PSYCHIATRIC TERMINOLOGY: ARE MENTAL HEALTH PRACTITIONERS SPEAKING THE SAME LANGUAGE?

by

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Abstract

Mental health practitioners working in an interdisciplinary environment use psychopathology descriptors to formulate diagnoses, evaluate treatment response and communicate about patient care. Few studies have examined the specific meanings that practitioners ascribe to psychopathology descriptors. It is not clear whether practitioners attribute similar meanings to technical terms or if they effectively communicate these meanings to one another. Transcripts of 14 interviews with mental health practitioners in a provincial psychiatric hospital are analysed to determine whether variations exist in understood meanings of the terms *manipulates* and *bizarre delusion.* A rating scale is used to measure the degree of disagreement caused by 15 commonly used psychopathology descriptors. The findings suggest that interpretive variations and disagreements occur among interdisciplinary team members. This may result in negative outcomes for interdisciplinary teamwork and patient care. Further research and education are indicated.

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Introduction

I began my career in psychiatric social work immediately upon graduation from the BSW program. Since that time, I have worked almost continuously in adult inpatient units in a Provincial psychiatric hospital. For the last nine years, I have been involved primarily with a research-oriented, psychodiagnostic unit where comprehensive, interdisciplinary clinical assessments are the norm. In the process of establishing the client's diagnosis and treatment plan, and determining the degree of symptomatic recovery, much weight is given to the criteria contained in the current edition of the Diagnostic and Statistical Manual or DSM (American Psychiatric Association, 1994). The information collected and presented to the interdisciplinary team by each individual member, is examined for its relation to DSM diagnostic criteria. This is the one and only conceptual framework used in many psychiatric care units.

In this context, debates frequently occur over whether client behaviours and/or symptoms adhere to DSM criteria. Such disagreements are often satisfied by the presentation of sufficient *evidence* to support a given point of view (eg., medical history, multiple occurrences of the same symptom), information that is frequently gleaned from rating scales and other assessment tools. In some cases, however, the debate cannot be extinguished by such proof, because the evidence is fundamentally based on one person's (the mental health practitioner's) interpretation of another person's (the client's) experience. It stands to reason that mental health practitioners, who are a large and diverse group, will not always interpret behaviours, symptoms, and the terms used to describe them, in a universally consistent way. It is this supposition that I set out to explore in the current research study. My research question is: do mental health practitioners use the technical language of psychiatry to represent psychiatric symptoms in a manner that is consistent and understandable between individuals and across disciplines?

Chapter One is a review of the function of technical terminology in psychiatry and its relationship to psychiatric discourse. Particular attention is paid to the process of psychiatric diagnosis and the medical ideology from which current classification systems have emerged. Chapter Two explores structuralist, post-structuralist and social constructionist theories as they relate to classification, language and communication. Chapter Three focuses on the research methodology employed in the study. Chapter Four elucidates the major findings in a manner consistent with the interview questions, as they were posed to participants. Chapter Five presents a discussion of the findings, while Chapter Six offers a review of the implications of the study and suggestions for future research.

This study involves interdisciplinary communication and since the different disciplines have different traditions for naming the individual to whom they provide care, the terms *patient* and *client* will be used interchangeably in the text. The names of participants have been changed in order to maintain confidentiality.

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Chapter One: Literature Review

Language in Psychiatry

Psychiatry is a descriptive field in which words are the primary tool used for diagnosis and treatment planning. Laboratory and other physical tests, which can be critical in the identification and treatment of corporeal disease, are of limited utility in determining the presence or absence of mental illness. Instead, the subjective observations of mental health practitioners are relied upon for the detection of symptom clusters characteristic of specific diagnoses. The communication of these observations from one practitioner to another involves the use of words or combinations of words collectively referred to as *psychopathology descriptors.*

Psychopathology descriptors are an integral part of the technical language used in psychiatry. In North America, the mental health practitioner is assumed to be a literate interpreter of this language. Mental health practitioners, regardless of personal or professional background, are thought to share a relatively consistent understanding of the abstract meanings associated with the technical terms they use. Psychopathology descriptors, many of which date back several decades, or even centuries, have been incorporated into prevailing classification systems and assessment devices such as rating scales. General confidence in the understandability of these terms may be assumed, given the dearth of literature examining interdisciplinary interpretations of their meanings.

As Kuipers (1989) points out, however, language in medicine is more than just "a tool for rapport and reference" (p.101), it is part of a larger structural entity known as *discourse.* Discourse "is implicated in expressing people's points of view and value systems, many of which are 'pre-structured' in terms of what is 'normal' or 'appropriate' in particular social and institutional settings" (Jaworski & Coupland, 1999, p.6-7). This is especially salient for psychiatry, which is itself concerned with thoughts and behaviours that deviate from a perceived norm.

The Medical Model

An understanding of the ideological framework of psychiatry is fundamental to the examination of its discourse. As Eaton (2001) points out, "the dominant interpretation for bizarre emotions and behaviours in modern, Western society is medical" (p. 9). Fundamental to this ideology is the belief that entities such as *mental illnesses* or *mental disorders* exist and upon identification, require medical intervention. Any improvement in patient symptoms that appears to be attributable to the use of psychotropic medications is generally held up as proof of the validity of this model.

For most mental disorders, etiology remains unclear. The medical model presumes, however, that these disorders are attributable to a diseased brain; hence the emergence of seminal psychiatric texts such as "The Broken Brain" by Nancy Andreason (1985). Despite advances in neuroimaging technology and genetic studies, medical science can only offer "viable hypotheses about dysfunction" (Kotrla & Weinberger, 1994, p.67), particularly for severe, persistent psychotic disorders.

The medical model is a mechanistic, reductionist perspective that focuses primarily on the body's component parts and processes. The model is credited with the proliferation of medical specialties (Bolaria, 2002), including psychiatry. Such specialization has contributed to advances in medical knowledge and practice, leading to the discovery of life-saving treatments and the restoration of physical and psychological functioning. In addition, it has freed individuals from personal blame and the stigma of culpability associated with many diseases whose biologic etiology had not previously been understood. Unfortunately, individuals with mental illness, particularly those identifed as having psychotic disorders, continue to live with social stigma. They are commonly represented in media portrayals as dangerous, unpredictable and non-functional (Bradley & Brown, 2002). Stereotypic views such as these, result in social distance between people perceived as mentally ill and those who consider themselves mentally healthy (Lauber, Nordt, Falcato & Rossler, 2004). This type of reaction has been noted in the general population and has also been observed among mental health professionals (Sartorius, 2002). The view of mental illness associated with the medical, or pathological model suggests that conformity to the established norms of society is in the patient's best interests (Fee, 2000; Sayce, 2000) and this is often the desired outcome of treatment.

Other conceptual approaches, including psychodynamic theory, the bio-psychosocial and psychosocial rehabilitation models, are associated with the practice of psychiatry, but only to the extent that they are an adjunct to the medical model.

Psychiatric Diagnosis

The medical model asserts that exceptional experiences of thought, emotion and behaviour are characterized as mental illness. Illnesses are identified through diagnosis, the primary medical methodology (Mechanic, 1978), and specific terms and categories are required to support this process (Eaton, 2001). According to Eaton (2001), the words *symptom*, *sign*, *impairment* and *pathology* are medical interpretations of phenomena that could be conceptualized in other ways: "a complaint is a statement about an unwanted or unpleasant feeling, and a *symptom* is a complaint…that is assumed to be due to a disease" (p.10).

Authors from various academic disciplines have examined the development and use of psychiatric terminology. Within the psychiatric literature, the aim of such scrutiny has generally been to refine symptom clusters in accordance with accepted nosological categories and to improve inter-rater reliability between practitioners who identify and treat psychopathology. These efforts serve to enhance the uniformity of psychiatric diagnosis in a manner consistent with existing classification systems (Sartorius, Ustun, Korten, Cooper & van Drimmelen, 1995; Sartorius et al., 1993), such as the Diagnostic and Statistical Manual or DSM, first published in 1952 (American Psychiatric Association, 1994) and the International Classification of Disease or ICD (World Health Organization, 1992), which has included mental disorders since its sixth edition in 1948 and has subsequently been revised and re-published four times (Widiger, Frances, Pincus, Davis & First, 1991).

As Lolas (1997) points out, legitimacy of word usage in psychiatry "derives from different sources" including "basic research, clinical experience and…common language endowed with technical meaning" (p.242). Psychopathology descriptors are not diagnostic labels per se; rather, they are the building blocks of diagnosis, allowing for the description of clinical phenomena that, in certain combinations, are considered to be indicative of a psychiatric disorder. Psychopathology descriptors have specific functions: labeling deviance, defining disease, and anticipating clinical interventions (Lolas, 1997).

Mezzich (1999) identifies diagnosis as "a central concept and activity in medicine and psychiatry" (p138). Despite the development of comprehensive classification systems, arriving at a psychiatric diagnosis is not an elementary process. Diagnostic work requires the skilled acquisition of relevant information from multiple sources, such as the patient's medical and social history; the evaluation and interpretation of clinical data, including observations of the individual's behaviour; and knowledge of diagnostic categories and the symptom criteria associated with them. In the event of a diagnostic assessment involving more than one practitioner, it would seem that the degree of consistency between their interpretations of observed clinical phenomena, understanding of terminological meanings, and adherence to classification systems would be of considerable importance. The interdisciplinary mental health care model, so popular in North America, often results in the involvement of multiple practitioners in the process of determining a patient's diagnosis. Furthermore, any diagnostic assessment that entails the review of historical patient records is by nature multi-practitioner, in that the observations and interpretations of past caregivers are incorporated into the current evaluation. Inter-subjective aspects of the description of psychopathology and the process of diagnostic assessment figure prominently in the ongoing debate over the concept of *scientific objectivity* (Goncalves, Machado, Korman & Angus, 2002; Eaton, 2001; Mirowsky & Ross, 1989; Kendell, 1986).

Much of the psychiatric literature on symptom recognition and diagnosis, as Harper (1992) points out, "reads as if notions of truth and falsity, of personal knowing and belief are unproblematic or at least only capable of one definition" (p. 359). In other words, the subjectivity of practitioner *observers* and the multiple contexts within which human thought and behaviour can be interpreted, complicate the identification of pathological beliefs and behaviour in their clients, *the observed.* The presumption that it is possible to arrive at an objective, or factual account of psychiatric symptoms, has been challenged by a number of academics (Palmer, 2000; Hak, 1998; Berg, 1996; Berg, 1992; Harper, 1992; Alpert & Rosen, 1990; Mirowsky & Ross, 1989). Social constructionist analyses, in particular, suggest that the definitions of core psychiatric terms such as *affect*, *delusion* and *paranoia* possess inherent inconsistencies and rest on a flawed belief in external reality (Hak, 1998; Harper, 1992; Alpert & Rosen, 1990). For example, a delusional belief, as defined in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 1994), must be measured against external reality but can, at the same time, be evaluated through inter-subjective consensus (Harper, 1992).

It has been argued that dominant medical and psychiatric discourses shape the social construction of mental illness (Palmer, 2000) and the language used to conceptualize it (Harper, 1992). Mirowsky and Ross (1989) assert that "a language of categories fits some realities better than others; it fits the reality of psychological problems poorly" (p. 11). Categorical classification is, however, precisely the context in which the practice of psychiatry is currently conducted. Psychiatric symptoms and disorders are often described as though they are discrete entities, which exist independently from the person in whom they are manifest (Mirowsky & Ross, 1989). This interpretation is supported by the widespread belief that diagnostic classifications are based on empirical research. Mirowsky and Ross (1989) point out, however, that all editions of the DSM, while informed by research, were validated by professional consensus. This inter-subjective validation of symptoms and disorders supports the argument that they are social constructs, rather than discrete, factual entities. As social constructs, they are limited conceptually by the terminology used to describe them.

Are We Speaking the Same Language?

Given the academic debate about our capacity to generate objective, factual accounts of psychiatric disorders and symptoms, it is not surprising to find similar discord in the clinical realm. Such disagreement is not wholly unwelcome; it allows for the expression of a variety of ideas that can lead to new theories and concepts, a process that may ultimately result in enhancements to patient care.

In clinical psychiatry, however, differences of opinion between interdisciplinary team members may significantly impact the course of treatment, particularly if the source of discord is the proposed diagnosis, therapeutic intervention(s) or discharge plan. The presence or absence of shared meanings between members of the health care team will likely determine whether professional efforts are coordinated and whether a coherent evaluation of the client's problems is taking place. It is possible that disagreements may be rooted in fundamentally different beliefs about the causal or purposive nature of client behaviour.

Team members communicate about client behaviour using psychopathology descriptors. Since the argument can be made that language is not *objective* or without contextual bias, such descriptors should be subject to exploration and analysis. A coherent debate requires that participants effectively send and receive information in a language that is commonly understood. A review of the literature failed to reveal any studies examining the meanings ascribed to psychiatric terms by mental health practitioners.

To fill this void, the present study explores the meanings that mental health practitioners associate with selected psychiatric terms. Descriptive terminology found in the Routine Assessment of Patient Progress (RAPP) is utilized (Ehmann, Higgs, Smith, Au, Altman, Lloyd et al., 1995). In addition to meaning attribution, the connotations of selected terms, and issues related to interdisciplinary communication, specifically agreement/disagreement are examined.

Chapter Two: Theoretical Foundations

The research question posed in this study intersects with many practical and theoretical considerations related to the provision of psychiatric care including: views of mental health and illness; dominant ideologies guiding psychiatric practice; the meaning(s) and usage of psychiatric terms; interdisciplinary roles, and interpersonal impressions and attitudes. Such broad scope necessitated the consideration of literature from many different academic fields; however, two primary theoretical perspectives, post-structuralism and social constructionism, informed the development of the study and the interpretation of its findings. In order to understand the tenets of post-structuralism it is necessary to examine the structuralist theory from which it emerged and to which it is opposed.

Structuralism/ Post-Structuralism: The Importance of Language

Structuralism holds that human life and social organization are guided by an inherent order composed of absolute truths sometimes referred to as *meta-narratives* (Palmer, 1999; Casey & Long, 2003). These meta-narratives are the foundation upon which societal institutions are built and essential dichotomies, such as masculine/feminine, right/wrong or normal/abnormal, are established. These binary opposites allow for the ordering and categorization of all aspects of human life, and shape values and beliefs (Palmer, 1999; Casey & Long, 2003). Medicine in general and psychiatry in particular, are thought to comprise their own meta-narratives (Richards, Brown, Crawford & Nolan, 1996), which are derived in part from the essential Cartesian dichotomy of physical/mental and the later distinction between sanity/insanity (Burr, 1995).

Categorization is of course, a way to make sense of a complicated and confusing world. It is a process that begins at the earliest stages of post-natal development (eg., as the infant learns to distinguish self from other). Categories can be very useful tools in the development of understanding. Major advancements in knowledge, such as the ordering of species, or the periodic table of the elements, are attributable to efforts at classification. As Sartorius (1990) suggests: "a classification is a way of seeing the world. It is the reification of an ideological position, of an accepted standard of theory and knowledge." (p.1)

Positivistic scientific inquiry, natural laws and language are all associated with, and supported by, a belief in the *one right way* (Palmer, 1999). It is against this backdrop that medical specialties such as psychiatry have evolved. However, since its emergence in the 19th century, psychiatry has struggled to define its field of practice and guiding principles. Different schools such as psychoanalytic, biological, and biopsychosocial have held positions of prominence, but none has been accepted as definitive. Efforts to establish a definition of mental illness and an allied classification system have resulted in only partial consensus, but the goal of a universally applicable structure persists. The following comments about classification in psychiatry are illustrative: "classifying means creating, defining or confirming boundaries of concepts. Through these...we define ourselves, our future and our past, the territory of our discipline, its importance and its exclusiveness. No other intellectual act is of such importance." (Sartorius, 1990, p.1)

What this observation fails to acknowledge is that every system of classification depends upon language for its structure. Theories, concepts and bodies of knowledge are only as good as the words we have with which to formulate them. Language can be a vehicle for the advancement of knowledge; however, it can also be a potent tool for the ordering and maintenance of society.

These ideas relate to fundamental criticisms of structuralism. One such criticism is that the institutions that profess to represent civilized order (eg., medicine, education) also become enforcers of that order. Those structures thought to be an inherent part of society establish, through their very presence, norms by which deviance can be measured. Language is fundamental to this process, it is the mechanism through which norms are defined and expressed. Critics of structuralism, commonly referred to as post-structuralists, argue that structuralism's conception of language as a purely representational, fixed, transparent tool, is flawed (Poster, 1997). Post-structuralists assert that language is a socially constructed, political entity, which is vulnerable to distortion in the pursuit of desire and/or power (Lye, 1999; Poster, 1997). For individuals with mental illness, differences in thought and behaviour identified as deviance may result in alienation from society and forced confinement (Foucault, 1965), outcomes which demonstrate the power of language. Upon close analysis, many of the norm-supporting beliefs and structures upon which such measures are based, appear to be derived from assumptions or unproven concepts such as *objectivity* (Palmer, 1999), a linch-pin of structuralist thought which is rejected by post-structuralists.

Post-structuralist thinkers argue that the assumptions upon which meta-narratives and their associated institutions are built should be subject to a process of scrutiny known as *deconstruction* (Palmer, 1999). Post-structuralists have attempted to deconstruct and discard structuralist dichotomies, such as the reason/unreason and presence/absence polarities (Foucault, 1965). According to Jacques Derrida, a prominent post-structuralist, *being* incorporates *non-being* and existence is a process of interaction between the past, present and future (Palmer, 1999). Such ideas contribute to the post-structuralist view that an absolute reality does not exist and that there is no one right truth or way of being. From this perspective, the belief that mental illness and mental health are separate, distinct and in opposition to one another, is presumed to be faulty. Such assertions challenge traditional positivist inquiry, and to the extent that it rests on empirical research, much of the established body of medical knowledge.

Post-structuralists emphasize the need for deconstructive analyses of language (Palmer, 1999). As Burr (1995) points out, "both structuralism and post-structuralism see language as the prime site of construction of the person" (p.39). A point of departure between the two however, is the post-structuralist view that: "meaning is always contestable…rather than language being a system of signs with fixed meanings upon which everyone agrees…it is a site of variability, disagreement and potential conflict…and…power relations" (Burr, 1995, p. 41).

The renowned post-structuralist, Michel Foucault, examined societal institutions such as medicine and psychiatry. He argued that the *discourses* associated with these institutions are inclusionary/exclusionary systems with rules that determine what can be said, and by whom:

> Medical statements cannot come from anybody; their value, efficacy, even their therapeutic powers, and, generally speaking, their existence as medical statements cannot be dissociated from the statutorily defined person who has the right to make them, and to claim for them the power to overcome suffering and death. (Foucault, 1969, p.56)

According to Foucault, discourse and power are related and all forms of discourse purporting to represent *the truth,* are in fact, deceptive and self-interested (Palmer, 1999). It is from this line of thought that the field of discourse analysis has risen (Burr, 1995).

Discourse in psychiatry is still dominated by the dichotomies, categories and classifications characteristic of structuralist thought. Gergen's (1998) assertion that there remains "a broadly shared belief in the capacity of language to represent or depict the world in an accurate or objective manner" (p.34) is of considerable relevance to the present study. The aim of this investigation is to determine whether mental health practitioners use the technical language of psychiatry to represent psychiatric symptoms in a manner that is consistent and understandable from person to person and across disciplines. Do understood meanings adhere to technical definitions or do they vary based on individual interpretations?

Social Constructionism

Social constructionism is a theoretical branch of Constructivism that shares much in common with post-structuralist thought. Like post-structuralists, constructivists challenge the notions of empirical realism, objective truth and essentialism. Constructivism is characterized by the view that knowledge and truth are not entities to be discovered, but are actively created in the mind (Schwandt, 1994).

Social constructionism focuses on collective, as opposed to individual, generation of meaning and knowledge. Constructions are efforts to make sense of, or interpret, personal experience (Guba and Lincoln, 1989). Gergen and Gergen (1991) argue that language and other social processes are central to the social exchange that contributes to our constructed reality. The range and scope of information available to a person, and the person's ability to deal with that information, are important factors in the construct(s) that results (Guba & Lincoln, 1989).

Burr (1995) has identified four central tenets of social constructionism: 1) a critical stance towards taken-for-granted knowledge; 2) the belief that categories and concepts are historically and culturally specific; 3) that knowledge is created and sustained by social processes, and 4) that knowledge and social action go together (p. 3-4). Language is considered a pre-condition of thought:

> We are born into a world where the conceptual frameworks and categories used by people in our culture already exist. These concepts and categories are acquired by all people as they develop the use of language...this means that the way people think, the very categories and concepts that provide a framework of meaning for them, are provided by the language that they use (Burr, 1995, p. 7).

Burr (1995) goes on to postulate that language is a form of social action; she argues that language is more than just a mode of expression: "when people talk to each other, the world gets constructed" (p.7). These features contest the generally held view that language is simply a "bag of labels" (Burr, 1995, p.32) that we apply to thoughts, feelings, behaviours, and events in order to communicate with another person. Thus social constructionism, like post-structuralism, places emphasis on the central role language plays in shaping our experiences. According to this view, mental health practitioners actively participate in the construction of mental disorder and psychiatric care through the use of language.

Chapter Three: Methodology

While this study relies primarily on a qualitative approach to inquiry, it is a multi-method study that employs quantitative methods as well, in the form of a simple rating scale. Qualitative methods are increasingly being used in health care research to address questions that cannot be explored adequately using traditional quantitative methods (Lacey & Luff, 2001; Mays & Pope, 2000; Wright & McKeever, 2000; Harding & Gantley, 1998). Wright and McKeever (2000) argue that "qualitative methods are often optimal for the investigation of social or psychological phenomena including behaviours, motivations, perceptions and expectations…the goal is to elicit subjective meaning" (p. 276). These authors go on to suggest that qualitative methodology has potential utility in exploring "how individuals and groups interpret health and disease, and interactions between players and aspects of health-care delivery" (p. 278). Black (1994) identifies the aim of qualitative research as investigation "in [the] natural setting, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them" (p. 425). These objectives are consistent with the aim of the study, which is to explore the meanings that mental health practitioners ascribe to clinical terminology. The specific focus of the study is one for which there is a paucity of relevant data in the literature. The use of a qualitative approach is supported given the exploratory aims of the study and the emergent nature of the results (Rossman & Rallis, 2003).

The purpose of inquiry in this study corresponds to the *enlightenment use* described by Weiss (as cited in Rossman & Rallis, 2003). The findings are not intended for direct, *instrumental use* (Rossman & Rallis, 2003) in the psychiatric care setting. Rather, the results may appropriately become part of an "accumulated knowledge…to improve practice by enhancing understanding of that practice" as well as "[challenging] existing beliefs" (p. 21) about psychiatric terminology and its uses.

Sample

Study participants were recruited from a provincial psychiatric hospital with approximately 600 inpatient beds in three patient care programs: adult psychiatry, neuropsychiatry, and geriatric psychiatry. Recruitment of participants was limited to the adult psychiatry program for two primary reasons: a) the use of the Routine Assessment of Patient Progress (RAPP), the source of the terms examined in this study, is most prevalent in the adult psychiatry program, as this is the patient-care area in which it was developed and b) practitioners may understand and/or use terminology differently with different patient populations. The adult psychiatry program is made up of 12 units, each serving 20 to 25 male and female patients. The 12 patient-care units are located in five different buildings and include a psychiatric intensive care unit; four rehabilitative or community re-entry units; a specialized unit for individuals suffering from self-induced water intoxication; four general psychiatry units; a "secure care" or locked unit, and the refractory psychosis unit which is a locus of research activity.

The provincial psychiatric hospital in which the study was conducted is a tertiary-level care facility. As such, referrals to the hospital are accepted only from secondary care providers such as private psychiatrists, mental health centres or acute care hospitals. In order to be admitted, patients must have received a diagnosis that corresponds to the first axis of the Diagnostic and Statistical Manual of Mental Disorders (APA, 1994) multi-axial system. The most common diagnoses associated with admissions to the adult psychiatry program are Schizophrenia, Schizoaffective Disorder and Bipolar Affective

Disorder. Comorbid diagnoses frequently include substance abuse and personality disorders. Patients receiving treatment in the provincial psychiatric hospital are generally suffering from what would be characterized as severe, persistent mental illness.

Recruitment was conducted through the use of posted advertisements and information disseminated by the practice leaders for the different clinical disciplines (see Appendix A). Practitioners from the following disciplines were invited to participate: medicine (general practice and psychiatry); nursing (including nursing aide or "health care worker"); social work; psychology; occupational, vocational and recreational therapies. Participants were excluded if they did not provide direct patient care within the adult psychiatry program. Due to the study's focus on language, participants were required to be fluent in English.

Fourteen mental health practitioners participated in the study: one general practice physician; two direct care nurses and a nurse clinician; one nursing aide; three occupational therapists; two recreational therapists; one vocational therapist, and three social workers. Despite multiple recruitment efforts, no psychologist or psychiatrist participated in the study. Eight of the participants split their time between two or more patient-care units in the adult psychiatry program; at least one participant was interviewed from nine of the 12 units.

Twelve of the participants were women and two were men. Participants ranged in age from 24 to 54 years; the mean age was 42 years. The mean was calculated based on the ages provided by 13 participants as one individual declined to provide a date of birth. Eleven participants identified English as their first language, a European tongue was the first language for two of the remaining participants and a Middle-Eastern tongue for the third.

Data Collection

Participants were asked to participate in a semi-structured interview conducted by the investigator. A semi-structured format was selected in order to limit the duration of the interview, a recruitment consideration given the busy schedules of participants. This format also ensured that all participants were asked the same core questions, enhancing the likelihood that responses to those questions could be compared. A combination of descriptive and interpretive questions were used to elicit, respectively, observations of behaviours and events, and information about their meanings (Maxwell, 1996). The interview schedule can be found in Appendix C.

Interviews were held in a private location chosen by the participant and were audiotaped. Following a series of demographic questions, participants were asked to describe the roles and duties associated with their current job. They were, sequentially, asked to describe their experiences of the terms *bizarre delusion* and *manipulates.* Participants were encouraged to offer their interpretation of the terms' meanings and an example(s) of a situation in which each term had been used clinically, either by the participant or another member of the clinical team. Participants were then provided with a list of 15 terms from the RAPP assessment tool and asked to rate the five terms that tended to cause the most interdisciplinary disagreement. The five terms were rated from 1 to 5, with 1 representing the most disagreement and 5 representing the least. Once the ratings were completed, participants were asked to indicate which of the 15 terms on the list had positive connotations (reflective of client strengths or capacities) and which had negative connotations (reflective of client deficits or defects). Participants were encouraged to describe in further detail their understanding of the meanings of the top five terms they selected. They were also asked which, if any term, they would like to see replaced with an alternate word or phrase. Participants were invited to comment further if they wished to, once the interview questions were completed.

The RAPP

The Routine Assessment of Patient Progress, or RAPP (found in Appendix E), is a standardized, clinical rating scale that was developed by a group of interdisciplinary researchers to "document treatment effects, assist in treatment planning, and provide ancillary judgments of psychopathology that may affect diagnosis" (Ehmann et al., 1995, p.289). It is specifically designed for use with clients experiencing symptoms of psychosis and is currently used to assess all patients admitted to the 12 units that make up the adult psychiatry program. The format of the RAPP includes information derived from interviews with the client and from behavioural observation, with the aim of contributing to a comprehensive assessment (Ehmann et al., 1995). The scale is intended for completion by trained nurses but incorporates functional domains of interest to most members of the interdisciplinary care team, including the client's basic needs (diet, sleep, movement problems), psychopathology and life skills (hygiene, budgeting, social problem solving). The RAPP is one of many nursing scales that have been developed to measure client functioning and/or psychopathology.

The 21 scoreable items on the RAPP permit the following ratings: absent (0); mild (1); moderate (2), or severe (3). When the scale is completed, these ratings are added together to obtain an overall total score; a high score is indicative of severe functional problems or psychopathology. In addition to assessing the severity of the client's difficulties, the rater must also determine which of the listed examples, if any, are present (eg., unkempt, loner, labile). In order to reduce *criterion variance,* Ehmann et al. (1995) offered descriptive guidelines for 13 items. Anchor points were established for all items to guide the assessment of severity.

According to Ehmann et al., (1995) the RAPP possesses "acceptable levels of reliability and validity and can accurately reflect changes in functioning over time. It can also discriminate those in need of further inpatient treatment from those about to be discharged to independent or semi-independent living situations" (p.293). The authors suggest that it is a helpful reference tool for physicians and other professionals.

Analysis

Audio-tapes of the interviews were transcribed and the resulting transcripts were analyzed using content analysis, a systematic examination of each transcript from beginning to end (Rossman & Rallis, 2003). Segments of text were coded, including words, phrases and sentences that represented answers to the interview questions. Similarities and differences between the responses were noted and themes were identified. Attention was also paid to irregularities within the text. Responses to questions regarding the meaning of specific RAPP terms were compared to technical definitions, as laid out in: psychiatric glossaries (Kaplan and Sadock, 1991; American Psychiatric Glossary, 1988); the DSMIV (APA, 1994); the psychiatric literature; or where no concise psychiatric definition could be found, a standard English dictionary. Demographic information about participants and data generated through the rating scale were analysed using simple, descriptive statistics.

Validity

Participants were encouraged to share their perspectives with as little interruption from the investigator as possible. The investigator spoke only to clarify questions and unclear responses or to encourage participants to expand on their answers. Responses were frequently reflected back to participants in order to gauge the interviewer's understanding.

Interviews were audio-taped and transcribed verbatim. Analysis of transcripts occurred immediately following transcription in order to prevent data loss or distortion. A reflexive approach was taken to inquiry. As the investigator was personally familiar with some of the participants, the "bracketing" of personal experience and/or bias was an important consideration. Regular dialogue with the supervising faculty advisor and a qualitative research instructor contributed to an ongoing examination of personal biases and assumptions.

Chapter Four: Findings

Experience and Training Related to Terminology

Participants possessed on average, 15 years of experience in the mental health field, with a range from under one year to 30 years. Nine participants reported exposure to psychiatric terminology in the course of their pre-employment education and/or training. Their training occurred on average, 14.5 years prior to the study. Seven participants indicated that they had developed or augmented their knowledge of terminology through workshops, conferences, courses or independent professional development activities such as reading books and articles. Ten participants reported that much of their education regarding psychiatric terminology had occurred on the job.

Twelve participants expressed confidence in their familiarity with the Routine Assessment of Patient Progress (RAPP); two indicated that they were less familiar with the tool but knew of its existence. All 14 participants indicated that the RAPP was used for charting and/or assessment purposes in the unit(s) where they worked.

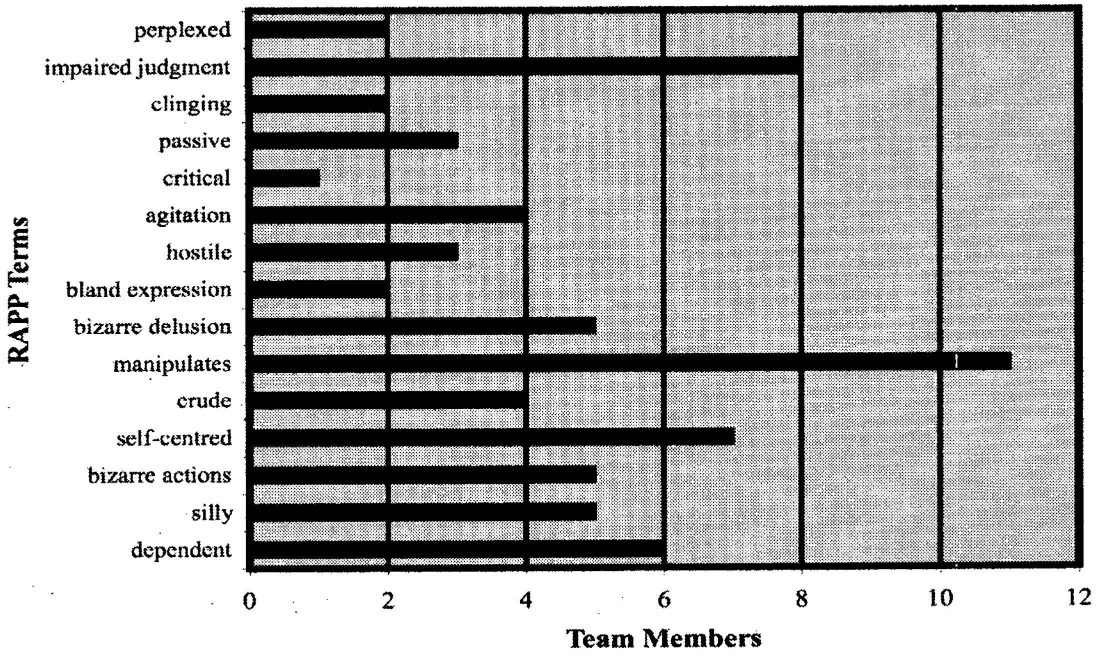
Perception of Role

Nine participants indicated that they conducted clinical patient assessments as part of their role. Eleven participants mentioned communication with the patient, family and/or other team members as an explicit function they conducted. Four of the eleven participants only made reference to communication when they described educating others, making recommendations and giving information. These descriptions imply a one-way exchange of knowledge. Although all adult patient care units incorporate an interdisciplinary approach to treatment, only eight participants mentioned teamwork or being a team member as part of their role definition. While many participants made reference to personal characteristics that they perceived as being advantageous for mental health work, only one mentioned professional resources for working with psychiatric clients such as practice standards or guidelines.

Terms That Cause Interdisciplinary Disagreement

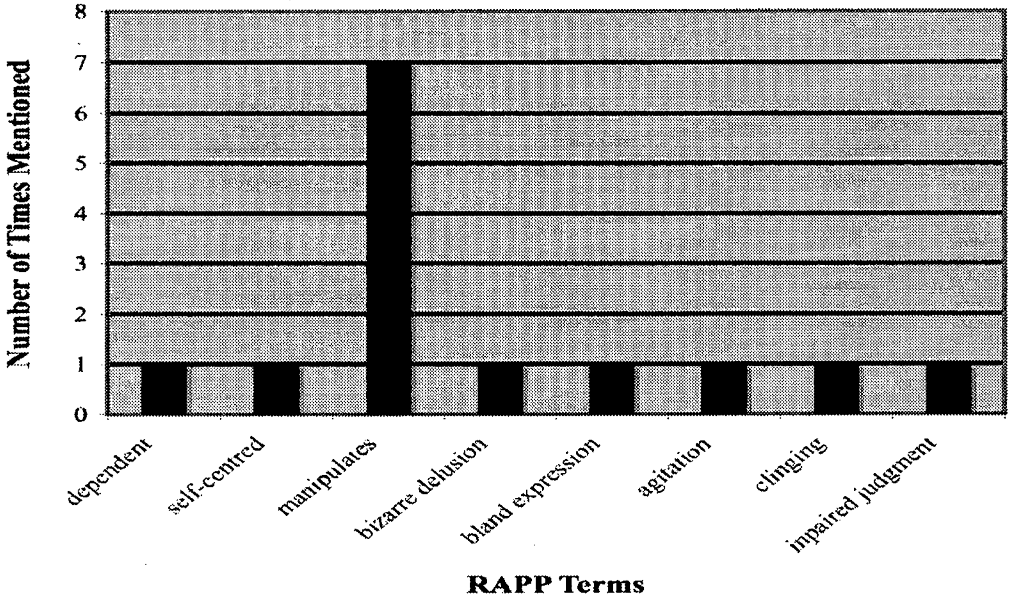
All 14 participants reported that disagreement arose among team members regarding the perceived meaning of certain psychiatric terms. On the 15-term rating scale provided, 11 participants selected *manipulates* as one of the top five terms likely to cause disagreement and seven rated it as "causing the most disagreement." The second most frequently rated term, by eight participants, was *impaired judgment*. Seven participants selected *self-centred*, making it the third most frequent, followed by *dependent,* which was chosen by six. Three terms tied for the fifth most frequent rating: *bizarre delusion, bizarre actions* and *silly*. The terms identified as causing interdisciplinary disagreement are displayed in Figure 4.1.

Figure 4.1. RAPP terms causing interdisciplinary disagreement



Seven participants rated *manipulates* as the term causing the most interdisciplinary disagreement. Seven other terms were rated at this level, each by one participant: *agitation*; *bizarre delusion*; *bland expression*; *clinging*; *dependent*; *impaired judgment*, and *self-centred.* The terms rated as causing the most disagreement are displayed in Figure 4.2.

Figure 4.2. RAPP terms rated as causing the most disagreement



Participants indicated that interdisciplinary disagreement over the perceived meanings of RAPP terminology could be the result of a term's ambiguity, the presence of multiple meanings, the differing perspectives of team members, or a combination of these factors.

Ambiguous Terms

The New Webster Encyclopedic Dictionary of the English Language (1971) defines *ambiguous* as "doubtful or uncertain; liable to be interpreted in two ways;

equivocal; indefinite" (p. 27). Many participants remarked on the ambiguity of specific RAPP terms, such as Erin: "...*dependent*...it could mean anything, physically, emotionally, whatever, it's very, very ambiguous. Bizarre actions...that can be anything, bizarre is so vague."

Sarah: "...everybody's interpretation of any of these words can be drastically different or slightly different..."

Marie: "...*self-centred*...*crude*...they're open to interpretation..."

Paul: "I think it really depends on the nurse's or other interdisciplinary [team member's] perception of things...there's still times when [manipulates] can be used as a vague description of a behaviour or a sort of, generalization...*hostile*...could also be misinterpreted."

Morgan: "*Impaired judgment,* I see it as a term that is very broad...it covers so many areas...*crude*...I understand the word in the English language, in normal conversation...but in a psychiatric assessment, I don't necessarily understand what it means."

Angie: "I have a really hard time with that [silly]...it just doesn't add anything to my understanding of the patient."

Stephen: "*Silly* is one that I find all over the map. I mean, I'm not even sure how to exactly define that term, as it applies to psychiatric patients in any case."

Multiple Meanings

Participants offered different definitions of *critical* which highlighted the term's multiple meanings. Three of the meanings offered were unrelated to the term's function as a descriptor of patient behaviour:

Erin: "If I want to emphasize a point I might say, "this is a *critica*l point here."

Leah: "...the word *critical*...from my knowledge as per definition, *critical* is a pretty serious life or death situation..."

Stephen: "I just noticed...there's actually two different meanings of this word here." I was thinking more in terms of a clinical, *critical* incident..."

Emily: "...it was used as a descriptor of some element of hostility I guess, meaning the person is *frequently critical*."

Another term that elicited different definitions was *silly:*

Jane: "*Silly* is somebody who is not behaving at the maturity level that you would expect for their age and who may be...acting childishly."

Catherine: "...*silly* games, to me that connotes someone's sense of humour..."

Emily: "I think...hebephrenic...where a person...does things...that make no sense that they can't explain...paper shredders and people who, without any sense of hostility, may be giggling and pulling the ward to pieces..."

Subjective Terms

The New Webster Dictionary (1971) defines *subjective* as "belonging to one's own mind and not what is external...characterized by prominence of the personality of the author..." (p. 834). Participants commented on the subjectivity of many of the RAPP terms, often in conjunction with observations about their ambiguity:

Erin: "What's *impaired judgment* to me isn't necessarily impaired judgment to someone else."

Marie: "*Crude* to me could be...somebody saying a swear word and to somebody else could be exposing themselves...it's kind of like, what's your line in the sand?"

Rose: "*Impaired judgment*...sometimes that comes up, the person's spent too much money buying something and that's evidence of impaired judgment. Well, who's judgment is that?...what's an appropriate amount to spend on something you like doing?...I think we often impose our own judgments on people's behaviour."

Emily: "I guess it's fairly individual how these things get rated...I guess the ones around problem solving style may be more value driven...I suppose I do have a definite judgment about that and about where I feel is the more useful sort of behaviours."

Paul: "There could be biases, definite biases about a variety of patients...I think it also depends upon male patients to female staff, that sort of thing. I think there is the influence of female staff [who] may have biases about men and women's relations...there's always a bit of interplay."

Leah: "*Agitation*...can be on such a huge scale it sort of loses its effectiveness without another word with it...severe agitation, mild agitation or some sort of scale, the word by itself is very subjective. [Crude] can be subjective depending on somebody's upbringing, somebody's culture...unless you're defining the word before you use it, it means different things to different people."

Positive Terms

Participants generally characterized the 15 RAPP terms as possessing negative connotations. Ten participants indicated that none of the terms on the list were positive. Seven terms, however, were identified as having positive overtones. *Manipulates* was specified by three participants, although one participant struggled to situate herself in relation to the term:

Sarah: "*Manipulation* is a form of survival...not that I think it's a good thing but if that's the way somebody survives and gets ahead so that they're comfortable...I don't necessarily think it's a bad thing. I don't like it, but they're having their needs met." Angie: "*Manipulates* could also be a good term...taking care of yourself, self-care." Morgan also identified *manipulates* as a positive term, although she acknowledged that her interpretation was not generally shared by other team members. Two participants indicated that *self-centred* could be construed as positive. The following terms were each identified as positive by one participant: *dependent*; *silly*; *clinging*; *bizarre actions*, and *passive*.

Dependent was interpreted by Olivia as "[reliance] on other people to help...make decisions [which] can be a real plus if you have somebody that's not capable of making decisions for themselves...it can also be a safety feature...if you have somebody that's at risk but they're very dependent and they rely on somebody to be there with them to go out...they're not going to wander off on their own, they're going to wait for someone..." Sarah defined *silly* in positive terms as "...giggling for no apparent reason...we all have private thoughts...I believe laughter is a very good thing, it stimulates certain glands and stuff and does very positive things...it needs to be something that...doesn't harm anyone..." Angie identified *clinging* with "hanging onto something..." Morgan described *self-centred* behaviour as a strength, as a form of assertiveness, and knowing one's self and limits.

Negative Terms

Four terms were most frequently identified as having negative connotations: *clinging*; *crude*; *dependent*, and *self-centred.* These were followed closely by *manipulates* and *silly*:

Olivia: "*Clinging* and cloying individuals…are always hanging on when they don't really need to be."

Rose: "*Clinging*…conjures up a really negative image of someone who is very needy, helpless, irritating, pathetic…it's just a terrible word."

Emily: "None of us are too keen on clingers."

Sarah: "*Crude* is just being outright rude and boorish…

Angie: "[self-centred], this is a value judgment on the personality."

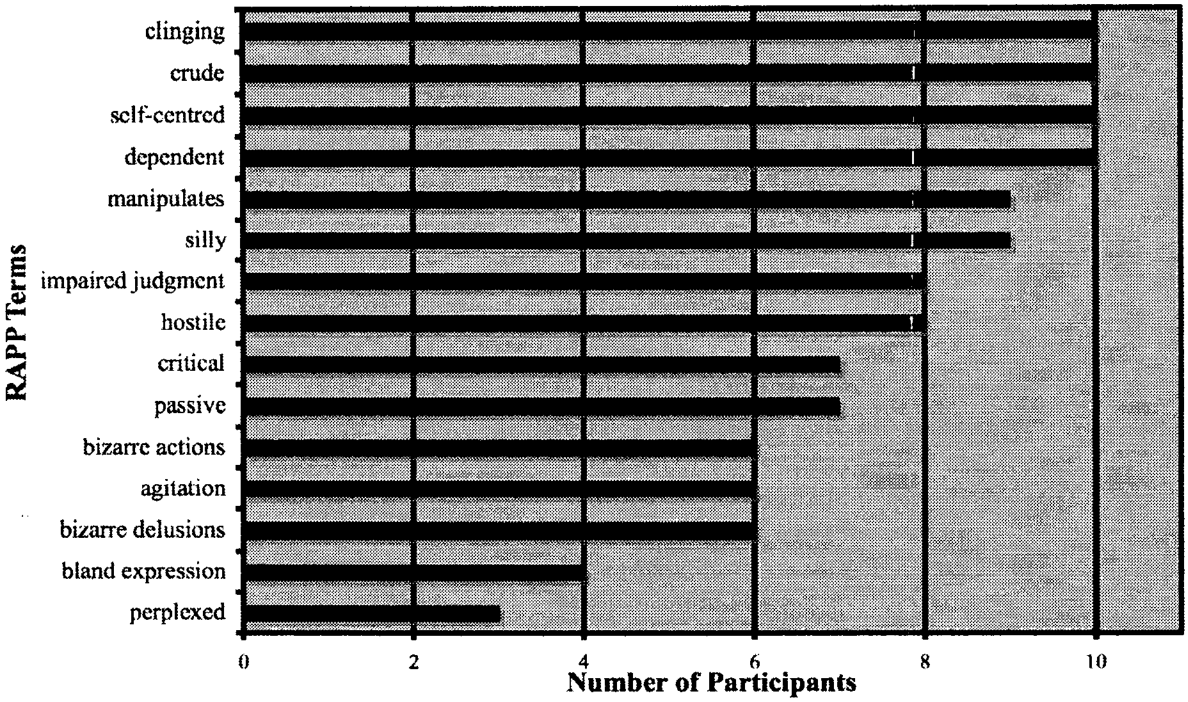
Stephen: "…*self-centred*, that's a term that I think clearly identifies somebody who is focused on their own needs and their own interests, usually at the expense of others and the environment around them."

Terms identified by participants as having negative connotations are displayed in Figure 4.3 (p.37).

"Why not say it this way?"

All 14 participants indicated that improvements in interdisciplinary communication could be achieved through modification of the terminology currently in use. Erin suggested that *dependent*; *silly*; *bizarre actions*; *manipulates*; *bizarre delusion*; *bland expression*; *critical*, and *impaired judgment* could be replaced with lengthier, more precise descriptions of the clinical phenomena being observed.

Figure 4.3. RAPP terms with negative connotations.



Jane: "...*manipulates* would probably be better if it was described differently...it would have to be a simple term...I would rather see *manipulates* described as unconstructive behaviour...*self-centred* [could be] inability to empathize or difficulty empathizing."

Sarah: "I think with all of these [terms] you need to look at the context...the situation...the individual."

Marie:"...write as it's spoken to you..."

Paul: "...I always feel it's important to have examples if your interpretation could be quite different from the next person."

Leah: "*Hostile* and *agitation* need some sort of a scale or...descriptive words like mild agitation, moderate...describing the behaviour more than labeling the behaviour...I know what the RAPP looks like, it's check marks and it's designed to be easy and quick but I don't think it says a lot once you're done."

Stephen: "…to be more accurate, or use language that's a little more precise, detailed."

Additional Terms

Participants identified four additional terms as being problematic due to their ambiguity, subjectivity or both: *attention-seeking*; *sabotage*; *inappropriate*, and *compliance/non-compliance*. With the exception of *attention-seeking* which was mentioned by two participants, the other terms were only referred to once.

"Manipulates" and "Bizarre Delusion"

Pilot interviews with six interdisciplinary clinical team members highlighted the terms *manipulates* and *bizarre delusion* as most likely to cause disagreement among care team members. This was, to a degree, borne out by the 14 in-depth interviews carried out during the study. *Manipulates* was identified as "most likely to cause disagreement" by 50% of participants and was rated in the top five by 79%. *Bizarre delusion* was rated "most likely to cause disagreement" by only one participant but was selected for the top five by 36% of participants, overall the fifth highest rating behind *manipulates, impaired judgment*, *self-centred*, and *dependent*. Based on the outcome of the pilot interviews, in-depth questioning on the terms *bizarre delusion* and *manipulates* was conducted with study participants.

Manipulates: Correspondence to Definitions

The American Psychiatric Glossary (1988) defines *manipulation* as "a behavior pattern characterized by attempts to exploit interpersonal contact" (p. 61). In their Comprehensive Glossary of Psychiatry and Psychology, Kaplan and Sadock (1991) define manipulation as "exploitativeness; the maneuvering by patients to get their own way, characteristic of antisocial personalities" (p. 113). *Exploitation* according to the NewWebster Encyclopedic Dictionary (1971) is: "utilization; the successful application of industry on any object…now, esp., selfish or unfair utilization" (p.310). A definition of *manipulation* is not contained in the DSM-IV (APA, 1994) glossary of technical terms.

In standard English the term *manipulate* possesses more than one meaning. The New Webster Dictionary (1971) offers the following: "to handle or operate on with the hands, as in artistic or mechanical operations; to subject to certain processes; to operate on for the purpose of giving a false appearance to (to *manipulate* accounts)" (p.515).

Many participants offered lengthy descriptions of the meaning of the term *manipulates,* often in conjunction with an example(s). Participant responses were partially concordant with some or all of the definitions provided above but rarely corresponded to any one definition precisely. Eight of the participants offered definitions that were consistent with The American Glossary (1988) although only one participant made explicit mention of exploitation. Three spoke of "taking advantage" of others; two participants described the behaviour of "splitting the team," and one mentioned "tricking others." The common thread between these descriptions was the act of making use of the weaknesses or limitations of other people.

Five participants gave definitions or examples that were consistent with the New Webster Dictionary's (1971) focus on "[giving] a false appearance" such as "playing games" and "saying what someone wants to hear."

The Kaplan and Sadock (1991) definition is the most complicated in that it requires exploitativeness and maneuvering to get one's way, both in a manner characteristic of an antisocial personality. For mental health practitioners the use of the phrase "antisocial personality" would generally connote traits associated with the diagnostic classification *Antisocial Personality Disorder*. The distinguishing characteristic of the antisocial personality type, as described in the Diagnostic and Statistical Manual IV (APA, 1994), is "a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood" (p.645).

Although the term *manipulates* does not appear in the diagnostic criteria for Antisocial Personality Disorder, the DSM-IV (APA, 1994) makes reference to "deceit and manipulation…in order to gain personal profit or pleasure (e.g., to obtain money, sex, or power)" as two central clinical features (p.645, 646). This behavior is associated with "disregard [for] the wishes, rights or feelings of others" (p.646).

None of the participant responses incorporated all of the factors associated with antisocial personality. The participant who came nearest, described behaviour consistent with the following elements: exploitation; trying to get one's way; deceit; disregard for the wishes, feelings and rights of others, and acknowledged that these factors constitute a pattern of behaviour. She did not, however, mention gaining personal profit or pleasure. Participant responses and the correspondence to standard and technical definitions of *manipulates* are displayed in Figure 4.4. Correspondence between participant responses and Kaplan and Sadock's (1991) definition are displayed in Figure 4.5.

Figure 4.4. Correspondence between participant responses and definitions of the term *manipulates*.

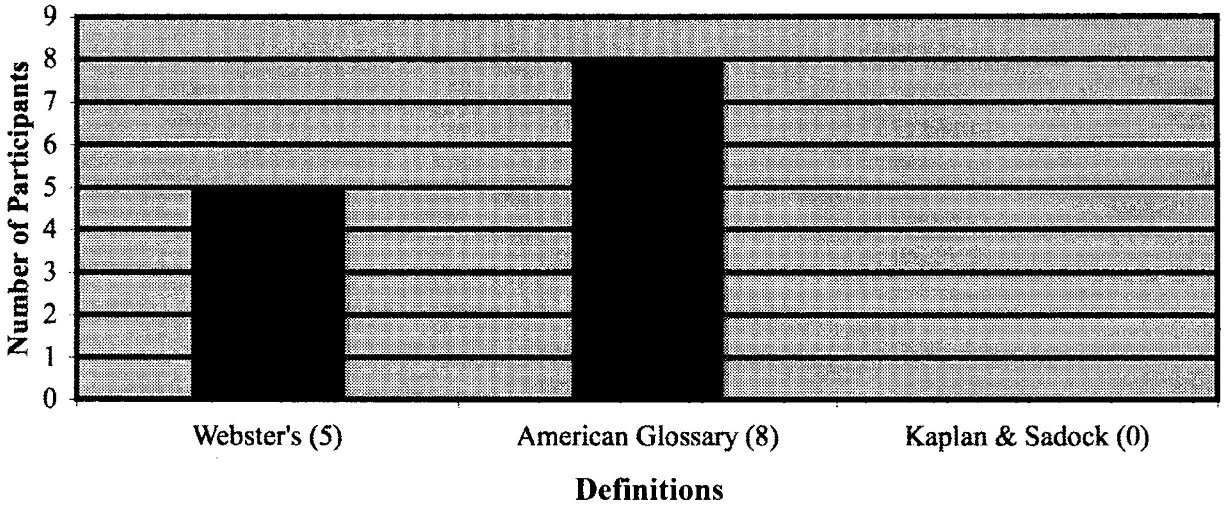
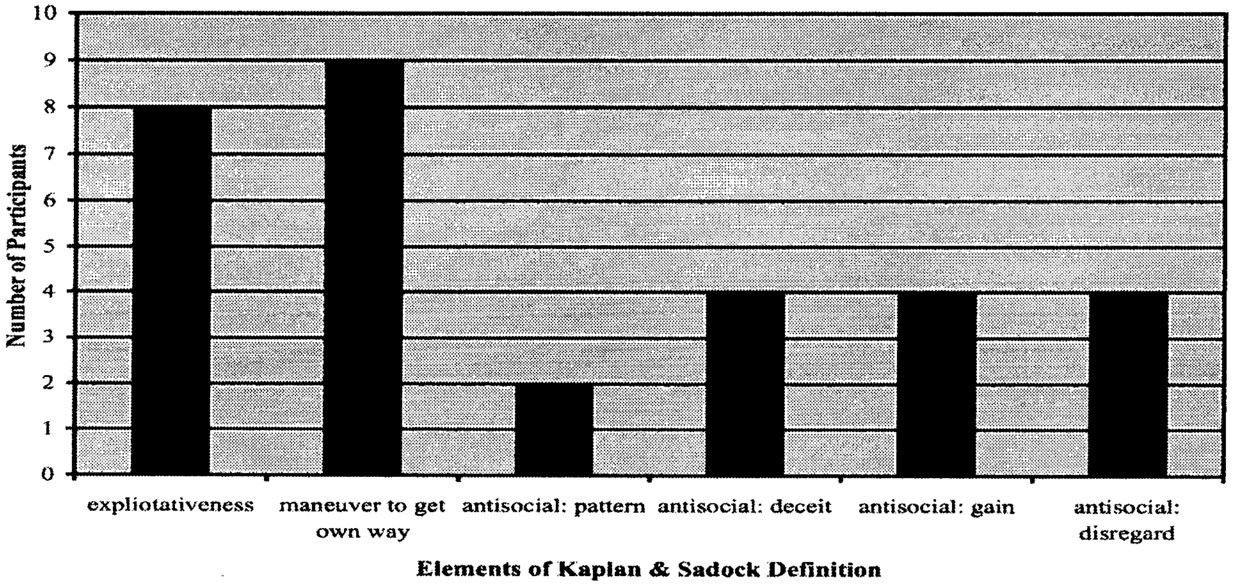


Figure 4.5. Correspondence between participant responses and the Kaplan & Sadock definition of manipulation.



It is interesting to note that two participants explicitly mentioned Borderline Personality Disorder in the discussion of manipulative behaviour. The DSM-IV (APA, 1994) suggests that manipulative behaviour associated with the diagnosis of Borderline Personality Disorder is specifically aimed at "gaining the concern of caretakers" (p.633). One respondent associated some of the manipulative behaviour she had witnessed with this diagnostic category. The other participant commented on her belief that borderline personality traits were frequently misattributed to individuals perceived as manipulative in the clinical context.

A third respondent identified manipulative behaviour with all personality disorders, collectively referring to them as "Axis II," and indicating that such a diagnostic distinction affected the team's perception of the client:

Jane: "I think [we're] less likely [to be judgmental of manipulation] if they have an axis one. I definitely would think [we] are less likely to see [the behaviour] as manipulative…see it more as part of the illness rather than within [the patient's] control."

Jane suggests that personality disorders, classified on the second axis of the DSM's multi-axial system, are perceived differently from those disorders identified on Axis I, such as Schizophrenia, particularly with regard to the client's conscious control over his/her behaviour. Jane implies that Axis I disorders are more disabling and therefore, warrant a different therapeutic approach. This naturally leads to consideration of how a practitioner's interpretation of the cause and purpose of client behaviour influences her/his choice of intervention.

Intentionality

Several participants appeared to struggle with the conscious/unconscious dichotomy as it applies to manipulative behaviour:

Jane: "Manipulation tends to be an intentional...deliberate thing...it may actually not be totally conscious but, you are not always aware that you are manipulating but you...it is on some level conscious and rather than being part of the illness it is more of a deliberate thing."

Paul: "I think it's sort of a...sometimes...unconscious type of behaviour or there's an unconscious drive behind that behaviour and the patient may not be deliberately trying to manipulate..."

Stephen: "Often it's not even a conscious thing...although it might be hard to argue that manipulation is secondary gain if it's not conscious...but sometimes it's not as well thought out...not sort of a carefully crafted thing."

Practitioner Reactions

Participants in the study described feeling "used;" "hoodwinked; "tricked;" "wanting to get the client out [of hospital] as soon as possible;" "frustrated," and "coerced" by what they perceived as manipulative behaviour. Participant responses suggested that manipulative behaviour challenged the practitioner's helping role and sometimes led to a process of detachment or the emergence of negative feelings:

Jane: "...[the team feels] this person is here getting fed and getting three square meals a day and getting a bed and we are not a hotel...we tend to want to get them out [of hospital] as soon as possible."

Rose: (makes a pushing gesture with her hands) "is it like pushing the client away? Yeah, absolutely."

Emily: "[manipulation] is its own reward, people lose faith in you and they make you wait longer than necessary to check you out over and over which may demean you but you sort of get, in a sense, what you ask for…"

Identifying Manipulative Behaviour: The Challenges

Participant responses suggest that some practitioners interpret manipulative behaviour as a behavioural state:

Jane: "…people sort of cringe when this person is coming along and then they can generalize a lot of their behaviours in terms of this manipulation when, you know, they are not totally and completely manipulative, there are other aspects to them."

Emily: "…maybe they're at a phase where they're…having a hypo-manic episode or a manic episode, that's the best they can do now and it'll clear up by itself but I think it's often just a habit people carry on and it's pretty entrenched…"

While others identify it as a dominant personality trait:

Marie: "I like the manipulators…I usually get all the manipulative patients assigned to me."

Participants struggled with the possibility that manipulative behaviour was, in some circumstances, more appropriately characterized as a coping mechanism, or assertiveness:

Olivia: "I think a lot of times we tend to say a person is manipulative when they repeat a behaviour over and over again or when as staff we perceive it as pestering, kind of intrusive or untimely behaviours and I don't think of those things as manipulative, I think that's just my lack of tolerance, and I often think that's a cue for me when I need a break or I need someone else to take over…"

Rose: "…I just thought, this is how she's probably been able to get her needs met in the past and it's a real need and we are here to make people's lives a little bit easier so I kind of wanted to give her credit for it somehow, you know I thought she was getting more assertive in some ways…resourceful…"

Catherine: "it's used most often in a way to sort of connote selfishness…it's not 'was able to manipulate another client to come to an exercise program' in that case it would be 'encourage'…but most times it is used in a way…*manipulates nurse into letting them stay up five minutes later*, that kind of thing…someone manipulating to get their stock up to $800.00 is brilliant, if someone gets an extra cigarette it's considered…evil…"

Morgan: "…I don't know if that's really a manipulative way of doing things or if that's a form of persuasion."

Emily: "…there can be circumstances where you keep presenting your case until you find someone who thinks it's worthy. Maybe that doesn't get you that kind of rating [manipulates], I hope we're not too easy at giving that…"

Participants appeared to be more inclined to perceive behaviour as manipulative if it was indirect:

Sarah: "If it is something I *can* do that isn't detrimental to that [patient] or to someone else and it is *reasonable* I don't have a problem doing it but I also acknowledge the fact that…*I know what you are doing and in the future…just ask…*"

Emily: "Manipulative people seem to not be able to straightforwardly ask for their needs to be met…they might be liars…in that they give you false information…maybe it's the only way they know…straightforward problem solving is a skill but a lot of people don't have [it], not just [patients] here…"

Angie: "…the first reaction I have…is a negative one…I want something of you or of the situation, I'm not going the straight way about it."

Clinical Interventions

Participants indicated that with a client displaying manipulative behaviour, their choice of interventions would depend upon the client's level of functioning, capacity to understand and her/his level of awareness of the behaviour.

Participants made 10 references to setting or enforcing rules, limits, structures and/or boundaries:

Marie: "I don't have any qualms about setting limits…"

Leah: "[set] really firm guidelines and [let] the client know what is and is not acceptable and to not bend…it's your responsibility to stick by your own care plan."

Stephen: "…clear boundaries, saying…what the guidelines [are]…reiterating, being firm, not wavering back and forth…have a very structured…approach."

Nine references were made to a consistent, unified team approach. Five participants mentioned that this could be facilitated through the use of a primary contact person to deal with the client's requests:

Jane: "…the team really has to come together on a consistent approach and they have to be talking to each other and they have to work as a team so that the person gets the same message…"

Stephen: "…it often leads to having to identify sort of a primary contact person so that people aren't going all over the place trying to achieve an agenda that goes around you or tries to split the team."

Emily: "often we get the 'you get assigned to one person' thing…the…approach which is nobody's going to listen to you at all, you will have to do your dealing through one [person]."

Six references were made to utilizing empathy, understanding or relationship-building strategies with the client. Five references were also made to discussion and education regarding alternate behavioural approaches open to the client:

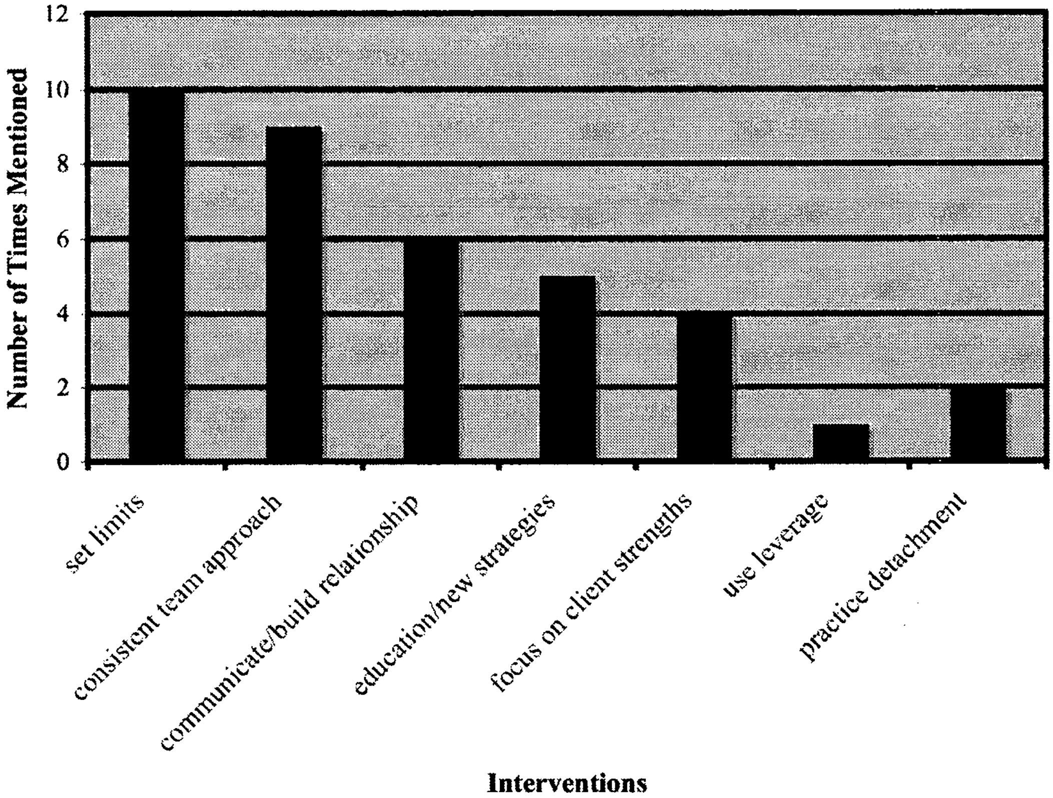
Rose: "I have at times, not just with clients but with other team members, [tried] to reframe [the behaviour]…maybe this is where the person's coming from or maybe…put yourself in that [client's] position…how would you respond?…"

Paul: "…help them gain awareness of their behaviour and point out that there are other ways of achieving your goal…that are a bit more socially appropriate or…better choices."

Emily: "…if you don't deal with it directly they may never click that it's certain ways they're going about solving their problems that aren't very straightforward. Maybe it's the only way they know, maybe they've grown up in a family where there's a lot of [manipulation] and everyone uses it…get this person to try new approaches…practice with them one-on-one and just encourage them…"

Other responses included: pointing out alternative problem-solving strategies; focusing on client strengths and capacities through the use of praise and the promotion of personal responsibility; cultivating professional detachment from the behaviour. One participant mentioned the use of leverage (eg., cigarettes) to shape client behaviour. Figure 4.6 displays the frequency of participant responses regarding clinical interventions.

Figure 4.6. The most frequently cited clinical interventions for manipulative behaviour.



Bizarre Delusion: Correspondence to Definitions

Kaplan and Sadock's (1994) Synopsis of Psychiatry defines *bizarre delusion* as "an absurd, totally implausible, strange false belief (for example, invaders from space have implanted electrodes in the patient's brain)" (p. 305). The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 1994) defines delusion as "a false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture (e.g., it is not an article of religious faith)" (p.765). The DSM-IV includes the following definition of the subtype *bizarre*: "a delusion that involves a phenomenon that the person's culture would regard as totally implausible" (p. 765).

Delusion

The *false* nature of delusional beliefs was identified by only six participants. A few participants acknowledged that the concept of *external reality* could present problems:

> Emily: I go through my experience and my reading and my university education, what I know about reality and I guess what I think the patient could know about reality...I have had strong disagreements with [staff] sometimes who...say that [something's] delusional as opposed to just a belief that the person has grown up with...I think...that people attribute their own beliefs as reality and someone else's beliefs as unreality.

Emily acknowledges that her experience and educational background may have exposed her to ideas with which the client is unfamiliar and vice versa. Furthermore, she describes how mental health practitioners can disagree on whether a belief is consistent with "reality" and that the practitioner's personal frame of reference might influence her/his assessment. Marie described how client beliefs that superficially seem outlandish routinely lead professionals to assume that they are delusional. She indicated that this has caused serious problems for clinical care:

> …maybe people didn't totally believe them on the outside because of their appearance or their manner…but it's come back to haunt us too…I've been surprised sometimes at some of the truth that we assume is delusion…a female was complaining that she was having sex with a male staff. She had gone to different people. Nobody believed her and of course she was a whiny type of personality…anyhow, it came out that there was a staff doing it, not only to her but to another female as well and she was reporting but in her way of reporting it, it sounded off the wall…you take from your experience…don't just pass off everything they tell you as delusional…you just never know.

Other participants who mentioned difficulties in establishing the nature of external reality did so in the context of cultural differences. Rose said: " I think that there's a tendency for us to describe something as being a… delusion…without giving enough consideration to the person's cultural background or religious background…"
Catherine: "…if someone was in a Pentecostal Church and was talking about *I've got the word from God and I'm saved*, that wouldn't be out of context…the culture does [have] an impact on whether we expect conformity or whether we can allow for a little more leeway."

Paul: "I think culture has an effect on different people's interpretations of whether they're mentally ill or not and their world views are quite different…so there's a chance of a lack of understanding just because of that."

Leah: "I was brought up Catholic but if you read the Bible and some of the stories that they talk about could sound like quite delusional things, statues crying blood and stuff like that…"

Respondents acknowledged that reaching a satisfactory definition of *delusion* was difficult, given the wide variety of possible human experiences and the influence of diversity.

Bizarre Delusion

The addition of the descriptor *bizarre* to the term *delusion* further hampered participants' efforts to provide a definition. Ten respondents gave either an example or explanation approximating the referenced technical definitions. However, many of them struggled to provide this information and only three explicitly identified *implausibility* as a feature of the bizarre delusion:

Angie: " I think if it's possible, it's not bizarre, but if it's *not* possible…a good example is the alien coming here. Is that bizarre or not? Some people talk about it being possible, so I guess it's not [bizarre]…I'm always struggling with what is possible…do I need physics in order to figure out what is possible…?"

Leah: "…it would be in relation to fantasy thinking or something that's not reality based, magical…not something that could have happened…"

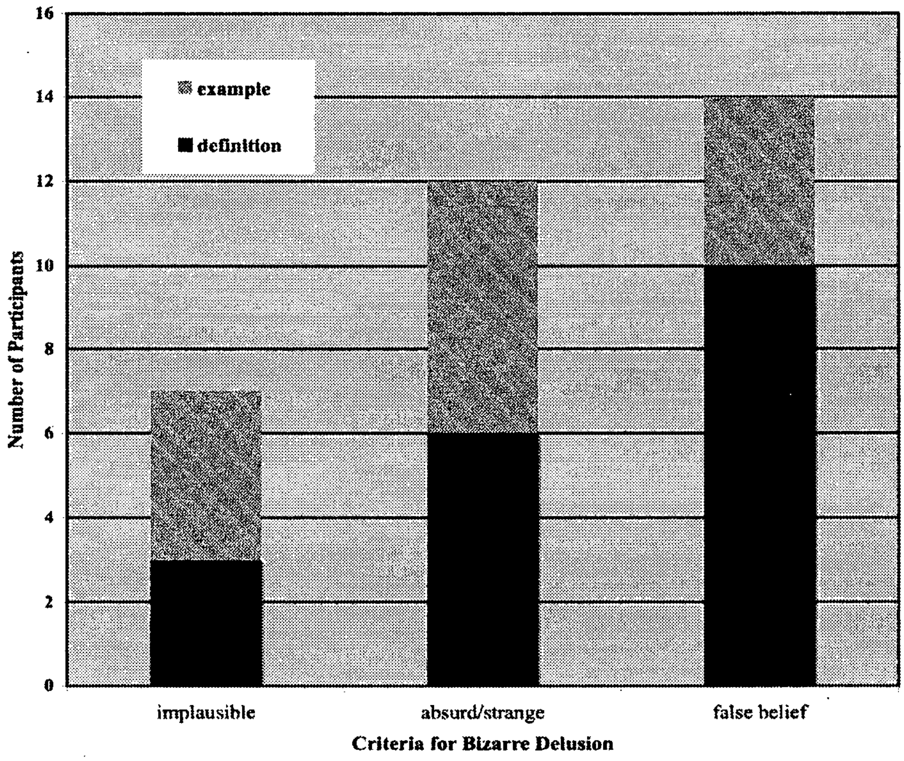
Emily: " A bizarre delusion is one that *cannot* be true, a thought that the person has…that is not only not true in the larger society's opinion but could not be true. That's hard to prove but…a patient who says *my father came to earth on a Spanish galleon from the planet A-109*…everyone knows that's not true."

Other participant explanations were suggestive of implausibility, for example:

Marie: "…I think some of the delusions, that there might be a grain of truth to some and the ones that are bizarre are way up there…hanging off of Mars or the space boys coming down…" Participants used the following terms in their attempts to define bizarre delusion: "irrational;" "unusual;" "odd;" "not accurate;" "strange;" "unconventional;" "unexpected;" "idiosyncratic," and "out of context."

Some participants gave an example(s) but not a definition, while others provided both. Participant definitions and examples were measured against the criteria of implausibility, absurdity or strangeness, and false belief. The results are displayed in Figure 4.7.

Figure 4.7. Correspondence between participant definitions, examples and the criteria for *bizarre delusions.*



Distinguishing between subtypes

Most participants offered definitions more closely related to the general term *delusion*:

Frances: "Bizarre delusions means something that's unreal, it's a belief held by a patient that's unrealistic."

Other respondents identified *bizarre delusion* as any delusion that didn't fit into the other sub-types, such as paranoid or grandiose:

Paul: "...extraordinary ideas...a multitude or sequence of different events that are somehow tied in together...it's quite colorful and quite circumstantial...it's very different from a very simplistic type of idea or delusion."

Rose: "...the strangest sort of story...a bizarre delusion that doesn't make a lot of sense, it's unusual...it doesn't sort of fit any of the other categories we have."

Jane: "There are some very clear paranoid delusions and some fairly clear erotic delusions but bizarre delusions...would be something that would fall outside of those."

Erin: "It is a delusion to an extreme..."

Some participants offered explanations more suited to another sub-type, such as *grandiose*:

Jane: "...they are writing music for some famous artist and they haven't yet gotten compensation..."

Catherine: "...he was telling me that he was the queen..."

Stephen: "...he believes himself to be personally responsible for the second World War."

Or *persecutory*:

Rose: " …his delusion is that his brother-in-law and his father-in-law…have accused him of sexually molesting his niece and nephew…he's afraid that the police are on to this and that if he leaves the hospital they're going to…brutally torture him…"

Morgan: "…she didn't want to go near TV's because people are watching her from the TV's…"

Unfamiliarity with the term

The examples given by three participants were inconsistent with the accepted technical definition of "bizarre delusion." In two cases, highly systematized paranoid delusions were described and in the third instance, an example more consistent with a "grandiose delusion" was offered. Two of the participants, with 24 years of mental health experience between them, reported that they had never heard the term used.

Clinical Interventions

Several participants indicated that their clinical approach to a client with a bizarre delusion would be influenced by contextual factors including: the client's emotional state or mood; the client's propensity for physical aggression; whether the delusion is likely to result in self-harm or put others at risk; how *fixed*, or firmly held the delusion is; how much of an impact the delusion has on day-to-day functioning and personal relationships.

The majority of responses indicated that clinical interventions fell into one of two main categories: "disregard and redirect" or "discuss and develop understanding". Five participants suggested that the client be "reoriented to reality" either through direct confrontation or a more subtle, reassuring approach. Only two participants mentioned the use of antipsychotic medication as a treatment for delusional beliefs; the use of Cognitive Behavioural Therapy (CBT) was mentioned once.

Disregard and redirect.

Seven participants made a total of 16 references to disregarding bizarre delusions, changing the subject, trying to distract or redirect the client:

Marie: "…I would cut [the person] off, I couldn't sit and listen to a whole bunch of drivel…I have the right to listen or not to listen."

Morgan: "…my clinical approach is just to leave it as is, because it's fixed. And it's not something I can fix and not something I can treat…"

These approaches were often suggested in combination with others:

Paul: "I don't focus so much on the delusion as trying to focus on helping the patient regain a sense of reality…offer them reassurance that would allow them to feel safe and using distractions…"

Olivia: " In general terms I would want to talk to him about bringing him back to reality, not maybe focus on [the delusion] at all…maybe changing the topic…"

Discuss and develop understanding.

Five participants made 11 references to direct discussion about the bizarre delusion and/or attempts to develop understanding about the delusion through the development of a relationship characterized by respect, acceptance and/or support:

Rose: "I like to try and…go through the person's history to understand more about who they are, what their experience has been, to see if maybe there is some kind of a tie…I like to try to be…respectful."

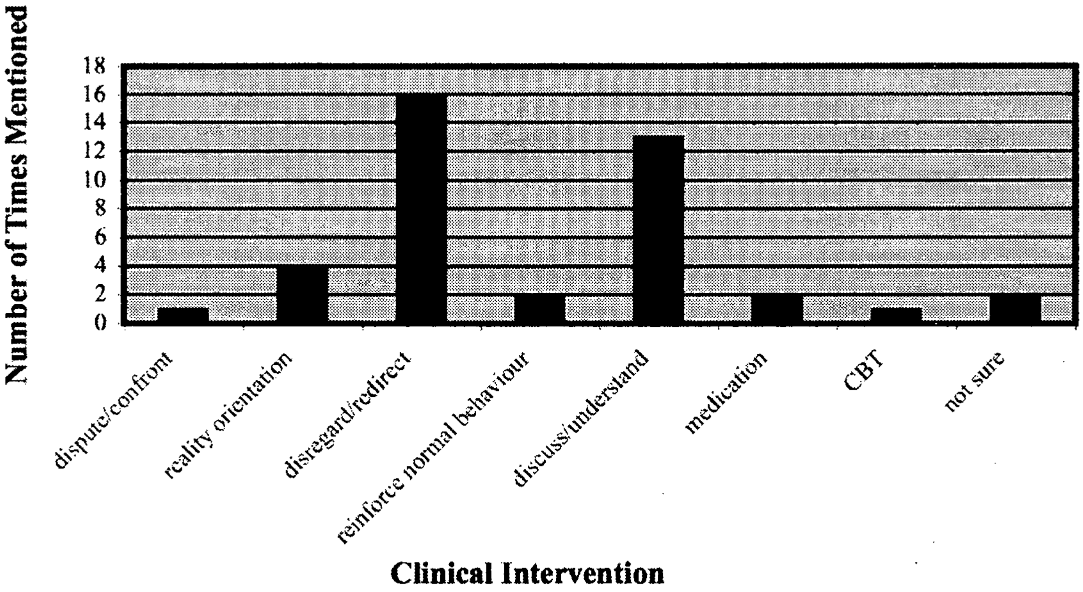
Emily: "…just accept what the patient says and try to get to know the patient, try to relate on some positive things that we can agree on and then eventually, as you're developing a relationship of co-respect with the patient to then introduce the idea that you haven't heard of something like that before..."

Catherine: "I speak to [the delusion] directly but not so much to the content as how it impacts what they're going to be able to do and not do."

Leah: "...comfort the person if they're obviously disturbed by their delusion..."

Three participants endorsed a passive response to the symptom: "I would not try to take it [the belief] away;" "I would be aware...and cautious; "I would do nothing, if it's not harmful." Two participants indicated that they were unsure what approach or clinical intervention they would use with a client who expressed a bizarre delusion. One participant did not provide a response to the question.

Figure 4.8. The most frequently cited clinical interventions for bizarre delusions.



Impact of Disagreement on Team Functioning and Patient Care

Participant responses indicated that disagreement about the meaning of psychiatric terminology may impact both team functioning and patient care. On the whole, these impacts were described as negative and harmful. Participants described such disagreements as leading to a fractured interdisciplinary team, characterized by misunderstandings and strained relationships. One participant suggested that in the case of disagreement over the meaning of a term, or the correct manner in which to describe a client's symptom or behaviour, the team member with the strongest point of view generally prevailed. It is not always the case, however, that the "strongest point of view" is the most accurate. Two participants commented on the potential such disagreements had to undermine the inter-rater reliability of clinical assessment rating scales such as the RAPP. These participants indicated that they assessed the accuracy of rating scores based on the perceived clinical acumen of the team member who completed them. Olivia suggested that issues could be overlooked: "I think it has a huge impact because you often talk about words [like] agitated, but we don't talk about…behaviours…an example of agitation might be that the person's dancing from foot to foot, what we're possibly not seeing is EPS, akathesia…the assessment part often doesn't get honed down…"

Participants identified a number of negative outcomes for clinical care including inaccurate assessments; the imposition of personal values/judgments on clients; fractured or conflictual team dynamics resulting in inconsistent care; the use of stigmatizing labels and the communication of mixed messages.

Paul: "The patient is going to suffer in the end because they're not going to be getting the most appropriate…or the most consistent care."

Additional Findings

Significant findings emerged that did not correspond directly to the specific questions asked of participants. Two areas of note included: how the practitioner's personal reactions impacted the practitioner-client relationship and the role of power in the therapeutic relationship.

The Practitioner-Client Relationship

Participants described a number of reactions to client behaviour that they perceived as manipulative:

Sarah: "…you care about everyone but you do have certain soft spots [for clients]…"

Catherine: "If I was hypomanic, I wouldn't want someone to think of me as silly, especially not a professional."

Emily: "I feel like I've been tricked…it's how you feel really. It's how the…person [staff] feels if they've kind of been hoodwinked..."

Rose: "…I've used the term when I'm just downright frustrated and at my wits' end…I don't like the way I'm feeling or I'm just totally frustrated."

Jane: "even though…in a professional life [you] are not supposed to like or dislike a patient it is hard to get away from that…"

Marie: "I like the manipulators, because I end up becoming a challenge to them."

These practitioners describe how interactions with certain clients give rise to feelings of attachment, betrayal, vulnerability, frustration, aversion, competitiveness and various other emotional responses. It is possible, if not likely, that such strong feelings impact on a practitioner's choice of intervention and/or the manner in which it is implemented:

Frances: “it has a huge impact [on patient care]...if they say somebody’s manipulative or self-centred...they tend to get frustrated with them, they tend to not put the time in with those patients that they would with somebody who was a little less troublesome. These patients...get the time-outs, the PRN’s [extra medications], they tend to get the meetings with the team around their behaviours...”

Frances’ comment is illustrative of conditions related to the other emergent finding: the role of power in the therapeutic relationship.

The Power to Decide

In explaining their roles, study participants used a variety of words to describe their efforts to modify client behaviour: promote; teach; manage; motivate; encourage; educate; evaluate; help; develop; rehabilitate; work with; deal with, and support. These terms carry more positive connotations, generally identified with “professionalism,” than the descriptors used to describe client attempts to modify their environment, including the behaviour of staff. Over the course of the interview, particularly during the exploration of clinical interventions, other expressions emerged which clearly represented the authority of the practitioner: confront; re-orient; set limits; reinforce; redirect; distract; ignore; downplay; reframe; minimize; set guidelines; set boundaries; reason with; explain; use leverage; “lay the law down;” give patient the “power.” Although the last phrase is intended to denote empowering the client, it demonstrates that in practitioner/client encounters the “power” generally lies with the practitioner.

Power over clients was also demonstrated in the way that many participants indicated they would instinctively know how to interpret or how to intervene with a specific type of client, symptom or behaviour:

Stephen: "…as far as manipulates goes…it's best described by how my daughter treats me…no I'm just kidding…just as with one's kids…one has to set firm boundaries."
Sarah: "…she'll play the disabled person…and you know, it'll just take a couple of times just saying *look, I don't take kids out, I take adults out, if you want to come [on the outing]…this has got to stop.*"

The above examples suggest a power differential between the practitioner and client that is analogous to a parent-child relationship. It suggests that the practitioner, like a parent, assumes the power to define behaviour and decide what is and is not acceptable.

The metaphorical usage of the word *manipulates* in everyday language has perhaps led people, mental health practitioners included, to the conclusion that its recognition is simply a matter of common sense. As a result, the interpretation and response to the behaviour in the realm of psychiatric practice is, for some, not very different from non-clinical experiences, such as disciplining a child. As in the case of bizarre delusion, many subtleties associated with the technical, psychiatric definition of manipulation are overlooked.

Chapter Five: Discussion

Study findings reveal that mental health practitioners hold differing perspectives on the meanings of psychopathology descriptors and on associated approaches to patient care. Interdisciplinary discord can, and in the experience of the respondents does, result from differing interpretations of terminology.

Participants generally possessed many years of front-line mental health experience, the average being 15. The nine participants who indicated that they had received some training or exposure to psychiatric terminology acknowledged that this occurred at the time of their training, on average 14.5 years prior to the study. Only half of the study group indicated that their knowledge was augmented in the intervening period through individual study or attendance at conferences or workshops. 71% of participants indicated that they relied all or in part on "on-the-job-learning" to understand and apply psychiatric terminology. These findings raise questions about whether practitioners have been able to integrate changes in mental health classification systems and terminology into their practice. For example, three of the participants completed their training before the publication of the DSM-III (APA) in 1980, nine completed their training prior to the publication of the DSM-IV (APA) in 1994, and 10 completed their training prior to the publication of the RAPP (Ehmann et. al, 1995). Given the divergent meanings offered by participants for the terms used in this study, it is questionable whether on-the-job-learning, which assumes that the individual learns from another team member(s), contributes more readily to a precise understanding of psychiatric terms or rather to the proliferation of outdated or ad hoc definitions/meanings.

Perception of Role

"Health care professionals are in an occupation that has interpersonal communication at its very core" (Morrall, 2003, p.50).

Since this study focuses on interdisciplinary communication as it relates to psychiatric terminology it is interesting to note that three participants did not spontaneously identify communication as part of their work role. Of the eleven who did, three described this function as educating others through the provision of information and/or recommendations. Their role descriptions did not include being the recipient of information from other team members, the client or community caregivers. This is consistent with the view of mental health practitioners as "experts" on the identification and treatment of mental illness.

Only half of the participants mentioned team membership or teamwork as part of their professional role. The interviews did not allow for full exploration of this area but given the prominence of the interdisciplinary team model of health care delivery it suggests a topic for further study. The literature is replete with articles suggesting that while it is respresentative of an ideal form of interdisciplinary collaboration, the multidisciplinary mental health team model, in practice, rarely reflects this ideal. Such teams are instead generally characterized by conflict and role confusion (Granville & Langton, 2002; Lankshear, 2003; Norman & Peck, 1999; Northouse & Northouse, 1992), differences in pay, perceived differences in status (Norman & Peck, 1999) and in autonomy (Northouse & Northouse, 1992).

While many participants made reference to personal characteristics that they perceived as being advantageous for mental health work, only one mentioned professional resources for working with psychiatric clients such as practice standards or guidelines. This suggests that participants have integrated their personal and professional identity to such a degree that consulting with references or sources of information outside of the clinical encounter is seen as unnecessary. This is consistent with participants' statements that on-the-job-learning is a central part of their professional growth and development and Abramson's (2002) observation that "induction into a professional role…comes about through observing mentors and others in the profession or responding to their support for certain behaviours and attitudes." (p.46).

Interdisciplinary Team: Many Members, Many Views

Participant responses revealed differing conceptualizations of client symptoms and behaviour and, as one would expect, different approaches to patient care. This trend was most pronounced in the participants' attempts to describe manipulative behaviour and the clinical interventions they associated with it. The contrast was almost dichotomous, with some participants favouring emotional detachment from the client along with the introduction of limits or rules and other participants emphasizing an empathic approach with a focus on the development of therapeutic rapport through understanding and/or reframing the client's behaviour. This dichotomy also held true for bizarre delusions where participants' responses fell into one of two categories: disregarding the symptom and redirecting the client, or discussing the impact of the symptom and developing understanding.

Participant responses appear to correspond roughly with the six-category intervention analysis proposed by Heron (as cited in Betts, 2003), which identifies helping responses as falling into two major categories: authoritative and facilitative.

Authoritative interventions include prescriptive responses (eg., "let's change the subject"), informative responses (eg., "this medication can help reduce your symptoms") and confrontative responses (eg., "your belief is not reality, you have delusions"). Facilitative interventions, by contrast, involve cathartic exploration aimed at the release of feelings (eg.," it sounds as though your belief may be masking emotional pain"), catalytic responses supporting the client's self-discovery and understanding (eg., "it seems as though it's very important for you to believe..."), and supportive responses ("you and I may see things differently but I value your point of view") that communicate affirmation, respect and acceptance (Betts, 2003). Respondents seemed to split upon these lines. Of the eight respondents who proposed active intervention(s) with clients who had a bizarre delusion, three described facilitative interventions, three described authoritative interventions and two offered a combination of both.

Participant responses made it clear that many of them located power within the team, the power to both develop and implement appropriate interventions for manipulative behaviour. This view diverged from those respondents who advocated giving the client "the power," or "ownership of the [treatment] plan," implying that the client's ideas or perspective would be included in the team's strategy and that the client would be primarily responsible for ensuring behavioural change.

It is, of course, difficult to say whether these differences are the result of personal beliefs and experiences or professional training. It seems likely that the divergence results from some combination of both. An interdisciplinary team is, by nature, comprised of individuals from many professional groups. As a result of professional socialization (Abramson, 2002), individual disciplines bring a distinct point of view to the practice of mental health care. The socialization that Abramson (2002) refers to, "shapes [the] values, language, preferred roles, methods of problem solving, and establishment of priorities [of these groups]" (p.46).

Participants agreed that differing interpretations of terminology are a source of interdisciplinary discord. In their book on Health Communication, Northouse and Northouse (1992) discuss the problem of *unshared meanings* in detail but only with respect to professional-patient communication (p.83). The issue of unshared meanings in professional-professional communication is one that has not received much attention, at least not in the available research literature. Nevertheless, Northouse & Northouse's observations regarding unshared meanings between caregiver and client have some transferability to the communication process between interdisciplinary team members. The authors note that: "what we perceive to be 'real' depends on our unique interpretation of events *and* on our different interactions with others – hence our reality is socially constructed" (p.83). Northouse & Northouse (1992) cite two main factors that contribute to unshared meanings between clients and professionals: jargon and differing interpretations of the same word(s). Participants in this study demonstrated that psychiatric terms are vulnerable to different interpretations and that some, such as *critical* also have multiple meanings.

The Practitioner-Client Relationship

In addition to divergent professional perspectives, mental health workers invariably have different personal reactions to the clients with whom they work (Heginbotham, 1999; Hinshelwood, 1999; Lankshear, 2003). Northouse and Northouse (1992) describe the professional-client relationship as "influenced by the personal and professional characteristics that both patient and professional bring to the relationship: characteristics such as an individual's age, sex, ethnic background, personality, values…"(p.74). Participants rarely made explicit reference to such characteristics during the course of the interview, except when they alluded to their personal values (eg., "not being judgmental"). Participants did, however, describe how the dynamic relationship between practitioner and client can elicit responses on a personal, as opposed to a professional, level. For example, some participants described personal identification with client behaviours ("it's best described by how my daughter treats me") and many respondents expressed aversive reactions ("…you're not supposed to…dislike a patient [but] it's hard to get away from that").

The use of a technical language is considered to be one of a number of strategies by which health care professionals defend themselves against the anxieties associated with their work (Wondrak, 1998). As participants described, psychiatric terms can serve to distance oneself from one's client. In certain circumstances this may be a very adaptive response, preventing the practitioner from responding to the client in a manner that would be rejecting or unsupportive. However, at its extreme, a detached, remote stance may replicate the social distance associated with stigma, preventing appropriate empathic responses on the part of the practitioner and/or contributing to the client's distress.

Manipulates

Manipulates was the term that received the most frequent mention and highest rating as a cause of disagreement. Given that standard dictionary definitions vary slightly from those found in psychiatric glossaries and that psychiatric glossary definitions differ slightly from one another, this is perhaps, not surprising. It has been suggested that attempts to develop a single, precise definition applicable in all possible contexts in which the word *manipulation* may be used, are misguided (Kligman & Culver, 1992). One basic constitutive element that can provide a point of focus, however, is the degree to which the manipulative behaviour is conscious, or intentional.

Intentionality

Despite assertions that elements of the definition should be readily apparent to all, as implied by the quote that: "there seems to be general agreement that manipulation involves the conscious attempt to influence another's behaviour, that it often involves the exercise of high skill, cunning, or artfulness, and that there is something unsavory about it, frequently attributed to the fact that it is often self-serving and involves deception" (Kligman & Culver, 1992, p. 175), this general agreement is not necessarily evident in practice. For example, Kligman and Culver (1992) emphasize that "the intentionality of the act is the essence" (p.178); other authors concur, describing manipulative behaviour as deliberate (Hamilton, Decker & Rumbaut, 1986). This view of intentionality represents a departure from early psychiatric analyses of manipulative behaviour that regarded it as largely unconscious (Kligman & Culver, 1992). Several participants clearly struggled with the conscious/unconscious nature of manipulation. Jane described the following:

> Manipulation tends to be an intentional...deliberate thing...it may actually not be totally conscious but, you are not always aware that you are manipulating but you...it is on some level conscious and rather than being part of the illness it is more of a deliberate thing.

Participants indicated that the client's level of functioning, degree of cognitive impairment and awareness of her/his behaviour would influence their choice of intervention. For some practitioners, the client's awareness of her/his behaviour appears to be the benchmark for determining the client's culpability and the corresponding practitioner response. This is consistent with Midgley's (2004) assertion that:

> …the distinction between deliberate activity and mere passive drifting is of the first importance to us…we need to know whether the people we deal with are in full charge of their actions or are in some way passive to outside forces – whether for instance, they are drunk or psychotic…our notion of responsibility centres on our understanding of people's purposes. And responsibility…covers the whole ownership of actions, the notions that we form of people's characters, the grounds of our entire social attitude to them (p.49).

Respondents indicated that clients thought to be engaging in conscious manipulative behaviour provoke different, often more negative responses, than those judged as having impaired awareness of their actions. And yet, the uncertainty expressed by respondents regarding the conscious/unconscious nature of manipulative behaviour would seem to render an assessment of the client's awareness of this behaviour difficult, at best.

Practitioner Reactions

Kligman and Culver (1992) acknowledge that "the label 'manipulative', once applied to a patient, can be…a powerful determinant of the perceptions and feelings that mental health workers subsequently have toward that patient," perceptions that are generally negative. "To describe someone as a manipulative person is to make a pejorative assessment of him" (Kligman & Culver, 1992, p.175). A parallel can be drawn here to the phenomenon of the *difficult patient* whereby a mental health practitioner experiences a dislike for her/his client, and as a result, suffers a "disagreeable or 'difficult' feeling" (Hinshelwood, 1999, p.187).

Hinshelwood (1999) proposes that difficult patient behaviour challenges the mental health practitioner's identity by failing to "complement the professional's helping role" and that practitioners generally respond by depersonalizing the client and/or "condemning, rejecting and physically discharging" the client (p.188-189).

The majority of participants indicated that in dealing with a client who displays manipulative behaviour, their preferred interventions involved setting and enforcing rules, limits, structures and/or boundaries. What does the choice of intervention say about their reaction to the client's behaviour? Hamilton, Decker and Rumbaut (1986) suggest that:

> ...medical caregivers are often authoritarian, feeling that their directives are in the patient's best interest and should be followed without question. This approach works well with passive, compliant...patients. It works poorly with patients who are independent, assertive, conscious of their rights as consumers, and somewhat mistrustful of caregivers in general. Such patients resist passive, compliant roles. They may argue overtly or even seek care elsewhere. If, however, they attempt to get their way more indirectly, staff may label them "manipulative" as a rough synonym for "we don't like you (p. 192-193).

Identifying Manipulative Behaviour: The Challenges

State or Trait?

Hamilton, Decker and Rumbaut (1986) point out that practitioners may confuse "an acute manipulative state with a chronic manipulative trait" (p.190) which then serves to define the client as a person. The term "manipulators," which was used by two respondents, echoes expressions such as *neurotics* or *depressives* which have fallen out of favor precisely because of the danger that the person is then defined by or reduced to a disorder or trait in the mind of the practitioner. The DSM-IV (1994) addresses this issue directly in its introduction:

> A common misconception is that a classification of mental disorders classifies people, when actually what are being classified are disorders that people have. For this reason, the text of the DSM-IV...avoids the use of such expressions as "a schizophrenic" or "an alcoholic" and instead uses the more accurate, but admittedly more cumbersome "a person with Schizophrenia" or "an individual with Alcohol Dependence" (xxii).

Manipulative vs. Assertive

Another risk that has been identified is the tendency to misapply the term *manipulative* to behaviour more appropriately described as assertive (Hamilton et al., 1986) or persistent. Emily's allusion to "presenting your case until you find someone who thinks it's worthy" describes a behaviour characteristic of North American legal, political and even economic spheres of life. In these contexts, such behaviour might be characterized as *advocacy*, *determination* or *competitive drive*. These terms do not carry the same pejorative connotation as *manipulates*; in fact, they are generally associated positively with the conception of the self-sufficient individual so valued in developed societies (Burr, 1995). The contrast between the roles of free individual and mental patient informs this distinction.

The free individual in closest proximity to the hospitalized mental patient is the mental health practitioner. The interpretation of practitioner behaviour, on the whole, tends to be more favorable than that of the patient. This is not surprising given that the discourse of mental health care is determined, by and large, by those who provide it. Burr (1995), elucidating the work of Gergen (1989), argues that: "We are all competing for 'voice' or the right to be heard, and…therefore present constructions of ourselves that are most likely to 'warrant voice', i.e. to use representations that offer us some validity and legitimacy…those in relatively powerful positions 'warrant voice' more easily than others" (p.90-91). This is consistent with the observation made by Hamilton et. al (1986) that mental health practitioners who use forms of coercion or persuasion are rarely described as "manipulative."

Indirect vs. Direct

Another distinction made by study participants centred on whether the client's efforts to manipulate their environment were direct or indirect.

Sarah: "If it is something I *can* do that isn't detrimental to that [patient] or to someone else and it is *reasonable* I don't have a problem doing it but I also acknowledge the fact that…*I know what you are doing and in the future…just ask…*"

Emily: "Manipulative people seem to not be able to straightforwardly ask for their needs to be met…they might be liars…in that they give you false information…maybe it's the only way they know…straightforward problem solving is a skill but a lot of people don't have [it], not just [patients] here…try to get this person to try new approaches." Angie: "…the first reaction I have…is a negative one…'I want something of you or of the situation,' 'I'm not going the straight way about it.' The more I look at it, I look at it as they're really coping and this is the only way they know how to do it…why do they feel they cannot get from us what they need directly? It's more of a reflection maybe on us."

Despite the superficial similarity of the preceding comments, all three participants are saying something different about the direct/indirect nature of the client's actions. Sarah implies that if the client were to make a direct request for her assistance rather than an indirect one such as "looking at me and [being] bashful" to obtain a cigarette, that the behaviour would cease to be manipulative. Emily's comments reflect an intersection between the issue of conscious awareness, mentioned earlier, and using a straightforward communication style. She suggests that some clients are manipulative because they don't know any other way to get their needs met; this is the approach that they have learned. Emily asserts that clients lack awareness of other methods for meeting personal needs, and she suggests an ameliorative strategy of getting the client to try new approaches. Angie, on the other hand, turns the question of why the client employs an indirect mode of communication back on mental health practitioners, implying that there may be something in the nature of the professional, team, organization or system that forces the client to behave in such a manner. Interestingly, none of the definitions of manipulative behaviour utilized for this study mention the use of indirect methods of communication. An argument could be made that "maneuvering" or "giving false appearance to" approximates the notion of "not being straightforward" and yet, the former terms are generally used in the context of deceit or lying, a phenomenon that can be quite direct.

Bizarre Delusion

While the term *manipulates* elicited many opinions and observations, *bizarre delusion* also brought to the fore difficulties associated with shared/unshared meanings in interdisciplinary psychiatric practice.

The definition of *bizarre delusion* has changed over time. Definitional issues are further complicated by the fact that *bizarreness* and *delusion* are two separate concepts within psychiatry, with their own definitions. Whatever difficulties exist in establishing their individual meanings, these are compounded by their use together.

Definitional Problems: Delusion

Oltmanns and Maher (1988) assert that "delusions may be the most poorly understood phenomena in psychopathology" and that "it is very difficult to obtain concensus on a specific definition" (p. ix), a view that is shared by other authors (Jones & Watson, 1997; Spitzer, 1990). An immediate problem with the definition of delusional beliefs is the requirement that they be *false* (Kaplan & Sadock, 1994, APA, 1994). This requires that mental health practitioners make a determination as to the nature of truth, which some argue, simply cannot be done (Heise, 1988). Heise (1988) suggests that "truth varies across acceptable social groups" and that "the same belief can be judged as a delusion or a non-delusion depending on the social conditions of the believer" (Oltmanns & Maher, p.259).

The *false* nature of delusional beliefs was explicitly identified by only one participant, five other respondents gave answers approximating falsity. In most cases, participants did not feel it was necessary to specify what *delusion* meant and focused primarily on the descriptor *bizarre*. This suggests that many participants assumed the meaning of the term *delusion*, on its own, was a given, requiring only superficial attention or none at all.

Another problem with the definition of the term *delusion* lies in its requirement that the false belief be based on "incorrect inference about external reality" (APA, 1994). There is disagreement in the literature about whether a delusion is best described as the result of an incorrect inference (Spitzer, 1990); the notion of external reality is also contested (Green & Lee, 2002; Turner, 1998; Burr, 1995; Harper, 1992).

A few participants acknowledged that assessment of the existence of external reality is problematic, especially in light of culturally specific beliefs. This makes the task of defining what is and is not a delusional belief extremely difficult. Consideration of the sub-type *bizarre* raised similar problems.

Definitional Problems: Bizarre

The inclusion of the sub-type descriptor *bizarre* to the term *delusion* only seems to make efforts to reach a precise definition more difficult. Several studies have established that inter-rater reliability for the identification of bizarre delusions is fair to poor (Flaum, Arndt & Andreason, 1991; Spitzer et. al., 1993; Mojtabai & Nicholson, 1995) among mental health professionals. According to the DSM-IV (APA, 1994), the characteristic that distinguishes a bizarre delusion from other sub-types, such as *persecutory* or *grandiose*, is its implausibility. Only three study participants acknowledged this defining feature in their explanation of the term's meaning. It could be argued that two more had an awareness of the criteria because five of the examples given could be classified as bizarre delusions.

Some participants' comments served to highlight the fact that many phenomena once considered implausible are now, by virtue of scientific advances and technological change, plausible. Some of the examples given by participants, such as a woman over the age of fifty giving birth to a child, and antennae or electrodes being implanted in the body, are not, strictly speaking, impossible. Even beliefs that appear to be widely held, for example that humans on earth are the only advanced life form in the known universe, are not undisputed and have provoked considerable controversy. The boundaries of the reality concept appear to be fluid.

Given that bizarre delusions have been identified as "a cardinal symptom for the diagnosis of schizophrenia in modern diagnostic symptoms" (Mojtabai & Nicholson, 1995) it is interesting to find that five participants gave definitions corresponding more closely to other sub-types (eg., grandiose, persecutory) and that two participants reported they had never heard the term used.

Practitioner Reactions

On the whole, when dealing with bizarre delusions, participants endorsed a therapeutic approach characterized by attempts to redirect the client to another topic of conversation. In total, 16 references were made, by seven participants, to distracting or redirecting the client, or ignoring the symptom altogether (either because it doesn't present a problem for day-to-day functioning, or because ignoring the symptom was associated with the goal of behavioural *extinction*). An effort to promote the client's awareness of *reality* was mentioned four times. Presumably, these approaches would require that the practitioner dismiss the content of the bizarre delusion and decline to discuss it. The opposite view, shared on eleven occasions, by five participants, was that the best way to intervene would be to talk with the client about her/his delusional belief(s) and supplement this understanding with as much background information as possible.

Historically, the literature on the treatment of delusions, and bizarre delusions in particular, has been limited (Oltmanns, 1988). Antipsychotic medication is frequently used (Myers & Ruiz, 2004); behaviour therapists have also tried to use operant learning procedures to discourage clients from talking about their delusional beliefs (Liberman, 1973). Recently, there has been a renewed interest in the use of cognitive-behavioural strategies in both individual therapy and group formats (Garety, Fowler & Kuipers, 2000; Chadwick, Birchwood & Trower, 1996; Kingdon & Turkington, 1994). Despite their prominence as treatment strategies, only one participant mentioned the use of antipsychotic medication and one other suggested the use of cognitive-behavioural therapy.

One participant indicated that this is an area of practice where she struggles. With respect to intervention(s) appropriate to a bizarre delusion Angie relates:

> …I don't have a theory. I'm not sure whether by me saying to that person 'it must be difficult' or 'it's so horrible to lose your daughter that way' is that what she needs? Am I supporting her delusion [of her daughter's death] by saying that?…or maybe if she's totally distracted from the delusion, maybe that's what

> she needs. I'm not sure…my tendency, personally, is to support her because [the distress is] a reality.

Given the various strategies that mental health practitioners employ in response to bizarre delusions and the lack of a clear link between these approaches and the psychiatric literature, this suggests an area for further study. How do practitioners decide which therapeutic approach is best? Where and from whom do they learn about intervention(s)? What rationale, or desired outcome, underpins the chosen strategy? Many participants seemed certain of the therapeutic value of their chosen approach but unclear on its theoretical basis. When responses were analyzed, participants had subscribed to one of two vastly conflicting main strategies. Only one participant pointed to the competing views associated with the choice of available interventions: to disregard the symptom or discuss it; to redirect the client to more socially acceptable forms of behaviour; or to acknowledge the client's present reality and attempt to develop an understanding of it.

It is possible that confusion over the theoretical bases for clinical intervention is related to the atheoretical stance that the DSM-IV (APA, 1994) professes to take: "a descriptive approach that [attempts] to be neutral with respect to theories of etiology" (p. xviii). From a post-structuralist, constructivist point of view, achieving such absolute objectivity is not possible. In the course of their training and work experience practitioners are exposed to theories of etiology and/or develop their own. This cannot be avoided, nor should it. However, does the illusion of diagnostic neutrality, reinforced by adherence to DSM criteria, permit practitioners to intervene without the guidance provided by theory? Or to utilize existing theories and biases without subjecting them to scrutiny? In other words, does the atheoretical stance of the DSM lull practitioners into the belief that clinical decisions that flow from the diagnostic process are inherently neutral and objective, and do not require self-awareness or examination?

Chapter Six: Implications and Directions for Future Study

A central question emerges from the findings of the study and the consideration of relevant literature: Is the basic problem the fact that practitioners do not agree on language or that they have too much faith in the language that they use? The answer seems to be that both questions are important and furthermore, are interrelated. Clinical responses then, must address both issues.

In light of the lack of precise, shared understanding of psychiatric terminology, attention should be paid, by all disciplines, to the issue of preparation for mental health practice and the maintenance of continuing education. Many participants indicated that they had received little training in the technical meanings and proper usage of psychiatric terminology prior to, or during, their careers. The frequent revisions of glossaries and classification systems in psychiatry requires a commitment to ongoing professional education on the part of practitioners in order to clarify the meanings of the terms being used.

Such education should not, however, be limited to the technical meanings of psychiatric terms. If the second problem is to be addressed, teaching should also focus on awareness of the debates surrounding controversial terminology and the potential socio-political implications arising from its use. In this way mental health practitioners may come to a fuller understanding that language is imprecise, fluid and imbued with power.

Disciplines must also consider how the professional role, once established, contributes to the perpetuation of unexamined assumptions about clinical phenomena. Abramson (2002) suggests that:

> As one becomes a social worker, a physician or a nurse, perspectives particular to a profession become so integrated with a professional role that awareness of them diminishes; they become taken for granted and thus remain unexamined for their impact on collaboration with other professions (p.46)

The interdisciplinary team model requires that the practitioner cultivate awareness of a broad range of phenomena, even that which would seem to be outside of her/his discipline's area of expertise. An interdisciplinary approach to assessment and treatment requires ongoing communication about all domains of client functioning and consistency in the application of many selected interventions. Such communication is also part of the mechanism by which terms may be clarified and categories/classifications revised.

The theoretical basis for the clinical interventions selected by participants was, in almost all cases, unstated or unclear. Therapeutic paradigms were rarely mentioned and several respondents indicated that they struggled to determine the most suitable clinical approach. It appears that some interventions are based on consensus, others on what is perceived to be *common knowledge*. A potential implication is that the inconsistent application of interventions makes it difficult to determine which, if any approaches, are effective. The lack of a therapeutic rationale and reliance on ad hoc determinations of vague concepts like *awareness* also make it difficult to assess what actual outcomes (positive or negative) are attributable to (eg., the attitude of the practitioner toward the client; the actual intervention). Another implication is that therapeutic rapport, a critical element in the provision of health care, can be eroded by inconsistency and an inability to explain one's rationale for treatment.

More qualitative studies examining the meanings mental health practitioners ascribe to psychiatric terminology are needed, as none could be found in the literature. Furthermore, existing studies on the clinical manifestations of manipulative behaviour in psychiatry are uncommon and need to be updated.

Open dialogue about the interpersonal factors that shape practitioner-client relationships is wanting. Additional qualitative inquiry, focusing on deeper exploration of practitioners' reactions to client behaviour, including personal/professional assumptions, biases and power dynamics, would be instructive. More research aimed at increasing the practitioner's reflexive awareness in therapeutic relationships with individuals suffering from severe, persistent mental illness is needed.

A quantitative approach to the topic, involving the replication of inter-rater reliability studies commonly done with psychiatrists, could be expanded to include practitioners from other health disciplines. A comparison of trends related to professional training, years of experience and/or gender could be considered.

Institutional ethnography presents another possible approach to the study of psychiatric terminology. This research method could be used to examine what role psychiatric terminology plays in supporting the functions and processes of the psychiatric hospital, community service agencies or the mental health system as a whole.

Limitations of the Study

Despite numerous attempts at recruitment, the study did not include the participation of psychiatrists and psychologists. The educational training required for these two disciplines and their relative prominence in the area of psychiatric diagnosis could have had a significant effect on the findings.

Due to time constraints and a cumbersome ethics and institutional approval process, the narrative accounts provided by participants in the study were not triangulated with other research methods such as chart reviews and/or participant observation.

The fact that many of the participants were known to the interviewer, and vice versa, may have influenced results as respondents may have been inclined to provide responses pleasing to the interviewer. Upon reflection, this does not appear to have been the case, as many participants were forthright about negative feelings toward clients and about areas in which they lacked knowledge; nevertheless this potential limitation must be considered.

Conclusion

Mental health practitioners use psychiatric terms to conceptualize and communicate the signs and symptoms of mental illness. These terms are considered important tools for assessment, diagnosis and treatment. In this study, practitioners did not consistently agree on the meanings of psychiatric terms or the clinical interventions associated with the signs or symptoms they describe. Diverse interpretations suggested different fundamental beliefs about patient behaviour and about the best approach to clinical care. These findings challenge the assumption that mental health practitioners speak a common technical language. Further discussion about and exploration of the meanings that mental health practitioners ascribe to psychiatric terminology may lead to greater clarity and precision in the description of clinical phenomena associated with mental illness. It may also contribute to an increased awareness of the limitations of language, its socio-political function and therefore, the need to doubt, question and to avoid unexamined assumptions.

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Potential Risks: This interview will involve sharing your knowledge about clinical terminology. This may make you uncomfortable. The interview is not a test. Every effort will be made to alleviate any distress you may feel, including termination of the interview if necessary.

Contact Information about the study: If you have any questions or would like further information with respect to this study you may contact Dr. Paule McNicoll or Natalia McCarthy at the phone numbers listed above.

Contact for concerns about the rights of research subjects: If you have any concerns about your treatment or rights as a research participant, you may contact the Research Subject Information Line in the UBC office of Research Services at (604) 822-8598.

Consent: Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time. Withdrawal from the study will have no consequences.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

Signature ____________________ Date ____________________

Print Name ____________________

APPENDIX C

Interview Schedule

Review of study purpose. Reassure participant that this is not a test and that there are no right or wrong answers.

1. Please tell me about your professional/work role.
2. Describe any and all training you have received related to psychiatric terminology.
3. Are you familiar with the nursing assessment known as the Routine Assessment of Patient Progress (RAPP)? Is it/has it been used in any unit where you have worked?
4. In your role as a member of an interdisciplinary health care team, please tell me about an experience you've had with the following term, as it is applied to the clients/patients you work with: *bizarre delusion*.
5. What clinical approach/intervention would you use with a client who is identified as having a bizarre delusion(s)?
6. In your role as a member of an interdisciplinary health care team, please tell me about an experience you've had with the following term, as it is applied to the clients/patients you work with: *manipulates*.
7. What clinical approach/intervention would you use with a client who is identified as being manipulative?
8. **Have participant complete rating scale.**
9. Are there any terms on the list that you feel describe the client in a positive way? If so, which ones? Please describe in more detail.
10. Are there any terms on the list that you feel describe the client in a negative way? If so, which ones? Please describe in more detail.
11. Are there any terms on the list that you would like to see substituted with an alternate word/descriptor? If so, which ones? Please elaborate.

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APPENDIX D

Below is a list of 15 descriptive terms from the Routine Assessment of Patient Progress (RAPP). Please select the five terms that in your experience, cause the most disagreement among interdisciplinary team members (with regard to interpretation of the term's meaning). Assign a rating beside these five terms from 1-5 with 1 being the most disagreement and 5 being the least.

dependent ______
silly ______
bizarre actions ______
self-centred ______
crude ______
manipulates ______
bizarre delusion ______
bland expression ______
hostile ______
agitation ______
critical ______
passive ______
clinging ______
impaired judgment ______
perplexed ______

Version: March 2, 2004

APPENDIX E

Instructions: Rate each item's severity as an average over the past 7 days. Check those exemplars on the right which helped you make your judgement of severity rating. Use the space to describe the behavior(s) which led to your rating. A description must be given when rating hallucinations or delusions and when a severity rating is not based on the given exemplars. Further instructions for rating items are discussed in the accompanying "Raters Guide to the RAPP©".

R.A.P.P.©

ROUTINE ASSESSMENT OF PATIENT PROGRESS©

Rater: ______________________ (Name) Period Covered by This RAPP© From: __________ To: __________

SCORE: BASIC NEEDS 1-5 _____ PSYCHOPATHOLOGY (6-13) _____ LIFE SKILLS (14-21) _____ TOTAL (1-21) _____

BASIC NEEDS

1.	Dietary Problems (Circle one rating, check all applicable exemplars, and add comments where necessary)
0 Absent 1 Mild 2 Moderate 3 Severe	☐ increased or decreased appetite, ☐ increased fluid intake, ☐ decreased fluid intake, ☐ special diet, ☐ vomiting, ☐ requires assistance, ☐ increased or decreased weight (how much?), ☐ other

2.	Sleep Problems
0 Absent 1 Mild 2 Moderate 3 Severe	☐ nightly use of sedatives (prn or hs), ☐ difficulty arising, ☐ daytime sleep, ☐ nightmares, ☐ excessive snoring, ☐ initial insomnia, ☐ middle insomnia, ☐ early awakening, ☐ other

3.	Elimination Problems
0 Absent 1 Mild 2 Moderate 3 Severe	☐ constipation, ☐ urinary retention, ☐ prescribed laxative/suppository/enema, ☐ painful elimination, ☐ urinary or fecal incontinence, ☐ needs assistance with toileting, ☐ prn laxative/suppository/enema, ☐ other

4.	Safety Problems
0 Absent 1 Mild 2 Moderate 3 Severe	☐ self-harm, ☐ suicidal, ☐ history of suicide attempts ☐ danger to others, ☐ impulsive, ☐ seizures, ☐ decreased consciousness, ☐ confused or disoriented, ☐ decreased mobility, ☐ unsafe smoking, ☐ substance abuse, ☐ acts on delusions or hallucinations, ☐ elopement risk, ☐ other

5.	Movement Problems
0 Absent 1 Mild 2 Moderate 3 Severe	☐ clumsy, ☐ tremulous, ☐ writhing, ☐ jerking, ☐ stiff, ☐ complains of restless legs, ☐ gait disturbance, ☐ falling, ☐ grimacing, ☐ swallowing problems, ☐ ocular problems, ☐ other

Medications for period covered by R.A.P.P.© ______________________

Date R.A.P.P.© Completed __________ ______________________

Patient Identification Area

RIVERVIEW
HOSPITAL

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RVH3790-08/04:SF-RVH-828

PSYCHOPATHOLOGY

6. Anxiety	
0 Absent 1 Mild 2 Moderate 3 Severe	☐ physical signs (e.g., tremor, sweating, palpitations), ☐ dependent/clinging/advice seeking ☐ subjective complaints (e.g., uptight, afraid, worried), ☐ obsessions, ☐ triggers (describe), ☐ other

7. Mood and Affect	
0 Absent 1 Mild 2 Moderate 3 Severe	☐ irritable, ☐ elevated/euphoric, ☐ increased self-esteem/grandiose, ☐ labile, ☐ perplexed, ☐ silly, ☐ sad/depressed, ☐ guilty, ☐ worthless, ☐ hopeless, ☐ suicidal speech/gestures, ☐ bland expression, ☐ loss of interest or pleasure, ☐ inappropriate affect, ☐ other

8. Activity Level	
0 Normal 1 Mild 2 Moderate 3 Severe	☐ bizarre actions, ☐ increase or decrease in goal-directed activity, ☐ agitation, ☐ psychomotor retardation, ☐ ritualistic or repetitive behavior, ☐ posturing, ☐ other

9. Delusions	
0 Absent 1 Mild 2 Moderate 3 Acts upon delusion(s)	☐ paranoid/persecutory, ☐ bizarre, ☐ erotic, ☐ somatic, ☐ grandiose, ☐ being controlled, ☐ other Describe:

10. Hallucinations	
0 Absent 1 Mild 2 Moderate 3 Acts upon hallucination	☐ auditory, ☐ visual, ☐ tactile, ☐ olfactory, ☐ gustatory, ☐ command: Denies hallucinations but: ☐ talks to self, ☐ appears to be listening to voices Describe:

11. Form of Speech	
0 Normal 1 Mild 2 Moderate 3 Severe	☐ increased/decreased volume, ☐ increased or decreased rate of speech, ☐ mute, ☐ slurred, ☐ monotone, ☐ difficult to interrupt, ☐ loose associations, ☐ incoherent, ☐ neologisms, ☐ disturbed rhythm, ☐ other

12. Hostility	
0 Absent 1 Mild 2 Moderate 3 Severe	☐ appears hostile, ☐ critical, ☐ suspicious, ☐ threats, ☐ yelling, ☐ swearing, ☐ angry, ☐ abusive comments, ☐ throws things, ☐ hits/breaks things, ☐ physically violent to others, ☐ other

13. Cognitive/Intellectual	
0 Normal 1 Mild 2 Moderate 3 Severe	☐ disoriented, ☐ memory problems, ☐ poor concentration/attention, ☐ distractible, ☐ concrete thinking, ☐ obvious reading/writing/arithmetic problems, ☐ impaired judgement, ☐ other

ROUTINE ASSESSMENT OF PATIENT PROGRESS© (Continued)
LIFE SKILL PROBLEMS

14.	Hygiene and Appearance
0 None 1 Mild 2 Moderate 3 Severe	☐ unkempt, ☐ unwashed, ☐ needs prompts, ☐ needs supervision, ☐ bizarre appearance, ☐ other

15.	Cooperation Problems
0 Absent 1 Mild 2 Moderate 3 Severe	☐ refuses or tongues medications, ☐ resists staff directions, ☐ resists ward rules/protocol, ☐ refuses to participate in off-ward therapies/activities (e.g., OT, Recreation Therapy), ☐ other

16.	Socialization Problems
0 Absent 1 Mild 2 Moderate 3 Severe	☐ shy, ☐ loner, ☐ withdrawn, ☐ will not initiate conversations, ☐ does not respond, ☐ self-centered, ☐ poor manners, ☐ crude, ☐ pesters others, ☐ other

17.	Budgeting and Property Problems
0 Absent 1 Mild 2 Moderate 3 Severe	☐ loses things, ☐ poor money management, ☐ heavy smoker with insufficient funds, ☐ hoards things, ☐ theft, ☐ poor care of personal belongings, ☐ other

18.	Sexual Expression Problems
0 Absent 1 Mild 2 Moderate 3 Severe	☐ excessive sexual interest, ☐ inappropriate sexual comments, ☐ inappropriate sexual actions, ☐ other

19.	Leisure Problems
0 Absent 1 Mild 2 Moderate 3 Severe	☐ no interests, ☐ joins only if prompted, ☐ avoids organized activities, ☐ avoids social activities, ☐ avoids solitary pursuits (e.g., walking, reading etc.), ☐ other

20.	Problem Solving Style
0 Absent 1 Mild 2 Moderate 3 Severe	☐ manipulates, ☐ aggressive (exerts own rights at expense of others), ☐ bullies, ☐ passive/unassertive, ☐ other

21.	Demands on Nursing Staff Time
0 Usual time 1 More time 2 Much more 3 Extremely demanding	☐ requests help too often, ☐ frequent physical complaints, ☐ frequent constant attention, ☐ bizarre, ☐ physical needs, ☐ frequent prn medication, ☐ other

MEDICATION USE (PRN)

Medication and Dose	Seven Day Total*	Weekly Trend Increase/Decrease	Most Common Reasons for Giving PRNs	Effective?	
				YES	NO

* "Seven Day Total" is the number of times a medication was given.

Does the patient usually request the prn ___ or is it a nursing decision ___ ?

Is there a pattern as to when prn medications are more likely to be requested and/or needed? ___ Yes ___ No.

Comments:

Time Out, Constant or Special Attention, Seclusion, and Other Non-Medication PRNs

Reasons:

Describe duration and frequency:

Effect:

Current patient interests/hobbies/strengths: ☐ socially appropriate dress: ☐ socially appropriate manner, ☐ good verbal skills, ☐ good social skills, ☐ insight into illness, ☐ other (describe)

Special nursing concerns/problems: (eg. psychiatric and medical conditions)

Nursing Treatment Plan and other comments to round out this evaluation:

RATER'S GUIDE TO THE ROUTINE ASSESSMENT OF PATIENT PROGRESS©

This Rating Guide outlines the intended purposes of the Routine Assessment of Patient Progress (RAPP) scale and provides anchor points and guidelines for making ratings. The RAPP has been designed to provide nursing staff with a standardized method of evaluating psychiatric inpatients. Newly admitted patients are typically assessed for at least one week and the obtained information is used to assist in making a diagnosis and to formulate a treatment plan. The RAPP is useful for both of these purposes in that it encourages nursing staff to observe and interact with a patient in order to obtain a systematized account of a patient's symptoms and functioning in several broad areas. A concern with changes in patient symptoms and functioning (perhaps as a result of initiating or terminating a treatment) can be addressed with the RAPP since the scale lends itself to repeated assessments. The RAPP, because it provides a comprehensive standardized assessment, makes it easier for nurses to present their observations at ward rounds. The standardized format with both ratings of severity and anecdotal notes also makes it easier for one nurse to present the observations of another. In order to use the RAPP, raters must read this guide. Inter-rater reliability should be established prior to using the RAPP on a ward.

Guidelines to Ratings

The RAPP is used to make ratings on a patient for a seven day period. Sources of information can include observation, discussion with the patient, discussion with other staff, and chart notes. The use of converging evidence from several sources improves the validity of a rating. For some items, the rater may make use of patient self-report in addition to observations but should not let patients self-report override an observation if the two do not agree. For most raters, this means rating "tough" and selecting the higher of two ratings when in doubt. Unless explicitly stated elsewhere, the guiding principle for rating the severity of an item is to judge the degree of impairment, distress, danger or abnormality. This may involve a consideration of frequency. Make ratings of severity relative to the general population not a psychiatric population. For each item on the RAPP, make a rating of severity and use the exemplars as a guide. This format has the advantage of considering a wide range of symptoms and behaviors for each item but can make the distinctions between severity levels difficult to define. In general, the severity rating for an item is dictated by the most severe problem within that category. For example, it is clearly of concern if a patient 'hits others' and, in this case, the item 'Hostility' could not be rated 'mild'. For other ratings, several problems may be present and, when combined, have a greater effect on patient functioning than any individual problem. Choose the severity level of each RAPP item on the basis of the anchors provided below. Sample interview questions for items involving self-report can be found at the end of this Rater's Guide.

ANCHOR POINTS FOR SPECIFIC ITEMS

1) Dietary Problems

If the patient has been losing weight in the recent past but not currently, it should be recorded under 'other' and rated as 'absent'. If the weight loss is ongoing, the overall weight loss should be considered when making a rating.

Severe: Significant weight loss or gain (three or more kilograms in one week) and intervention is instituted, or water consumption which leads to intoxication.

Moderate: Significant weight loss or gain (approximately two kilograms in one week) and intervention is instituted.

Mild: Decreased appetite without significant weight loss

2) Sleep Problems

Use caution when relying solely upon a patient's subjective account. In order to make a rating of severe, external validation is required (e.g., seeing patient awake).

Severe: Two PRN's a night for three or more consecutive nights, or two hours or more of initial, middle or terminal insomnia if it occurs three or more consecutive nights, or daytime bedseeking most of the time almost every day.

Moderate: PRNs for at least three nights in the week, or frequent daytime bedseeking at least four days a week.

Mild: Two to three PRN's in the week, or daytime bedseeking several times throughout the week.

3) Elimination Problems

Severe: Incontinence or has needed assistance with toileting more than two times.

Moderate: Incontinence one or two times or the patient needed assistance with toileting.

Mild: Regular laxative or enema use.

4) Safety Problems

Elopement may or may not constitute a safety risk in that a patient may leave on unauthorized absence but be a very low safety risk.

Severe: Ongoing or high risk of harm. Grounds privileges are withdrawn and the patient may require special nursing care at times (e.g., constant attention) or current suicidal ideation.

Moderate: A reasonable likelihood that the patient is at risk for harming self or others (incidences may be infrequent).

Mild: Minimal risk of physical harm to self or others--patient can have full grounds. May be a history of suicide attempts but no current suicidal ideation .

5) Movement Problems

Severe: Major impairment or distress (e.g., patient is constantly pacing and complaining of movements). Movements may make dressing or eating difficult.

Moderate: Obvious movement problems that cause some impairment or distress.

Mild: Barely noticeable movement problems and/or minimal functional impairment.

Psychopathology

6) Anxiety

Either subjective complaints or objective signs can be used to make 'mild' or 'moderate' ratings. For a rating of 'severe', both must be present.
Do not attempt to discriminate between akathesia and anxiety--rate observations.

Severe: Overwhelming physical signs of agitation and fear. Physical signs may include dilated pupils, hand wringing, sweating, fidgeting, tremor, frequent changes in posture, and picking/scratching.

Moderate: Moderate subjective symptoms of anxiety that includes subjective complaints of nervousness and some physical signs.

Mild: Some signs of anxiety and/or complaints of nervousness.

7) Mood and Affect

Rate depressed mood on the basis of expressions of sadness, worthlessness, hopelessness, guilt and negative views self, world and future. This includes suicidal ideation (suicidality is also rated under item 4, 'Safety Problems'). Suicidal ideation should be investigated by direct questioning. Distinguishing between depression and negative symptoms such as flat affect and poverty of speech involves difficult judgements and rating errors are minimized by placing negative symptoms in this section. Rate manic mood on the level of euphoria or irritability that is inconsistent with circumstances.

Severe: Severely depressed mood and/or a suicidal plan. Severe manic mood and or patient believes he/she has unlimited power. No emotional expression, content of speech inappropriate to emotion.

Moderate: The patient shows little enjoyment and is difficult to cheer up. Patient's voice is monotonous, flat and/or there is little facial expression, or affect is restriceted to sadness, irritability, etc. Moderate manic mood that may include emotions consistent with beliefs of power or great abilities which are out of proportion to circumstances and are not related to unlimited power.

Mild: Patient states she/he would be better off dead but has no plan or intention. Hypomanic mood. Emotional expression is blunted, or restricted in range.

8) Activity Level

Use frequency to guide the rating of activity level.

Severe: Patient is very agitated and/or hyperactive most of the time.

Moderate: Agitation and/or hyperactivity 25-75% of the time.

Mild: Occasional agitation or hyperactivity.

9) Delusions

Severe: Delusions are clearly present and considerably influence behavior.

Moderate: Delusions are clearly present but minimally influence behavior.

Mild: Delusions are suspected.

10) Hallucinations

Severe: Hallucinations are clearly present and considerably influence behavior.

Moderate: Hallucinations are clearly present but minimally influence behavior.

Mild: Hallucinations are suspected.

11) Form of Speech

The specific content of the speech is not being rated (except neologisms). The rater should assess abnormalities in speed, articulation, tone, and flow of speech. Assess speech content in context. Does the patient abruptly shift topics? How much logical connection is there between topics? Are the words intelligible but the general message incomprehensible? Base the rating on clarity, pace and intelligibility.

Severe: Loose associations, frequent neologisms, incoherence, or clang associations. Speech is very difficult or impossible to understand.

Moderate: Some disorganization of speech which may include tangentiality, occasional loose associations, or pressure of speech. Some speech is difficult to understand.

Mild: Occasional tangential speech, abnormally slow speech or mild pressure of speech. Speech can be generally understood.

12) Hostility

Base this rating on the frequency and intensity of hostility, and take into account any provocation that preceded the hostility.

Severe: Intense, ongoing, unprovoked hostility.

Moderate: Ongoing, unprovoked hostility at a low level of intensity or infrequent intense hostility. Definitely out of proportion to the degree of provocation.

Mild: Occasional low level hostility.

13) Cognitive/Memory

Assess orientation to place, time and person. Memory can be informally assessed by asking about recent events or occurrences about which the patient should be aware. Do not make global estimates of intelligence.

Severe: Confabulation, confusion, or gross errors in orientation.

Moderate: Deficits that are reasonably obvious to the casual observer.

Mild: Minor problems with orientation to date or some difficulty learning names and routines.

Life Skills

The rater should adopt current community standards for adult behavior in order to assess life skills of the patient.

14) Hygiene/Appearance

A patient who independently bathes, grooms and changes clothes about three times week without encouragement would be rated 'absent' on this item.

Severe: Patient needs much assistance to maintain hygiene and appearance.

Moderate: Patient needs supervision or some assistance to maintain personal hygiene. Markedly odd appearance, including unusual dress or make-up.

Mild: Prompts are needed to ensure maintenance of personal hygiene.

15) Cooperation Problems

This item refers to cooperating with staff and adherence to treatment and assessment regimes. Do not rate as pathological a patient's reluctance to engage in an activity or treatment for which he/she may be in need of an explanation.

Severe: Persistent refusal to adhere to directions or otherwise cooperate.

Moderate: Occasional refusal to comply.

Mild: Some encouragement is needed but patient generally complies.

16) Socialization Problems

This item assesses both the quantity (the proportion of time spent interacting with others) and quality of social interactions. Issues of respect for others are considered under quality. (The related concept of assertion skills is rated in item 20).

Severe: Patient does not initiate interactions or respond to the advances of others.

Moderate: Patient does not initiate interactions but occasionally responds to others and/or most interactions are unskilled or inappropriate.

Mild: Patient rarely initiates interactions but generally responds to advances from others.

17) Budgeting/Care of Property

Severe: Gross neglect of property or no concept of money management.

Moderate: Quickly spends all money, frequently loses or damages property.

Mild: Cannot keep to a budget, occasionally loses or damages property.

18) Sexual Expression

Do not attempt to rate decreased libido. Inappropriate sexual expressions, either verbal or behavioral, are best rated by considering both frequency and intensity.

Severe: Grossly inappropriate sexual expressions such as public masturbation or persistent unauthorized touching.

Moderate: Unauthorized touching, and/or outright solicitation.

Mild: Inappropriate flirtation or sexual comments.

19) Leisure Skills

Consider frequency and level of interest. Assess non-socially oriented activities as well as social activities.

Severe: No interests shown on most days (e.g., lies in bed most of day or remains inactive in a common room).

Moderate: A limited range of activities on most days.

Mild: Spends some days doing few or no activities.

20) Social Problem Solving

This item assesses problem solving style, ability to tolerate frustration, and interpersonal assertiveness.

Severe: Passive or aggressive coping style most of the time. Patient is unable to tolerate frustration.

Moderate: Passive or aggressive coping style 25% to 75% of the time. Patient is unable to tolerate frustration.

Mild: Infrequent passive or aggressive coping style. Patient shows some ability to tolerate frustration.

21) Demands on Nursing Staff

Severe: Frequent constant attention is required, or excessive staff time needs to be devoted to the patient.

Moderate: Patient makes frequent demands on the staff or needs considerable attention or assitance.

Mild: Occasional extra attention is needed.

Interview

A number of the items on the RAPP require self report from the patient. The following questions are suggested to obtain information about those areas which must be covered in the RAPP interview. If you receive a partial or vague response ask for more information with questions such as "tell me more about that". The first question is a general probe which represents the very least one could ask. The following questions help elaborate the area.

Sleep Problems: "Have you had any problems with your sleep in the past week?" "Any trouble getting to sleep?" or "...staying asleep?"

Mood and Affect: "How has your mood been in the past week?" If the answer is vague then ask "Have you been feeling down or depressed most of the time?" or "Have you been feeling really up or energetic or on top of the world?" "Have you been feeling more irritable?" or "...less interested in things?" "How do you feel about yourself?" "Have things gotten so that you seriously think about harming yourself" or "...thinking that you would be better off dead?"

Delusions: "Do you have any ideas or beliefs that other people think can't be true?" "Does it ever seem that people are taking special notice of you?" or "...talking about you?" or "...that special messages are being sent to you?" "Is there anybody going out of their way to give you a hard time?" "Do you have any special powers?" If yes to any of the above questions ask "What do you do about ... (e.g., Mr. X is out to get you)?" This is intended to find out whether the patient acts on the delusion.

Hallucinations: "In the past week, maybe when you feel really stressed, did you ever hear things that other people couldn't hear like noises or people talking?" "What about seeing (smelling,tasting, feeling) strange things or things other people couldn't?" If yes, ask for more details before asking "What do you when ...(e.g., you hear the voice of the devil)?" This is intended to find out if the patient acts upon the hallucination.

Socialization Problems: Poor socialization may result from psychotic beliefs or other psychiatric problems or may reflect long-standing difficulties. "How do you get along with the people around here?" "Do you get nervous around other people or find it hard to talk with them?" "do you ever get to the point where you want to hurt somebody?" or "...plan it out?" "How about in the past week?"

Anxiety: "Have you felt nervous or uptight lately?" "Do you have any physical signs of nervousness?"

Cognition: See Rater's Guide. Assess orientation to time, date, location, who he/she is, birthday, what was for lunch today and yesterday, names of ward staff, etc.