active participation and cooperation are essential.

40. For therapeutic change to occur, there must be new, personally meaningful and emotionally important experiencing within the therapy relationship.

Systems

39. Therapeutic change occurs by interrupting maladaptive behavioral sequences, ie., changing the way people behave toward one another.

14. It is important to join a family or organization before attempting to restructure it.

12. Reframing (redefining the meaning of events and behavior) is an essential ingredient of therapeutic intervention.

15. Suggestions and directives are most effective when they are compatible with the client's (or family's) own idiosyncratic "language".

26. It is not necessary (or even helpful) for the therapist to share his strategy openly with the clients.

Hospitalization

Non-Systems

35. The hospital can offer protection, containment, and a

- therapeutic life space for the patient.
16. Hospitalization is often necessary to interrupt regressive, disruptive or dangerous patterns of behavior.
 15. Suggestions and directives are most effective when they are compatible with the client's (or family's) own idiosyncratic "language".
 20. During initial stages of treatment patients displaying high levels of symptomatic behavior often require management in a closed hospital setting.
 17. Psychiatric hospitalization provides an opportunity for the remission of the patient's symptoms and allows families to rest when they have reached a point of frustration and exhaustion.
 37. The hospital milieu can provide a valuable opportunity for the patient to learn and practice more effective interpersonal functioning.
 30. The hospital environment enables the severely disturbed patient to recognize the compulsive and driven quality of his behavior and to make connections between feeling states and action.
 1. The more tenacious the symptom, the more important it is to separate the patient from a deviant family context via hospitalization in order to promote intensive

involvement in therapy.

Systems

21. It is important for one therapist to be in charge of decisions to hospitalize, medicate, and discharge.
6. Psychiatric hospitalization perpetuates the very problems it is intended to alleviate.
34. Psychiatric hospitals should be closed, torn down, plowed under and then, like Carthage in antiquity, sowed with salt.
29. People are not usually put in mental hospitals because they have symptoms such as delusions and hallucinations, but because they make trouble or are apathetic and will not take care of themselves.
43. Therapeutic change does not occur with hospitalization but rather with returning the client to a normal situation in the community.
3. One way a person can stabilize a family is to develop an incapacitating problem requiring psychiatric hospitalization.
44. Hospitalization perpetuates deviant behavior because it artificially reduces stress in a social system and defines problems in terms of individual dysfunction.

Nature of Problems

Non-Systems

7. Many problems reflect stressful or unresolved earlier experiences.
41. The cause of relapse in many psychiatric conditions is a stressful family environment.
11. The mentally ill are sick people deserving of treatment and humane care.
22. Maladaptive behaviors are, to a considerable degree, acquired through learning, the same way that any behavior is learned.
31. The medical or organic aspects of psychological problems are often underemphasized.

Systems

24. Psychiatric symptoms occur at points of transition in the family life cycle.
42. Pathology exists within relationship systems, not within individuals.
32. It is useful to think of the problem unit as including at least two people.
25. "Therapy" is a growing social problem: As a habit, it can be enormously expensive and time consuming; as a solution, it may only perpetuate the problem.

28. The wisest strategy for a therapist is to assume that there is no organic basis for mad behavior and to proceed as if the problem is a social one.

APPENDIX D

Q-Sort Instructions

The accompanying deck contains 44 statements about therapy, hospitalization and the nature of psychiatric problems. Please rank the items by sorting them into nine categories according to how well they represent your own way of thinking and working. The categories follow a continuum from "most disagree" (category 1) to "most agree" (category 9). For statistical reasons the Q-sort is structured so that a specific number of statements must be placed in each category (eg., 3 in categories 1 and 9; 4 in categories 2 and 8 etc.). The ordering of items within categories is irrelevant.

To help with the sorting, nine category-header cards (which can be spread out across a table) are included at the end of the deck of statements. Sometimes it is easier to sort in stages--for example, by first arranging the items in two or three general categories then making finer discriminations from there.

After the slips of paper have been sorted, copy the item numbers into the corresponding boxes on the attached Q-sort answer sheet.

Thank you for your participation.

3. _____

Is your theoretical orientation reflected in your approach to screening patients for psychiatric hospitalization?

1	2	3	4	5	6	7
not at all			so-so			very well

What factors other than theoretical orientation (eg., clinic policy, legal constraints) influence how you conduct prescreenings. Please explain.

Did the prescreening survey influence how you conducted prescreenings? If so, how?

Comments:

Appendix F

**Items (factor scores) with Highest and Lowest Factor
Scores in the Analysis of Clinician Q-Sorts**

Factor I Items with High Factor Scores

12. Reframing (redefining the meaning of events and behavior) is an essential ingredient of therapeutic intervention. (2.42)
19. It is important to understand the function served by the client's symptom in the family system. (1.51)
44. Hospitalization perpetuates deviant behavior because it artificially reduces stress in a social system and defines problems in terms of individual dysfunction. (1.43)
14. It is important to join a family or organization before attempting to restructure it. (1.43)
3. One way a person can stabilize a family is to develop an incapacitating problem requiring psychiatric hospitalization. (1.24)

Factor I Items with Low Factor Scores

33. Psychotherapy increases the individual's self knowledge, emotional awareness and capacity for effective

life decisions. (-1.19)

8. A functional analysis identifying the antecedents and consequents of deviant behavior is critical to an appropriate treatment strategy. (-1.20)

1. The more tenacious the symptom, the more important it is to separate the patient from a deviant family context via hospitalization in order to promote intensive involvement in therapy. (-1.28)

37. The hospital milieu can provide a valuable opportunity for the patient to learn and practice more effective interpersonal functioning. (-1.53)

30. The hospital environment enables the severely disturbed patient to recognize the compulsive and driven quality of his behavior and to make connections between feeling states and action. (-1.95)

Factor II Items with High Factor Scores

21. It is important for one therapist to be in charge of decisions to hospitalize, medicate and discharge. (2.55)

11. The mentally ill are sick people deserving of treatment and humane care. (1.47)

2. Accurate diagnosis is the cornerstone of effective treatment. (1.37)

18. It is important to understand how other agencies or therapists are involved with a case. (1.25)
10. Careful diagnosis maximizes the possibility of matching the patient and his disturbance to the most appropriate treatment. (1.23)

Factor II Items with Low Factor Scores

3. One way a person can stabilize a family is to develop an incapacitating problem requiring psychiatric hospitalization. (-1.32)
22. Maladaptive behaviors are, to a considerable degree, acquired through learning, the same way that any behavior is learned. (-1.35)
42. Pathology exists within relationship systems, not within individuals. (-1.62)
32. It is useful to think of the problem unit as including at least 2 people. (-1.72)
39. Therapeutic change occurs by interrupting maladaptive behavioral sequences, ie., changing the way people behave toward one another. (-1.84)

Factor III Items with High Factor Scores

5. Because change depends on experiential and emotional learning, the patient's active participation and cooperation are essential. (2.86)

40. For therapeutic change to occur, there must be new, personally meaningful and emotionally important experiencing within the therapy relationship. (1.75)

33. Psychotherapy increases the individual's self-knowledge, emotional awareness and capacity for effective life decisions. (1.45)

23. Knowledge of the client's personality functioning, skills and deficits is important in developing a treatment strategy. (1.26)

8. A functional analysis identifying the antecedents and consequents of deviant behavior is critical to an appropriate treatment strategy. (1.18)

Factor III Items with Low Factor Scores

3. One way a person can stabilize a family is to develop an incapacitating problem requiring psychiatric hospitalization. (-1.41)

28. The wisest strategy for a therapists is to assume that there is no organic basis for mad behavior and to proceed as if the problem is a social one. (-1.43)

1. The more tenacious the symptom, the more important it is to separate the patient from a deviant family context via hospitalization in order to promote intensive involvement in therapy. (-1.46)

11. The mentally ill are sick people deserving of treatment and humane care. (-1.69)

2. Accurate diagnosis is the cornerstone of effective treatment. (-1.82)

Factor IV Items with High Factor Scores

9. Medications play an important role in the therapeutic management of psychiatric illness. (2.36)

32. It is useful to think of the problem unit as including at least two people. (1.55)

19. It is important to understand the function served by the client's symptom in the family system. (1.47)

11. The mentally ill are sick people deserving of treatment and humane care. (1.38)

31. The medical or organic aspects of psychological problems are often underemphasized. (1.31)

Factor IV Items with Low Factor Scores

5. Because change depends on experiential and emotional learning, the patient's active participation and cooperation are essential. (-1.18)

44. Hospitalization perpetuates deviant behavior because it artificially reduces stress in a social system and defines problems in terms of individual dysfunction. (-1.25)

28. The wisest strategy for a therapist is to assume that there is no organic basis for mad behavior and to proceed as if the problem is a social one. (-1.63)

34. Psychiatric hospitals should be closed, torn down, plowed under and then, like Carthage in antiquity, sowed with salt. (1.92)

21. It is important for one therapist to be in charge of decisions to hospitalize, medicate, and discharge. (-2.76)

Factor V Items with High Factor Scores

38. The goal of clinical assessment is to construct a working image or model of the client from which intervention strategies can be developed. (2.86)

39. Therapeutic change occurs by interrupting maladaptive behavioral sequences, ie., changing the way people behave toward one another. (2.08)

2. Accurate diagnosis is the cornerstone of effective treatment. (1.89)

36. In evaluating a psychiatric problem, characteristics of the patient are less important than the interactional patterns in which the problem is embedded. (1.11)

7. Many problems reflect stressful or unresolved earlier experiences. (1.03)

Factor V Items with Low Factor Scores

17. Psychiatric hospitalization provides an opportunity for the remission of the patient's symptoms and allows families to rest when they have reached a point of frustration and exhaustion. (-1.14)

21. It is important for one therapist to be in charge of decisions to hospitalize, medicate, and discharge. (-1.43)

28. The wisest strategy for a therapist is to assume that there is no organic basis for mad behavior and to proceed as if the problem is a social one. (-1.57)

29. People are not usually put in mental hospitals because they have symptoms such as delusions and hallucinations, but because they make trouble or are apathetic and will not take care of themselves. (-1.93)

9. Medications play an important role in the therapeutic management of psychiatric illness. (-2.22)

Factor VI Items with High Factor Scores

38. The goal of clinical assessment is to construct a working image or model of the client from which intervention strategies can be developed. (2.18)

4. Effective treatment involves correcting behavioral, psychological and/or biological dysfunctions of the individual. (1.60)

41. The cause of relapse in many psychiatric conditions is

a stressful family environment. (1.54)

15. Suggestions and directives are most effective when they are compatible with the client's (or family's) own idiosyncratic "language". (1.38)

28. The wisest strategy for a therapist is to assume that there is no organic basis for mad behavior and to proceed as if the problem is a social one. (1.37)

Factor VI Items with Low Factor Scores

1. The more tenacious the symptom, the more important it is to separate the patient from a deviant family context via hospitalization in order to promote intensive involvement in therapy. (-1.34)

2. Accurate diagnosis is the cornerstone of effective treatment. (-1.37)

12. Reframing (redefining the meaning of events and behavior) is an essential ingredient of therapeutic intervention. (-1.44)

10. Careful diagnosis maximizes the possibility of matching the patient and his disturbance to the most appropriate treatment. (-1.87)

31. The medical or organic aspects of psychological problems are often underemphasized. (-2.04)

Factor VII Items with High Factor Scores

2. Accurate diagnosis is the cornerstone of effective treatment. (2.26)
22. Maladaptive behaviors are, to a considerable degree, acquired through learning, the same way that any behavior is learned. (1.95)
10. Careful diagnosis maximizes the possibility of matching the patient and his disturbance to the most appropriate treatment. (1.28)
3. One way a person can stabilize a family is to develop an incapacitating problem requiring psychiatric hospitalization. (1.21)
27. The main goal of assessment is to understand how a client's symptoms are connected to present patterns of family functioning. (1.20)

Factor VII Items with Low Factor Scores

31. The medical or organic aspects of psychological problems are often underemphasized. (-1.34)
34. Psychiatric hospitals should be closed, torn down, plowed under and then, like Carthage in antiquity, sowed with salt. (-1.39)
12. Reframing (redefining the meaning of events and behavior) is an essential ingredient of therapeutic intervention. (-1.42)

17. Psychiatric hospitalization provides an opportunity for the remission of the patient's symptoms and allows families to rest when they have reached a point of frustration and exhaustion. (-1.78)

18. It is important to understand how other agencies or therapists are involved with a case. (-1.89)

Appendix G

**Items With High and Low Factor Scores
In the Analysis of Clinic Q-Sorts**

Factor I Items with High Factor Scores

19. It is important to understand the function served by the client's symptom in the family system. (highest rank)
12. Reframing (redefining the meaning of events and behavior) is an essential ingredient of therapeutic intervention.
14. It is important to join a family or organization before attempting to restructure it.
13. One should study family coalitions and apparent power balances or imbalances in relation to symptomatic behavior.
15. Suggestions and directives are most effective when they are compatible with the client's (or family's) own idiosyncratic "language".

Factor I Items with Low Factor Scores

20. During initial stages of treatment patients displaying high levels of symptomatic behavior often require management in a closed hospital setting.

37. The hospital milieu can provide a valuable opportunity for the patient to learn and practice more effective interpersonal functioning.

31. The medical or organic aspects of psychological problems are often underemphasized.

1. The more tenacious the symptom, the more important it is to separate the patient from a deviant family context via hospitalization in order to promote intensive involvement in therapy.

30. The hospital environment enables the severely disturbed patient to recognize the compulsive and driven quality of his behavior and to make connections between feeling state and action. (lowest rank)

Factor II Items with the Highest Factor Scores

16. Hospitalization is often necessary to interrupt regressive, disruptive or dangerous patterns of behavior. (highest rank)

5. Because change depends on experiential and emotional learning, the patient's active participation and cooperation are essential.

8. A functional analysis identifying the antecedents and consequents of deviant behavior is critical to an appropriate treatment strategy.

33. Psychotherapy increases the individual's self-knowledge, emotional awareness and capacity for effective life decisions.

10. Careful diagnosis maximizes the possibility of matching the patient and his disturbance to the most appropriate treatment.

Factor II Items with the Lowest Factor Scores

3. One way a person can stabilize a family is to develop an incapacitating problem requiring psychiatric hospitalization.

6. Psychiatric hospitalization perpetuates the very problems it is intended to alleviate.

1. The more tenacious the symptom, the more important it is to separate the patient from a deviant family context via hospitalization in order to promote intensive involvement in therapy.

34. Psychiatric hospitals should be closed, torn down, plowed under and then, like Carthage in antiquity, sowed with salt.

28. The wisest strategy for a therapist is to assume that there is no organic basis for mad behavior and to proceed as if the problem is a social one. (lowest rank)

Appendix H

Summary of Prescreening Data (All Clinics)

Variable	Glc	Sal	War	Wms	Man	All
Part A. Background Information						
1. General						
Age(mean yrs.)	34.1	41.2	44.7	35.8	38.3	36.6
Sex(% female)	35.2	20.0	9.1	43.6	42.9	35.7
Education (%)						
Less than H.S.	49.3	33.3	81.8	63.6	58.1	55.2
H.S. grad.	37.3	25.0	9.1	18.2	29.0	28.6
Some college	13.4	33.3	0.0	12.1	9.7	13.0
College grad	0.0	8.3	9.1	6.1	3.2	3.2
Marital Status (%)						
Ever married	47.9	60.0	63.6	68.4	54.3	55.9
Now married	25.4	46.7	18.2	36.8	20.0	28.2
Non-white (%)	21.1	46.7	27.3	41.0	17.1	27.5
Employed (%)						
Full/pt. time	25.7	28.6	27.3	33.3	17.6	26.2
Ever > 6 mos.	58.3	64.3	81.8	76.7	69.2	66.7
Receiving SSI (%)	13.0	38.5	18.2	7.9	12.1	14.0
Any public assist.	18.8	46.2	27.3	23.4	27.3	24.4
Private insurance	27.9	26.7	9.1	21.6	25.8	24.7
2. Living Arrangements and Social Supports						
Lives alone (%)	14.1	20.0	36.4	18.0	17.1	17.5
Lives w/ parents	41.4	35.7	45.5	15.4	31.4	33.1
Lives w/ relative	73.2	80.0	63.6	59.0	71.4	69.6
Close relative						
within 50 miles	93.9	100	81.8	80.0	90.6	89.8
Daily contact						
with relative	68.3	75.0	55.6	50.0	57.1	61.9
Weekly contact w/						
close friend	68.0	66.7	40.0	85.2	21.7	61.1
Participation in						
community or						
religious group	8.7	50.0	33.3	34.8	8.3	17.5

Variable	Glc	Sal	War	Wms	Man	All
3. Legal History						
Criminal charges pending (%)	18.2	53.3	27.3	10.8	12.5	19.3
Currently on probation/parole	2.9	0	0	5.6	6.3	3.8
Ever declared incompetent	0.0	8.3	0.0	0.0	20.0	4.8
4. Medical/Psychiatric History						
Medical condition requiring treatment(%)	36.8	27.3	36.4	33.3	40.7	36.0
Previous psychiatric hospitalization	50.7	60.0	63.6	64.1	65.7	58.5
Weeks hospitalized in past year(mean)	2.3	1.3	.6	4.5	5.1	3.2
Mean age at first hospitalization	24.7	37.0	34.9	25.2	27.9	27.3
Previous drug/alcohol treatment (%)	49.2	62.5	45.5	44.8	33.3	45.7
Drug/alcohol problem now (%)	42.2	26.7	54.6	41.7	45.2	42.0
Outpatient treatment in past month(%)	33.3	28.6	18.2	37.8	29.0	32.1
Previously seen at this clinic (%)	68.6	33.3	45.5	47.4	66.7	58.7
Any psychiatric history (%)	80.3	80.0	72.07	89.7	71.4	80.1
History of:						
Suicidal behavior	32.9	6.7	18.2	10.5	34.3	24.9
Assaultive behavior	36.2	60.0	45.5	18.4	57.1	39.3
Client involved with (%)						
Soc. Svc. Agency	17.9	40.0	9.1	10.3	30.3	20.0
Medical Agency	32.4	20.0	0.0	18.0	14.07	22.2
Private physician	25.0	33.3	27.3	18.0	17.7	22.8
Law enforcement	41.8	53.3	27.3	18.0	32.4	34.3
Clergy	1.5	6.7	9.1	2.6	0.0	2.4

Part B. Assessment

Prescreening requested by:						
Family member (%)	58.6	53.3	45.5	20.5	62.9	49.4
Friend, neighbor	5.7	0.0	0.0	12.8	5.7	6.5
Client	25.7	6.7	9.1	10.3	11.4	16.5
Medical agency	10.0	13.3	0	28.2	8.6	13.5
Mental Health Prof.	10.0	0.0	0.0	7.7	5.7	7.1

Variable	Glc	Sal	War	Wms	Man	All
Law enforcement	20.0	40.0	45.5	18.0	14.3	21.8
Social Svc. agency	4.2	6.7	0.0	2.6	2.9	3.5
Number of different agencies requesting prescreening (mean)	1.4	1.7	0.8	0.9	1.0	1.2
Time from request to evaluation (%):						
Less than 30 min.	19.7	0.0	0.0	26.5	37.0	21.2
30 to 90 minutes	47.0	14.3	20.0	41.2	40.7	39.7
90 min. to 12 hrs.	24.2	64.3	50.0	20.6	22.2	28.5
More than 12 hrs.	9.1	21.4	30.0	11.7	0.0	10.6
Duration of Prescreening						
Less than 1 hr.	2.8	6.7	50.0	21.6	12.1	12.0
1 to 2 hrs.	54.9	53.3	50.0	56.8	51.5	54.2
2 to 3 hrs.	28.2	33.3	0.0	18.9	33.3	25.9
More than 3 hrs.	14.1	6.7	0.0	2.7	3.0	7.8
Prescreening at mental health center (%):	78.9	53.3	81.8	30.8	73.5	64.7
Hospitalization recommended by:						
Relative	55.7	60.0	36.4	30.8	57.1	49.4
Physician	15.7	20.0	18.2	20.5	28.6	20.0
Attorney	5.8	0.0	27.3	5.1	2.9	5.9
M.D. saw client (%)	16.9	6.7	0.0	56.4	44.1	29.4
M.D. consulted (%)	30.4	13.3	45.5	66.7	61.7	44.6
Client accompanied by relative (%)	73.2	60.0	45.5	43.6	57.1	60.2
Relatives or others asked to participate (%)	91.4	60.0	72.7	56.4	91.2	79.3
Number of other people contacted (mean)	3.2	3.3	2.5	1.7	3.2	2.9
Others contacted (%):						
Client's parent	55.7	20.0	36.4	15.4	37.1	38.2
Client's spouse	21.4	20.0	18.2	15.4	17.1	18.8
Client's child	11.4	13.3	9.1	7.7	14.3	11.1
Other relative	27.1	20.0	27.3	10.3	34.3	24.1
Friend	21.1	13.3	0.0	10.3	17.1	15.8
Law enforcement	40.9	26.7	63.6	15.4	28.6	32.8

Variable	Glc	Sal	War	Wms	Man	All
Relatives were cooperative(%):	74.7	46.7	63.6	41.0	62.9	61.4
Relatives wanted client hsptlzd	59.2	53.3	45.5	25.6	54.3	49.1
Relative or friends were available to supervise client:	69.2	61.5	44.4	58.1	59.3	62.8
Severity of symptoms (%)						
Not present	2.8	6.7	50.0	21.6	12.1	12.0
Mild	54.9	53.3	50.0	56.8	51.5	54.2
Moderate	28.2	33.3	0.0	18.9	33.3	25.9
Severe	14.1	6.7	0.0	2.7	3.0	7.8
Problems during the last week (%):						
Trouble at work or school	26.8	46.7	18.2	18.0	14.3	23.4
Complaints from household members	71.8	60.0	63.6	28.2	68.6	59.7
Complaints from community	18.3	20.0	63.6	20.5	37.1	25.7
Destroyed property	18.3	40.0	36.4	5.1	22.9	19.3
Apathetic behavior	39.4	13.3	18.2	15.4	28.6	28.1
Danger to self	57.8	40.0	36.4	18.0	65.7	47.4
Danger to others	35.2	53.3	54.6	15.4	51.4	36.8
Abused alcohol	38.0	20.0	54.6	28.2	28.6	33.3
Abused other drugs	19.7	0.0	9.1	15.4	22.9	17.0
Bizarre or Unusual behavior	54.9	40.0	63.6	25.6	54.3	47.4
Inappropriate sexual behavior	5.6	0.0	9.1	2.6	11.4	5.9
Evaluation Procedures (%)						
Physical exam	5.6	6.7	0.0	10.3	5.9	6.5
Lab work	4.2	0.0	0.0	18.0	2.9	6.5
Medical history	23.9	33.3	36.4	20.5	47.1	29.4
Medication consult	21.1	13.3	18.2	12.8	14.7	17.1
Evaluation of family hierarchy	35.2	13.3	54.6	7.7	29.4	27.1
Genogram	0.0	0.0	27.3	0.0	8.8	3.5
Mental status	81.7	66.7	81.8	69.2	52.9	71.7
Investigation of social support alternatives	80.3	53.3	18.2	38.5	70.6	62.4
Primary diagnosis (%):						
Schizophrenia	21.1	20.0	36.4	28.2	37.1	26.9
Affective disorder	21.1	6.7	9.1	15.4	8.6	15.2

Variable	Glc	Sal	War	Wms	Man	All
Substance abuse	26.8	13.3	54.6	25.6	20.0	25.7
Organic	2.8	13.3	0.0	5.1	5.7	4.7
Adjustment d/o	16.9	0.0	0.0	2.6	8.6	9.4
Retardation	2.8	13.3	0.0	0.0	0.0	0.0

Part C. DISPOSITION

Hospitalization recommended (%)	49.3	40.0	90.0	71.8	77.1	62.0
Client hsptlzd (%)	46.5	40.0	80.0	69.2	64.7	56.8
Living situation after prescreening (%)						
Hospital	46.5	40.0	80.0	69.2	64.7	56.8
Own residence	32.4	33.3	0.0	17.9	17.6	24.3
Other	21.1	26.7	20.0	12.8	17.6	18.9
Hearing if hospitalized (%)	36.8	50.0	80.0	55.2	55.6	50.9
Hearing at hospital (%)	100.0	75.0	44.4	94.1	62.5	78.3
Instructed relatives or friends	83.8	66.7	27.3	32.4	71.2	65.0
Instructed other professionals	78.8	78.6	45.5	50.0	38.7	62.0
Meds prescribed or adjusted (%)	20.6	21.4	0.0	14.7	25.0	18.8
Hospitalization related to substance abuse (%)	50.0	33.3	60.0	48.0	33.3	45.4
Alternate arrangements if not hsptlzd (%)	52.4	25.0	0.0	35.3	33.3	42.0

ONE MONTH FOLLOWUP

Hsptlzd at any time	59.2	54.6	90.9	76.9	92.6	71.0
Where hsptlzd						
State hosp	65.0	100.0	100.0	90.0	100.0	82.4
Private hosp	25.0	0.0	0.0	5.0	0.0	12.1
General hosp	7.5	0.0	0.0	5.0	0.0	4.4

Table 1
Mean Factor Loading Differences on Factor I

Clinic	N	Mean Loading	\bar{X}_4	\bar{X}_2	\bar{X}_5	\bar{X}_1	\bar{X}_3
Wmsbg(4)	8	-.06	-	-.22	-.64*	-.71*	-.82*
Sal(2)	3	.16	-	-	-.42*	-.49*	-.60*
Man(5)	12	.58	-	-	-	-.07	-.18
Glc(1)	5	.65	-	-	-	-	-.11
Warsaw(3)	3	.76	-	-	-	-	-

*p < .05

Table 2

Clinician Q-Sort Factor Loadings*

Clinicians	1	2	3	4	5	6	7
Gloucester	-	-	-	-	-	-	-
S1	.75	-.32	-	-	-	.34	-
S2	.70	-	-	-	-	.51	-
S3	.78	-	-	-	-	-	-
S4	.71	-	-	-	-	-	-
S5	.30	-	-	-	-	.58	.21
Saluda	-	-	-	-	-	-	-
S1	-.30	.31	.44	-	.48	-	-
S2	-	-	.72	-	-	.31	-
S3	.51	-	.69	-	-	-	-
Warsaw	-	-	-	-	-	-	-
S1	.82	-.33	-	-	-	-	-
S2	.67	-	-	-	.42	-	-
S3	.78	-	-	-	-	-	-
Williamsburg	-	-	-	-	-	-	-
S1	-	-	-	-	.84	-	-
S2	-	-	-	.49	.55	-	-
S3	-	.74	-	-	-	-	-
S4	-	-	-	.47	.50	-	.43
S5	-	-	-	.77	-	-	-
S6	-	-	-	-	-	-	.87
S7	-	.34	.51	.56	-	-	-
S8	-	.83	-	-	-	-	-
Manassas	-	-	-	-	-	-	-
S1	.76	-	-	.34	-	-	-
S2	.74	-	-	-	-	.34	-
S3	.52	-	.49	-	-	.37	-
S4	.38	-	.36	-	.40	-	.44
S5	-	-.75	-	-	-	.32	-
S6	.78	-	.34	-	-	-	-
S7	.52	-	-	.62	-	-	-
S8	.82	-	-	-	-	-	-
S9	.38	-	-	.42	-	.34	-
S10	.84	-	-	-	-	-	-
S11	.48	-	-	-	-	.65	-
S12	.47	-	.49	.37	-	-	-
% Variance	37.2	16.4	5.3	4.7	4.7	3.8	3.3

* Principle components extraction of factors with eigenvalues > 1.0; varimax rotation

Table 3

Factor Analysis of Clinic Q-Sorts (based on averaged sorts of clinicians at each clinic)*

Clinic	Factor I	Factor II
Gloucester CMHC	.94	-
Saluda CMHC	-	.83
Warsaw CMHC	.90	-
Colonial CMHC (Williamsburg)	- -	.91 -
Prince William CMHC (Manassas)	.90 -	- -
% Variance	56.5	29.3

* Principle components extraction of factors with eigenvalues > 1.0; varimax rotation

Table 4

Analysis of Variance Summary Table on Factor Scores
Grouped by Orientation and Content Area

Source	SS	df	MS	F
Between Subjects	45.53	39	1.17	
A	4.07	1	4.07	7.98*
C	22.30	3	7.43	14.57*
AC	2.75	3	.92	1.80
Subj w.groups	16.32	32	.51	
Within subjects	42.22	40	1.06	
B	0	1	0	0
AB	33.64	1	33.6	140.17*
BC	.13	3	.04	.17
ABC	.65	3	.22	.92
Bxsubj w.groups	7.8	32	.24	
Total	87.75	79		

* $p < .05$

Table 5

Averaged Q-Sort Consensus and Difference Items

A. Averaged Q-sort Consensus Items

Item	Factor Score	
	<u>Factor I</u>	<u>Factor II</u>
39. Therapeutic change occurs by interrupting maladaptive behavioral sequences, ie., changing the way people behave toward one another.	1.089556	1.076483
41. The cause of relapse in many psychiatric conditions is a stressful family environment.	.591592	.486101
22. Maladaptive behaviors are, to a considerable degree, acquired through learning, the same way that any behavior is learned.	.284803	.374078
18. It is important to understand how other agencies or therapists are involved with a case.	.889006	.776777
17. Psychiatric hospitalization provides an opportunity for the remission of the patient's symptoms and allows families to rest when they have reached a point of frustration and exhaustion.	-.621538	-.486679

B. Averaged Q-sort Difference Items

28. The wisest strategy for a therapist is to assume that there is no organic basis for mad behavior and to proceed as if the problem is a social one.	.157553	-2.569258
3. One way a person can stabilize a family is to develop an incapacitating problem requiring psychiatric hospitalization.	1.094576	-1.500796
10. Careful diagnosis maximizes the possibility of matching the patient and his disturbance to the most appropriate treatment.	-1.147301	1.230701

42. Pathology exists within relationship systems, not within individuals.	.893348	-1.247821
16. Hospitalization is often necessary to interrupt regressive, disruptive or dangerous patterns of behavior.	-.705322	1.428349

Table 6

Summary of Clinician Characteristics

Variable	Glc	Sal	War	Wmsbg	Man	All
N	5	3	3	8	12	71
Mean Age	35.6	32.3	32.0	44.75	34.0	36.7
Sex						
male	1	2	2	4	2	11
female	4	1	1	4	10	20
Discipline						
Nursing	-	-	-	1	-	1
Alc/Sub	-	-	-	-	-	0
Counsel	1	-	2	5	1	9
Soc.Wrk	-	1	-	1	6	8
Psych	4	2	1	1	5	13
Medicin	-	-	-	-	-	-
Education						
<B.A.	-	-	-	2	-	2
B.A.	-	-	-	4	-	4
Masters	4	2	3	2	12	22
PH.D.	1	1	-	-	-	2
Mean Yrs. at Clinic	2.4	2.0	1.3	7.9	3.7	4.2
Mean Yrs. of Exper.	6.2	5.0	8.3	9.8	6.8	7.4

Table 7

Mean Clinician Age Differences

Clinic	N	\bar{X}_{Age}	\bar{X}_3	\bar{X}_2	\bar{X}_5	\bar{X}_1	\bar{X}_4
Warsaw(3)	5	32.0	-	.3	2.0	3.6	12.75*
Sal(2)	3	32.3	-	-	1.7	3.3	12.45*
Man(5)	12	34.0	-	-	-	1.6	10.75*
Glc(1)	3	35.6	-	-	-	-	9.15*
Wmsbg(4)	8	44.75	-	-	-	-	-

*p < .05

Table 8

Mean Years of Employment (YOE) Differences

Clinic	N	\bar{X}_{YOE}	\bar{X}_3	\bar{X}_2	\bar{X}_1	\bar{X}_5	\bar{X}_4
Warsaw(3)	3	1.3	-	.7	1.1	2.4	6.6*
Saluda(2)	3	2.0	-	-	.4	1.7	5.9*
Glc(1)	5	2.4	-	-	-	1.3	5.5*
Man(5)	12	3.7	-	-	-	-	4.2*
Wmsbg.(4)	8	7.9	-	-	-	-	-

*p < .05

Table 9

Mean Differences in Educational Level(EL)

Clinic	N	\bar{X}_{EL}	\bar{X}_4	\bar{X}_5	\bar{X}_3	\bar{X}_1	\bar{X}_2
Wmsbg.(4)	8	2.0	-	1.0*	1.0*	1.2*	1.33*
Man.(5)	12	3.0	-	-	0	.2	.33
Warsaw(3)	3	3.0	-	-	-	.2	.33
Glc.(1)	5	3.2	-	-	-	-	.13
Saluda(2)	3	3.33	-	-	-	-	-

*p < .05

Table 10

Summary of Client Characteristics

Variable	Glc	Sal	War	Wms	Man	All
Age(mean yrs.)	34.1	41.2	44.7	35.8	38.3	36.6
Sex(% female)	35.2	20.0	9.1	43.6	42.9	35.7
Education (%)						
Less than H.S.	49.3	33.3	81.8	63.6	58.1	55.2
H.S. grad.	37.3	25.0	9.1	18.2	29.0	28.6
Some college	13.4	33.3	0.0	12.1	9.7	13.0
College grad	0.0	8.3	9.1	6.1	3.2	3.2
Marital Status (%)						
Ever married	47.9	60.0	63.6	68.4	54.3	55.9
Now married	25.4	46.7	18.2	36.8	20.0	28.2
Formerly Married	22.5	13.3	45.5	31.6	34.3	27.7
Non-white (%)	21.1	46.7	27.3	41.0	17.1	27.5
Employed (%)						
Full or pt. time	25.7	28.6	27.3	33.3	17.6	26.2
Ever > 6 mos.	58.3	64.3	81.8	76.7	69.2	66.7
Receiving SSI (%)	13.0	38.5	18.2	7.9	12.1	14.0
Any public assist.	18.8	46.2	27.3	23.4	27.3	24.4
Private ins.	27.9	26.7	9.1	21.6	25.8	24.7

Table 11

Mean Difference in Symptom Severity (SS)

Clinic	N	\bar{X}_{SS}	\bar{X}_2	\bar{X}_4	\bar{X}_3	\bar{X}_1	\bar{X}_5
Sal.(2)	14	2.71	-	.50	.65	.95*	1.0*
Wmsbg.(4)	39	3.21	-	-	.15	.45*	.50*
Warsaw(3)	11	3.36	-	-	-	.30	.35
Glc.(1)	68	3.66	-	-	-	-	.05
Man. (5)	34	3.71	-	-	-	-	-

*p < .05

Table 12

Use of Medical/Individually-Oriented Assessment Procedures

Variable	Glcstr (%) N = 71	Sal/Wmsbg (%) N = 54	Signif Level*
N	71	54	
Physical examination	5.6	9.3	ns
Lab work (eg., drug screen, med. level DST)	4.2	13.0	ns
IP/fam med history	23.9	24.1	ns
Neuro. Exam	0.0	1.0	ns
Medication Consult	21.1	13.0	ns
Mental Status Exam	81.7	68.5	ns
Psychological Testing	0.0	0.0	ns
IP Social/Fam History	40.9	46.3	ns

* chi-square

Table 13

Placement of Clients Diverted from Hospitalization

Variable	Glcstr(%) N = 71	Wmsbg/Sal(%) N = 54	Signif. Level*
Group Home	0.0	0.0	ns
Jail	44.4	17.4	ns
Transitional Living Situation	0.0	0.0	ns
Foster Care	11.1	0.0	ns
Relative or Friend	33.3	65.2	ns
Specialized Care Facility	11.1	8.7	ns
Other	0.0	8.7	ns

*chi-square

Table 14

Summary of Stepwise Multiple Regression Predicting for
Recommendation for Hospitalization Among Systems-Oriented
Clinicians

Predictor Variable	Correlation w/ criterion	Usefulness index	b	Standard error of b	$\frac{t}{b} = 0$
Relative Available	-.43	.170	-.52	.10	-4.95*
Symptom Severity	.30	.137	.13	.05	2.57*
Danger to Self	.33	.074	.34	.10	3.73*
Nonwhite	.25	.074	.35	.12	2.99*

$R^2 = .455$, $F(4,66) = 13.78$, $p < .0001$

* $p < .05$

Table 15

Summary of Stepwise Multiple Regression Predicting Actual
Hospitalization Among Systems-Oriented Clinicians

Predictor Variable	Correlation w/ criterion	Usefulness index	b	Standard error of b	$\frac{t}{b} = 0$
Schizo- phrenia	.49	.236	.33	.11	2.98*
Relative Available	-.45	.131	-.52	.10	-5.36*
Danger to Self	.40	.129	.31	.09	3.63*
Symptom Severity	.38	.060	.14	.05	2.98*

$R^2 = .555$, $F(4, 66) = 20.61$, $p < .0001$

* $p < .05$

Table 16

Summary of Stepwise Multiple Regression Predicting
Recommendation for Hospitalization Among
NonSystems-Oriented Clinicians

Predictor Variable	Correlation w/ criterion	Usefulness index	b	Standard error of b	$\frac{t}{b} = 0$
Symptom Severity	.67	.432	.33	.04	8.18*
Relative Accompany	-.33	.074	-.52	.11	-4.61*
Organic	.22	.102	.89	.17	5.13*
Medical Problem	-.05	.076	-.36	.10	-3.44*

$R^2 = .684$, $F(4, 49) = 26.52$, $p < .0001$

* $p < .05$

Table 17

Summary of Stepwise Multiple Regression Predicting Actual
Hospitalization Among NonSystems-Oriented Clinicians

Predictor Variable	Correlation w/ criterion	Usefulness index	b	Standard error of b	$\frac{t}{b} = 0$ for
Symptom Severity	.58	.33	.22	.05	4.22*
Instruct Relatives	-.54	.115	-.44	.11	-4.11*
Organic	.22	.097	.59	.18	3.25*

$R^2 = .541$, $F(3, 50) = 19.71$, $p < .0001$

* $p < .05$

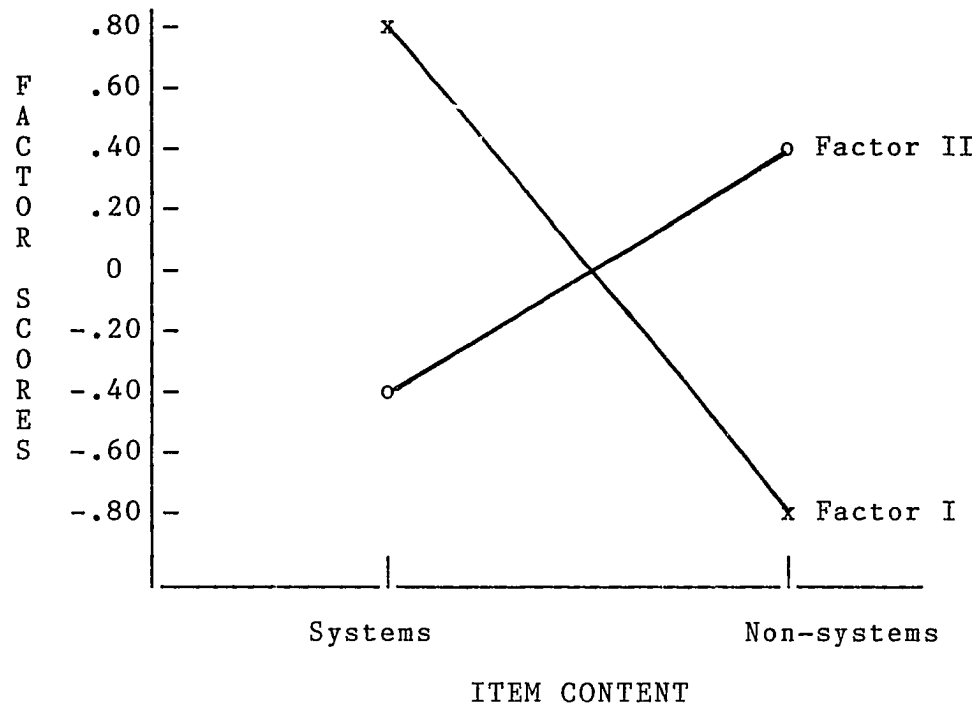


Figure 1. Mean Scores on Each Factor of Items Reflecting Systems and Non-Systems Approaches

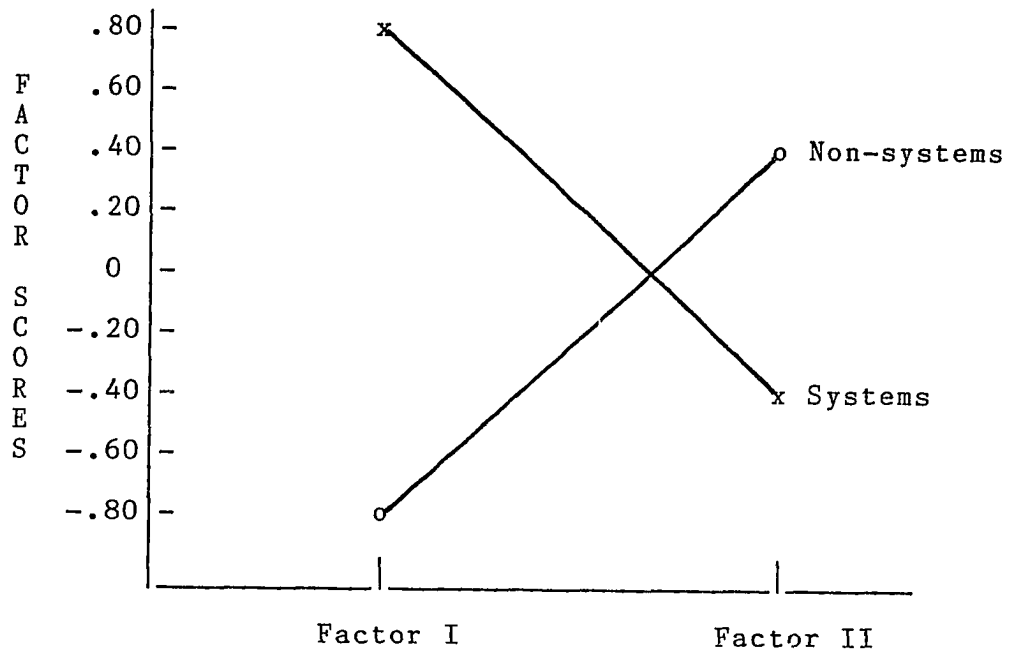


Figure 2. Mean Factor Scores of Systems and Non-Systems Items on Each Factor

AUTOBIOGRAPHICAL STATEMENT

James H. Bullock was born in Washington, D.C. on June 26, 1953. He received his B.S. in Psychology from the College of William and Mary in Virginia in June, 1975. He then enrolled in a Master's Program in experimental psychology at Wake Forest University where he graduated in 1978. While at Wake Forest, Mr. Bullock received a University Fellowship during the 1976-77 academic year.

After completing his Master's degree, Mr. Bullock was employed as a Staff Psychologist at the Surry-Yadkin Area Mental Health Authority based in Mount Airy, North Carolina. During his tenure there he coordinated the Quality Assurance Program for the two county catchment area and developed a special interest in the topic of accessibility to mental health services.

During his training at the Virginia Consortium for Professional Psychology, Mr. Bullock received a William and Mary Fellowship in academic year 1983-4 and was elected to the Alpha Chi National Honor Scholarship Society in February, 1984. He completed his internship in clinical psychology at the Medical College of Virginia in Richmond, Virginia in July 1984. During his last year of coursework, he developed a concentration in the strategic systems therapies.

Since completing his doctoral coursework, Mr. Bullock has been employed by the Henrico Area Mental Health and Retardation Services located in Richmond, Virginia.

Currently, he holds the position of Coordinator of
Outpatient Services at this public mental health agency.