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**THE ATTITUDE EXAMINATION OF WORKERS OF
PSYCHIATRY WITH THE
HELP OF Q-METHOD**

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1. Introduction

As a healing profession working at hospitals for decades, I managed to gain some experiences about the health system in Hungary. The opportunities of healings and interventions are being expanded, while in some cases the aims are being changed as well. In our work some new social categories and economic terms such as health profit and health factory can be heard more and more often. The role of the patients has also changed a lot in substance (along with the patients' benefits), as well as the skills and the motivation of health professions. An employee as an individual represents a personal value, that is influenced by his or her upbringing and environmental factors. During the performance of the tasks and challenges of the work, the integration of the professional consciousness with the individual values and mindset is arises. Is it possible that an individual value or mindset vary as an effect of working in Health Care? Does employee attitude sign different from the general social attitude? During my long work at the Psychiatry I have had a chance to learn about general opinions, social stigma, prejudices towards Psychiatry and psychiatric patients. Psychiatry has a special place among the medical sciences and the social environment has a special impact on mental illnesses. The aim of my research is to assess the attitude of the staff in relation to their stereotype and opinions in connection with psychiatric patients. I would like to know if their work affects their individual value in relation to psychiatric patients and care. Almost every area of health care can be described by the human resource shortage. In the field of Psychiatry, specialists have a special task of communicating a system of norms to patients. The unclear competence limits, the tasks those considered to be unnecessary and the lack of moral assessment can



lead to more serious problems, such as early burn out or career abandonment, than in any other fields of the Health Care.

In my opinion a research on this topic, using a yet less known method, may reveal new contexts and other relevant factors. The results of the use of Q analysis can contribute to reducing the mental use of workers, provide data by understanding their individual setup and supporting their mental state and well-being. The multidisciplinary approach of concepts is timely. Many publications in the international literature refer to the importance of the topic, both at the popular level and at the professional level of doctors. The processing of the international literature provides an overview of the different approaches. A review of the cultural history and social policy history of Psychiatry highlights the interconnectedness of the professional and social problems that affect society's members, the quality of life of workers and patient expectations alike. An important factor is the structure and functioning of the Hungarian Health Care and the efforts of the reform of the past period. Among domestic professional factors, Psychiatry has also undergone a transformation. As its tools has changed over the past decades, the expectation of society and the perception Psychiatry has also changed. The differences or equality of opinion of workers and outsiders can have a major impact on the quality of life and well-being of the workers and similarly revulsion can also weaken it. The scientific review beside the description of the basics of the Q method, examines the public discourse, which forms the basis of the three-phase research. There was a 24-member study, which beside psychiatric workers, it analysed people working in other fields than Psychiatry. A 16-member study analysed the attitudes of psychiatric workers. In the last phase the joint opinion of the members were described completed by the researcher's own assessment.



2. Choice of subject and the aim of the research

The aim of the research was to prove the hypothesis that can be read below:

- C1: The quality of life and well-being of health workers is better than the average population, as their knowledge can help them to live a healthier lifestyle and through self-awareness and personal experiences to improve their coping mechanisms are better.
- C2: Those who work at a Psychiatric Ward can be described by different attitude in connection with the psychiatric disorders and patient care than those who work in other fields of health care.
- C3: Attitudes towards psychiatric patients and their care vary with life experience and work experience among employees.
- C4: In Psychiatric patient care those members of the staff, who work by the bedside can be characterised by different attitude than those who have an administrative job.
- C5: The attitude and expectations of the patients about treatment are significantly differ from workers attitude.
- C6: The Q method is suitable for identifying dissenting opinions on the care of psychiatric patients.

The aim of the research is to increase the self-knowledge of those working in the field of Psychiatry, and to analyse the advantages and disadvantages of professional team operation. Furthermore, self-awareness can improve attitudes to work. Individually, the internal tension and stress resulting from differences in social expectations and workplace expectations can be reduced.



3. The relationship between health, quality of life and well-being. A brief history of Psychiatry

3.1. Relationship between health and quality of life, determination of well-being

„Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 2009). This definition has replaced the traditional patient-centred definition. The paradigm shift is significant. It means the extension of the definition of health. Health can never be defined objectively, as it represents a subjective image that is significantly influenced by the society linked to the social system and norm system. By the end of the 20th century several researches were written about the role of the environment (structural approach) and the role of the role of the human behaviour (lifestyle approach) that can decrease the chances of illnesses and premature death. The social model of health has been created by the Ottawa Charter that represents the holistic view of health.

The quality of life demanded a definition in the second half of the 20th century. The research of the quality of life consists of five overlapping traditions: the social indicators, happiness, aging, wellbeing and health. The examination of quality of life and examining various indicators raised its economic, social interpretation, sociological definition and psychological definition. As a consequence of a disease resulting decrease in the quality of life not only do the physical processes of a person suffer disadvantages but it also adversely affects other competences in life. There are some other concepts in the scientific literature which are also related to the definition of subjective quality of lifestyle, such as



„subjective well-being”, „life satisfaction” and „happiness”. It does not necessarily mean that the enjoyment of life can be derived from only from the subjective assessment of life, i.e. the role of material security is not insignificant. There are two opposite point of view on well-being. According to one group, if prosperity rises on the basis of GDP, well-being is also moving in a positive direction. The other view is that, despite the rise in GDP, Subjective well-being remains the unchanged. A country’s negative GDP-GNI gap should be taken into account, where GNI (Gross National Income) means the actual disposable income, i.e. the income that can be spent does not reflect the increase in GDP, so prosperity remains unchanged. The assessment of prosperity is obviously interdisciplinary, affecting Economics, Philosophy, Psychology and Sociology. According to one of the main trends it is not “utility” that counts, but the possibility of what someone can do or what someone can become. It means the broadening of opportunities and not owing essential goods. The skill approach is mostly used as an alternative form of the utilitarian approaches. The concept of skills and abilities can include a lot of things: not only the means necessary for prosperity, but also the relevant human traits, that an individual is able to put at the service of the achievement of his or her fundamental goals (for example, to achieve the right work for his or her personality). The theory of psychological approach focuses on someone’s role and on the achievements of self-realization. Autonomy, the fulfilment of personality, self-acceptance, life goals, self-realization together create a complex image in accomplishments. The approach to the concept of well-being, through various theories enables the effects of health system, damage to health or disease prevention on the well-being of the individual, equally for psychologically, sociologically and financially. The well-being of health-



care workers can be linked to their own motivations, competences and knowledge of their skills. One of the fundamental aims of my empirical research is to explore the possibilities of healthcare workers to contribute to improving their personal well-being by exploring their relationship to patients and healthcare.

3.2. The essence of Psychiatry and its social influence

Psychiatry is a branch of science that is specialized on exploring and treating disorders of higher-superior brain functioning, consciousness, cognition, spiritual functions and behaviour. The causes of disorders can be diverse (multifactorial) and they have complex retroaction to the minor and major environment. The social environment, culture, behavioural rules have a significant influence on the actual norm system, and the sociocultural surroundings have a determinative factor on the development of mental illnesses. Therefore, nowadays' the aim of the more and more effective psychotherapy and medical treatments is not only to restore the brain functioning but to help patients finding their duties in their minor and major social environment while easing their adaptation to it.

3.3. Cultural history of Psychiatry and the Social Psychiatric approach

The history of Psychiatry based on the found written records looks back on millennial history. Several detailed descriptions of symptoms of mental illnesses can be read in the Old Testament, Indian and Chinese written records. In the descriptions, which remained from the antique Greek and Roman culture, certain symptoms referred to as illnesses, the attempt on new treatment methods were successful. Hippocrates reflects



to the origin of mood disorders and mental illness as a change in the equilibrium ratios of the four basic bodily humour. In the middle ages the first mental hospitals were established in Arabic countries in Bagdad, Cairo, Damascus and Aleppo. In the medieval Europe referring to religious doctrines the mental patients were held in handcuffs under lock and key. During the French Revolution Pinel removed the chains from the mentally ill, placing treatment on moral doctrines, emphasised the role of the society and the community first. Instead of jails mental patients were placed in mental hospitals. They were treated humanely but they were kept still isolated from the society. In the second half of the 19th century the principles of depth psychology were developed by Adler's, Jung's, Ferenczi's and Freud's academic and scientific achievements. From a social point of view one of the most important milestones of the depth psychology tendency was that when the 'historicity' of psychological processes was accepted. The psychological state of a person is significantly affected by current life and childhood traumas, social and community changes. Despite the invasive and continuously developing pharmaceutical researches there is a growing need of improving communication skills and the ability of socialization in all fields of health care.

Centuries earlier, an individual had been observed through his or her social context (family, work, social relationship). By the 19th century social psychiatric approach and the practice of the psychiatric patients was evolved both during their perception and care. The emotional manifestation and pathological behaviour of a patient can be explained in a social context. The Social Psychiatry emphasizes the role of the families and the role of the society in the development of a (mental) disorder as well. The social changes and uncertainties play significant role in the



development of certain psychiatric disorders. Clearly the tendency to heal is also significantly influenced by the social medium. Later, therapeutic colonies were established to relieve the overcrowding of mental health institutions, where work therapy with family care was combined.

By organising group and community therapies, a new philosophy was developed. According to that an individual will only become a responsible and independent, self-supporting person if he or she is able to take responsibility for his or her own problem and actions. Rejection, isolation linked to otherness and stigmatisation associated with otherness can be observed in all social levels in psychiatric patients. The most inordinate example was Germany, where the sterilisation of psychiatric patients and intellectually disabled people was enacted in 1933 and the liquidation of those affected from 1939. The community sometimes extends its judgement and stereotype to the nursing, caring families too. Nowadays the bio-psycho-social model is considered to be timely, which can also be interpreted in social terms, that the development of disorder related deviances, includes significant environmental factors in addition to biological factors, which then affect the social medium after the onset of the disorder, forming a complex interaction.

3.4. Theories explaining the relationship between the social norm system and psychological disease

Deviance is a violation or non-compliance with social norms or legally regulated community behaviour. It means an unconventional behaviour or appearance. In the field of Sociology, they include alcoholism, drug addiction, self-harming behaviour such as suicide, mental illness. A behaviour does not become deviant by a specific action of an individual,



rather by the perception of the society and by the norms accepted by the given society. These vary from society to society and from age to age. (**Deviance Theory**). From a cultural anthropological point of view, the perception of mental illness varies widely from one culture to another, despite the fact it occurs in all societies. According to the **Role Theorists** a disease is dysfunctional in terms of the functioning of a social system. It causes problem on the social front if members of the society are unable to fulfil the social role assigned to them. If they are unfit for work, they are not able to contribute to the maintenance of the community thereby endangering the integration of the society. An illness in this context is a kind of complex social role. Therefore, it is the interest of the society to take illness and patients under its control. This role can be learnt, transferred to anyone and it can be enforced based on a pre-written set of roles. In a complex social role system, people caring for patients have a prominent role. They have greater control and their instructions may lead to a complex patient role system during a long-term treatment. It can become the identity of the patient. A chronic psychiatric patient is not only a participant in a long-term treatment process, but they get a complex social status through those social roles that are expected and selected by the others. Not only the patients' motivation is important toward recovery but the health care workers' motivation as well. In terms of optimizing healing and its social role the course of an illness and the process of healing are in interaction with each other. According to Parson there are four aspects of expectations towards patient roles. The first of those is that the patient gets an exemption from the obligations that would be required from the society, which is legitimated by the treatment staff in particular the doctor towards the society. According to the second aspect the patient cannot be expected to be healed by his or her own motivation



and internal determination. They can get exception from the obligations, but they are expected to heal as soon as possible and to accept the instructions and regulations and help. The third aspect is that the patient needs to desire to heal and he or she needs to take part in the healing process actively. And the fourth is that the patient shall demand constant help from the professionals. The patient role assumes a complementary role structure, since without a patient there is no doctor. The role of various social motivational factors in a disease is clear from the description, that widens the institutionalised role of the disease. The **theory of symbolic interactionism** is based on the fact that reality is a collective construction. Language has an overriding importance in collective symbol formation. It is the most significant example of collective symbol formation. Collective interaction is based on the collective description of symbolic content in language developed by the community. According to the theory, the concepts of chronic psychiatric illness and patient status are also common in social construct. with language symbols. The role previously detailed can be characterized by language symbols learnt in addition to language symbols. The specific professional concepts used in healthcare system form a closed world, in which the concepts and symbols that are used in Psychiatry differ from those that are used in any other biological field of the health care, forming a narrative. Let us think of the residents of the mental homes: where the more time they spend there the more the patient role and the hospital environment will determine their everyday. In case of several years of hospitalization in Psychiatric wards, the milieu of the department over time means the whole world for them. As time goes it becomes increasingly impossible to carry on their former identity, outlook on life and values. Those people, member of the staff, who work for hospitals,



especially for mental homes are in similar situation as the patients, because although they live in an open community, the hospital's environment has a significant impact on their everyday life. This kind of external dependency makes it impossible to maintain their previous identity, favouring the development of new identity associated with the patient-role. **The theory of labelling** is a Sociological tendency which is based on the human rights. It had a huge impact on the psychiatric care system and their functioning. The dominant and consolidated social institutional system that represents and enforces the community standards plays major role in theories. According to its representatives, an individual becomes deviant not because of his or her behaviour, but in the classification process in which that behaviour is judged in the social institutions detailed above. An individual is forced into a way of functioning by the given society that is followed by the majority through the institutions and the legal system. The definition of normality not only describes a form of expected behaviour, but it removes (punishes) those forms that differ from the expected ones. The concept of stigmatization was formulated through this. All the things are removed what is not adapted to the optimal picture: it is not beautiful; it is not healthy. The image of normality includes active, working lifestyle is accepted, otherwise people who are not yet active or who are no longer active (elderly) may be exempted. The other possible option is illness. Psychiatry with a role of patients provided, supports and embraces the person who has been eliminated from work. The phenomenon of mental homes, the atmosphere and functioning of psychiatric wards is a way of getting out of the population. But it is not attractive enough for the individual to voluntarily undertake this living space.



4. The purpose and functioning of the Health System in Hungary

4.1. Health System and Health Care System

The Health System is a structured system of the society's activities. Its main purpose is to preserve health, prevent and cure diseases and treat chronic diseases. The state of Health Care in Hungary can be described by several parameters, such as life expectancy at birth, the occurrence and the risk factors of certain diseases. By analysing the maintaining cost of the Health System as a percentage of GDP, our country spends far less than the other European countries. In 2017, it represented 6,9% of the GDP with a total health expenditure of €1468 per capita. The figure alone is difficult to be assessed, as beside the technical progress, drug prices and the price of the health care have been increased as well. Two-thirds of Health System's spending is provided by government funding and the national Health Insurance System, and one third (27%) is financed by the population in the form of direct contributions. Most of the private spending was mostly used to provide medicines and medical aids, but there has also been a significant increase in the turnover of Private Health Care System, generating costs, due to the waiting lists in the public care system.

4.2. Structure of the National Health Care System and Health System Funding

The Hungarian population is provided by a single Health Insurance System, and it takes care of almost the entire population. The financing is provided by employer and employee contributions and tax revenues. The government is responsible for controlling funds, funding strategies and it



Mostly provides care. The fund is managed by the National Health Insurance Fund Manager under the supervision of the Ministry of Human Resource. The central government has a powerful control over the health system. The government is responsible for the strategic health management, the legislative background and the funding control. Since 2012, the central government has taken back control of hospitals from county and municipal authorities (centralisation). The Health Care System is now hospital-centric. The Inpatient Care can be divided into three main groups: Active Inpatient Care, Rehabilitation Care, Chronic Care. Some of the outpatient care is ambulatory, the other part of the care is long-term care (continuous supervision and treatment of people with chronic diseases). One of the most important pillars of the care system is the primary care. The primary care is made up of practices and practice communities in a privatised form. Primary Care includes General Practices, Nurses and Central Emergency Services. Primary Care is responsible for first observation of health, disease screening and integrative direction to other examinations and care („gatekeeper function”). Over the past five years there is an increasing focus on the Private Care System in all segments of the care system.

The health market as an economic concept has a short history. Market regulations cannot be applied in classical economic terms as demand is not able to optimally regulate supply, due to the consumer’s information asymmetry (in doctor -patient relation) and a special consumer behaviour in health care. The patient’s behaviour will never become a rational consumer behaviour. It is no longer enough to be ensured high-quality medical professional organisation and performance by the management of today’s Hungarian hospitals and institutions, but a cost-effective, economical operation and liquidity of the institution must be ensured as



well. As of 1st July, in 1993m instead of the previous base-minded method of budget planning and financing method, a service and performance-based funding was established in the Hungarian Health Care too. The guaranteed (base) revenues of hospital institutions have ceased to exist, and their functionality is crucially determined by their ability to generate revenues on the basis of service performances. The increase in the unemployment rate and the shift in the average age have led to a decrease in resources due to reduced contributions. In addition to the reduction in resources, the demand for care has increased parallelly. The sorting principle in the current distribution target system of the Hungarian Health Care System is the normative principle of performance funding. This would (theoretically) make resource allocation fair and encourage rational management. In Hungary, the cost of operation and the cost of investment is separated from each other in the dualistic financing system. The service and the operation are paid by the National Insurance Service, while the investment is the responsibility of the owner. It is important to mention 'ex post' which on the basis of the invoices submitted, finances the activities carried out ex post by deferring several months. There was an important change in 1993, when funding for Primary Care, Specialist Care and Inpatient Care was separated. The financing of Hungarian performance is based on the creation of Homogenous Disease Groups. During the creation of the Homogenous Disease Groups, the primary subdivision was made by taking into account medical professional considerations. Diseases were grouped according the degree of total cost-consuming. Unfortunately, by the increasing level of development of the technology and pharmaceutical industry, the need for Human Resource has become less and less important in the development of the Homogenous Disease Groups. The anomalies in funding cannot be



ignored during the examination of the system, as it plays a crucial role in the situation of Human Resource and on the quality of care. The Care Funding System means a closed coffer, which means no more coverage for more patients and more cases. I will detail the need for human resources and the related issues to that in a separate chapter. However, it is important that the funding system does not include the total wage needs of Human Resource and it does not take into consideration Human Resources needs related to professional conditions.

4.3. Reforms of the Health System from 1990 to the present

Over the past decades, a number of plans and surveys have been carried out to introduce to Multi-Insurance Systems, but this has never been succeeded. However, in addition to the National Insurance System a number of voluntary health funds have started to operate as part of self-care, involving emerging private practices. There was a significant change in the funding of Health Care when the base funding was replaced by the case funding, which was based on the Homogenous Disease Groups funding. The scheme began in 1986 but it was actually introduced on 1st July, 2004. As a next step, the performance of given intervention of the institutions was determined in the Performance Volume Limit. The aim was to reduce unnecessary interventions and examinations in order to reduce cost. It was initiated in 2004. The later government criticised its introduction, but it persisted after 2010 too. Its regulations and frameworks are negotiated annually. By the change of regime, in 1990 the privatisation of basic care had been initiated, which was realised by the late 1990s. In 1992, as the first organisation the General Practices got the opportunity to enter into a contract with the National Health Fund. From



1998, the Health System was characterized by structure transformation, by establishing Central Hospitals. The main purpose of the reorganisation was inherently to rethink the outcome of the diseases. Caring regions were set up and the definition of Regional Caring Obligation was brought into existence. When the Regional Caring Obligation was established the distance between hospitals and the residential area of patients and the capacity of the centre of care was taken into consideration. During the restructuring the amount of the active beds was downsized, while the amount of the rehabilitation beds was increased. The development of Outpatient and One-Day Treatments System was only partly successful. Regional Caring Centres have been created from European Union tenders. In 2003, the minimum professional conditions were fixed, which determines the content of the weight number material and personal conditions according to each professional level.

The liberalisation of pharmacies, which began at the time of the regime change, simplified the opening of the pharmacies and it allowed the distribution of non-prescription drugs in other shops. The government has ordered that doctors have to prescribe cheaper so-called generic products and bidding negotiations for active substances have begun to make the pharmaceutical price subsidies possible. Since 2007, the government has taxed companies as company representatives to maintain medical visitor status.

In the period 2014-2020, Hungary has received financial support of €438 million, which is divided between the development of health infrastructure (€253 million), improving access to health and social services (€215 million) and health improvements (€15 million).



4.4. The situation of Human Resource in the Hungarian Health System

The human resource management deals with people as an organisation's resource. Their purpose is to ensure that employees' resources are used most effectively to achieve organisational and individual objectives. The human resources are the organisations' most valuable resources. It is innovative, it makes innovative decisions, it is able to solve problems and it has an ability to change in quality. Human resource constitutes intellectual capital that is able to create, develop and improve other resources and it is able to creatively enhance performance and improve quality. The basic condition for ensuring a high level of operation is the physical and mental health of the workers and the employment of motivated and loyal workers. Human resource is responsible for defining jobs together with well-defined jobs, competences and responsibilities (job descriptions). In health care systems, the provision of adequate quality and sufficient human resources has now deteriorated in some areas to such an extent that threatens safe patient care.

Table 1.: Number of people registered in the basic records on 31st December of a given year.

Profession	2011	2012	2013	2014	2015	2016	2017	2018
Doctor	48355	49609	51699	52951	54334	55806	55603	56540
Dentist	7769	8101	8403	8754	9126	9514	9780	10148
Pharmacist	11422	11788	12047	12302	12593	12956	12799	13044
Clinically qualified healthcare worker	1272	1477	1587	1696	1812	1818	2028	2035
Health care worker	199952	206960	214890	223272	231968	237874	243770	249585

(Source: basic register of AEEK-EFF, 2019)



Some specialized medical professions require a high level of human resource. For example, in Psychiatry with minimal device demand, a number of high-skilled medical and paramedical specialists are required to ensure quality care. Optimal results should be achieved during a minimal nursing time. The shortage of the professional staff not only makes nursing time longer, but it also generates an extra cost. From a professional point of view, it is also unfavourable for the psychiatric patients if they need to stay in hospital for a longer time than it would be necessary.

Demographic changes pose a serious challenge in human resource management of the health system in general. On the other side, the negative impact of demographic change is also shown on the age of professionals. It is difficult to judge the situation of the human resource of inpatient institutions and outpatient care, as nowadays doctors and specialists work in more posts and in several institutions at the same time. Optimally for healthcare in Hungary, 21920 doctors would be needed. According to data from the Central Statistical Office, 20299 posts are filled (without detailing whether these are part-time or full-time jobs, posts). There were 1621 posts unfilled by doctors in January 2020. Between 2010 and 2016, nearly 5500 doctors left Hungary to work in another European Union country or third country. Over the past two or three years, the migration of nurses and other health workers has also increased dramatically. The increase in the number of private cares over the years cannot be ignored. Nowadays 92% of those doctors in addition to their main activities in public hospitals work in private sector as well, as an ancillary activity. The above reasons demonstrate that optimal care is increasingly dependent on access to human resources. We are witnessing the appreciation of the human factor. It is the responsibility of



the human resource management to understand and preserve the skills and preparedness of the workforce in the field of health care. It would be appropriate to identify the underlying factors in order to prevent and reduce further migration.

4.5. The evolution of social perception of Psychiatry in Hungary

Throughout history, social attitudes have always been divided towards psychiatric patients. The social expectations are twofold towards care staff and institutions: in one hand psychiatric patients are expected to be separated from the community as “unwanted elements”, so they cannot disturb others. In the other hand the importance of human and personal rights against the physical and chemical limitations is underlined by the society too. Psychiatric care was always considered to be mysterious by outsiders due to its hiddenness and the patients’ disturbed and incomprehensive behaviour and bizarre appearance, where the aggression as a phenomenon is not rare either. In some cases, aggressive reactions are required in the course of care. Beside penal institutions, psychiatric department is the only place where, in some cases, aggressive restrictions are required in the course of care. Referring to the historical memories of Psychiatry, mental illness was more than biological imbalance. Its regulations were intertwined with social, culture-related expectations, which also represented “normality” developed by the community. Looking at the historical background it is necessary to look back to the founding of the state. Since the reign of Stephen the first, reigning families have brought regulations for treatment of the mentally ill, and it was defined as well who can be considered to be mentally ill. In 1514, Werbőczy’s Tripartium provided rules for placing the “mentally retarded”



and confused people under the care of guardianship. Maria Theresa ceased the witch-burning in Hungary. According to her decree issued in 1755, people behaving in confusion must be transported lunatic asylum. In the absence of lunatic asylum, psychic patients most have been placed in prison among common criminals according to a newer decree issued by the end of the 18th century. The decision to establish a national madness was taken by the parliament in 1791. Unfortunately, the implementation of the plan took decades. With the investment of József Pólya, the country's first private mental hospital was established in 1841. It could accommodate twelve lunatics. However, in the absence of support, the institution had to be closed within a year. But the model had followers, and several institutions were opened, by the second part of the 19th century. In 1868 the Hungarian Royal State Madness in Lipótmező was established in 1868 based on the ideas of Ferenc Schwartzler. It could accommodate 500 lunatics. This had very considerable importance in the history of Hungarian psychiatric patient care. Similar to the European model, special departments had been set up for the mentally ill in hospitals. One of the first departments was established in Kaposvár, in 1880. At the beginning of the 20th century in addition to the development of psychoanalysis, several major scientific professional trends were initiated, mainly psychotherapeutic trends. Let us think of the work of Sándor Ferenczi, Lipót Szondi, Géza Róheim, and Mihály Bálint and the negative attitude of the society. It is related to the social political situation of that age, that their merits and achievements were recognised and accepted decades later by medicine. After the World War II, the Hungarian Association of Neurologists and Mental Doctors was founded. Social changes and political considerations have significantly delayed the development of psychiatry as an independent discipline and the



development of the institutional care. The Hungarian Psychiatric Association was founded in 1980 with a considerable delay compared to the other European countries. In medical disciplines, similar stigmatisation can be observed in Psychiatric Care Facilities. Nowadays 21st century is said to be the century of Psychiatry by the press statements and media reports as psychological disorders are the most common causes that make people unable to work for the longest time. The transformation of the institutional system can only take place in a complex way by changing social attitudes, and the attitudes of those working in the institutions are not negligible.

4.6. The quality of life of health workers in Hungary, the threatening of stress and burnout

Health workers are presumed to be more informed and enlightened about health preservation and prevention. Time spent on the field of Health System strengthens their self-defence mechanisms, making them more protected from certain psychological traumas. The use of the **concept of resilience** has become more common. It means the ability of an individual to cope with certain situations. The feeling of competence or feeling of inefficiency, stress and burnout at a workplace plays a decisive role in the quality of life. Among health care workers, nurses are more disadvantaged, both in terms of physical health damage and social support. As for the stress-related health damage they belong to the group of high risk. The level of qualification and the resilience of the nurses are shown to be in a significant correlation. There is an increased number of suicides for doctors and nurses who work in certain fields (intensive care, psychiatry) compared to the population.



5. A hospital's staffs' opinion of the mentally ill and their carers. Experiences of empirical analysis using Q method.

5.1. The theoretical basics of the Q method.

Q Method was developed by William Stephenson to examine individuals' psychological attitudes. Q method is an inverted factor analysis, which analyses the people themselves not their characteristics, according to Stephenson. The method focuses not on the differences between individuals, but in differences within individuals. The mathematical basis of the method is the same as the mathematical basis for factor analysis. By using Q method relatively large number of statements can be assessed with relatively small number of individuals involved in the research. Correlation coefficients that are calculated by the method show correlation between people. The Q method can be considered as an inverse factor analysis and it is less rigorous in terms of mathematical conditions than factor analysis using the R method. In the case of Q method, it can generally be accepted that the ratio between the number of statements and the number of people included in the study is approximately 2:1. According to previous studies the analyses are usually done with 20-60 statements involving 20-30 people. Previous experiences has shown that there are only a limited number of divergent positions on any subject (Brown, 1993). Therefore, if the set of statements, the so-called "Q set" is well structured (i.e. it maps as widely as possible the range of opinions on the subject under consideration) we will probably be able to explore a wide range of dissenting positions in public discourse with the help of up to 20-60 statements. In statistics the reliability of the

test is important because we want to know how generalised the results can be. Generalization is less important for analyses when using Q method. In Q method, the main role is played by the individuals embodying the opinions and not by the percentage of the population. The practical application of the method can be divided into six steps.

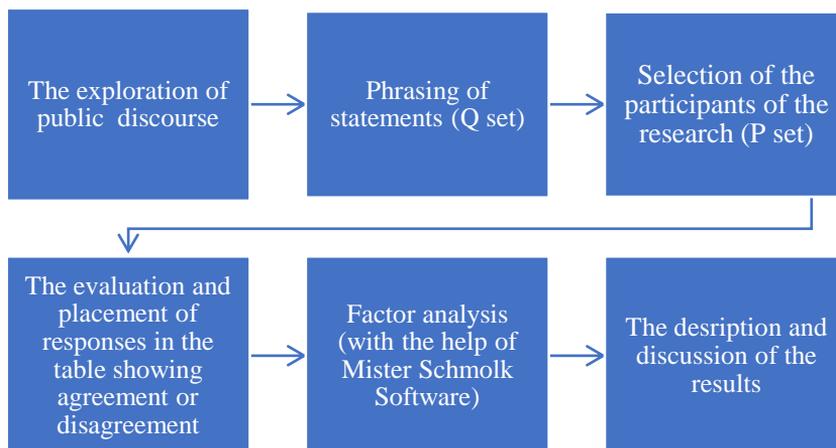


Figure 1.: Steps to apply the Q method

In the case of method Q, representativeness should not be given to interviewees (individuals), but to the 'public discourse'. Public discourse must be explored in every detail very carefully, in order to have a chance to reflect almost all but most important elements of public discourse in the statements made. We may use brainstorming method and involve the individuals' involved in the investigation in the formulation of the allegations. We can also rely on the opinions of the experts.

In the case of the Q method as well we can also talk about representativeness, but it is not a function of the number and composition of the people in the sample, it depends on the quality of the statements,



the full description of the public discourse. By using the Q method, we do not examine what percentage of the people have the same opinion on certain issues, but we determine the ways in which public discourse can be typed. In fact, the results will not show who you agree with, but what causes the consensus and what are the statements that divide people. Q method is only a quasi-quantitative method; therefore, it provides a broad space for the intuition of the experts. The theoretical requirements of interpretation can be summarised in one sentence: each factor shall have an equity which is greater than 1.0, two Q lines in each factor shall be significantly displayed, at least two participant shall be identified in each factor and there should be at least two distinguishing statements per factor.

5.2 Empirical research among hospital workers, exploring public discourse

The first step of the application of this method is the exploration of the so-called public discourse. I have participated in several professional conferences which subject has been closely linked to the subjects of my investigation, which has allowed me to compare my own experience to the experience of those working in other similar departments. Some of the literatures published on the subject has also helped me to formulate the statements. The 39 statements that were used in the analyses are as follows:

1. A psychological disorder can be seen on someone at first sight.	2. People find it much harder to accept mental illness than physical illnesses and psychiatric patients are condemned the majority of the society.
3. A significant proportion of psychological patients live in poverty and under privileged.	4. Psychiatric patients feel ashamed in general.



5. A significant proportion of psychological patients are unable to get a job because employers are prejudiced against them.	6. People with psychological disorders are equally motivated to find a job as their peers with other diseases.
7. The majority of the psychological disorder derives from the patients' fault.	8. People with psychological disorders could do more for themselves and their environment.
9. Everybody is responsible for their own destiny including the majority of psychological patients.	10. Those members of the staff who work at the Psychiatry tend to have a different attitude toward those patients who suffer from addiction who are themselves to blame for their fate.
11. Majority of hospital workers oppose hospital treatment of patients admitted for poverty or housing.	12. Access to hospital care should be determined by health needs, not social circumstances and the economic situation of the patient.
13. During the registration of returning, self-harming patients in hospital, based on the patient's previous experience, during treatment, workers see a better chance to recovery.	14. Psychological patients often prey on their disorder to gain advantage.
15. For psychiatric patients, the most important factor is that they are understood and accepted by the staff, which is less experienced in the social context.	16. Psychiatric hospitalization of elderly dementia patients does not change their condition and quality of life.
17. It is widely believed that psychiatric patients are more prone to crime.	18. Treatment of young people should be prioritised over older people, as they are expected to benefit a higher health gain.
19. The prevention of psychological disorders is more important than the treatment of the treatment of an existing disorders.	20. Advantage should be given to those patients during their treatment, who pose higher financial and mental burden to their family members.
21. Health workers in the case of regularly returning patients see a similar chance to recovery.	22. Caring and supervision of the elderly, confused patients would be primarily the responsibility of the family.
23. When treating dementia patients, relatives place unjustified and often excessive expectations of staff and treatment.	24. Elderly dementia patients should spend the final stages of their lives in hospital rather than among their families.
25. Hospitalizations that lasts for several months are beneficial for patients because they are safe in the hospital environment.	26. Healthcare workers should be expected to be able to accept and treat all patients in the same way.
27. Behind the too long care for psychiatric patients there is a social problem that is also harmful to the patient.	28. Psychiatric patients treated in the hospital ward should be given advantages when being housed in nursing homes.



29. The placement and employment of mental patients is a social problem, which currently places a huge burden on hospital wards.	30. The professional care in the homes of the mentally ill can improve the condition of the patients, their quality of life and it can reduce the need for new hospitalization.
31. The majority of people view colleagues who work at psychiatry differently than those who work somewhere else.	32. The method and the duration of the psychological treatment is usually decided by the treatment team together, so the responsibility for the decision is also shared.
33. The opinion of the medical and professional staff is always the same as for the professional reasons for the psychiatric treatment.	34. The dependency of patients to hospitalization and their presence in the community always help them to heal or it provides a better quality of life after returning home.
35. Crimes committed by the mentally ill people are mostly subsistence crimes, that are less and rarely related to their illness.	36. Compared to other medical treatments, during the process of psychological treatment sometimes it is necessary to be confronted by the patients and we need to take on conflict so that they can face reality.
37. The mental use of psychiatric professionals is greater than physical exertion.	38. The mental homes' professionals should have a share in the aim that their patient should get into hospital as rarely as possible.
39. During psychological care the restriction and possible aggression of the patient is a natural inherent part of the treatment, which is necessary and it can be get used to.	

In this case, the investigation was carried out in two parts. At the first part, the participants (16 people) were members of the staff of the psychiatric ward led by me. At the second part the research was extended to 24 people and colleagues from other hospital wards were involved as well (as externals). The “two-phase” research allowed us to examine whether the 39 statements we created were suitable for describing “discourse” on psychiatric patients, or it reflected the views of community of special sensitivity to the subject. As it will be able to be seen later, the expanded and repeated investigation proves that our 39 statements were capable of identifying dissenting opinions. The results of the 24-people analysis will be presented below, and then I will analyse in more detail the attitudes of colleagues in the psychiatric ward.

5.3. The extension of the research to non-psychiatric wards (24 evaluations)

The literature discusses in detail the problems of selection the participants included in the evaluation. The Q method study requires a limited number of respondents. Only so many respondents are needed, that underpins the existence of a factor, which underpins the existence of a factor, so one factor can be compared to another. The so-called “P-set” is a set of people included in the evaluation. The selection of the participant is not random. My aim was to identify the types of opinions represented by my colleagues in the psychiatric ward by exploring “public discourse “. As the above shows, this has mostly succeeded. In the next part, the participants had to express their views on the statements on a 9-point Likert Scale. They were given 39 cards, which must have been placed into a triangle shaped table.

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

Figure 2.: The triangle in which respondents had to place 39 statements in the cells

It makes analysis easier by using factor analysis to identify people whose opinions are mostly similar. The factor weights are shown in the table below.

Table 2: The % of the factor weights and variances (24 cases of hospital staff)

	Factor 1	Factor 2	Factor 3	Factor 4
kamilla	0.7612X	-0.1803	0.2555	0.2669
gina	0.6432X	0.3717	0.1893	-0.0301
melinda	0.5462	0.1545	0.4272	0.4474
szilvia	0.6532X	0.2418	0.2662	-0.0351
edina	0.6632X	-0.1843	0.1492	0.2755
ágota	0.2642	0.4590	0.2675	0.4877
szabolcs	0.6213X	0.0045	0.0527	-0.0763
borbála	-0.2051	0.0510	0.2252	0.7299X
frida	0.0420	0.7082X	0.1987	0.0956
teréz	0.3079	0.5061	0.4656	-0.1806
anita	0.6168X	0.2785	0.2324	-0.2333
klementina	0.2824	0.5184X	0.2183	0.1493
kálmán	0.5685X	-0.1169	0.3021	-0.2919
pál	0.6017X	0.3933	0.3166	-0.0039
mariann	0.1428	0.6878X	-0.3410	0.1679
eleonora	0.1228	0.2970	0.7599X	0.2224
amália	0.7700X	0.0968	-0.0306	0.2105
kristóf	0.3445	0.6760X	0.0281	-0.0575
lora	0.1629	-0.0526	0.8825X	0.0675
karolina	0.5934X	0.1576	0.3377	-0.1544
léna	0.6130X	-0.0853	0.4584	-0.0400
anikó	0.0164	0.1285	0.7210X	0.3268
emese	0.7322X	0.1078	0.3465	-0.1682
piroska	0.1147	0.5721X	0.4634	-0.0603
Variancia				
%	25	13	15	7

Participants marked with X belong to a factor. As it is shown in factor one this means 12 participants. Each factor weighs are more than 0,6 in the first factor. Therefore, it can be expected that 12 of them have very similar point of view. The four factors together explain 60% of the variance. If the fourth factor is not taken into account, the explained variance is still 53%. Positive factor values show that although in a different way but the

participants agree with these statements, while the negative values mean that they tend not to agree with them. The characteristics of the four factors of hospital staff (24 people) are summarised in the 3rd Table.

Table 3.: Factors identified for hospital staff and their characterisation

Name of the factor	Factor 1.	Factor 2.	Factor 3.	Factor 4.
	Professional identity and tolerance	Representatives of the public discourse	Without psychiatric experience	On the way to the professional field
The main characteristics of the group	They have expertise and they have experience working in Psychiatric Ward, they walk on the ground		The former self-consciousness, youthful will to help	Open to everything, in the learning phase, but with ambivalent feelings.
People clearly classified in factors	Kamilla Gina Szilvia Edina Szabolcs Anita Kálmán Pál Karolina Léna Emese Amália	Klementína Frida Kristóf Mariann Piroska	Elenóra Lora Anikó	Borbála
People who can be classified to a factor	Melinda	Teréz	Teréz	Melinda

5.4. The examination of attitudes among Psychiatric Department staff (P-set, 16 people)

In parallel with the formulation of the statements, the participants were selected (P set). In the first phase, 16 members of the staff of the psychiatric ward led by me were selected. Similarities and differences can be seen in the factor matrix below.



Table 4: Factor weights and % of variances (16 participants, the case of the psychiatric workers)

	1	2	3	4
kamilla	0.5808x	0.5155	0.3156	0.1646
gina	0.3825	0.1461	0.0822	0.7351X
melinda	0.3270	0.3745	0.6045x	0.3724
szilvia	0.5889X	0.0117	0.1604	0.4850
edina	0.4508	0.4782	0.3590	0.0731
ágota	0.1648	0.0462	0.7176X	0.2480
mira	-0.2588	0.3657	0.0930	0.6751X
szabolcs	0.5990X	0.2774	-0.0713	0.1149
barbara	-0.2022	0.8255X	0.0479	0.1175
kincső	0.0774	0.0500	-0.0281	0.4553X
borbála	-0.1588	-0.1108	0.7214X	-0.1227
frida	0.0836	-0.5356	0.3749	0.5237
teréz	0.1386	0.1613	0.0859	0.6944X
anita	0.4845	0.2760	-0.1007	0.5583
klementina	0.1873	-0.1092	0.2330	0.6459X
kálmán	0.7974X	0.0807	-0.1046	0.1039
expl.Var. %	16,00	12,00	12,00	20,00

The four above factors explain the total of 60% (16+12+12+20) variance of the variables. Therefore the loss of information is 40%, which is significant, but all 16 people can be identified in a factor.



Table 5.: Factors identified for colleagues in the psychiatric ward and their characterisation

	Factor 1.	Factor 2 .	Factor 3.	Factor 4.
	Social polity thinkers	The framework of thought is the Psychiatric Department	Direct professional empathy	Significant professional routine and some enduring
The main characteristics of the groups	Greater social engagement and interest. The statements go beyond a tight environment. They are not hospital political but of a social political nature.	The outside world does not count, they think inside a hospital. Patient's point of view.	Professional commitment, optimism, empathy. Youthful commitment.	Experienced people. less optimism, clear values and moderate enervation
People clearly classified in factrs	Kamilla Szilvia Szabolcs Kálmán	Barbara	Borbála Ágota	Gina Mira Teréz Kincsó Klementína



6. Summary

My research was based on my medical activities – curing patients – and on my open-minded views on society. Health, prosperity and having a relatively good life quality are basic human needs. My literature and historical overview surveyed the aims of Psychiatry and the views of the society connected to it. However, reaching the acceptable quality of life and welfare for the members of society might be in conflict with the interests of the patients and this may even result in inner conflicts for psychiatry staff. The views of the members of the society on psychiatric illnesses and treatments are controversial and this controversy might deteriorate the conditions of treatment. This ambivalence may result in an inner tension for workers which increases their workload. The aim of the research is to examine the different opinion groups and the analysis can contribute to understanding the motivations between activities and opinions. The formation of factor groups does not necessarily mean identical motivations behind the opinions.



7. The novel findings of the research

1. Several examinations have been carried out on health care workers' quality of life and health on the basis of international and Hungarian literature. Results show that health care workers' life quality and health are far below those of average population. The reason is not only of financial; they have worse results than others in their age group regarding their social relationships and mental conditions, too.
2. Both stages of the examination proved that the attitudes of psychiatry workers are different from those of the workers in other areas. Regarding the evaluation of the statements, belonging to the same factor was primarily indicated by professional aspects and experiences: I consider it as a significant finding that group formation was not based on statements related to stigmatization.
3. The research has proved that the attitudes to psychiatric patients and their treatments changes along with life experience and professional experience. The older workers formed a separate group in both examination stages not only in direct patient care.
4. According to the results of the survey including 16 respondents working in Psychiatric Ward, a clearly separate group was formed from those who work directly at hospital beds as they regard it as a larger burden to treat patients with conditions that are not professionally justified to be treated at hospitals.
5. Patients' attitudes to and their insight into their psychiatric illnesses are clearly different from workers' opinions. This is shown by "Brigi's" situation who forms a separate group on her own within the 16 respondents.



6. The Q-method proved to be a suitable tool to reveal and analyse different opinion groups. The evaluation of the results from the two examination stages proved that the Q-method is appropriate and efficient to be used in this area, too.

The respondents of the research regard their participation as beneficial and effective and they consider the research findings to be thought-provoking and useful for their daily work. By examining varying views in public discourse and by analysing them along the factors, their eventual differences turn out to be of positive value.



8. Publications on the theme of the dissertation

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9. Publications beyond the topic of the present dissertation

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