EXAMINATION OF ATTITUDES OF PSYCHIATRIC WORKERS BY Q METHOD

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Abstract: *Throughout history, social attitudes have been divided over psychiatric patients and their care. It is questionable which subjective motivational factors and characteristics make the staff members best suited for the optimal performance of the task. The 16 people involved in the study were grouped into 39 groups, commenting on 39 sharing statements. The study was analyzed using the Q method, with three main groups of participants, the first group having a social policy mindset, presumably with a higher routine, , persons characterized by burnout. The characterization of the factors can be elaborated by the correspondences and differences with the statements.*

Key words*: social expectations, deviance, concurse, employee attitude, Q-method*

INTRODUCTION

Throughout history, social attitudes have been divided over psychiatric patients. The social expectation for care professionals and institutions is twofold: to isolate deviant, unwanted elements of society from the community (do not disturb others), and to enforce human and personal rights against closure and physical, chemical restriction. Psychiatric care has always been mystified due to its hidden nature, disturbed and incomprehensible behavior to outsiders, and its bizarre appearance, and it has been burdened with aggression. Many patients are treated because of their aggressiveness or as a result of abuse. [5] The management of aggression goes hand in hand with the day-to-day management of workers, and, apart from punishment enforcement, is a rare area where in some cases aggressive restraint of care is required. Centuries earlier, referring to the historical memories of psychiatry, mental illness was more than biological imbalance, and its regulation was intertwined with social, cultural expectations, which also represent the "normality" of the community. In the XX. From the middle of the 20th century, social science had an even greater impact on psychiatry, and in the 1960s, representatives of sociology, cultural anthropology, and social psychology devoted considerable energy to describing and articulating psychiatric and mental disorders. The research and results of the social sciences have also gone far beyond the level of criticism, facilitating the development of healing and medicine eg. reforming the institutional system, changing the legislative framework and ensuring the protection of human rights.[9] In the XX. In the first decades of the twentieth century, similarly to psychiatry, sociology made significant strides, and we can call it the era of theory-makers. Theories seek an answer to the social and psychiatric processes and disorders that overlap in psychiatry and sociology.

With regard to the history of psychiatry, she is feeling increasingly marginalized in relation to other medical disciplines. It is socially divisive, and psychiatric patients and care are surrounded by considerable mystification. People are curious about it, yet they try to stay away from it as if they were afraid of being infected. [2] As a result of social changes and crises, there is an increase in psychiatric involvement and illness at all ages. Part of the social care, elderly care in this area is blended with health care. In many cases in the field of psychiatry, social reintegration becomes impossible, and cases requiring prolonged care and care are frequent. Illnesses are also divisive among people, with many people assuming mental illness as a sham, often making the patient responsible for the outcome of their condition, and being viewed with pity by others. The question that arises

is whether psychiatric practitioners are also subject to discrimination. [13] On the other hand, the extent to which those performing the task identify with the attitude of the average population. Frequent burnout, staff shortages, long nursing care, recurring, relapsing or incurable patient care lead to feelings of hopelessness and discrimination. [4] Each employee also works with his or her own personality on a daily basis, giving attention, empathy, and care. necessary human factors. Obviously, there is a difference of opinion between our employees on certain professional and human issues. Interestingly, the attitude of psychiatric workers may differ from that of the general population on critical issues regarding care and patients. [3]

MATERIALS AND METHODS

I sought the answer to this question in a study, which was carried out using the Q method. In the case of the Q method, representativeness should not be ensured for the interviewees (individuals) but for the "public speech". The purpose of investigations is to examine subjectivity, not to know objective facts. The procedure is based on correlation analysis and factor analysis. [7] The persons involved in the study classified the 39 statements made on the basis of "public discourse", thus forming groups. Based on the analysis of the groups, conclusions can be drawn about attitudes.

RESEARCH RESULTS

The Q method is a qualitative test method in the field of communication and political science, developed by the English psychologist William Stephenson. Numerous health science studies have been conducted using the Q method since the end of the last century. The purpose of investigations is to examine subjectivity, not to know objective facts. It serves to get to know the value judgments and attitudes related to a given topic. [1] Data collection and data analysis is performed using a quantitative method. When using the Q method, a small number of elements is sufficient to detect differences of opinion. The method relies on correlation analysis and factor analysis, but there is a significant difference as it performs the "inversion" of factor analysis. It does not rely on a large number of observations and does not calculate the correlation between opinion characteristics, but with a small number of observations it looks for common or similar viewpoints between individuals. [14] The main elements of the method are: set of statements (Q-set), set of respondents (P-group), data recording (Q-group). Respondents are not randomly selected, mostly on the basis of personal characteristics, and there is a presumption of disagreement between respondents. [15] The selection of respondents also focuses on the detection of differences. It is not a goal to project the result obtained to the whole population. In the course of data collection, respondents should place statements made previously on a pyramid grid, in accordance with their degree of agreement. (Figure: Pyramid Grid)

-4	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**

The participant places it on the left side of the grid which he disagrees with at all (-4) and on the right side of the grid he fully agrees (+4). You agree with the statements in the same columns, the rows are irrelevant.

In the present case, the 39 statements included attitudes towards psychiatric patients, attitudes towards protracted care, social care for health, and attitudes towards stigmatization of psychiatric patients. We have tried to highlight factors that are divisive in population opinion formation. It also includes social judgment and judgment of the institutional system, including external expectations related to treatments and social expectations related to patients.

1. Psychic disturbance appears to people at a glance.

2. People are much less likely to accept mental illness than physical illness, and most people in society condemn psychiatric patients.

3. Most psychiatric patients are disadvantaged and live in poverty.

4. Psychiatric patients live in shame.

5. Many psychiatric patients are unable to find a job because they are prejudiced by employers.

6. People with mental disorders are as motivated to seek work as their peers with other illnesses.

7. Most psychiatric patients can make their own illness.

8. People with mental disorders could do more for themselves and their environment.

9. Everyone is responsible for their own destiny, including the majority of psychiatric patients.

10. Psychiatric workers tend to have different attitudes towards addicts, who themselves can make a difference.

11. A majority of hospital workers are opposed to hospitalization for patients admitted to poverty or housing.

12. Access to hospital care should be determined by health needs, not by social circumstances and the economic situation of the patient.

13. Recurring, self-destroying patients In hospital admission, relying on the patient's past experience, workers see a greater chance of recovery during treatment.

14. Psychiatric patients often abuse their illness to gain advantage.

15. For psychiatric patients, the most important factor is understanding and acceptance by staff, which is less experienced in the social environment.

16. The psychiatric hospitalization of elderly demented patients does not substantially change their condition and quality of life.

17. Psychiatric patients are generally believed to be more prone to crime.

18. Treatment of young people should be given priority over older people, as they can expect greater health gains.

19. Prevention of mental illness is more important than treatment of emerging diseases.

20. Priority should be given to curing diseases that place a greater financial and mental burden on family members.

21. Health workers, as well as those who return regularly, see a similar chance of healing in the past.

22. In the case of elderly, disturbed patients, care and supervision would be primarily the responsibility of the family.

23. When treating patients with dementia, relatives place unreasonable and often exaggerated demands on staff and treatment.

24. Elderly patients with dementia should spend the last stages of their lives in hospital rather than in their families.

25. Hospital treatment over several months benefits patients because they are safe in the hospital environment.

26. Healthcare professionals are expected to receive all patients in the same way, always presenting themselves in the same way.

27. Too long care for pb is a social problem that is harmful to the patient.

28. Psychiatric patients treated in a hospital ward should be given preferential treatment in a nursing home.

29. The placement and employment of psychiatric patients is a social problem that currently places an unnecessarily heavy burden on hospital wards.

30. Quality professional care in psychiatric patients' homes can improve the quality of life and condition of patients and reduce the need for additional hospitalization.

31. Most people view colleagues in psychiatry differently from other health workers

32. The form and duration of psychological treatment are usually decided jointly by the treatment team, thus sharing the responsibility for the decision.

33. Medical and professional opinion is always the same as regards the professional reasons for psychiatric treatment.

34. Patient dependency and community presence always help with healing or provide a better quality of life after discharge.

35. Crime committed by psychiatric patients is mostly a livelihood crime, less and rarely associated with their illness.

36. During psychological treatment, it is sometimes necessary to confront and confront other medical treatment in order to confront the patient with reality.

37. Mental use of psychiatric workers is more important than physical exercise.

38. The home of psychiatric patients should be made more interested in getting hospitalized patients as little as possible.

39. In psychological care, limiting and possibly aggressing the patient is a natural part of the treatment, which is necessary and routine (everyday).

In parallel with the formulation of the allegations, the persons involved in the investigation were selected. In the first round, 20 people were selected from the psychiatric department I lead. Following the collection of data, the responses of four of the respondents were not included in the evaluation.

The correlation matrix shows agreement and disagreement among participants, with similar attitudes among employees. (Correlation Matrix)

SORTS	NAME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1	kriszta	100	36	64	52	64	24	31	35	18	20	6	-7	29	41	28	46
2	g.eva	36	100	45	59	37	34	39	39	15	36	-6	32	52	59	51	32
3	monika	64	45	100	43	49	48	35	25	30	19	24	29	38	43	41	29
4	szidonia	52	59	43	100	38	34	26	30	-8	26	-8	29	39	47	32	37
5	h.edit	64	37	49	38	100	28	16	21	24	13	-3	4	19	25	16	27
6	k.agi	24	34	48	34	28	100	11	19	21	6	29	38	28	18	32	9
7	m.erika	31	39	35	26	16	11	100	-2	28	25	0	14	38	20	39	-1
8	szilard	35	39	25	30	21	19	-2	100	26	21	-9	2	9	41	18	41
9	brigi	18	15	30	-8	24	21	28	26	100	-5	-10	-23	18	25	-1	-6
10	b.kriszt	20	36	19	26	13	6	25	21	-5	100	6	12	31	19	6	4
11	dorka	6	-6	24	-8	-3	29	0	-9	-10	6	100	9	6	-13	-1	-15
12	p.fruzsi	-7	32	29	29	4	38	14	2	-23	12	9	100	26	13	46	3
13	r.tunde	29	52	38	39	19	28	38	9	18	31	6	26	100	54	29	31
14	h.adri	41	59	43	47	25	18	20	41	25	19	-13	13	54	100	41	45
15	bp.klari	28	51	41	32	16	32	39	18	-1	6	-1	46	29	41	100	18
16	k.laci	46	32	29	37	27	9	-1	41	-6	4	-15	3	31	45	18	100

Factor matrix (factor weights greater than 0, 45)

Identifier Name	Factor 1 Social Policy Thinkers	Factor 2 The psychiatric class is the frame of thought	Factor 3 Direct professional empathy prevails	Factor 4 Routine and some nervousness
1. kriszta	58	51		
2. g.eva				73
3. monika			60	
4. szidonia	58			48
5. h.edit	45	47		
6. k.agi			71	
7. m.erika				67
8. szilard	59			
9. brigi		82		
10. b.kriszt				45
11. dorka			72	
12. p.fruzsi		53		52
13. r.tunde				69
14. h.adri	48			55
15. bp.klari				64
16. k.laci	79			

1. Factor 1 Social Policy Thinkers	2. Factor 2 The psychiatric class is the frame of thought	3. Factor 3 Direct professional empathy prevails	4. Factor 4 Routine and some nervousness
Kriszta, Szidónia, Szilárd és K.Laci	Brigi	K.Ági és Dorka	g.éva, m.erika, B.Kriszt, R.Tünde, Bp. Klári
Factors in Factor 1 are characterized by a greater degree of social or social commitment and interest than others. Their statements are most clearly formulated with the highest intensity in relation to health policy claims. Keep in mind that there were only three statements that you could totally agree with or disagree with. For them, all of these statements go beyond the narrower environment, not of a hospital policy but of a socio-political nature	The outside world matters less. He thinks inside the hospital and the ward.	Professional commitment and empathy. Can they be young optimists?	This is the most populous group, probably made up of the most experienced people who have tried many things. In many respects, they are similar to Factor 3, perhaps less likely to believe in the profession than Factor 3. Clear values, little energy?

CONCLUSION

Analyzing in detail the opinions of the four separate groups, it is clear that their attitudes are influenced by different individual motivations and life history events. The second group is a long-term hospitalized, recurrent patient who is on the staff ranks as a "side effect" of long-term treatment, making it impossible for them to reintegrate into society. The similarity of the responses to the statements and the differences in the factors allow the subject to comment and act. The second phase of the study allows comparisons to be made with social attitudes, in which the study group was supplemented with the involvement of people working in other health care fields and persons outside the health care field.

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