This dissertation has been microfilmed exactly as received

DENMAN, Loretta Mae, 1913–
PATIENTS' PERCEPTIONS OF THE THERAPEUTIC FUNCTIONING OF NURSING PERSONNEL IN A PSYCHIATRIC SETTING.

The Ohio State University, Ph.D., 1962
Health Sciences, nursing

University Microfilms, Inc., Ann Arbor, Michigan
PATIENTS' PERCEPTIONS OF
THE THERAPEUTIC FUNCTIONING OF
NURSING PERSONNEL IN A PSYCHIATRIC SETTING

DISSERTATION
Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of the Ohio State University

By
Loretta Mae Denman, B.S. Ed., M. Litt.

*****

The Ohio State University
1962

Approved by
Earl W. Anders
Adviser
Department of Education
ACKNOWLEDGEMENTS

The writer acknowledges with gratitude the helpfulness extended to her by many people. Especial recognition is due the staff and patients of the Columbus Psychiatric Institute and Hospital who cooperated so fully; her doctoral committee, especially Professor Earl W. Anderson; and her forebearing family, especially her sister, Lela, who so arduously devoted herself to the tasks of keeping the writer on the job and of laboriously typing this manuscript.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>ii</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>iii</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>v</td>
</tr>
<tr>
<td>LIST OF ILLUSTRATIONS</td>
<td>vi</td>
</tr>
</tbody>
</table>

## Chapter

### I. INTRODUCTION ........................................ 1

- Statement of the Problem
- The Setting and Sources of Data
- Definition of Terms
- Limitations
- Assumptions
- Organization of the Study

### II. SURVEY OF THE LITERATURE ............................ 10

- Social Psychology
- Nursing Research

### III. METHODOLOGY ........................................ 17

- The Participant-Observation Methodology
- The Interviews
- The Checklists
- The Selection of the Wards for Study
- The Analysis of the Data
- Time Schedule of the Study

### IV. THE SETTING .......................................... 31

- The Hospital
- The Women's Ward
- The Men's Ward
- The Philosophy of Nursing Care and The Educational Program
V. THE FINDINGS ........................................ 58

The Presentation of the Data
  Participant-Observation Data
  The Interviews
  The Checklists
Analysis and Interpretation of Data

VI. IMPLICATIONS FOR NURSING EDUCATION .......... 106

General Implications
  Implications for the Education of Student Nurses
  Implications for Nursing Service and Its In Service Educational Programs

VII. RECOMMENDATIONS FOR FURTHER STUDY .......... 114

VIII. SUMMARY ........................................... 116

APPENDIXES ............................................. 118

A. A Sample Hospital Day ................................ 118
B. Guide Sheet for Patient Interview .................. 120
C. Checklist ........................................... 121
D. Instructions to Personnel Accompanying Checklist of Nursing Behaviors 125
E. Instructions to Patients Accompanying Checklist of Nursing Behaviors 128
F. Case Summaries ..................................... 131

BIBLIOGRAPHY ........................................... 179

AUTOBIOGRAPHY ......................................... 185
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tentative Diagnoses of Women Patients First and Tenth Week of the Study</td>
<td>38</td>
</tr>
<tr>
<td>2. Tentative Diagnoses of Men Patients First and Tenth Week of the Study</td>
<td>52</td>
</tr>
<tr>
<td>3. Percentages of Men Patients Who Perceived Nursing Functions During Last Nine Weeks of Study</td>
<td>59</td>
</tr>
<tr>
<td>4. Percentages of Women Patients Who Perceived Nursing Functions During Last Nine Weeks of Study</td>
<td>60</td>
</tr>
<tr>
<td>5. Sample Group Interviewed</td>
<td>67</td>
</tr>
<tr>
<td>6. Interest and Concern Items Checked by Patients and Personnel</td>
<td>78</td>
</tr>
<tr>
<td>7. Social-Recreational Items Checked by Patients and Personnel</td>
<td>80</td>
</tr>
<tr>
<td>8. Emotional Support Items Checked by Patients and Personnel</td>
<td>82</td>
</tr>
<tr>
<td>9. Therapeutic Items Checked by Patients and Personnel</td>
<td>84,85</td>
</tr>
<tr>
<td>10. Summary of Agreements and Differences Between Patients and Personnel on Perception of Items Used and Should Be Used As Shown By The Number of Checks</td>
<td>87</td>
</tr>
<tr>
<td>11. Number of Highest Patient-Agreement Scores With Students, Nurses and Aides in Each Category for Used Items</td>
<td>90</td>
</tr>
<tr>
<td>12. Number of Highest Patient-Agreement Scores With Students, Nurses and Aides for Each Category for Should Be Used Items</td>
<td>91</td>
</tr>
</tbody>
</table>
# LIST OF ILLUSTRATIONS

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Weekly Ward Activity Chart</td>
<td>39</td>
</tr>
<tr>
<td>2.</td>
<td>Personnel Checklists Completed by Patients</td>
<td>75</td>
</tr>
<tr>
<td>3.</td>
<td>Patient Checklists Completed by Personnel</td>
<td>76</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

Programs in nursing education are designed to prepare nurses to function where their services are needed. Traditionally, the greatest demand for these services has come from hospitals, although nurses are found in homes, schools, doctors' offices, industrial plants and other areas. As changes have occurred in medical science and in treatment, and as hospitals have expanded and streamlined their services, programs in nursing have been revised to prepare nurses to meet the changing functions. This has been true in mental hospitals as well as in general and other special hospitals.

Many new concepts of adequate care of psychiatric patients have been introduced since the advent of the social scientist into the mental hospitals. Social psychiatry has focused attention away from the therapy hour to the other twenty-three hours of the patient day and has brought forth some challenging descriptions and analyses of happenings in mental hospitals. The reports of Caudill, Devereaux, Stanton and Schwartz, and Jones have served as catalysts in the swiftly changing therapeutic programs of care in private and public institutions across this Nation and the world. Edward A. Kennard, in discussing a resident training program in psychiatry, referred to the body of literature being produced and commented that it has produced little change in the
training of the psychiatrist. He further pointed out that the psychotherapeutic techniques being taught were seldom used by the psychiatrists in the hospital under discussion as the current organization and patient load precluded that possibility.

Educators in basic and advanced psychiatric nursing programs have been more immediately willing than psychiatrists to make use of the new body of literature. The psychiatrist sees the patient an hour a day, at the most. The other twenty-three hours of the patient's day are the domain of the psychiatric nurse. In 1950, Marian Kalkman pointed out to a group of psychiatrists and others at a dinner meeting of the American Psychiatric Association, that, in addition to providing physical care and observing and reporting, "the psychiatric nurse is responsible for creating a therapeutic environment for the patients." The Group for the Advancement of Psychiatry in 1952 published a survey report on psychiatric nursing which stated in part:

A chief responsibility of the psychiatric nurse is to create a therapeutic ward atmosphere. More specifically, she should be able to influence favorably the group interactions in social, recreational and occupational activities on the ward. It should be emphasized that the nurse's role in this regard should enable her to make a unique contribution in the ward care of hospitalized mental patients. Through her continuous presence on the ward the nurse has many opportunities for daily direct contacts with individual patients as well as with the total patient group. A dynamic understanding of the patients' behavior in its many manifestations will enable the nurse to respond appropriately to the behavior.

---


This is the essence of the nurse's therapeutic activity.¹

Later on, the same report referred to another important therapeutic influence of the nurse with respect to working with subsidiary personnel:

In relation to those responsible to her, the psychiatric nurse should not only specify duties and see that they are carried out, but she should also carry on continuous training by precept and discussion. Attendants, practical nurses, aides, technicians—regardless of designation and duties—should be kept aware of the role that they play in the welfare of all patients and should be stimulated to improve their contribution to the team effort.²

Nursing educators having these expectations of performance to be met were quick to utilize the contributions of social scientists to enhance their educational curricula. When a National Working Conference on Graduate Education in Psychiatric Nursing was held in Williamsburg, Virginia in 1956, climaxing a series of five regional meetings, four social scientists were in attendance as active contributors. A similar conference on Basic Nursing Education also included social scientists as participants.

As a result of collaboration with social scientists in such meetings, and in the hospital settings, psychiatric nurses have been studying their nursing care of patients and investigating ways of improving it. In moving from custodial to therapeutic nursing, they have encountered many problems, particularly in the area of attitudinal changes. The Expert Committee on Psychiatric Nursing of the World Health Organization points out that philosophy of psychiatric care


²Ibid, p. 3.
moves from the concept of protecting the community through protecting the patient from himself and others to providing opportunity for the patient to recover through therapeutic means.\textsuperscript{1} To make such a change a reality requires time for working through attitudes and feelings; in many cases changes have been instituted in hospitals before nursing staffs could assimilate the new ideas and develop appropriate approaches to care.

A particular point of interest to the writer is the question raised by the three editors of The Patient and the Mental Hospital concerning the extent to which patients should participate in planning and carrying on their therapy.\textsuperscript{2} Each wrote a summarizing chapter and each brought forth the need for research into different phases of patient treatment and ways of involving patients in the process. The writer has followed the curricular trends in psychiatric nursing education and has long wondered what patients really have to say about their "therapeutic experience." Students have been taught to plan for patients, provide for patient needs and do for patients. Patients, however, are not usually included in the planning and are, therefore, sometimes resistive to the providing for and the doing for. In some hospitals advocating milieu therapy, patients are said to be members of the therapeutic team—pass receivers, perhaps—but unlike the pass receiver who is in on the play, they have no opportunity to sit in on the team conferences with doctors, psychologists, social workers, nurses and occupational therapists and help plan their therapy. Nor do they


\textsuperscript{2}Greenblatt, Levison and Williams, pp. 611-649.
get to evaluate the results directly. The evaluations are made by means of the staff perceptions of their improved behavior; patients may perceive their improvement as the results of something quite apart from the treatment.

The increasing emphasis on psychotherapy as a learning process, with the patient in the role of learner, and nursing personnel the extenders of the psychotherapy into all aspects of his daily living, has made clear the need to give the learner an opportunity to express himself about the appropriateness and the effectiveness of the teaching-learning process. Fromm-Reichman and Bondura have expressed doubt that therapists really act on this principle, but psychiatric nurses are beginning to "listen" to the patient. Suhrie stressed the importance of teaching nurses to listen to patients as a way first to understand them and then to care for them in a way which helps them to grow.¹ Coulter described the teaching-learning process in nursing education in terms easily transposed to nurse-patient interaction:

...a reciprocal relationship which depends on the capacities of those involved...as the learner matures the objectives of the two become more similar and may eventually become the same.²

The writer wonders if nurses have become so imbued with the idea of administering to patients that they find the concept of listening to and working with the patients difficult to implement. What clues


can be found for nursing educators by exploring patient perceptions of the therapeutic functioning of nursing personnel? How do patients perceive the therapeutic nursing care which nurses so carefully devise for them?

Statement of the Problem

The purpose of this study was to learn if there were implications for nursing education to be elicited through the exploration of patients' overtly expressed perceptions of the therapeutic functioning of the nursing personnel. Three main questions are formulated:

1. What behaviors do patients perceive being used by personnel in the given setting? Which of these perceived behaviors do they identify as therapeutic for them?

2. Do patients and personnel agree as to which behaviors in personnel are therapeutic for patients? What differences are there?

3. What are patient expectations of behavior for personnel in different roles- students, staff nurses, aides?

Since the study was exploratory it was felt that additional facets of pertinent information would be uncovered in process. In the case study of the two wards participant observation techniques, including the interviewing of patients and the utilization of checklists marked by both patients and personnel, were employed.
The Setting and Sources of Data

This exploratory study was carried out on one of the floors of the Columbus Psychiatric Institute and Hospital, a one hundred twenty-six bed institution which is a part of the Ohio State University Health Center. A research and teaching hospital, it is used as a field placement for students enrolled in various curricula of the university, including basic and graduate students in nursing. The setting is described in detail in Chapter IV.

The primary sources of data were the patients and personnel of the two wards comprising the floor studied. All were utilized in the participant observation study, while twenty-four patients and twenty-six personnel completed the behavior checklists. The twenty-four patients were also interviewed by the writer.

The secondary sources of data were the many ward records—patient charts, nursing notes, daily reports, conference reports—and informal conversations with personnel.

Definition of Terms

While the writer has endeavored to make clear her use of terminology as she proceeds, there are certain clarifications to be made early. The following definitions apply:

1. **Milieu therapy** is defined as the conscious use of all facets of the environment in ways designed to promote a higher level of wellness in each patient.

2. **Nurses**, as used in the behavior checklist, refers to the category of worker being considered; if the
person being checked is an aide, the term applies to him. This is done to simplify the marking procedure. In other sections of the study, personnel are referred to by their role name and nurse applies to the student or registered nurse.

3. Perception is the process of understanding and dealing with the social environment.

Limitations

Exploratory studies tend by their nature to be limited both in scope and in the extent to which generalities may be inferred. They are beneficial in that they may become the sources of important hypotheses which may be tested and thus provide generalizations.

There were two limitations in this study.

1. The scope was limited to one floor of a small psychiatric hospital, and the number of patients included was small (24).

2. The number of hours per day spent in the setting was limited; the total period of the study covered five months.
Assumptions

While the introductory statements concerning the study have highlighted the theoretical background on which it is based, certain assumptions of the author have been paramount.

1. The environment is an important element of treatment for the mental patient.
2. Nursing personnel strongly influence the nature and extent of therapeutic and/or non-therapeutic experiences of individual patients in the ward environment.
3. Mental patients perceive and evaluate these experiences and are able to communicate their perceptions effectively.

Organization of the Study

In the following portions of the report, the literature survey will be found in Chapter II. Chapter III presents the methodology of the research. Chapter IV describes the setting for the study and the early observations. Chapter V contains an analysis and interpretation of the resulting data. In Chapter VI, the implications for nursing in the setting are identified. Chapter VII sets forth the recommendations for further study and Chapter VIII presents a summary of the research.
CHAPTER II

SURVEY OF THE LITERATURE

Social Psychology

Several of the more important socio-psychiatric studies have been long-term multi-faceted investigations covering several years and utilizing staffs of varying sizes. Stanton and Schwartz reported on their study at Chestnut Lodge, a private psychoanalytically-oriented psychiatric hospital of 120 beds. This covered a number of complex researches of different aspects of the institutional structure and interactions.\(^1\) Stanton, as the administrative psychiatrist, had direct access to patient opinion; interviews were held with patients as well as with personnel, but the extent to which patient perceptions of their care were elicited was not given nor were such findings reported at any length. Otto Von Mering\(^2\) interviewed patients in his fourteen-month survey of twenty state hospitals, three Veteran's Hospitals, four joint university and state hospitals, and three private hospitals in search of trends in psychiatric care in 1953-54. Some mention of patient perceptions was made but not emphasized in the report. Another study, financed by The Russell Sage


Foundation and involving long-term team-approach techniques was that reported by Greenblatt, York and Brown.\(^1\) A veteran's hospital and a large state hospital undertook to reorganize along the principles set up at Boston Psychopathic Hospital. The process as observed and interpreted was published in the book, *From Custodial to Therapeutic Care in Mental Hospitals*. Among the concomitant studies reported in this investigation was that done by Mary E. Hatch, a social worker. She interviewed one hundred patients from the convalescent wards of Boston Psychopathic Hospital to learn what they found distressing and uncomfortable in their ward living. That the results were worthwhile was shown by the fact that many changes were made in ward living, and patient government was established. The value of eliciting patient perceptions was demonstrated further by the development of a series of educational and communicative devices for nursing personnel, who had been criticized in the interviews. Ward conferences and team conferences developed at Boston have been used as models by other hospitals.

Caudill\(^2\) interviewed patients as well as personnel, using a set of pictures depicting various hospital situations. He was seeking perceptions of the therapy, the administration, and the human relations aspects of the hospital. One finding of significance to the current study was that patients tended to be pessimistic about

---


therapeutic interactions with nurses while nurses tended to be optimistic about what was presumed to be the same or similar interactions.

Two reports\(^1,\,^2\) on the continuous research developments in the Social Rehabilitation Unit at Henderson Hospital in England have discussed findings of many researchers on a number of aspects of the therapeutic community, but stressed the attempts to involve the community in the hospital affairs and treatment program. One of the experiments was in the use of young college women as "social therapists", comparable to the aide in our terminology. Rapaport analyzed the problems and advantages in the use of these persons and felt the advantages outweighed the problems. He implied that while turnover was high, these young women were available and enthusiastic while employed. The employment of college level personnel at the aide level would certainly be a boon to patient care in this country but the economic barriers make the possibilities quite remote.

Harry Wilmer,\(^3\) as the charge physician of an admission ward of a naval hospital, was able to introduce a number of democratic practices into a highly autocratic situation. He pointed out that while both personnel and patients had been subjected to indoctrination into an autocratic system (the Navy) the nurses had had that superimposed on the authoritarian orientation which their nursing education had begun.


Most of the research done by the "pure" social psychologists has been experimental in nature, and has been done in controlled laboratory settings; mental patients are not available for such studies. Tagiuri and Petrullo\(^1\) reported some of the most important such studies. Maccoby and her associates\(^2\) also reported a number of studies on perception; few of these have been concerned with psychiatric patients. The emphasis in all these studies has been on furthering the body of knowledge concerning perception, and not on applying that knowledge in any particular area.

**Nursing Research**

A close search of nursing literature showed that psychiatric nurses have been more concerned about exploring their own role in therapeutic nursing than in studying the patient’s potential role. There have been very few doctoral studies in nursing and most of these have been in the broad areas of nursing education or administration rather than in clinical nursing. June Mellow\(^3\) has demonstrated how information and inferences transmitted to her by patients, sometimes verbally and directly, and sometimes in non-verbal ways, were used to


guide her in modifying her behavior in the relationship or in clarifying for the patient her reasons for the behavior so that their relationship could progress. Using the critical incident technique, Frances M. Carter identified nineteen behavioral criteria of therapeutic patient-patient interactions. One of her recommendations for further research reads:

...that since the present study shows that psychiatric patients are interested, able and willing for the most part, to participate in studies that have direct bearing upon themselves, the psychiatric patient as a resource should be used more often for this purpose.¹

Miss Carter went on to say that her research has meaning only if one accepts the judgements of the patient population and pointed out that this acceptance marks a beginning phase in psychiatric therapy. She also indicated that the report was a pilot study and that further results would be forthcoming.

In other clinical fields, patients have been used as respondents quite frequently, often with the idea of improving nursing education. Sometimes the studies aim at helping hospital administrators improve services but the results have had implications for education which may or may not have been listed. Faye Abdellah and Eugene Levine have carried on a number of such studies. They developed a checklist which

they gave under specific conditions to 8,660 patients and over 9,000 personnel in 60 general hospitals. One study sought to establish staffing patterns which would result in satisfactory care. Another was concerned with areas of dissatisfaction with nursing care and reported disturbances of rest, undue noise, neglect of patients' needs and "nurses always in a hurry" as high on the list. If, as the authors suggested, these were coverup complaints for patient insecurity and apprehension, this writer feels that there are indeed educational implications for nursing; the present stress on identifying and dealing with such feelings as a function of the nurse would seem to be falling short of expected goals. A third study analyzing the factors influencing the patients' opinions on care revealed that single patients between 20 and 29 years of age were less satisfied than married persons of the same age group, while those between 30 and 39 were more satisfied with nursing care than their married peers. This raises a further point of inquiry for nursing educators.

In the area of maternal and child health, two dissertations report the use of combined projective play techniques and interviews

---


with children. Florence Erickson\textsuperscript{1} explored four-year olds' feelings about intrusive procedures and the personnel who administered them. Claudia D. Gips\textsuperscript{2} studied a more general problem concerning children's ideas about illness, hospitalization and treatment. In each case, implications for nursing education were identified, and Miss Erickson has incorporated her findings in her education programs at the University of Pittsburgh School of Nursing.

\textsuperscript{1}Florence Erickson, "Play Interviews for Four-year Old Hospitalized Children." (Unpublished doctoral dissertation, University of Pittsburgh, 1957.)

CHAPTER III

METHODOLOGY

Amy Frances Brown cautions beginning researchers that there are no clear-cut mutually exclusive categories as research methods.\(^1\) Other writers on research have described similar methods in varying terms. The social science methods of Jahoda and her collaborators seem to be most adaptable to the study of psychiatric nursing. These authors sum up the problems in research in the social science field:

> The relative youth of social science and the scarcity of social science research make it inevitable that much of this research, for a time to come, will be of a pioneering character......In these circumstances, exploratory research is necessary to obtain the experience that will be helpful in formulating relevant hypotheses for more definitive investigation.\(^2\)

Information about existing situations may encourage or prevent the testing of hypotheses. Exploratory research serves as a means of discovering the practical possibilities for carrying out different types of research. Frequently, the researcher finds that he has


neither the power nor the resources to create the situations required for the testing of hypothesis; this is the usual situation in nursing. In such a case, existing situations may provide the only possibility for the collection of evidence related to his hypotheses. Jahoda et al indicate that studies of "insight stimulating" cases are important contributions which often have led to the formulation of hypotheses to be tested. They cite the many cases reported by members of the medical profession. This writer feels that study of the two ward situations might lead to some important hypotheses to be explored by educators in psychiatric nursing.

Allport points out that the case study serves as a framework for all observations gathered by a variety of methods and gives a number of procedural suggestions.\(^1\) Hillway differentiates the case study from the survey by pointing out:

> The case study differs from the survey in that it constitutes a detailed examination of a few typical cases rather than an accumulation of quantitative data from a vast number of respondents.\(^2\)

The case study method like other methods, has been acknowledged to having certain weaknesses. Hillway indicates some of these:

> The method suffers from several defects. One of these is the difficulty of selecting cases for study which are known to be definitely typical. Another is the strong element of subjectivity, which thus far, seems to be unavoidable in this kind of research. Nevertheless, the case study, especially

---


when used in conjunction with a quantitative survey, often draws attention to information that cannot be obtained successfully in any other way and thus can be justified scientifically.¹

The problems which Hillway associates with the case study are cited by Jahoda et al as problems of social relations research in general. This bias (or subjectivity) of the worker has been widely discussed. The writer theorizes that a self-awareness developed through a number of years of experience in psychiatric nursing establishes an alertness to possible areas of bias and diminishes the possibility of its occurring. Difficulties in sampling in social relations studies are discussed by Jahoda and her collaborators.² Brown³ suggests that the problems are similar in nursing and points out that incidental samples, that is, groups of individuals readily available for study, have been frequently used. She goes on to state that in such cases it is the researcher's task to describe the sample in as exact detail as possible. This is the basis for the sampling of the wards studied. The sampling dilemma and the methods of handling it will be discussed in Chapter IV.

Another problem in social relations research has been the lack of adequate statistical methods for analysis of social science data. Leon Festinger points this out and offers some ways of utilizing available statistical techniques in this field, adding that in many instances it is feasible for the researcher to enlist the aid of

¹Ibid, p. 222.
²Jahoda et al, pp. 90-93.
³Brown, p. 61.
The writer was concerned more with the qualitative analysis of the findings than with quantitative and has confined her statistical methods to the few frequency tables and grouping devices which are adequate for presenting the necessary quantitative findings.

The methods used in the case study of the two wards are participant-observation, interview and the use of checklists. They are described in the following sections.

The Participant-observation Methodology

Participant-observation as a research methodology was recognized and utilized by Harry Stack Sullivan in his work at Sheppard and Enoch Pratt Psychiatric Hospital, beginning in the late 1920's. He began studying the interactions of patients and personnel (attendants mainly, since there were few nurses) and tried differing patterns of assignment. He reported in 1931 that "The mental hospital became a school for personality growth rather than a custodian of personality failures."² It was Sullivan's analyses of social interaction in the psychiatric process and its relation to the field of social science which interested social scientists in the mental hospital as a field

---


of study, by showing that these could be successfully studied.¹

Nurses have made use of participant-observation techniques as a method of collecting the information reported on charts of patients from the beginning of organized nursing but have done it in a random, fragmentary fashion for the purpose of the moment and have not intended it as anything more than a reporting device to help the physician.

With the advent of graduate programs in nursing, the methodology has been refined and used much in the same way that Sullivan has described. Kandler and Morimoto have demonstrated this usage in published reports.²,³ The diary form of recording data has been commonly employed. Gwen Tudor was one of the first nurses to demonstrate the importance of this device in nursing research.⁴ Participant-observation as it has been utilized in nursing research, has been described by Jahoda et al.⁵ They point out that data must be analyzed as the study goes on and one's observations changed as the need indicates.


They list twelve characteristics of social situations which could be used as guidelines for observations, and recommend that notes describing the particular interactions be much more detailed. Interpretations would then be possible. The notes should describe the actual events, and interpretations should be labeled as such if incorporated. The authors stress that there should be validation of the observations and of the interpretations.

Two tasks of the participant-observer to be carried out at the outset of his study were listed by Jahoda and her collaborators. The first of these tasks is the achievement of the proper entrance into the field. They point out the necessity for explaining clearly the purpose of the study and enlisting and securing the cooperation of the residents of the community concerned, in this case the patients and personnel of the wards and of the larger hospital community. They warned that successful acquisition of data might not be possible if the worker does not carry out these steps.

The second early task of the participant-observer is to determine the extent of his participation in the community, in this case, the hospital community. Sullivan points out that when an observer enters a community he exerts influence on the social climate by his presence and thus becomes a participant, voluntarily or otherwise. Jahoda et al feel that the extent of participation can be determined by the researcher on the basis of what he desires to accomplish and


2Sullivan, American Journal of Psychiatry, 88:3:982-985 (May, 1931.)
will be influenced by the degree of acceptance generated.

The writer planned to participate actively as a graduate nurse student for the early part of the study and to withdraw to an observer status at the end of the period of collecting data. She began by spending twenty-four hours a week on the wards in uniform and at the end of the study was appearing in street clothes for the unit meetings, for the interviews and for the administering of the checklists.

The tentative categories established at the start of the data-collecting period were the broad functions of psychiatric nurses outlined in the first report of the Expert Committee on Psychiatric Nursing of the World Health Organization. The administrative function of the nurse was discussed in detail in this report, and then three other overlapping aspects of functioning were described - the technical, the social and the interpersonal (or therapeutic). These four became the major categories.

During the first month of the study detailed process recording was done by the writer; from this raw data nineteen sub-categories of nursing functions were identified and verified through the nurses' notes on patients' charts or through the various nursing reports which were written.

---

1Jahoda et al., Revised one-volume edition, pp. 200-234.

The sub-categories under each major function identified in this way are listed below:

Administrative Functions

Runs ward
Coordinates activities
Explains (procedures, policies, etc.)
Reports (to supervisors, doctors, etc.)
Records (charting, etc.)

Technical Activities

Gives medications
Gives treatments
Supervises hygiene
Supervises eating
Supervises sleeping
Supervises care of clothing

Social

Talks with patients
Walks with patients
Plays with patients (cards, activity games, etc.)

Therapeutic

Gives emotional support to patients
Shows concern for patients
Listens to patients
Teaches patients
Intervenes in order to help patients
From the tenth week to the end of the data-collecting period a weekly check was made to determine the number of patients who perceived these functions being carried out by personnel. The participant-observation recordings during these weeks were processed on these types of information. At the end of every week, the data of the recordings which could be confirmed by nursing notes, reports and other written data of the ward records were tallied for each patient. Since the number of patients on each ward varied from week to week, those in residence at least four days were considered to comprise the census for the week, and their reported perceptions were tallied. This data is summarized in Tables 3 and 4 presented in Chapter V, pages 59 and 60.

The Interviews

While the informal interview, long a tool of the nurse, was utilized in varying ways with individual patients, it became evident that a more structured use of certain questions for every patient studied would more readily provide useable data. The writer prepared a guide with these objectives in mind:

1. to learn what patients' expectations of hospitalization were at the time of admission;
2. to learn to what extent patients felt their expectations about the hospital were being fulfilled;
3. to ascertain whether patients expected and/or received different kinds of help from different groups of personnel;
4. to elicit those behaviors or situations which patients identified as harmful or not helpful.
An interview guide was constructed to cover these objectives and was tested, using patients from a ward other than the ones to be studied. Since the vocabulary was not clear to some patients the terminology was simplified and the guide retested. It was found to elicit the types of responses desired. However, patients in the test situation could respond about only one or two specific personnel in a twenty-minute interview. Since there were 12 personnel on one ward and 14 on the other, it was felt that verbal interviews would be too long and too distressing to most patients. It was decided to use the twenty-minute structured interview for information on personnel by groups and to prepare a checklist of specific therapeutic behaviors which each patient could mark for each person on the ward.

Each patient was interviewed once. The interviews were conducted in the fifteenth, sixteenth and seventeenth weeks of the study. Appointments were made in advance so that there were no interruptions of their schedule activities. At the end of the interview, each patient was asked to mark the checklists at a later date and each agreed to do so.

The Checklists

The data collected by the time the checklist was considered in the third month was quite inadequate in terms of the technical and administrative categories (see page 24). The checklist was, therefore, limited to the social and therapeutic behaviors of the personnel. The first checklist was a scaled one; thirty-eight specific behaviors and their opposites were placed on a five-point scale. The behaviors were taken verbatim from the nursing care plans which were devised
for all patients on the ward. This checklist was tested on the same ward where the interview guide had been tested.

It was found again that patients did not understand the terminology used. Also, the scoring was confined almost entirely to the midpoint of the scale. Patients, while not understanding some of the terms, identified one side of the scale as "good" and the other as "bad" and marked the middle in order to maintain a sort of neutral status. The writer felt that other patients might react the same way, especially when terms were understood. Therefore, it was decided to present patients with lists of beneficial nursing behaviors with instructions to check the behaviors used for them by the specific person being considered. They were also asked to indicate, by checking in the second column, whether or not they felt this particular behavior was necessary for them. It was expected that this would produce data showing whether or not patients desired different behaviors from different personnel.

There remained the task of making the statements clear and specific. The author went to the nurses on the wards and asked for interpretations of the statements on the nursing care plans, particularly the specific behaviors which they used to implement the plans. Since many plans on all wards utilized similar statements, nurses from the five wards were queried. A list of 105 behavioral items was obtained, most of which were found to be commonly used on all wards. These seemed to fall roughly into four categories:

1. Items expressing interest in and concern for patients.
2. Items of social and recreational nature.
3. Items concerned with emotional support.

4. Items concerned with educative or rehabilitative behavior, termed therapeutic.

A few items did not fall into any of these four categories and there were some items which were very similar. The categories inappropriate and duplicate were added.

The 105 items were typed on 3" x 5" cards and five experts in psychiatric nursing were asked to sort the items into the six categories.

Sixty-five items were categorized the same by all five judges; 13 of these were in the inappropriate and duplicate categories. Fifty of the remaining 52 items were used in the final checklist, two being omitted in order to make a round number of items. The checklist is found in Appendix C.

The directions were modified to fit the new items and the revised checklist submitted to patients and to personnel on the other ward for testing. It was found that the directions needed further clarification. After further revision, the tool was tried out again on different patients and personnel on the ward previously used. It was found to be adequate for the purposes of the study. The average time required to mark one checklist by the test group was three and a half minutes. It was estimated that the groups being studied could complete them on 12 or 14 personnel within an hour. The directions for personnel are found in Appendix D and those for patients in Appendix E.
The Selection of the Wards for the Study

The two wards of the second floor were selected for this exploratory study after consultation with the medical director and the director of nursing and her associates. Staff physicians on these wards had been in their situations for a longer period than had those on other wards. The head nurses had held those positions longer than those on the other wards, and in general, the therapeutic teams were settled into their jobs. Also, the program in these wards represented the "generalized idea" of the hospital philosophy - the attention to individual psychotherapy in a therapeutic milieu wherein every contact was meant to be healthful for the patient. At the same time, the expectations of performance of the personnel were reasonably within their potential capabilities to achieve. People were comfortable enough with each other that therapeutic interactions with patients were possible. These interactions the writer wished to explore.

The Analysis of the Data

The data was grouped first according to the method of collection and analyzed. The tally of the participant-observations was completed and interpretations made in terms of some of the interactions from which the numerical data were derived. The answers to each interview question were listed by groups and studied. The responses to the checklist questions were compiled for patients and for personnel and were studied by categories. The findings on each patient from each tool were then compiled and studied. These were studied also in relation to the several categories of workers - staff nurses, students and aides.
From these analyses of data the conclusions were drawn and certain implications for nursing education identified.

**Time Schedule of the Study**

During the first month of the study the writer spent the time in becoming oriented to the nature and functioning of the two ward units as a participant-observer. She began collecting the data for the participant-observation study in the fifth week of the study and continued through the eighteenth and final week. The interviews were conducted during the fifteenth, sixteenth and seventeenth weeks of the study; the checklists were submitted to personnel and patients during ten days in the sixteenth and seventeenth weeks.
CHAPTER IV

THE SETTING

The Hospital

Stanton and Schwartz\(^1\) consider the hospital to be the important organizational base from which the therapeutic community is developed. They point out that if the operational philosophy is democratic, if channels of communication are open and two-way, if mutual respect and cooperation are demonstrated at the higher levels, then the ward milieu is apt to be therapeutic. Mark Lefton, in a study of the Columbus Psychiatric Institute and Hospital has shown that even when the organization of the hospital as a whole was so oriented, there was a great variation among the five wards as to the degree to which they were functioning as therapeutic milieus.\(^2\) His explanation for this and its effect on the study is set forth later in this chapter.

The Columbus Psychiatric Institute and Hospital had been functioning for ten years, having begun admitting patients in November, 1951. While considered a part of a university health center, organizationally it had been a unit of the State's Department of Mental Hygiene and Correction. A recent legislative act had placed it and another


\(^2\)Mark Lefton, "Staff Participation in a Mental Hospital," unpublished doctoral dissertation, The Ohio State University, 1958.
hospital correctly within the university as facilities of the health center. The hospital philosophy and its objectives have been described in *A Visitors' Guide*, a brochure prepared by the hospital and presented to families of newly admitted patients:

Hospital care affords specific and continued treatment; specific in that it is directed towards meeting the needs of the individual, and continuous in that every contact that the patient makes throughout every day should guide him toward the same treatment goal.

It is important in a hospital concerned with emotional and mental illness to create an atmosphere of confidence which will lead to the patient's early recovery. This inspires his confidence in the staff, belief in himself and faith in the prospect of success in treatment. It is very important that everything the patient does and all persons with whom the patient has contact, contribute to his improvement.1

The brochure gave information on admission, treatment and hospital routine and later spelled out more explicitly the "team approach" to treatment:

It is evident from the foregoing that treatment is promoted where there is cooperation among all members of the psychiatric team - physicians, psychologists, social workers, nurses and occupational therapists.

In addition to the psychiatric team, the patient will have contacts with aides, laboratory technicians, the clerical staff, members of the dietary, housekeeping and maintenance departments, all of whom contribute importantly to the patient's needs.2

---

1. *A Visitors' Guide* (Columbus, Columbus Receiving Hospital and State Institute of Psychiatry, 1953) p.2.

2. Ibid. p.8.
The 1960 annual report of the Hospital indicated that psychotherapy, medication and electric shock therapy were the three strictly medical approaches relied upon in addition to the milieu therapy described previously. The short-term intensive nature of treatment was confirmed in the statistical data which showed the average stay of patients in that year to be 43 days.¹

The brochure on the Hospital outlined the patient's day from rising to bedtime. Each ward carried out the same schedule. Appendix A is a sample schedule. The meeting of the psychiatric team for each ward was held at 8:30 a.m. each day. The staff physician, residents, psychologists, social workers, occupational therapists and head nurses of each unit met to discuss the problems of the unit and to plan further courses of action.

While patients were at breakfast, those personnel not helping in the dining room met on each unit for a nursing team conference; this was for the purpose of formulating nursing care plans for individual patients according to the treatment goals set by the treatment team. Marilyn Ebert analyzed a series of these nursing team conferences in 1956. She found that the graduate staff nurse was more active in the leadership role in the conferences than students or aides, although students assumed more leadership as they gained experience. Aides took little leadership action. Most personnel felt the conferences helped them and accomplished the designated purpose.² During a discussion of

¹Annual Report: Columbus Psychiatric Institute and Hospital and Starling-Loving Mental Hygiene Clinic Fiscal Year 1959-60, Mimeographed Report, October 1960.

the conferences in the course of this study, one staff nurse explained: "Of course, it's mainly held for the benefit of the students!" There was little recognition on her part that this conference was anything more than a teaching device for the students. Other nurses made use of the conferences, however, and spoke of them as devices to facilitate and improve patient care by all personnel.

Periodically, there were special conferences for the professional staff, when guests were invited to attend and participate in the presentation and interpretation of patient studies. Staff presentations of such studies occurred weekly, with the wards rotating on a set schedule; all the team from the ward concerned participated in the presentation of the material. The patient was asked to appear and answer a few questions. There were few refusals; actually, patients seemed to enjoy the attention and spent days discussing their presentation afterwards.

The various departments of the hospital had their complement of administrative meetings at regular intervals. The Nursing Department was no exception. There was a weekly schedule of supervisory, head nurse, staff nurse and other group meetings, some administrative in nature, others designed as in-service education.

The informal organization of the hospital was warm and friendly. Coffee hours morning and afternoon gave evidence of the extent of social interaction among personnel. There were various off duty social events - parties for new personnel and/or students, or for those departing. Special events and professional honors were publicized in the small weekly hospital news sheet. The staff participated in the annual Medical Center Night Out and spent many hours together in
Mark Lefton demonstrated that regardless of the milieu therapy orientation of the hospital as a whole, each ward had a therapeutic orientation of its own, exemplified by the ward physician and implemented through his supervision of the therapeutic team. One ward he found to be extremely "milieu therapy oriented"; the ward physician relied on all personnel to make decisions and judgments as to behavior when problems arose. Another ward was quite regimented. Not only did the physician make all major decisions, but the treatment regime itself was more controlling and greater emphasis was given to medication and electric shock therapy, with fewer hours of psychotherapy scheduled. The wards used by this writer were middle-road, according to Lefton; psychotherapy was emphasized but in coordination with a milieu which was therapeutic. Personnel were encouraged to make decisions and carry on in the areas in which they felt secure. Guidance and support were forthcoming when needed; unwise decisions were minimal, since decisions were discussed beforehand in most cases. Sister Joan Marie Upjohn found that such support of the nurses by the physician resulted in the nurses being more motivated in providing better patient care. The nurses felt that their wards were better organized and they had more positive attitudes regarding the policy of the open door.

Construction of an addition to the building had begun around the

---


time the writer was getting acquainted on the wards. Soon construction activities were in high gear and groups of patients and of personnel reacted to the noise, the dirt, the intrusion of privacy and the general confusion that accompanied such work; at the same time everyone looked forward to the forthcoming improvements.

The ground floor of the building was given over to the administrative and service functions of the hospital. The library, laboratory, classrooms, locker rooms and other facilities were located there. The first floor housed one women's ward and the Research Department. The second floor consisted of two ward units and the Occupational Therapy Department. The third floor contained two more ward units and some conference rooms and offices. The three women's units were at the west end of the building on the first, second and third floors; the men's units were above the research wing at the east end, on the second and third floors. The dining rooms were located off the center halls between the wards. Men and women ate together on the second and third floors.

The physical layouts of the wards were the same except that the two third floor wards each had a special care unit in lieu of one dormitory area. Here there were two seclusion rooms, and bath and toilet facilities, so that disturbed patients could be cared for apart from the others. If patients on other floors required such care, they were transferred to these units until they were well enough to return to regular ward life. All wards were furnished and equipped similarly; the inevitable replacement of furniture had begun on the first floor women's unit and would eventually be extended to the other units.

There were then, five hospital wards, physically very much alike,
staffed very similarly in terms of numbers and of like groups, functioning under broad general principles of therapy and management, but actually demonstrating a good deal of variety of care. The patients on the selected wards were randomly assigned. The personnel were not so randomly placed. The staff physicians were permanently assigned; the residents were on an assigned rotation plan to fulfill their training schedules. The aides were on a thirteen-week rotation pattern moving from one shift to another each thirteen weeks and frequently from one ward to another as well. The nurses were assigned for longer periods to the wards for which they were best prepared, and moved if their personal growth justified a different type of experience, or more responsibility as assistant head nurse or head nurse, or if they had difficulty adjusting to the ward. Thus, the nursing personnel at the professional level were somewhat selected. The other members of the therapeutic teams were also on fairly stable and specific assignments.

Since the writer felt that it would be necessary to refer to names in the descriptions of situations and interactions, she systematically assigned fictitious ones to all personnel and patients described in the study. Of the personnel, doctors were given names beginning with the letters S or R, the occupational therapists were assigned names with the first letter O and the social workers were given assumed names beginning with the letter W. Student nurses were assigned names beginning with S, staff nurses those beginning with N and aides were allocated names beginning with A.

The patients described were given assumed names beginning with the letter P if they were among the twenty-four who were interviewed and
who completed checklists. All other patients mentioned by name in the study were assigned fictitious names beginning with the letter B.

The Women's Ward

The orientation period gave the writer a more concrete picture of the units as dynamic interacting clusters of people than could be obtained in any other fashion. Table 1 shows the distribution of patients on the women's ward, according to tentative diagnoses in the first week of the period and also in the tenth week, when patients were selected for more detailed study. The fluctuation in diagnoses can be seen by

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>FIRST WEEK</th>
<th>TENTH WEEK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Age Range</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>6</td>
<td>16 - 42</td>
</tr>
<tr>
<td>Psychoneurosis</td>
<td>12</td>
<td>18 - 38</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>1</td>
<td>29</td>
</tr>
<tr>
<td>Manic Depressive</td>
<td>1</td>
<td>38</td>
</tr>
<tr>
<td>Involutional</td>
<td>3</td>
<td>46 - 55</td>
</tr>
<tr>
<td>Organic</td>
<td>1</td>
<td>43</td>
</tr>
</tbody>
</table>

24 22

comparing the two patient populations. In the earlier period most of the psychoneurotic patients were of the reactive depressive type and consequently the activity on the ward was at low ebb. Figure 1 shows the activity graph of the two wards during the entire study as derived
from the daily reports under the heading "general mood" of the ward. The women's unit, as the graph shows, was extremely listless for quite a few weeks; then, with the admission of some teenagers and a decline in the admission of depressed individuals, the group became more cohesive and active.

Figure 1

WEEKLY WARD ACTIVITY CHART

Hostile Acting Out, Individual and Small Group

Quiet, tense Activity in Small Groups

Cooperative Group Activity

Quiet - Small Group Activity

Apathy, Little Activity

Week

Men's Unit

Women's Unit
The twelve women who were interviewed and who completed the checklists were Miss Pax, and the Mrs. Puhl, Pole, Price, Pug, Poke, Plum, Pegson, Patton, Plane, Penn and Puck.

Miss Pax was an 18 year old girl who had been on the ward 21 days at the time of interview. She had been given a diagnosis of "Schizophrenia of Adolescence Associated with Lumber Scoliosis." She was often alone; even when in a group she remained aloof and silent on the fringe. Personnel were uncomfortable with her and other patients found it difficult to be around her.

Mrs. Pole was least known to personnel. She was 29, had had three years of college and was the mother of three children. She had been on the ward 38 days when interviewed. She seemed to interact well with other patients but "clammed up" when personnel approached her. She had a diagnosis of "Undifferentiated Schizophrenia".

Mrs. Price had been readmitted three weeks before the interview. She was 35, the mother of five children and had been a schizophrenic patient for several years. She was fearful and suspicious; other patients tended to mother her, but when really upset, she gravitated to the nearest staff nurse and as Miss North said, "Just hangs on!"

Mrs. Pug was 33 and had two children. She was given the tentative diagnosis of "Manic Depressive, Manic," on admission 42 days before being interviewed. She was very inquisitive; her curiosity caused other patients to avoid her. Personnel found her irritating also.

Mrs. Poke was a 49 year old divorcee, mother of one child, who had been on the ward 32 days. A drug addict with a diagnosis of "Involutional Melancholia", she was quite debilitated physically and was
also "looked after" by her fellow patients, along with Mrs. Price.

Mrs. Plum, 59, was also diagnosed "Involutional Melancholia". A widow, she was a "complainer" and found fault with patients and personnel. She spent a good deal of time with Mrs. Pug; other patients implied that they 'gossiped about us all' all the time.

Mrs. Puck had been readmitted to the ward 28 days before the interview. Her diagnosis was "Schizophrenia", and she displayed confusion and hallucinatory behavior often. She remained apart from the other patients most of the time, although all seemed to like her.

Mrs. Pegson, a divorcee at 17, was the youngest patient studied and the most colorful in some ways. She had been on the ward 17 days; was having difficulty in adjusting to group living, although in the interview she indicated blandly that everything was fine.

Mrs. Patton was a thin, emaciated woman of 39 whose illness was identified as "Psychophysiological Reaction". She had a long history of periodic prostrating headaches and constantly reviewed this for anyone who would listen. Other patients were very sympathetic and she always had some one waiting on her.

Mrs. Plane was also a readmitted "Schizophrenic" patient, a nurse. She was quite withdrawn and ill at ease with personnel. She was able, however, to accept attention for a recently sprained ankle and seemed to be more outgoing as a result. She was pleased when other patients called on her to play the piano for group singing.

Mrs. Penn, with a diagnosis of "Catatonic Schizophrenia", had been quite confused and out of contact for sometime after her admission. Even so, she had displayed a good deal of wit and humor, most of which
she directed toward herself. And, while some patients were a little wary of her because of her bizarre behavior, she was generally well liked and sought out by others. She was the mother of five children and related many amusing incidents about them. She showed keen insight and understanding of the problems of others and intervened in defense of some of the older patients when the teenagers were critical of them.

Mrs. Puhl was another patient about whom the others were fearful. Her diagnosis was "Paranoid Schizophrenia". She had been on the ward only three weeks and was noisy, quarrelsome and frequently out of contact. She often wandered around the ward smoking cigarettes rather carelessly and it was noted that other patients "observed" her quite closely, so that she would not cause a fire. At first their frequent reminders that smoking was not permitted in certain areas, coupled with those of the personnel, irritated her, but she came to accept the patients' reminders quite well. Mrs. Price remarked astutely one day, "She just smokes where she shouldn't to get our attention! She knows now where she can smoke and where she can't."

Further descriptive information concerning the women and their progress during the study period will be found in the case summaries in Appendix F. To include such detailed information on all the patients who came and went during this time would be a lengthy task; however, some had major influence and are mentioned.

Miss Bird and Miss Bridge were referred to by the others as the "dancing duo." Both were in their twenties and were undergoing what their therapist termed "problems of adolescence." They were together a great deal, spending many hours practicing modern dances to the tunes
of the record player. Miss Bolt was a 19 year old "schizophrenic" who had gradually emerged from her shell and was learning to dance and be sociable under the encouragement of the dancing duo and Miss Butler, another girl of her own age who was diagnosed "Psychoneurotic." All of these and Miss Pax, were part of the group of adolescents who were undergoing group psychotherapy. From time to time, they brought up their group and its problems. They tended to socialize together and in mixed affairs seemed to seek out the young male adolescents who were also in their group.

Mrs. Bull and Mrs. Billay were older women with organic changes associated with cerebroartiosclerosis. Mrs. Bull was also diabetic. She was an avid television fan; she, Mrs. Berwick and Mrs. Poke occasionally got into verbal arguments with the adolescents over whether television or dancing should prevail. Usually, these were settled through compromise; the weekly unit meeting was often the vehicle for settling such difficulties. Mrs. Berwick was a leader on the ward and was respected by all. She was in her early forties, had had a psychoneurotic depression and was convalescing at the time of the study. Mrs. Black was another influential figure in the sense that other patients rallied around her. She had been quite depressed but had gone home in the early weeks of the study. Two weeks before the termination of the research, she was readmitted, after having taken an overdose of her medication. Once again she was given considerable attention and support by those who remained who had known her, except for Mrs. Pug, who seemed to take delight in her misfortune, stating, "She went home in such fine shape; she sure didn't stay well long." Mrs. Pug went
home shortly thereafter and other patients commented on "being rid of that spiteful gossip."

The professional team for the ward consisted of the staff man, Dr. Stream, three residents, Doctors Rose, Ricu and Ritz; a psychology resident, Dr. Rine, who began having patients in therapy toward the end of the orientation month; the occupational therapist who worked with the women assigned to this therapy, Mrs. Otis; the social worker, Miss Wilkins; the head nurse, Miss North. Dr. Rose was a third-year resident, the others were in their second year. With the exception of the head nurse and, to a more limited extent, the occupational therapist, the members of the professional team, while exerting a great deal of influence on the patients through their individual contacts and the group decisions which they made regarding plans for therapy, had little contact with the ongoing living experiences. When present on the ward, these members of the team were either in the nurses' station to gather information or leave orders, or seeing patients individually in their offices on the ward. This was essentially the way this team functioned, leaving the realm of the day-to-day living to those whose duty it was to carry on - the nursing personnel.

The head nurse of the ward, Miss North, was functioning as the night supervisor at the time of the writer's initial contact. Miss Nixon was acting in her stead. By the end of the month Miss North had returned to her regularly assigned role and Miss Nixon had become the evening head nurse for the floor. The other nurses were Miss Nest, Mrs. Nagle and Miss Nunn, Mrs. Allen, Mrs. Able, Mrs. Adler and Mrs. Alton were aides and the student nurses were Misses Smith, South, Spade and
Shull. Mrs. Norge, the evening nursing supervisor, was asked to participate in the study by checking the behavior checklists on the women patients. The age, experience, educational preparation and certain other data on these personnel were obtained through the biographical questions of the checklists.

With the exception of the supervisor, Mrs. Norge, who was 39, with a Master's Degree in psychiatric nursing, together with five-year's experience, the nurses were graduates of basic nursing programs. One was a diploma school graduate, the others collegiate. They were between the ages of 19 and 26 and had less than two year's experience in psychiatric nursing. The students were between 19 and 23 years of age. All were single and were seniors in the collegiate school of nursing of the University. The life experiences of this group were limited in comparison to those of the aides whose ages ranged from 31 to over 39. The experience of the aides ranged from six months to over five years. All four aides had been married (one was divorced) and each had children; Mrs. Norge, the supervisor, was married and the mother of two children; two of the staff nurses were married but had no children.

There were usually two nurses on day shift, one on evening shift and one off. Similarly, one aide was on night duty, one on evening, one on day duty and one off. The students' time on duty each day was assigned by the instructional staff; this time was limited and varied as to the hours of the day. Maids from the hospital housekeeping staff performed routine duties daily on the ward. They were not on regular assignment and they remained apart from any ward activity, except on rare occasions. Dietary maids brought nourishments and these persons
had no other interactions with patients. Mr. Norton, the recreational worker, spent a proportion of his time on the ward with the patients and also arranged activities with patients from other wards. On the ward, activities ranged from the ever-ongoing card games to dancing lessons, pingpong tournaments or other participant games. Off-the-ward dances, baseball games, croquet contests, picnics and such were periodically scheduled for the total hospital patient group or for two wards or more. The schedule of activities was posted each week and patients who wished to attend were responsible for being ready at the appointed time. Students and personnel were active in the total recreational program, both on and off the ward.

Mrs. Otis, the occupational therapist, participated in limited onward activities with patients who pursued sewing or other handcraft projects as knitting or crocheting during their free periods of the day. The patients were scheduled for a definite period of time in the occupational therapy department where their range of activities was much increased. Only patients who had had specific prescriptions for occupational therapy by their doctor could go. Certain patients were permitted on special prescriptions, to go to the shop for additional periods, when patients from other floors were there.

The Men's Ward

The patients on the men's unit were very active and quite hostile when the writer first went on the ward. There were five young men in their late teens and early twenties who seemed to be testing the personnel through criticism, complaints and acting-out behavior. The leader, Mr. Bloom, was a young college sophomore with a diagnosis of
"Personality Disorder", who competed with Mr. Burt, an older man, for the role. Together they engendered dissatisfied verbal agitation among the group, both tending to withdraw, however, if there was any danger of physical violence.

The others were Mr. Brown, a 19 year old schizophrenic youth who assumed a beatnick role; Mr. Baxter, another young schizophrenic who was regarded as a "wolf" by the female teenagers; Mr. Boles, the psychasthenic youth who was easily led by the others, and Mr. Price, another college youth who was diagnosed "Schizophrenic." The latter was a neighbor and childhood friend of Miss Bird and they met together frequently to talk about mutual friends. Mr. Boyles was the patient who labeled himself "chronically insane." The expectations of his fellow patients that he could do as well as they, and their encouragement of him in this, was a surprise and challenge to him, to which he responded by behaving more and more appropriately, until he was able to have all the privileges allowed and handled them well.

Mr. Burt and Mr. Buston were two sociopaths who had known each other prior to admission and who had similar histories of extreme dependence on doting mamas, many failures in job situations and a good deal of verbal hostile behavior toward women. Mr. Buck was an elderly professional man who had organic brain damage. He was sometimes confused and irritable but was always treated with respect and consideration by the others as was Mr. Buttons, an 84 year old depressed man who stayed on the ward for a month toward the end of the study. Brief summaries for the twelve patients studied more intensely, Mr. Pride, Mr. Prose, Mr. Pate, Mr. Pall, Mr. Point, Mr. Pender, Mr. Paxton,
Mr. Pitcher, Mr. Player, Mr. Pearce and Mr. Printer, are presented here. More complete details with discussions of their results on the test tools have been placed in Appendix F.

Mr. Pride had been on the ward 33 days when interviewed. He was 44, and had a history of periods of restlessness, somatic complaints, and depression. On the ward he usually was to be found in the company of one of the aides or with Miss Squire, a student. He seemed to avoid other patients. He continued to be quite concerned about his physical condition, reporting his complaints periodically.

Mr. Prose was a young man of 23 who had been in the hospital 40 days. He had a great deal of difficulty in talking; he tended to avoid all situations involving verbal efforts, and consequently spent a great deal of time alone. He was beginning to feel easier with his fellow patients and could talk to them often without blocking, but was unable to be so free with personnel. The younger group of patients passed him by, and personnel tended to interact with verbal patients; consequently, Mr. Prose remained on the fringe of things.

Mr. Pate, 37, enjoyed the distinction of being one of the old timers on the ward, having been there 79 days. His diagnosis was "Paranoid Schizophrenia." He had had delusions about communists being present in his community and was quite suspicious of both personnel and patients. He had once been in a state hospital and found the permissive climate of the ward something in itself to question. The program of activities was also viewed askance, but at the time of the interview he was able to participate in most of them with enjoyment. He spent more time with the male aides than with the female personnel, except that he
frequently sought out the head nurse.

Mr. Pill, 50, had been in the hospital 20 days at the time of the interview. He had been restless and depressed, frequently moaning that he had "sinned beyond forgiveness" and begging staff nurses to stay with him. Other patients seemed uncomfortable around him, and kept away; the staff allowed him to cling and continued to assure him that he was worthwhile. Mrs. Price and Mrs. Puck seemed to be able to tolerate him well, and the three made a little group in every social activity bringing the two wards together.

Mr. Pale was 48 and an ex-salesman. He had gone into a "Reactive Depression" following a laryngectomy induced by a cancerous growth. His voice had become a hoarse rasping whisper. He felt that his ability to earn a living had been drastically curtailed. He tended to act very gay and participated in all ward activities, but was found often sitting alone with a sad facial expression. He teased patients and personnel a lot; but when nurses were the object of harassment, he would switch and defend them against his fellow patients. He behaved in a fatherly way toward the student nurses but was quite suggestive toward some of the women patients.

Mr. Point was a 41 year old divorced male who seemed to be alone a great deal. He avoided personnel and interacted with only a few of his fellow patients. A schizophrenic patient, on several occasions he had become angry and physically assaultive. Because of this and his resistance to psychotherapy he was being discharged with recommendations to his family that he be committed to a state hospital for further treatment. Personnel were wary of him and patients who had seen
his outbursts also avoided him.

Mr. Pender was another patient who tended to drive away both patients and personnel. Only 22, he had been reared in a rigid religious sect which restricted social behavior. He felt that he had sinned and was "lost" and when he had any verbal contacts, immediately turned the conversation to his religious beliefs and to criticism of the behavior of others. He had alienated most of those around him after a few days, and could be found alone in his room or in the dayroom.

Mr. Paxton, readmitted two months before the interview with a diagnosis of "Manic Depressive Psychosis, Depressed", was a 61 year old man who could usually be found sitting quietly in his room reading. He had always been quiet and reticent, according to his wife, and was considered pretty much back to his normal personality at this time. He was guarded in his conversation with personnel and with patients, and participated in only a few activities, notably pool and group walks.

Mr. Pitcher was a college student who was preoccupied with ideas of being mentally retarded and doomed to life in a state mental hospital, even after 64 days on the unit. He held himself rigidly erect, and seemed perpetually poised for flight. He was overly polite and seemed to annoy the younger women patients, who bemoaned the fact that such a handsome young man "had to be so dopey!" Mr. Pitcher paid so much attention to detail that he was extremely slow in anything he undertook. Nevertheless, he was a regular member of the group of card players who gathered periodically.

Mr. Player was a 45 year old colored man who had been in the hospital a little over a month at the time of the interview. His
diagnosis was "Paranoid State." He stated he was in the hospital for physical care, and had no need for a "doc who just talks." He had been injured several years before and since had gone from doctor to doctor demanding treatment. Each time he became more belligerent and assaultive when examinations produced no definitive evidences of injury. On the ward he kept busy with other patients but avoided personnel. Among other things, he was trying to bring about a program of physical exercise for fellow patients without much success. Also, he seemed afraid of other patients.

Mr. Pearce had been in the hospital one month at the time of the interview. A religious farmer of 51, he had become quite fanatical and had threatened his wife and son with a gun just prior to admission. On the ward he was not very popular with other patients, for he always steered the conversation to religion and provoked animosity. Mr. Briscoe had struck out at him, and he remained in his room, reading his Bible and arranging newspaper clippings which he had accumulated. Personnel were somewhat relieved, for they too were uncomfortable and wanted to avoid violence.

Mr. Printer was 38, with a diagnosis of "Psychoneurosis", and had been hospitalized several times, having been in the house 46 days on this occasion. He moved about the ward quietly, speaking softly and avoiding any situation which seemed controversial. Personnel tended to give him a lot of attention especially the students; other patients liked him but verbalized that he didn't "have much get up and go!"

Immediately after the depressed patients were admitted the mood of the ward became apathetic (see Figure 1). Later the character of
the group changed again and there was more activity. Table 2 shows the
distribution of patients on the men's ward by diagnosis and age during
the first and the tenth weeks of the study.

TABLE 2

TENTATIVE DIAGNOSES OF MEN PATIENTS FIRST AND TENTH WEEK OF STUDY

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>FIRST WEEK</th>
<th>TENTH WEEK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Age Range</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>5</td>
<td>25 - 48</td>
</tr>
<tr>
<td>Psychoneurosis</td>
<td>4</td>
<td>19 - 43</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>4</td>
<td>19 - 51</td>
</tr>
<tr>
<td>Manic Depressive</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>Involutional</td>
<td>3</td>
<td>45 - 53</td>
</tr>
<tr>
<td>Organic</td>
<td>2</td>
<td>41 - 75</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td></td>
</tr>
</tbody>
</table>

The staff man for the ward was Dr. Stroll. The residents were
Dr. Ray, Dr. Riley and Dr. Ruhl, a woman physician. The psychologists
was Dr. Pace; the social workers, Mr. Wilce and the occupational therape­
ist, Mrs. Olson. Dr. Ray was a third-year resident; the others were in
their second year.

Mrs. Napes, the head nurse, aged twenty-five, was a graduate of
the university's baccalaureate program in nursing, with less than four
years of experience in psychiatric nursing. The three staff nurses were
all graduates of the same nursing program with less than one year's
experience as graduates. The night nurse, Mrs. Needle, was an older
graduate of the same program, with about six year's experience. The three students, Miss Shoop, Miss Squire and Miss Shore, were seniors in the School of Nursing who were just starting their psychiatric nursing experience when the study began. The three male aides, Mr. Ames, Mr. Astor and Mr. Ajax were also fairly new in their jobs.

The daily schedule of the men's unit followed the pattern of the women's ward. Nursing personnel maintained the closest relations with the patients; the physicians, psychologists and others entered only briefly into the living activities of the ward. The physicians confined their interactions with patients chiefly to the therapy hours.

The staffing pattern was similar to that of the women's ward. There was a great deal of interaction between the two wards; groups of patients visited back and forth, and joint activities were arranged frequently. When it became necessary, the personnel of the two wards relieved each other, so that communication among personnel and patients of the two wards remained high.

In the first month of the study, participant observation was used mainly to gain acceptance into the social environment and at the same time to become familiar with it. The observer was introduced as a graduate nurse student and had to establish this fact. The Governor of the State had been gaining a great deal of attention in his drive to "clean up" the mental hospitals of the state. At this time he was visiting each institution in turn and was expected soon at this one. On her second day on the ward, Mr. Boles approached the writer and asked: "Are you a stooge for the Governor? Some of the boys say you're too old to be a student, the Governor 'planted' you here; is that true?" She
replied that she was not a stooge for the Governor but really a graduate student. She explained that she had been working for some years and had only recently decided to complete her graduate work. On succeeding days, Mr. Boles seemed to be testing the truth of these statements. He frequently approached the observer with questions about his therapist, his physical condition, and general ward nursing problems, and seemed pleased to find that she could supply information. Suspicion on the part of other male patients and some female patients lessened after similar episodes of testing the writer's nursing knowledge. The women patients at first asked, "Aren't you a supervisor? You know too much to just be a student!" or similar questions. In these instances, the several patients who had been nurses were helpful; they explained to their fellow patients that nurses sometimes went back to school after years of experience, and pointed out the ways in which the writer's status on the ward was like that of the undergraduates students: She did not make decisions such as allowing patients to leave the ward without the head nurse's permission, and performed no nursing functions in the setting which her position as student prohibited. Patients indicated in many ways their awareness of and use of the writer's greater nursing experience. The older male patients expressed the feeling that they could talk more easily with her than with the younger staff and student nurses. "They have a lot of living to do yet" was a remark which was made repeatedly. The writer soon learned, too, that when patients questioned the actions or decisions of the nursing staff, they (the patients) frequently sought her opinion on these matters in indirect fashion. Since the staff actions were always
approved in such cases, this behavior gradually disappeared.

During this same period, the writer was becoming acquainted with the staff and with ward routines. She was able to identify the specific ward activities which would yield the data she required and began to record data as she wanted about the ward, so that patients and personnel became accustomed to this activity. Patients at first made such comments as "Did you get all this down?" or "Are you going to report what I say to the doctor?" They were told the notes were for the writer's use only and when nothing occurred to indicate otherwise, the note-taking became an accepted behavior, and no further comments were forthcoming.

The writer's observations were validated by various records which were kept by the nurses and doctors. The nurse conducting the unit meeting kept notes on the topics discussed and made verbal and written reports on the patient behaviors during the meetings. In addition, the nurses who attended, charted in detail the behavior of the particular patients assigned to them for observation. This allowed for a consensual validation of the recordings of the writer. Only the data which could be so validated is reported in the study.

At the end of the sixth week a tentative patient sample of fifteen men and fifteen women were selected for the interview and checklist studies. These were selected from each diagnostic category in proportion to the numbers of each diagnosis in the total population. The persons with organic illness were excluded because of their inability to communicate effectively; otherwise, all age groups and various marital states were represented. The number of days of hospitalization of each patient fell within a range of 20-79 and averaged 39, somewhat
below the average length of hospital stay of 43 days for 1960. All regularly assigned nursing personnel were included in the personnel sample.

The Philosophy of Nursing Care and the Educational Program

In order to learn the role of nursing in the hospital philosophy of care, the writer met with the director of nursing and her assistant in both formal and informal conferences. The institution was viewed as one which provided education in the area of psychiatry for professional personnel. This included the professional nurses and the students who were enrolled in the baccalaureate professional nursing program. The aides were excluded because they were regarded as extensions of the professional nurses, and were there to relieve these persons of certain technical tasks which they learned through on-the-job training, so that the nurses could spend more time in professional duties working directly with patients.

The objectives of the educational program in psychiatric nursing were:

1. To develop sensitivity to and understanding of the dynamics of human behavior.
2. To develop basic understanding of current concepts of mental health and mental illness.
3. To evolve beginning ability to give comfort, support, nourishment and stimulation which will enhance the restorative process of mentally
ill persons toward better mental health.¹

The educative experiences provided for the student nurses were similar to those provided many student nurses in other settings but were arranged to meet the specific objectives listed above. The students attended classes which were structured to provide knowledge and understanding of human behavior, mental illness and its treatment, and other related topics. Their experiences on the ward were selected to enable them to gain increasing competency in applying the new knowledge to the care of patients. The emphasis on their roles as members of the professional health teams was evident in their assignments and in their attendance at conferences where the health teams presented patients.

The in-service program for the staff nurses was designed to promote the growth of these individuals in ability to assume responsible nurse functions in the health teams and to provide increased depth in understanding of and ability to work with individual patients. The total educational effort was toward the achievement by these psychiatric nurses of the full potential which their capabilities insured. The interpretation of the therapeutic nature of the nurse in the total milieu was in harmony with the treatment philosophy of the institution.

¹Nursing 636, Course Objectives and Major Principles (The Ohio State University School of Nursing) p. 1 (Mimeographed).
CHAPTER V

THE FINDINGS

This chapter is divided into two parts. The first part is the presentation of the data collected by each method. The second is concerned with the analysis and interpretation of that data.

The Presentation of the Data

The Participant - Observation Data

The entire process recordings accumulated during the study were too voluminous to present, and included much unverified data which was discarded. Tables 3 and 4 show the percentages of the ward populations who perceived the personnel functioning according to the described categories which were tabulated during the last nine weeks of the study from the process recordings. Further data from these recordings in abstracted form follows the tables and still more is interspersed in the analysis and interpretation section to clarify the findings presented. The several sub-categories of functions in each of the categories were identified through behavioral expressions. Thus, the most common phrase concerning administrative function was "the nurse runs the ward" or "she's in charge", and the number of patients who knew exactly who was in charge at any one time, remained fairly large. Patients also were aware of the recording, reporting and explaining functions of personnel and the coordinating activities which were...
<table>
<thead>
<tr>
<th>FUNCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERCEIVED</td>
</tr>
<tr>
<td>Week of the Study</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>ADMINISTRATIVE</td>
</tr>
<tr>
<td>Runs Ward</td>
</tr>
<tr>
<td>Coordinates</td>
</tr>
<tr>
<td>Explains</td>
</tr>
<tr>
<td>Reports</td>
</tr>
<tr>
<td>Records</td>
</tr>
<tr>
<td>TECHNICAL</td>
</tr>
<tr>
<td>Medications</td>
</tr>
<tr>
<td>Treatments</td>
</tr>
<tr>
<td>Supervises hygiene</td>
</tr>
<tr>
<td>Supervises eating</td>
</tr>
<tr>
<td>Supervises sleeping</td>
</tr>
<tr>
<td>Supervises care of clothing</td>
</tr>
<tr>
<td>SOCIAL</td>
</tr>
<tr>
<td>Talks with</td>
</tr>
<tr>
<td>Walks with</td>
</tr>
<tr>
<td>Plays with</td>
</tr>
<tr>
<td>THERAPEUTIC</td>
</tr>
<tr>
<td>Gives emotional support</td>
</tr>
<tr>
<td>Concern for</td>
</tr>
<tr>
<td>Listens</td>
</tr>
<tr>
<td>Teaches</td>
</tr>
<tr>
<td>Intervenes</td>
</tr>
</tbody>
</table>

*Numbers in parentheses indicate the ward census.*
**TABLE 4**

**PERCENTAGES OF WOMEN PATIENTS WHO PERCEIVED NURSING FUNCTIONS DURING LAST NINE WEEKS OF STUDY**

<table>
<thead>
<tr>
<th>FUNCTION PERCEIVED</th>
<th>(Week of the Study)</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>17</th>
<th>18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADMINISTRATIVE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Runs Ward</td>
<td></td>
<td>89</td>
<td>71</td>
<td>69</td>
<td>88</td>
<td>98</td>
<td>75</td>
<td>71</td>
<td>69</td>
<td>85</td>
</tr>
<tr>
<td>Coordinates</td>
<td></td>
<td>50</td>
<td>69</td>
<td>78</td>
<td>80</td>
<td>60</td>
<td>51</td>
<td>52</td>
<td>51</td>
<td>71</td>
</tr>
<tr>
<td>Explains</td>
<td></td>
<td>78</td>
<td>71</td>
<td>63</td>
<td>70</td>
<td>69</td>
<td>72</td>
<td>66</td>
<td>68</td>
<td>73</td>
</tr>
<tr>
<td>Reports</td>
<td></td>
<td>76</td>
<td>78</td>
<td>80</td>
<td>81</td>
<td>79</td>
<td>83</td>
<td>81</td>
<td>84</td>
<td>85</td>
</tr>
<tr>
<td>Records</td>
<td></td>
<td>78</td>
<td>80</td>
<td>76</td>
<td>79</td>
<td>69</td>
<td>77</td>
<td>81</td>
<td>80</td>
<td>83</td>
</tr>
<tr>
<td><strong>TECHNICAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td></td>
<td>96</td>
<td>92</td>
<td>88</td>
<td>76</td>
<td>79</td>
<td>73</td>
<td>88</td>
<td>89</td>
<td>91</td>
</tr>
<tr>
<td>Treatments</td>
<td></td>
<td>78</td>
<td>73</td>
<td>76</td>
<td>79</td>
<td>69</td>
<td>73</td>
<td>71</td>
<td>67</td>
<td>72</td>
</tr>
<tr>
<td>Supervises hygiene</td>
<td></td>
<td>81</td>
<td>83</td>
<td>79</td>
<td>74</td>
<td>82</td>
<td>80</td>
<td>79</td>
<td>77</td>
<td>80</td>
</tr>
<tr>
<td>Supervises eating</td>
<td></td>
<td>70</td>
<td>72</td>
<td>63</td>
<td>66</td>
<td>71</td>
<td>69</td>
<td>73</td>
<td>77</td>
<td>75</td>
</tr>
<tr>
<td>Supervises sleeping</td>
<td></td>
<td>60</td>
<td>71</td>
<td>66</td>
<td>65</td>
<td>70</td>
<td>69</td>
<td>71</td>
<td>73</td>
<td>71</td>
</tr>
<tr>
<td>Supervises care of clothing</td>
<td></td>
<td>67</td>
<td>72</td>
<td>69</td>
<td>78</td>
<td>75</td>
<td>68</td>
<td>73</td>
<td>71</td>
<td>77</td>
</tr>
<tr>
<td><strong>SOCIAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talks with</td>
<td></td>
<td>71</td>
<td>62</td>
<td>77</td>
<td>80</td>
<td>83</td>
<td>85</td>
<td>87</td>
<td>90</td>
<td>91</td>
</tr>
<tr>
<td>Walks with</td>
<td></td>
<td>63</td>
<td>71</td>
<td>78</td>
<td>74</td>
<td>72</td>
<td>68</td>
<td>71</td>
<td>78</td>
<td>81</td>
</tr>
<tr>
<td>Plays with</td>
<td></td>
<td>63</td>
<td>77</td>
<td>71</td>
<td>76</td>
<td>80</td>
<td>81</td>
<td>80</td>
<td>83</td>
<td>85</td>
</tr>
<tr>
<td><strong>THERAPEUTIC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gives emotional support</td>
<td></td>
<td>31</td>
<td>33</td>
<td>40</td>
<td>41</td>
<td>44</td>
<td>43</td>
<td>50</td>
<td>51</td>
<td>56</td>
</tr>
<tr>
<td>Concern for</td>
<td></td>
<td>30</td>
<td>31</td>
<td>29</td>
<td>43</td>
<td>39</td>
<td>37</td>
<td>38</td>
<td>36</td>
<td>40</td>
</tr>
<tr>
<td>Listens</td>
<td></td>
<td>38</td>
<td>37</td>
<td>41</td>
<td>39</td>
<td>40</td>
<td>43</td>
<td>44</td>
<td>45</td>
<td>50</td>
</tr>
<tr>
<td>Teaches</td>
<td></td>
<td>12</td>
<td>16</td>
<td>18</td>
<td>22</td>
<td>27</td>
<td>31</td>
<td>30</td>
<td>33</td>
<td>40</td>
</tr>
<tr>
<td>Intervenes</td>
<td></td>
<td>29</td>
<td>41</td>
<td>33</td>
<td>37</td>
<td>41</td>
<td>38</td>
<td>35</td>
<td>36</td>
<td>39</td>
</tr>
</tbody>
</table>

*Numbers in parentheses indicate the ward census.*
implicit in nursing responsibilities. In the technical functional areas
the responsibilities for medications, treatments, supervision of per-
sonal hygiene, eating and sleeping were perceived accurately and often.
The social-recreational functions of talking with, playing with and
walking with patients were important perceptions by patients. The thera-
peutic functions were less often perceived as such, but five sub-cate-
gories were defined in the first nine weeks of observation and confirmed
through personnel charting and reporting.

The figures for the first three functions are relatively high for
both men and women, while the therapeutic functions were perceived by
much smaller percentages. One factor which may have influenced this
difference in reported perception is that personnel are prone to dis-
cuss and explain the rather concrete behaviors relating to their work,
whereas they find it difficult to discuss the more abstract behaviors
which are called therapeutic. This was demonstrated when the writer
asked personnel to be more specific in defining the meanings of the
phrases taken from the nursing care plans (for instance; "show him we
like him") when preparing the checklist.

The nursing behaviors listed were perceived by patients for the
most part as necessary and logical functions of the personnel. It was
evident, however, that patients did not always perceive the personnel
carrying out these functions in the most helpful manner to themselves.
The communications aspects of the administrative functions were often
perceived by patients as a means of control for the personnel. An ex-
ample here cited will indicated this.

In the fourth week of the study, toward the end of the
observational period, the male patients requested permission to stay up after the 10:30 p.m. lights out time to watch a championship fight on television. Mr. Burt and Mr. Bloom, the two patients who competed for control in the unit, were the instigators of the request. They were supported by a number of others in the ward; Mr. Buck, the older patient with a cardiovascular illness who was respected by all, Mr. Brown, the young temperamental beatnik of the ward, Mr. Baxter, a "loud-mouthed show-off", according to Miss Bridge of the women's unit, and Mr. Boles, the neurasthenic who had earlier questioned the observer's role on the ward. Mrs. Napes agreed to take this request to the therapeutic team and did so. It was agreed that the men could stay up until the fight ended. Mrs. Napes was requested by the ward physician, Dr. Stroll, to make the necessary arrangements with the Nursing Service Department, and it was duly reported to the group that they could stay up for the fight.

On the evening of the fight, illness of a nurse necessitated a change in the staff assignments and a relief nurse was assigned to the ward. It was relayed to her that patients were to stay up for the fight but she assumed this meant they still were to be in bed by the time the night nurse came on the ward. Thus, a few minutes before the hour she shooed everyone off to bed, despite their protests. It was at a tense moment in the fight; a knock-out occurred a few minutes later and patients might have seen it and still gotten to bed before the night personnel arrived. The patients were very hostile the next day; Mr. Boles told the observer about it as she entered the ward and expressed the belief that Mrs. Napes had been aware all along that
they would be made to go to bed at a specific time but had withheld the information. Mr. Bloom and Mr. Burt were also indignant; both expressed the feeling that the head nurse had withheld information from them. Even Mr. Buck and Mr. Brent, who usually upheld the nurse, felt that she had withheld the real decision of the therapeutic team from them and that she had known all along that they would be asked to go to bed before 11 p.m.

Mrs. Napes herself felt that there had been a breakdown in communications to the relief nurse, perhaps due to the emergency shifting of personnel. She discussed this with the other personnel but made no explanation to the patients, except to state that she was sorry that there had been a misunderstanding. This misperception of her control of communication might have been gradually corrected had not another event occurred about ten days later.

Mr. Boyles had been admitted shortly after the fight incident. He was a middle-aged man, a veteran who had been given a Neuro-psychiatric discharge and who had been in and out of a veteran's psychiatric hospital since the war. He announced to the admitting nurse that he was "chronically insane" and that he was a schizophrenic. He had the flat, disheveled appearance of a chronic patient, and exhibited a number of mannerisms. He had been home on parole from the veteran's hospital but told the nurse he was getting on his wife's nerves and had come into this hospital to give her a rest. The family lived nearby, and he learned a few days after admission that his children had the measles; one was quite ill. Since he was aware that the door was unlocked, he awaited an opportunity and after lunch, when there were no personnel around
he left the ward and went home to see his children. Miss Nunn, the young staff nurse in charge that day, went out to look for him without success, after reporting his absence. He returned to the ward about 6 p.m. about the time the outside door was usually locked. He said he'd gone home - he hadn't signed out because his doctor hadn't given him permission to go out on his own.

On the day following this incident, painting of the dining room used for personnel coffee hour was begun and the second floor dining room was used instead. Mrs. Napes decided to lock the ward door until after coffee hour in order to lessen the confusion in the hall. She did not explain to the men on the ward her reason for locking the door during a period it was usually open. When the writer entered the ward, she was first met by Mr. Boles, then in succession by Mr. Buck, Mr. Paxton, Mr. Pate and Mr. Printer. All of them asked the same question, "Is the door still locked?" and when she replied in the affirmative, indicating she thought it was because personnel were coming and going for coffee hour, each reply was in the same vein:

"No, she locked it just because Willy went home to see his sick kid. He came back, though! He didn't hurt anyone."

The writer's comments that this might not be the reason were brushed off. The head nurse left the door open as soon as the painting was completed. Mr. Boyles began going home without leave again; the door remained unlocked. His physician, Dr. Riley, decided to "make it legal" and gave him city privileges. Thereafter, the patient signed out and in as decreed. Despite this evidence that Mr. Boyles was not being punished, the majority of the men patients continued to insist
that the nurses were exerting undue control over them in a number of ways:

1. by withholding or sifting communications to and from doctors, other nurses or family, so that complete information was not forthcoming,
2. by showing favoritism to some patients, and
3. by placing undue restrictions in the ward living arrangements through neglecting to have repairs made, ignoring food complaints, curtailing recreational activities, and other similar actions.

In reality, these were unwarranted criticisms. They were occurring as the hostile acting out period was lessening; they seemed, indeed, to bring the men together in small cooperative groups of productive community living. Mr. Burt and Mr. Bloom reinforced these perceptions of the nurses as controllers by their frequent comments about "Living in a place run by women" and "Women have the upper hand."

Both of these men had been dominated by their mothers and were really reveling in acting out against a group of women who did not retaliate. The nurses were eventually rewarded later on, for in the final month of the study, Mr. Bloom and Mr. Burt were stoutly commending and defending the nurses to the other patients, insisting that they were "doing a good job."

On the women's unit, which had been lethargic during the early weeks in terms of group activity, patients were prone to demand controls from the nurses. As for communications, they did not perceive nurses as withholding or sifting information; rather, they felt that they
sometimes passed on information too readily and too completely. Mrs. Black, Miss Bolt and Mrs. Plane, on the same day, stated to the observer that the nurses reported everything to their doctors. Miss Bolt said, "I don't have anything to talk about. The nurses have already told him everything about me." This patient was a young, withdrawn girl of 18 who related very poorly at this time and who was sometimes alarmed at the amount of verbal interaction which occurred. The other two had been on the ward for a while and were able to interact more comfortably with personnel and with other patients. Few other comments were made about communications. Evidence seemed to indicate that the women were more actively urged by personnel to seek direct communication with their doctors ("Your doctor is in his office; knock on the door and ask him for an appointment") whereas the personnel on the men's ward tended to convey messages back and forth. This may have accounted for the increased concern on communication on the part of the men.

In the unit meetings the women frequently indicated their perceptions of the beneficial nature of the nursing personnel's behaviors toward them. This was done in a general way; thus in the twelfth week Mrs. Price, a very confused, frightened patient, said: "Nurses help me when I'm fearful." Mrs. Patton said, "They sure help me." Mrs. Puck said, "It makes me feel better when they just sit with me." Mrs. Peg, a new admitted 17 year old divorcee commented, "Well, I don't know about that, but everyone's been nice to me!"

As was stated earlier, patients on both wards tended to speak in general terms about the personnel and seldom singled out one person to discuss. It was felt that more information concerning perceptions of
particular persons might be gained from the use of checklists and, perhaps, through the interview. The writer was fairly well accepted on the ward by the beginning of the third month and began preparing the guide sheet for the interviews and the checklist.

The Interviews

Table 5 indicates the number of patients by diagnosis, sex and age group who made up the final sample selected for interviews and who later completed the checklists.

TABLE 5

SAMPLE GROUP INTERVIEWED

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>NUMBER</th>
<th>AGE RANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Men</strong></td>
<td><strong>Women</strong></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Psychoneurosis</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Manic Depressive</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Involutional</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Organic</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td><strong>12</strong></td>
<td><strong>12</strong></td>
</tr>
</tbody>
</table>

This was not the same sample which was selected at the end of the sixth week, since many of those went home before the interviews were begun. The above group fits the general description of the previous sample, having been in the hospital an average of 37 days and having all the age groups represented. Also, the number of patients in each diagnosis were in proportion to the number in the total population.

Of the 12 women interviewed, 11 were able to complete the
procedure and to communicate effectively. Mrs. Puhl was restless and was able to answer only the first question. Mr. Prose, Mr. Point and Mr. Pender wanted to cooperate but found it difficult to give more than a general statement for the second question. The questions were not stated in exact words and were rephrased if patients did not seem to comprehend.

Each patient was interviewed separately once only. Interviews were spaced over several days and were alternated between men and women so that the possibility of prearranged answers was avoided. Patients were not informed ahead of time of their being selected; at the time of interview, each agreed to complete the checklists at a later date. The first question had to do with patient expectations of help through being in the hospital:

1. How did you expect to be helped through living in this ward situation? (What did you expect to occur?)

The initial responses of the twenty-four men and women were almost identical. Three thought they would profit through living with others, three others expected to be helped by personnel and six were "too sick to know." Two expected general hospital care, and one expected "a state hospital." While two others expected the hospital to be "like a jail." Two patients were able to say they were unaware of their need for care while two others indicated they came at their doctors' suggestions. One woman was afraid and felt she would be taken care of while another, with several children, expected the
"getting away from things" to help.

The question was rephrased and elicited other responses such as "I was so miserable, I just wanted help," "I'd talk to a doctor" and "I thought we'd line up for everything; do everything in a group." Other responses indicated expectations of social activity and close relationships with people, being helped by seeing patients sicker than they, being fed and cared for, and "sitting around all day taking pills."

There did not seem to be any difference in responses of men and women; sometimes the responses were phrased very much alike. In general, patients expected restrictions, schedules, and group living. They considered the social and recreational activities "added bonuses" and were pleasantly surprised by the warm, friendly, caring atmosphere of the hospital.

The second question had to do with their perceptions of the personnel as helpful.

2. How do personnel help you?
   a. Students.
   The men referred to the students as hostesses (2) who kept them comfortable and entertained (4). They help pass the time (2), they helped with housekeeping chores (2) and in general functioned in a social way as the men perceived them.

   Seven women stressed that verbal
interaction with students was helpful to them. They also identified the recreational activities with students (6) and two found them helpful in assistance with personal hygiene.

b. Aides.

The men looked upon the male aides as being understanding and helpful (2), someone to talk to man to man (1), sociable, likeable pals (2), and helpful in the practical and personal hygiene aspects of the ward living (3).

Three women didn't know the female aides, others found them providing recreational activity (3), their help in housekeeping chores such as bedmaking and ironing was recognized (3) and one lady said that talking to an aide was helpful.

c. Nurses.

The major response of the men as to how the nurses help was "they're the bosses" or "they run the ward" (4). "They give medicines" (3). "They are there when needed" (2). "They carry out orders" (1). "They are someone to depend on (lean on)" (2). One patient said he didn't need nursing care.

The women's major response about the helpfulness of nurses was someone to talk about problems (4). One patient said, "Some things I take
to my doctor, others to the nurses." Some said
nurses helped by staying with them (2), they
gave explanations (2). One woman said, "They
run the ward" and one felt they did nothing for
her.

The third question was intended to elicit whether patients per­
ceived the supervisors and ward clerks as helpful.

3. How do the supervising nurses and the ward clerk help you?

a. Supervising nurses.

One man found the night supervisor sup­
porting when he was wakeful, one felt they checked
on him, two said they kept things running and six
couldn't recall who they were.

One woman said she saw them; that was all.
Another identified one supervisor as seeing "how
she got along" and seven didn't know who the
supervisors were.

b. Ward clerk.

Five men didn't know the ward clerk, two
said she always gave them their mail, three said
she was "nice" and one said she brought the canteen
cart around.

The women regarded the ward clerk as the
"hander-outer" of equipment, mail, etc. from the
nursing station (5); all these and one other
regarded her as friendly and four others did not know her.

The fourth question was designed to identify perceptions of non-therapeutic elements of care.

4. What things take place in this situation which you feel interfere with your getting better?

The men were reluctant; there were six who said nothing, one said it was over-socialized, two felt they just didn't need to be in the hospital and one said, "Familiarity breeds contempt - I don't get too personal."

The women were more verbal. All but three had something to say. It was too protected (1), there was no privacy (1), it's noisy (3), other patients were upsetting (1), and group living was upsetting (1). One did not approve of dancing; another thought she shouldn't be there.

Do any personnel block your progress?

Six men replied they "Couldn't say", one said, "Everyone's nice" and the others just said nothing.

The women had some comments. "One nurse sure throws her weight around", "One nurse forced me to eat - she shouldn't have done that!" "One nurse hardly speaks to us older patients; does she think she's too good for us?" "One nurse thinks she's pretty good - too good for me, I guess."
The final interview question was designed to elicit suggestions for improving care.

5. How do you think the ward situation could be made more therapeutic for you?

Eight men indicated they didn't see any need for improvement. One said, "Just let me go home!" One patient wanted the pool table repaired, one felt more attention should be given to keeping the bathroom door closed and one felt the billing of patients was unfair and discussed it at some length.

Two women felt noisiness should be curbed; two wanted more leisure time activities; one felt group therapy should be explained to participants in more detail; three felt the ward setting was very helpful and three did not comment.

The Checklists

Arrangements were made for small groups of patients to meet together on their respective wards to complete the checklists on personnel. The checklists for each person to be checked were given to each patient, along with an instruction sheet. The names of the personnel were attached to the lists by means of a paper clip and as each one was completed, patients were told to destroy the names. Code information for the researcher was written on the back of each list. When all the checklists were distributed, patients were requested to read the directions and then ask any questions they might have. There
were few questions. Nevertheless, the writer stayed with each group and clarified anything which arose.

It was assumed that the personnel were well oriented to their work role and that the items they would check would be reliable evidence against which to check the perceptions of behavior of the patients. Therefore, all the regular personnel were asked to do one checklist on each patient from their ward participating in the study. The Director of Nursing Service graciously allowed time for groups of personnel to meet to do this. Those unable to be present were given individual instructions; all followed the same procedures as did the patients.\(^1\)

Behaviors of patients and personnel were somewhat similar also. Personnel found they could not identify for themselves some of the patients; patients in turn indicated they did not know the identity of the personnel. This was an interesting fact, since all personnel wore name pins and functioned on the assumption that all patients knew them. Also, every patient was photographed and personnel were accustomed to examining the photos in order to identify patients.

Figure 2 shows the number of checklists completed by the twenty-four patients. The maximum numbers were fourteen for the women and twelve for the men. One man knew all the personnel. Two women knew eleven of the fourteen female personnel.

---

\(^1\)Instruction sheets and checklists are reproduced in Appendixes C, D and E.
Figure 2

PERSONNEL CHECKLISTS COMPLETED BY PATIENTS

<table>
<thead>
<tr>
<th>NO. OF PATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

Figure 3 shows the number of patients the personnel were able to recall. It was noted that the personnel completed more lists on patients than patients completed on them, but there were very few items checked on some of the forms; they did not really have much awareness of the patient as an individual, but only as a name.
Table 6 is a tabulation of the times each of the items of Category I, Personal Interest and Concern, were checked by patients and by personnel. The ten items are identified below.

1. The nurse moves quietly about the ward at night.
2. The nurse protects the confused patient from those who would take his belongings.
3. The nurse intervenes when others tease patients.
4. The nurse expresses interest in the patient's progress in Occupational Therapy.
16. The nurse listens with interest to what patient has to say.
21. The nurse inquires about off-unit activities the patient has attended.
25. The nurse adjusts ventilation at night.
32. The nurse removes things from environment when patient is destructive.
38. The nurse expresses interest in, and concern for, patient.
48. The nurse tells the patient she wants to help.

Table 6 on page 78 shows that 18 patients checked Item 1 as used by personnel 113 times while personnel checked the behavior 95 times but for 22 patients. Eighty-seven of these times, the personnel indicated that these behaviors should be used for the 22 patients while 16 of the 18 patients found the behavior necessary to be used for them 75 times.
### TABLE 6

INTEREST AND CONCERN ITEMS CHECKED BY PATIENTS AND PERSONNEL

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>113</td>
<td>18</td>
<td>95</td>
<td>22</td>
<td>75</td>
<td>16</td>
<td>87</td>
<td>22</td>
</tr>
<tr>
<td>3.</td>
<td>66</td>
<td>15</td>
<td>47</td>
<td>21</td>
<td>66</td>
<td>15</td>
<td>56</td>
<td>23</td>
</tr>
<tr>
<td>9.</td>
<td>54</td>
<td>11</td>
<td>32</td>
<td>18</td>
<td>60</td>
<td>12</td>
<td>61</td>
<td>23</td>
</tr>
<tr>
<td>14.</td>
<td>75</td>
<td>14</td>
<td>55</td>
<td>20</td>
<td>59</td>
<td>11</td>
<td>87</td>
<td>24</td>
</tr>
<tr>
<td>16.</td>
<td>159</td>
<td>24</td>
<td>252</td>
<td>24</td>
<td>117</td>
<td>17</td>
<td>235</td>
<td>24</td>
</tr>
<tr>
<td>21.</td>
<td>88</td>
<td>19</td>
<td>119</td>
<td>24</td>
<td>74</td>
<td>16</td>
<td>154</td>
<td>24</td>
</tr>
<tr>
<td>25.</td>
<td>63</td>
<td>16</td>
<td>79</td>
<td>24</td>
<td>60</td>
<td>15</td>
<td>76</td>
<td>24</td>
</tr>
<tr>
<td>32.</td>
<td>57</td>
<td>10</td>
<td>42</td>
<td>22</td>
<td>46</td>
<td>10</td>
<td>48</td>
<td>23</td>
</tr>
<tr>
<td>38.</td>
<td>135</td>
<td>23</td>
<td>239</td>
<td>23</td>
<td>116</td>
<td>21</td>
<td>214</td>
<td>23</td>
</tr>
<tr>
<td>48.</td>
<td>109</td>
<td>18</td>
<td>112</td>
<td>24</td>
<td>89</td>
<td>16</td>
<td>157</td>
<td>24</td>
</tr>
</tbody>
</table>

A - times checked by patients.
B - number of patients checking.
C - times checked by personnel.
D - number of patients checked for.
Table 7 shows the tabulation of the time each of the items of Category II, Social-Recreational, was checked by patients and personnel. The ten items are identified below.

8. The nurse carries on conversation with patient around patient's interests.
12. The nurse invites patient to join in physical activities, as shuffleboard, dancing or ping-pong.
13. The nurse takes other patients to bedside of patient who stays in bed.
18. The nurse invites patient to participate with her in games and other activities.
22. The nurse asks patient to join a group of patients.
24. The nurse introduces patient to other patients.
30. The nurse participates with patient in activities patient enjoys and does well.
34. The nurse invites patient out of room to activity.
35. The nurse goes with patient to off-unit activities.
47. The nurse assists with group activities and asks patient to join in.
TABLE 7

SOCIAL-RECREATIONAL ITEMS CHECKED BY PATIENTS AND PERSONNEL

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>CHEEKED - USED</th>
<th>SHOULD BE USED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>8.</td>
<td>121</td>
<td>24</td>
</tr>
<tr>
<td>12.</td>
<td>122</td>
<td>21</td>
</tr>
<tr>
<td>13.</td>
<td>38</td>
<td>7</td>
</tr>
<tr>
<td>18.</td>
<td>125</td>
<td>24</td>
</tr>
<tr>
<td>22.</td>
<td>139</td>
<td>23</td>
</tr>
<tr>
<td>24.</td>
<td>108</td>
<td>20</td>
</tr>
<tr>
<td>30.</td>
<td>104</td>
<td>22</td>
</tr>
<tr>
<td>34.</td>
<td>121</td>
<td>23</td>
</tr>
<tr>
<td>35.</td>
<td>100</td>
<td>19</td>
</tr>
<tr>
<td>47.</td>
<td>109</td>
<td>22</td>
</tr>
</tbody>
</table>

A - times checked by patients.
B - number of patients checking.
C - times checked by personnel.
D - number of patients checked for.
Table 8 indicates the number of times each of the items of Category III, Emotional Support, were checked by patients and personnel. The list of the items is given for clarification.

4. The nurse gives honest praise.
6. The nurse sits with wakeful patient.
7. The nurse stays close to patient who is anxious.
17. The nurse encourages patient to play pool or another game with others.
23. The nurse walks with patient who is pacing the hall.
42. The nurse sits quietly with patient.
43. The nurse sits with patient in the dining room.
44. The nurse encourages patient to make decisions.
45. The nurse encourages patient to do things on own, as use of campus privileges.
46. The nurse encourages patient to go to the dining room.
### TABLE 8

**EMOTIONAL SUPPORT ITEMS CHECKED BY PATIENTS AND PERSONNEL**

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>CHECKED - USED</th>
<th>SHOULD BE USED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>4.</td>
<td>151</td>
<td>21</td>
</tr>
<tr>
<td>6.</td>
<td>42</td>
<td>10</td>
</tr>
<tr>
<td>7.</td>
<td>96</td>
<td>18</td>
</tr>
<tr>
<td>17.</td>
<td>144</td>
<td>23</td>
</tr>
<tr>
<td>23.</td>
<td>81</td>
<td>18</td>
</tr>
<tr>
<td>42.</td>
<td>96</td>
<td>18</td>
</tr>
<tr>
<td>43.</td>
<td>58</td>
<td>14</td>
</tr>
<tr>
<td>44.</td>
<td>76</td>
<td>16</td>
</tr>
<tr>
<td>45.</td>
<td>54</td>
<td>10</td>
</tr>
<tr>
<td>46.</td>
<td>73</td>
<td>13</td>
</tr>
</tbody>
</table>

A - times checked by patients.
B - number of patients checking.
C - times checked by personnel.
D - number of patients checked for.
Table 9 presents the tabulation of checks by personnel and patients of the twenty Therapeutic items of Category IV, the content of which are given below.

2. The nurse speaks directly and explicitly to the patient.

5. The nurse discusses the meaning of campus privileges with patient.

10. The nurse explains clearly to the patient the policies and purposes of the hospital.

11. The nurse, in telling patient to stop attempts at physical contact, indicates that she likes him but not the behavior.

15. The nurse explains the effects of medication in a calm, factual way.

19. The nurse grooms herself neatly as an example to the patient.

20. The nurse keeps her word or explains why she can't.

26. The nurse gives explicit directions, as "Let's walk in the hall", then does it with patient.

27. The nurse tells patient matter-of-factly he is sick.

28. The nurse tells patient she likes him but cannot agree with his ideas: "I understand you feel this is so but I do not believe it is true."

29. The nurse tells the patient to stop advising others about their problems, pointing out this is the therapist's function.

31. The nurse points out inappropriate comments of patient by saying "I don't understand" or "Please explain what you mean."
33. The nurse reminds patient of hospital rules about smoking, visiting, etc., in private, when patient is disregarding these.

36. The nurse listens to the patient's complaints, then diverts him into some activity without expressing a reaction.

37. The nurse discusses with patient reasons for unit regulations and inspections.

39. The nurse talks with patient alone about what makes him anxious.

40. The nurse asks patient to wash and mend own clothes; she assists when necessary.

41. The nurse moves calmly and unhurriedly.

49. The nurse reminds patient that he came to hospital to be helped and indicates that this is what she is trying to do.

50. The nurse tells patient what behavior is expected of him.

**TABLE 9**

**THERAPEUTIC ITEMS CHECKED BY PATIENTS AND PERSONNEL**

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>149</td>
<td>24</td>
<td>196</td>
<td>24</td>
<td>116</td>
<td>21</td>
<td>201</td>
<td>24</td>
</tr>
<tr>
<td>5.</td>
<td>72</td>
<td>14</td>
<td>45</td>
<td>18</td>
<td>54</td>
<td>14</td>
<td>85</td>
<td>23</td>
</tr>
<tr>
<td>10.</td>
<td>107</td>
<td>19</td>
<td>127</td>
<td>24</td>
<td>82</td>
<td>16</td>
<td>168</td>
<td>24</td>
</tr>
<tr>
<td>11.</td>
<td>46</td>
<td>8</td>
<td>16</td>
<td>9</td>
<td>31</td>
<td>7</td>
<td>34</td>
<td>16</td>
</tr>
</tbody>
</table>
TABLE 9 Continued

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>94</td>
<td>20</td>
<td>99</td>
<td>21</td>
<td>55</td>
<td>15</td>
<td>121</td>
<td>24</td>
</tr>
<tr>
<td>19</td>
<td>162</td>
<td>23</td>
<td>154</td>
<td>23</td>
<td>127</td>
<td>18</td>
<td>153</td>
<td>23</td>
</tr>
<tr>
<td>20</td>
<td>131</td>
<td>22</td>
<td>209</td>
<td>24</td>
<td>109</td>
<td>20</td>
<td>155</td>
<td>22</td>
</tr>
<tr>
<td>26</td>
<td>51</td>
<td>12</td>
<td>85</td>
<td>22</td>
<td>60</td>
<td>11</td>
<td>76</td>
<td>22</td>
</tr>
<tr>
<td>27</td>
<td>66</td>
<td>12</td>
<td>75</td>
<td>21</td>
<td>46</td>
<td>10</td>
<td>108</td>
<td>24</td>
</tr>
<tr>
<td>28</td>
<td>45</td>
<td>9</td>
<td>69</td>
<td>22</td>
<td>51</td>
<td>8</td>
<td>93</td>
<td>24</td>
</tr>
<tr>
<td>29</td>
<td>42</td>
<td>10</td>
<td>24</td>
<td>12</td>
<td>40</td>
<td>8</td>
<td>45</td>
<td>17</td>
</tr>
<tr>
<td>31</td>
<td>48</td>
<td>12</td>
<td>118</td>
<td>24</td>
<td>50</td>
<td>11</td>
<td>144</td>
<td>24</td>
</tr>
<tr>
<td>33</td>
<td>89</td>
<td>13</td>
<td>82</td>
<td>24</td>
<td>65</td>
<td>11</td>
<td>90</td>
<td>24</td>
</tr>
<tr>
<td>36</td>
<td>75</td>
<td>18</td>
<td>100</td>
<td>22</td>
<td>61</td>
<td>14</td>
<td>87</td>
<td>24</td>
</tr>
<tr>
<td>37</td>
<td>102</td>
<td>18</td>
<td>101</td>
<td>24</td>
<td>77</td>
<td>15</td>
<td>130</td>
<td>24</td>
</tr>
<tr>
<td>39</td>
<td>85</td>
<td>16</td>
<td>133</td>
<td>23</td>
<td>87</td>
<td>16</td>
<td>171</td>
<td>23</td>
</tr>
<tr>
<td>40</td>
<td>45</td>
<td>10</td>
<td>30</td>
<td>13</td>
<td>35</td>
<td>8</td>
<td>76</td>
<td>22</td>
</tr>
<tr>
<td>41</td>
<td>150</td>
<td>23</td>
<td>150</td>
<td>23</td>
<td>112</td>
<td>16</td>
<td>157</td>
<td>24</td>
</tr>
<tr>
<td>49</td>
<td>90</td>
<td>14</td>
<td>105</td>
<td>24</td>
<td>81</td>
<td>14</td>
<td>134</td>
<td>24</td>
</tr>
<tr>
<td>50</td>
<td>53</td>
<td>13</td>
<td>55</td>
<td>23</td>
<td>40</td>
<td>10</td>
<td>62</td>
<td>24</td>
</tr>
</tbody>
</table>

A = times checked by patient.
B = number of patients checking.
C = times checked by personnel.
D = number of patients checked for.
It will be noted that personnel generally indicated that behaviors were used and should have been used for patients more frequently than the patients perceived their use or the need for them.

There was relatively close agreement, in proportion to the numbers of each group checking, on twelve used items and six should be used items. These are summarized, along with the items patients checked as used more often proportionately than did personnel, and those which personnel checked more often than did patients in Table 10.

In the Personal Concern and Interest category, the one item agreed upon was the item on adjustment of ventilation (#25). The behaviors patients perceived more often than personnel in this category had to do with protection, i.e. intervening when patient was teased or was destructive, and with interest in Occupational Therapy. The personnel indicated that they listened to patients, asked about off-unit behavior and expressed their interest in and desire to help patients.

The behavior agreed upon by the two groups in the Social-Recreational category was that of introducing patients to each other. The two behaviors patients identified more than personnel were those involving bringing other patients to those remaining in bed, and accompanying patients off the unit. The personnel reported themselves as carrying out the seven other more specific behaviors in the category much more frequently than patients reported them doing so.

The three behaviors agreed upon in the Emotional Support category were concerned with staying with the wakeful patient (at night), walking with the pacing patient, and in encouraging the patient to go
## TABLE 10

**SUMMARY OF AGREEMENTS AND DIFFERENCES BETWEEN PATIENTS AND PERSONNEL ON PERCEPTION OF ITEMS USED AND SHOULD BE USED AS SHOWN BY THE NUMBER OF CHECKS**

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>I No.</th>
<th>Item</th>
<th>II No.</th>
<th>Item</th>
<th>III No.</th>
<th>Item</th>
<th>IV No.</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Items agreed upon:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Used:</strong></td>
<td>1</td>
<td>25</td>
<td>1</td>
<td>24</td>
<td>3</td>
<td>6,23,46</td>
<td>7</td>
<td>15,19</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>27,33</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>37,41</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50</td>
</tr>
<tr>
<td><strong>Should be used:</strong></td>
<td>4</td>
<td>1,3,14</td>
<td>2</td>
<td>24,35</td>
<td>6</td>
<td>7,23</td>
<td>11</td>
<td>5,15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Items checked more often by personnel than by patients:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Used:</strong></td>
<td>4</td>
<td>16,21</td>
<td>7</td>
<td>8,12,18</td>
<td>6</td>
<td>4,7</td>
<td>9</td>
<td>2,10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>38,48</td>
<td>22,30</td>
<td>17,42</td>
<td>34,47</td>
<td>43,44</td>
<td>20,26</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>36,39</td>
<td>49</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Should be used:</strong></td>
<td>4</td>
<td>16,21</td>
<td>7</td>
<td>8,12,18</td>
<td>2</td>
<td>4,17</td>
<td>5</td>
<td>2,10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>38,48</td>
<td>22,30</td>
<td>43,47</td>
<td>36</td>
<td>39</td>
<td>20,31</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Items checked more often by patients than by personnel:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Used:</strong></td>
<td>5</td>
<td>1,3,9</td>
<td>2</td>
<td>13,35</td>
<td>1</td>
<td>45</td>
<td>4</td>
<td>5,11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>14,32</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>29,40</td>
</tr>
<tr>
<td><strong>Should be used:</strong></td>
<td>2</td>
<td>9,32</td>
<td>1</td>
<td>13</td>
<td>2</td>
<td>6,46</td>
<td>4</td>
<td>11,23</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>29,33</td>
</tr>
</tbody>
</table>
to the dining room. Patients perceived the personnel encouraging them to do things on their own more often than personnel identified this behavior in themselves; personnel identified the supportive behaviors more often in themselves than did the patients.

In the Educational-Therapeutic category, the agreement between patients and personnel mainly concerned behaviors of example, as grooming or calmness, and explaining behaviors - effects of medication, reasons for rules. Patients perceived personnel employing regulatory behaviors more often than personnel said they did.

Item No. 11 stated:

"The nurse, in telling patient to stop attempts at physical contact, indicates that she likes him but not the behavior."

This item was considered an important factor in the nursing care plans of two male patients; these men, and four others, as well as two women, checked it as a behavior used toward them by a majority of the personnel they knew.

Item No. 29 ("The nurse tells patient to stop advising others about their problems, pointing out this is the therapist's function") was specified on only four nursing care plans of patients but ten perceived it used quite frequently.

These seemed to be the two items most misperceived by patients, in relation to the nursing care plans for patients and the items checked used by personnel.

Table 10 also shows the areas of agreement and disagreement between personnel and patients over items checked should be used. These figures were based on total numbers of times each item was checked. On
this basis it can be seen that there was agreement on more should be
used items (23) than on used items (12). Nine of these items were com-
mon to both groups; 6 of these were in the Therapeutic category with
one in each of the other 3 categories. In items checked more often by
personnel than by patients, there was a decrease of 8 from the number
marked used (Table 11). Four of these were in the Therapeutic category,
3 having been agreed upon as should be used and one having been checked
more frequently as should be used by patients than by personnel. The
others were in the Emotional Support category and the two groups agreed
they should be used. There was a decrease of 3 in the total number of
items checked more frequently by patients than by personnel; in the
Personal Interest and Concern category (I) items 1, 3 and 14 were
agreed upon as should be used. In the Social-Recreational category
(II), item 35 was agreed upon as should be used, but item 13 remained
the same. In the third category, Emotional Support, item 45 was agreed
upon as should be used but items 6 and 46, which patients and personnel
had perceived as used, were marked should be used more often by patients
than by personnel. Also, in the Therapeutic category, items 5 and 40
were agreed upon as should be used but patients marked items 28 and 33
should be used more often than did personnel. Item 28 stated: "The
nurse tells patient she likes him but cannot agree with his ideas: 'I
understand you feel this is so, but I do not believe it is true'".
Item 33 concerned prompting patients about rules: "The nurse reminds
patient of the hospital rules about smoking, visiting, etc., in private
when patient is violating them."

These items plus the two others marked should be used more often
by patients than by personnel, seemed to be important therapeutic behaviors in personnel for patients. They were items which implied examination of patient behavior in a constructive way. Patients wanted this; personnel did not consider it necessary. Or were they too unsure to do it?

Individual agreement scores for each patient with each of the personnel were computed by categories, and examined to find which personnel groups patients agreed with most in each category. The results are shown in Tables 11 and 12. Significant individual agreement scores are reported in the short descriptive summaries of each patient studied in Appendix F.

**TABLE 11**

**NUMBER OF HIGHEST PATIENT-AGREEMENT SCORES WITH STUDENTS, NURSES, AND AIDES IN EACH CATEGORY FOR USED ITEMS**

<table>
<thead>
<tr>
<th>Category</th>
<th>I - 10 Items</th>
<th>II - 10 Items</th>
<th>III - 10 Items</th>
<th>IV - 20 Items</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>W</td>
<td>M</td>
<td>W</td>
</tr>
<tr>
<td>Students</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Nurses</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Aides</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

|          | 13 | 14 | 12 | 13 | 14 | 13 | 12 | 13 |

Table 11 shows the numbers of patients whose agreement scores were highest with students, with nurses and with aides on behaviors used, while Table 12 shows the numbers of patients whose agreement
TABLE 12
NUMBER OF HIGHEST PATIENT-AGREEMENT SCORES WITH STUDENTS, NURSES, AND AIDES FOR EACH CATEGORY FOR SHOULD BE USED ITEMS

<table>
<thead>
<tr>
<th>Category</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>W</td>
<td>M</td>
<td>W</td>
</tr>
<tr>
<td>Students</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Nurses</td>
<td>5</td>
<td>7</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Aides</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>12</td>
<td>14</td>
<td>15</td>
</tr>
</tbody>
</table>

scores were highest with students, with nurses and with aides on should be used items. In the categories having 10 items, I, II and III, the range of scores was 0-9, with the mean scores ranging from 1-2.4. In Category IV, having 20 items, the range was 0-13, with mean scores range of 1.7 to 2.5. The low means were obtained because of the number of zero scores which resulted when patients did not know the personnel and, therefore, had no agreement with them. The sums totaled more than 12 in some instances because there were two or more personnel with whom some patients had the same agreement scores. In Category III in Table 12 the total for men was 11; one patient had agreement scores of 0 with all personnel on this category.

Analysis and Interpretation of Data

In this discussion the data reported in the preceding pages has been considered generally and not in terms of the method of collection,
although the sources will be mentioned.

This exploratory study of patients' overtly expressed perceptions of the therapeutic functioning of nursing personnel has produced some revealing data. The summaries of the findings from the process-recordings on the ward populations (Tables 3 and 4) have shown that, in most cases, 60 percent to 100 percent of the patients present on the wards, were able to perceive the administrative and technical functions of personnel correctly; from 43 percent to 91 percent of the patients perceived the social functions. The therapeutic functions were less commonly identified; the range from 10 percent to one instance of 80 percent with the majority of scores below 40 percent. This data included only those instances when the patients indicated their awareness of the helpful or therapeutic nature of the behaviors.

Analysis of the process-recordings acquired during the total participant observation period showed evidence that there were specific occasions when patients viewed the coordinating, explaining and reporting activities of the nurses as controlling devices which were threatening rather than therapeutic. The male patients particularly verbalized their feelings about nurses using administrative communicating tasks as power devices in relation to the door-locking episode and to the transmission of information from patients to families and/or doctors and vice versa. The males who were interviewed stressed the "running the ward" functions of nurses and in unit meetings on the male ward, the controlling nature of the nurses' role being referred to repeatedly. The interviewees, however, were prone to stress the fact that the control on the part of the nurses was a necessary power delegated to them
by the hospital administration; they indicated that the nurse were "acting under orders."

There was evidence in the data reported that some of the negative feelings concerning communications expressed by the men were brought about by the frailties of the individual personnel concerned rather than the system. Provisions for communications through nursing reports, team meetings, ward unit meetings and informal discussions between nurses and doctors, as described in Chapter IV, were more than adequate. The human beings involved sometimes were not, and adverse reactions occurred.

The data showed that the nurses on the women's ward urged patients to seek out their doctors themselves to get information; on the men's ward, the nurses acted as buffers between patients and their doctors. The reason for this was not ascertained; it was quite possible that it was because of the influence of the administrative physician of the ward who was somewhat more directive than his counterpart on the women's unit.

Patients on admission indicated some understanding of the concrete functional behaviors of nursing personnel in terms of "running the ward," giving medications, supervising bathing, eating, sleeping and other activities common to any type of hospitalization. Many had been in general hospitals and some were returning for a second or third time to this specific hospital. Also, nurses showed the ability to state these functions: "I will give your medicine when it is due. I will let you know when you can wash your hair." Some, Miss Nob, Miss Nap and Mrs. North in particular, were noted as saying to patients at
various times: "I am here to help you. Do you want to talk about why you are anxious?" Or, "I will help you all I can. Let me know when you want me to stay with you," and "I am one of your nurses, if you get upset or anxious, I will be here to help you." These nurses were the ones with whom patients had the highest agreement scores.

In general, patients indicated that the student nurses were most helpful to them when they served as socializers and recreational partners. This was stressed in the process-recordings, the written reports, and in direct comments of patients to the writer during the total period of the study, and was reinforced in the interview findings and in the checklist results. The latter results indicated that not only did patients mark more items used by students than by other personnel, but also students themselves marked more used items in Category II than they did for any other category. This might be interpreted either that the students considered these to be their most important functions in the setting or that they were more comfortable in carrying out these behaviors rather than the more self-involving therapeutic ones. It seems important to note that these results were obtained at the end of the students' learning experience in psychiatric nursing and also at the end of their total basic educational program in nursing. They finished their nursing program on the day the checklists were marked by the male patients; when the investigator returned to collect further data two weeks later, several were back on the wards as new staff nurses. It occurred to her that here was an important question to be pursued: "What different expectations of functioning do patients have of the new staff nurse whom they knew as a student?"
The nurses' helpfulness to patients was regarded by patients as being related to the general administration of the ward. "They keep things going," and "They see that I get my medicines" and "They run the ward," were frequent comments. The coordination of all therapeutic efforts in their behalf by the nurses was accepted early by all patients. New patients were indoctrinated by those who had been on the ward for a while. The following is an example:

Mrs. Penn had been admitted in a confused state and as she began to become oriented, indicated concern as to who was caring for her children, what had been done about her financial obligations and her community commitments. Mrs. Price said to her: "Just talk to one of the nurses. They'll take care of everything. They know who to talk with about it. Just tell Miss North what's worrying you." Mrs. Penn went to Miss North, the head nurse, who arranged for the social worker to investigate the situation.

Patients also recognized that the nurses coordinated their treatment activities with their recreational and socializing activities.

When the men were discussing plans for a ping-pong tournament among the several wards, they decided that the best way to insure its success was "to have Mrs. Napes talk to the nurses on the other wards; otherwise, they'll schedule treatments or something else at the same time." Mrs. Patton became quite concerned when she was to have an X-ray, a psychological interview and an interview with her doctor on the same day; she feared she would be called upon for all three at the same time. Mrs. Pug said to her: "Don't worry, you can depend on Miss North not to let that happen. She's got things organized."

From Tables 3 and 4 it can be seen that the percentages of the total ward populations who perceived the Therapeutic nursing functions, such as providing emotional support, listening, teaching, interviewing,
and showing concern for, gradually increased each week in the nine-week period. The data from which these statistics was summarized showed that most of the events recorded related to staff nurses rather than to students or aides.

Patients' perception of aides' behaviors had to do with situations involving personal hygiene, escort services and housekeeping duties, the technical nursing tasks. Three male patients indicated that they were able to talk over their personal problems with certain aides. One woman said talking to the aides was "helpful". The writer's record of observations substantiated by nursing notes and reports indicated that there was really a wide variation of aide behaviors in the carrying out of their technical nursing functions; from the performance of a procedure for or with a patient with no verbal interplay whatever and little affective display, to the warm, compassionate listening and responding interchange carried on concomitantly with a task. This was to be expected in light of the varied backgrounds and experience records of these on-the-job trained persons. In view of the expectations of aides functioning on the ward of nursing service, it might be postulated that, generally speaking, the aides were exceeding the therapeutic performances required of them.

It has already been shown that the administrative roles of personnel were identified and accepted as therapeutic by most patients on both wards. The specific behaviors included in the checklist have been presented in Table 10 according to the agreement or differences of patients with personnel. There were nine items which were agreed upon as both used and should be used. In Category I, the item which indicated
Interest and Concern on the part of the personnel had to do with adjustment of ventilation. The lone Socialization item in Category II had to do with introducing new patients to others on the ward while the Emotional Support item of Category III had to do with staying with a pacing patient. The items under Category IV were all verbal ones of explaining or telling except #19 which had to do with the nurse serving as an example to patients.

Items which were not agreed upon as used but were identified by both groups as therapeutic (should be used) in addition to those mentioned above included, in Category I, being quiet at night, protecting the confused patient and showing interest in patients' occupational therapy activity.

In Category II, the additional item concerned accompanying the patient off the ward. The Emotional Support items of Category III agreed upon as therapeutic had to do with staying with patients and giving encouragement to patients. The Therapeutic items of Category IV considered beneficial had to do with explaining, listening and teaching patient to do things for himself.

Whereas there were 12 items which were agreed upon as used by both patients and personnel, there were 26 items checked used more often by personnel than by patients. Table 10 shows further that of these 26 items, four in Category III and three in Category IV were agreed upon as therapeutic (should be used). One item was not checked should be used as often by personnel as it was checked by patients.

The remaining 12 of the 50 items were checked used more often by patients than by personnel. Three items in Category I were agreed upon
as therapeutic by both patients and personnel. The other two were considered therapeutic by patients more often than by personnel. In Category II, one item marked used more often by patients was marked should be used by both groups, while another was marked more often by patients as used and should be used. The only item in Category III checked used more frequently by patients than by personnel was agreed upon by both groups in checking should be used. In Category IV, two of the four items checked used more often by patients were checked should be used with the same frequency by both groups while two other items were marked should be used also more often by patients than by personnel. In summarizing from Table 10, it can be said that 23 behaviors or 46 percent of the 50 included in the checklist were regarded as therapeutic with the same frequency by both patients and personnel; 18 additional items were checked as used and as therapeutic for patients more frequently by personnel than by patients and 9 items were checked as used and as therapeutic for themselves more frequently by patients than personnel checked them. Overall, personnel considered 82 percent of the items therapeutic and necessary for patients while the patients considered only 64 percent of them therapeutic and necessary for themselves. Patients agreed with personnel on 56 percent of the items. These results are similar to Caudill's who using another methodology, found that personnel tended to view their therapeutic functioning more optimistically than patients perceived it. He also found that patients viewed the administrative functions of nurses more positively than did the nurses themselves.

The summaries of the agreement scores on used and should be used items in Tables 11 and 12 (pp. 90-91) show the difference between how patients found the different groups of personnel functioning and what they expected in the way of therapeutic functioning in the four categories of behaviors of the checklist. Students and aides had more high agreement scores with patients than nurses in all categories but Category IV, students rating better than aides in Categories II and III on used behaviors, according to Table 11. Table 12, however, shows that in all four categories, patients expected more therapeutic behaviors from nurses; the students ranked next in Categories II and III with aides last while the latter two groups ranked the same in Categories I and IV.

These data were collected during a period when new measures were constantly being put into use which would increase the therapeutic nature of the environment. Campus privileges had been extended and city privileges were instituted so that patients could go downtown for a shopping trip or for lunch or movies, trips which required more time than one hour campus privileges allowed. The opening of doors had been increased during this time and patients had access to all their personal belongings at all times.

All of these measures and others, had been discussed with patients before being put into effect, through the medium of the weekly unit meeting. They had been considered administratively by personnel beforehand. Therefore, both patients and personnel were undergoing a growth process in terms of the changing patterns of living together in the hospital situation. Many patients had expected more controls and found it hard to accept the fact that some of these controls really
rested in their hands. Personnel were willing to make the necessary adjustments, but some found it difficult to do. The learning processes were painful for both patients and personnel.

Since a good deal of the literature in the past has implied that direct findings from mental patients might be greatly distorted, the writer examined her results in relation to those of Abdellah and Levine, who have studied large patient groups in general hospitals. While their study differed in methodology and stressed the negatives, that is, areas of dissatisfaction with care, the topics mentioned as being high on the list of complaints were the ones which patients in the study brought up, over and over again, in unit meetings; the undue noise, especially at night, inattention to needs, and the hurrying of nurses. There seemed to be no difference between the groups in ability to identify and understand the functioning of nursing personnel; and individual summaries show that the sicker patients agreed with personnel on behaviors used as often as did those who were about to go home improved. There are no studies of other types of patients with which to compare these findings. Because of this, there can be no conclusion reached as to whether this particular group of patients were high or low in their 56 percent agreement with personnel on the therapeutic behaviors used. It was noted from the data that the personnel were at variance at times as to the therapeutic value of certain behaviors for specific patients. Since psychiatric nursing is so highly individualized for each patient and is based on the unique relationships between each patient and each nurse, this was to be expected. Each person marked the checklist for each patient in terms of her own ability
and the status of her particular relationship with that patient.

The individual summaries reveal that personnel did not measure up to some patients' expectations in terms of dealing with anxiety. This was most noticeable for two male patients, Mr. Prose and Mr. Pate, both of whom stressed the need to have some one to talk with or stay with them because of anxiety. Three other male patients felt they should have been curbed in their attempts at physical contact with personnel, but personnel did not recognize any need for this, even for Mr. Pill, who tended to cling to everyone. This was accepted as a stage of his illness and it was not deemed necessary by personnel to try to eradicate the behavior at the time of the study by intervention.

Among the women patients, such misperceptions were not evident. Mrs. Pegson, the youngest patient studied, did not perceive any of the behaviors indicating interest in and concern for her by personnel, according to her checklists. However, in the interview she expressed a need to be helped to learn new things through her general statement: "New, self-centered patients should be helped to learn new things."

There seemed to be a direct relationship between the ability of the personnel to spell out for patients the ways they could be helpful to them and their rank in terms of total high agreement scores. Table 12 indicated the agreement scores by groups of personnel for each category of behaviors. When the data supporting this table were examined they showed that the nurses who ranked among the first ten personnel in high agreement scores were the two head nurses, Mrs. Napes and Miss North, and Misses Nob, Nux and Nest, all of whom were recorded as spelling out explicitly their therapeutic roles to patients. Mr. Astor, an aide, and
three students, Miss Shoop, Miss Shore and Miss Spade, who made up the remainder of the first ten, were also noted to have specifically indicated to patients the ways in which they could be of help to them and encouraged patients to seek such help from them.

There also seemed to be a relationship between the institutional experiences of patients and their ability to perceive therapeutic behavior in personnel. This could be expected, especially when the experiences were in the same setting with some of the same personnel.

In patients' expectations of therapeutic behaviors in personnel, nurses were first in each category but one. More patients agreed with nurses about therapeutic behaviors which should be used for them except that male patients agreed with aides as often as they agreed with nurses on Category I, the Interest and Concern items. Female patients agreed next with students while male patients agreed next most often with aides, except in Category III, the Emotional Support items.

These results differed from what they actually perceived from the three groups as indicated by the agreement scores of Table 11. Nurses were most often perceived correctly as carrying out the Therapeutic behaviors of Category IV, while students were most often perceived carrying out the Social-Recreational behaviors of Category II and the Emotional Supportive ones of Category III. In expressing Interest and Concern, aides were most often perceived correctly by male patients and students by female patients. Nurses fell below patient expectations in their actual perceived behavior while students and aides exceeded patients' expectations.

It could have been that the actual assignments of duties in the
ward situations brought about these results. The writer did not analyze the assignments of students, nurses and aides in the setting. The duties assigned to students were designed to promote their learning in order to achieve the ability to function at a staff nurse level. This could have resulted in students having more duties which allowed patients to perceive them readily and often functioning as recorded. The patients' perceptions of staff nurses as busy but helpful when needed may be accurately presented in Table 11. The interview results showed, however, that patients verbalized few expectations of help from students beyond the social and recreational roles which they identified.

The findings concerning the perceptions by the patients studied of the therapeutic functioning of personnel during a specific period do not lend themselves to broad generalizations but may indicate some implications for nursing education and nursing service in the setting. A summary of these findings is presented herein: the implications derived from them will be discussed in the next chapter.

1. Patients perceived correctly the majority of the technical, administrative and social-recreational behaviors of nursing personnel in the setting and interpreted them as therapeutic in nature.

2. Male patients tended to view the communicating and coordinating roles of nurses as means of control which were employed against them.

3. Patients agreed with personnel that 56 percent of the items checked by the latter were therapeutic for themselves.
4. On the checklists, female patients had more high agreement scores with students and with nurses than with aides, while male patients had more high agreement scores with aides and with students than with nurses, on behaviors used.

5. On therapeutic behaviors expected (should be used) both groups had more high agreement scores with nurses than with students or aides. While patients viewed the nurses' role as that of "running" the ward, they expected her also to carry out the therapeutic behaviors of the checklist which applied to them individually.

6. While patients viewed the aides' roles as those of housekeeping assistants or technical workers, they correctly indicated that they found them carrying out many behaviors considered therapeutic.

7. Students, who were expected to be socializers, were also found by patients to carry on other therapeutic behaviors as well.

8. Students indicated, through consistently marking more Social-Recreational behaviors used and should be used than others, that they viewed these behaviors as their main contribution to patient care.

9. Patients' perceptions of personnel behaviors in the setting were generally consistent with the behavior of personnel observed by the writer and with reports on their own behavior by personnel, except in the few specific instances discussed.
10. In individual instances, certain patients indicated feelings of anxiety or of aggression which were not identified by personnel.

11. Proximity, daily contact and the use of name tags and photographs did not insure patients and personnel of "knowing" each other; both groups indicated a higher degree of unfamiliarity with each other than seemed logical in a therapeutic milieu.

12. Those persons who were able to verbalize their therapeutic usefulness or potential to patients were perceived by patients to be as therapeutic as they felt themselves to be.
CHAPTER VI

IMPLICATIONS FOR NURSING EDUCATION

General Implications

It should be made clear that the implications which are inferred from these data are in reality problems for further study in the setting, in view of the exploratory nature of this research.

Perhaps one of the implications which should have meaning for nursing as a whole derives from the fact that the patients studied, perceived and spelled out fairly well many of the ways in which nurses were helping them in their recovery process. The major areas of difficulty, those of communication and coordination of activities, were the ones with which nurses themselves had problems. From this it might be hypothesized that patients can help psychiatric nursing personnel to identify and assess the therapeutic nursing techniques which can be utilized for their benefit and that patients can help identify the non-therapeutic techniques used by nursing personnel.

Many psychiatric nurses already accept these as basic assumptions in their nursing practice but to date they have not been substantiated in reported nursing research.

The tendency of the male patient group to look upon the nurses as exerting control through the use of their communicating and coordinating activities causes one to speculate upon further educational
implications for nursing. Psychiatrists generally view the nurse as the "mother surrogate" and the staff physicians as the "father surrogate" of the ward population. A certain amount of rebellion against "parental authority" by the ward population under such a focus, would be in order, but not in a long-sustained way. Why was there so great a difference in "rebelliousness" between male and female patients? Was it due to the preparation of the nurses for assuming these activities, or to the individual differences of the nurses involved? How much of the difference was due to the variable of sex? How much was due to other factors? It seems implicit that nursing service and nursing education personnel should examine carefully this aspect of nurse functioning and devise ways of lessening the conflict in the area of control of communications.

Personnel who communicated to patients their willingness to be helpful and the ways they felt they could be helpful were not only perceived as being therapeutic by the patients but were observed by the writer to be functioning in more therapeutic ways with patients. This may be an indication both to nursing service directors and to nursing educators that here is an area in which personnel can be given concrete help in developing their therapeutic potentialities. Further, the high degree of empathy which seemed to exist between certain personnel and specific patients, as indicated by high agreement scores on the checklists might have been a potential tool for more effective nursing care if it had been recognized and utilized. Supervisors and instructors could well help staff nurses and aides to be aware of and to utilize such interpersonal rapport in the assigning of personnel to specific
patients and in helping them to develop in ability to make their inter-
actions more meaningful in terms of the therapeutic goals set up by the
psychiatrists.

The data indicating that some personnel and some patients did not
know each other well enough to identify behaviors was surprising, in view
of the facts that steps were taken to provide means for identification,
and that these were the regularly assigned personnel whose common re-
sponsibilities included knowing and interacting with all patients. Cer-
tainly this implies that the steps taken to have personnel know patients
and vice versa were insufficient, and that other means need to be con-
sidered if a therapeutic milieu is to be maintained.

The findings seemed to the writer to imply the need in the ward
settings for a nurse with the knowledge to deal with all these problems
in nursing care which arose. Most of the nurses were young, the aides
were on-the-job trained for limited services, and the supervisors were
present for relatively short periods. Also, instructors and supervisors
had specifically assigned functions to carry out. There was a need for
someone who was free to help identify and analyze nursing problems, to
help devise ways of dealing with them, and to demonstrate effective nurs-
ing care. If personnel had had such help at the times when the prob-
lems presented themselves, some of the non-therapeutic situations might
have been avoided. It seems feasible to suppose that the example of
such an expert nurse - a clinical specialist - would encourage, stimu-
late, support and enrich the ward personnel so that the resulting
potential for therapeutic care would be greatly enhanced.
Implications for the Education of Student Nurses

The data collected seemed to suggest some implications which further study may find to be common to many settings. The first of these implications had to do with the students' own conceptions of their roles with patients in the final weeks of their preparation for nursing. In their marking of the checklists, students indicated that they used the Social-Recreational behaviors to a far greater extent than they used the other behaviors which were deemed helpful to patients in this particular environment. According to the educational objectives of the program, the goals were to prepare students to function as beginning practitioners of nursing, i.e. staff nurses, who were to utilize the supportive, explaining, intervening and other behaviors included in the checklists as well as carrying out the administrative, technical and social behaviors.

It would seem logical to expect students, at the end of an educational program, to be utilizing a majority of the behaviors which staff nurses are expected to use; these students did not perceive themselves doing so, nor did the participant-observation reports reveal much evidence to this effect. It has been pointed out that assignments may have impeded this. Nevertheless, there is a need for nursing educators to examine the effectiveness of the actual experiences in moving students toward the fulfillment of their goals. Patients expected social and recreational behaviors of the students, and little more, according to the data. It seems implicit that patients should be informed of the goals of the learning experience for students so that they may evolve more realistic expectations of performance from them. Do the expectations of patients influence the performance
of the students more than the expectations of their teachers?

The data showed that the student nurses who were able to verbalize their potential roles in helping patients were perceived as more therapeutic than the others. This implies for nursing educators, the need to continue to help students to communicate to patients and to others, their capacities for helping. The shortening of the hospital stay of psychiatric patients has meant the stepping up of all interpersonal maneuvers between patients and personnel. In order to move more rapidly to a relationship which can assist patients toward a higher level of wellness, nurses must learn more direct ways of making patients aware of how they can be expected to help. These communicating experiences must be begun early in the preparation of nurses if they are to be sufficiently skilled and comfortable enough through practice to utilize them in the highly personal manner required in interacting with emotionally disturbed patients.

A further implication for the education of students in the setting is that patients may provide important clues as to student functioning if they are consulted, and may be able, as consumers of the service, to shed a great deal of light on what students are doing in the way of therapeutic nursing care. In psychiatric settings, this is sometimes difficult to assess. It is easier to evaluate the student's growth on the basis of supervisory conferences than to investigate her real performance with patients, since the latter is less tangible than that of a student giving specific, technical care to a surgical patient, for instance. The problem of accurate evaluation of students is as yet not fully solved in psychiatric nursing nor in the other clinical areas.
The psychiatric patients studied seemed to be perceiving therapeutic behaviors in students, were comfortable in participating in the investigation of nursing in the setting, and indicated their pride in being asked to do so. It seems reasonable to assume that this is another way that patients might participate in the planning for and evaluating their care.

**Implications for Nursing Service**

**And Its In-Service Educational Programs**

The inservice education program for staff nurses provided by nursing service in the Columbus Psychiatric Institute and Hospital was intended to help the staff nurses to achieve the full potentials of their capabilities for psychiatric nursing and to function with increasing competency and security as members of professional health teams in a therapeutic milieu. The methods used to achieve these goals were sound and are generally recognized among nursing leaders as effective tools. The nursing service director and her assistants indicated that the staff nurses as a group were steadily improving in their therapeutic skills. The findings in this study, however, were that the staff nurses were not perceived as functioning as therapeutically as they felt themselves to be doing, and that patients' expectations were not being fulfilled. It would appear that patients' expressed perceptions of therapeutic behaviors of the staff nurses might provide some helpful criteria for effective assessment of the progress of each nurse toward her performance goals, and might give clues to existing discrepancies between behaviors and reported attitudes of staff nurses.
Patients interviewed by the writer expressed strongly-held concepts of nurses as busy administrators. This was not considered to be so by nursing service. Theoretically, nurses were to spend the greatest share of their time interacting with patients individually and in groups; realistically, there were times they were hard pressed to get the necessary administrative tasks done. The writer feels that there is an implicit need for a nursing study to determine if there might be better ways of administering nursing service in this setting so that the therapeutic potential of the nursing staff could be realized. Research studies in nursing report many innovations: nurses tape-record their notes which are then transcribed by secretaries; patients are given their own medications to take, eliminating a time-consuming nursing task; non-nurse administrative teams handle the administrative details of the wards. Is there a better way of providing optimum nursing care in this setting, stressing the therapeutic milieu?

The aide function had been defined as a technical one in this setting, and only incidental teaching was done after the initial period of on-the-job training for each new aide. The participant-observation data and the checklists indicate, however, that aides carried out most of the behaviors considered to be nursing behaviors. It further appeared that many patients perceived these behaviors as highly therapeutic for them. This could be construed as indicating a need to re-assess the aide function in the setting. Should aides in this setting be helped to carry out the behaviors which they reported to this writer - interviewing, explaining, discussing anxiety, et cetera - or should they be helped to refer patients to the nurses who are theoretically prepared
to carry out such therapeutic activities? This question should be investi-
gated concomitantly with the study of the administration problem.

There were implications for the encouragement of explicit com-
munication with patients concerning the limits and potentials of therapeu-
tic functions on the part of aides and staff nurses also. Nursing
service has provided the system of communication and needs to give in-
creasing support to the staff so that this can be done.

Both nursing education and nursing service personnel in the
setting might view with optimism the possible contributions of patients
to the improvement of student learning and of patient care in the setting.
CHAPTER VII

RECOMMENDATIONS FOR FURTHER STUDY

The implications for nursing education and nursing service within the setting discussed in the preceding sections embody some of the recommendations for further research in the area of patients' perceptions of the therapeutic functioning of nursing personnel. Certain of these which the writer feels might provide new knowledge for all psychiatric nursing are discussed below.

1. The study of patients' perceptions of personnel functions might well be extended into many settings. The checklist might be further refined so that additional information could be obtained. Specifically, the answers to be checked for each item might read: most of the time; occasionally; seldom; never. Some of the items might be omitted.

A study of any size should extend over a period of time and include enough investigators so that observations and interviews on each patient could be more detailed than those in this study, and cover the whole period of each person's hospitalization. It might be feasible in a broad study to incorporate other methods of collecting data to obtain findings concerning the individual differences of the patients studied such as might be obtained by psychological tests. Certainly statistical methods would be necessary in order to present such findings in a meaningful way.
2. The evidence that patients have considerable insight into their own needs in terms of relationships with personnel and that they can perceive how these needs are met leads the writer to suggest that nurses might do well to study how this might be used constructively. Hospital administrators have listened to the reports of social scientists on patient views of the treatment. Stanton and Schwartz have reported what happened at Chestnut Lodge and Caudill's study at Yale produced changes in medical administration. Nurses are becoming prepared in research and some might want to consider investigating this area.

3. Research is needed in all aspects of psychiatric nursing. In nursing service and in the practice of psychiatric nursing, the role of the clinical specialist should be explored. This should lead to some research in patterns of nursing service to include the specialist as well as to give the patient a definite role as suggested above. The emphasis on community mental health and the rapid return of patients to their families presents a problem for study concerning the extension of institutional nursing services into the home under well defined policies.
CHAPTER VIII

SUMMARY

This exploratory case study of two wards of the Columbus Psychiatric Institute and Hospital was undertaken to determine the nature of patient perceptions of personnel functioning in a therapeutic environment and to learn if there were implications for nursing education to be derived from these perceptions. The writer spent five months in the setting as a participant-observer, making process-recordings of interactions, collecting data from various nursing records and from patient charts, and gathering additional information from 12 patients from the men's ward and from the women's ward through interview and the administration of a checklist. The latter was given also to the personnel on the two units studied. The categories of nursing functions were those postulated in the report of the Expert Committee on Psychiatric Nursing of the World Health Organization.

From the data collected, it was deduced that the patients studied were able to perceive in a realistic way the administrative, technical and social functions of personnel, and that they accepted most of these as therapeutic. The less concrete therapeutic functions were not as often perceived by patients as they were said to have been performed by personnel. There was 56 percent agreement with personnel on 41 items of the checklist. Patients had highest agreement on therapeutic behaviors used with the personnel who were able to communicate to them
the specific ways in which they might help. Students tended to respond to patient expectations in viewing their main functions as socializing rather than the more intense therapeutic interacting. While aides were to be used to perform technical tasks and free nurses for their more therapeutic functions, they were, nevertheless, perceived by some patients (more males than females) as carrying out many of those therapeutic behaviors theoretically conceded to be in the nurse's realm of interaction. While patients expected nurses to carry out these therapeutic behaviors, they actually perceived correctly aides and students doing so to a greater extent than they did the nurses. These expressed perceptions of patients were in general verified by the recorded materials from charts, reports and process-recordings.

Implications for nursing education and nursing service in the setting were derived from the findings. The student's progress toward acquiring beginning skills in staff nurse behaviors might be more realistically assessed when patients are consulted about their functioning. If students have not clearly defined the above as their goal in this setting, nursing educators must help them to do so. Personnel in both nursing education and nursing service need to give more attention to the encouragement of direct communication to patients concerning their therapeutic capabilities by students and staff personnel. Exploration of better ways to reduce administrative and technical loads of staff nurses so that therapeutic functions may be fulfilled was indicated in the findings, as was the study of the realistic function of the aide in the setting, and a reconsideration of the preparation needed for it.
## APPENDIX A

### A SAMPLE HOSPITAL DAY

<table>
<thead>
<tr>
<th>TIME</th>
<th>ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30 a.m.</td>
<td>Patients are awakened and helped to prepare for the day.</td>
</tr>
<tr>
<td>8:15 a.m.</td>
<td>Breakfast in one of the hospital dining rooms.</td>
</tr>
<tr>
<td>8:45 a.m.</td>
<td>Further preparation for the day, such as making beds and personal grooming with help as necessary.</td>
</tr>
<tr>
<td>9:00 a.m. - 12:00 noon</td>
<td>Planned activities, including treatment as ordered by physician, group walks, occupational therapy, group psychotherapy or similar types of activity.</td>
</tr>
<tr>
<td>12:00 noon</td>
<td>Preparation for lunch.</td>
</tr>
<tr>
<td>12:30 p.m.</td>
<td>Lunch.</td>
</tr>
<tr>
<td>1:00 p.m.</td>
<td>Preparation for visitors.</td>
</tr>
<tr>
<td>1:15 - 2:15 p.m.</td>
<td>Daily visiting hour except Tuesdays when visiting hours are 6:30-7:30 p.m., and Sundays and holidays, 2:00-4:00 p.m.</td>
</tr>
<tr>
<td>2:30 - 5:00 p.m.</td>
<td>Period of activities similar to that in morning.</td>
</tr>
<tr>
<td>5:00 p.m.</td>
<td>Preparation for dinner.</td>
</tr>
<tr>
<td>5:30 p.m.</td>
<td>Dinner.</td>
</tr>
</tbody>
</table>
A SAMPLE HOSPITAL DAY (CONTINUED)

<table>
<thead>
<tr>
<th>TIME</th>
<th>ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:00 - 9:00 p.m.</td>
<td>Recreation and relaxation period. There is opportunity for a choice of activities through the day. The evening provides additional opportunities for letter writing, social activities of various sorts, reading, supervised visits to movies and plays, the enjoyment of music and the pursuit of hobbies. Evening planning includes supervised baths (choice of tub or shower).</td>
</tr>
<tr>
<td>9:00 p.m.</td>
<td>Evening nourishments are offered.</td>
</tr>
<tr>
<td>10:00 p.m.</td>
<td>Retiring hour.</td>
</tr>
<tr>
<td>10:30 p.m.</td>
<td>Lights out.</td>
</tr>
</tbody>
</table>
APPENDIX B

GUIDE SHEET FOR PATIENT INTERVIEW

1. How did you expect to be helped to get better through living in this ward situation when you came here?
(What things did you expect to occur?)

2. How do the personnel help you?
   a. The nurses?
   b. The students?
   c. The aides?

3. How do the supervising nurses help you?
   a. The ward clerks?

4. What things take place in this situation which you feel interfere with your getting better?
   Do any personnel block your progress?

5. How do you think the ward situation could be made more therapeutic for you?
### APPENDIX C

#### CHECKLIST

<table>
<thead>
<tr>
<th></th>
<th>Used</th>
<th>Should be used</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The nurse moves quietly about ward at night.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>The nurse speaks directly and explicitly to patient.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>The nurse protects the confused patient from those who would take his belongings.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The nurse gives honest praise.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>The nurse discusses the meaning of campus privileges with patient.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>The nurse sits with the wakeful patient.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>The nurse stays close to the patient who is anxious.</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>The nurse carries on conversation around the interests of patient.</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>The nurse intervenes when others tease patient.</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>The nurse explains clearly to the patient the policies and purposes of the hospital.</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>The nurse, in telling patient to stop his attempts at physical contacts, indicates that she likes him but not the behavior.</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>The nurse invites the patient to join in physical activities as shuffleboard, dancing or ping pong.</td>
<td></td>
</tr>
</tbody>
</table>

121
<table>
<thead>
<tr>
<th></th>
<th>Used</th>
<th>Should be used</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.</td>
<td>The nurse takes other patients to the bedside of patient who stays in bed.</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>The nurse expresses interest in patient's progress in Occupational Therapy.</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>The nurse explains the effect of medication in a calm, matter-of-fact way.</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>The nurse listens with interest to what patient has to say.</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>The nurse encourages patient to play pool or another game, with others.</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>The nurse invites patient to participate with her in games and other activities.</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>The nurse grooms herself neatly as an example to patient.</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>The nurse keeps her word or explains why she can't.</td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>The nurse inquires about off-unit activities patient has attended.</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>The nurse asks patient to join a group of patients.</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>The nurse walks with patient who is pacing the hall.</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>The nurse introduces patient to other patients.</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>The nurse adjusts ventilation at night.</td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>The nurse gives explicit directions as, &quot;Let's walk in the hall,&quot; then does it with patient.</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>The nurse tells patient matter-of-factly he is sick.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>28. The nurse tells patient she likes him but cannot agree with his ideas: &quot;I understand you feel this is so, but I do not believe it is true.&quot;</td>
<td>Used</td>
<td>Should be used</td>
</tr>
<tr>
<td>29. The nurse tells patient to stop advising others about their problems, pointing out that this is why they have a therapist.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. The nurse participates with patient in activities patient enjoys and does well.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. The nurse points out inappropriate comments of patient by saying &quot;I don't understand you&quot; or &quot;Please explain what you mean.&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. The nurse removes things from the environment when patient is destructive.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. The nurse reminds patient of the hospital rules about smoking, visiting, etc., in private when patient is violating them.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. The nurse invites patient out of room to activity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. The nurse goes with patient to off-unit activities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. The nurse listens to patient's complaints, then diverts him into some activity without expressing a reaction.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. The nurse discusses with the patient reasons for unit regulations and inspections.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. The nurse expresses interest in, and concern for, the patient.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. The nurse talks with the patient alone about what makes him anxious.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40. The nurse asks patient to wash and mend own clothes, assisting him when necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Used</td>
<td>Should be used</td>
</tr>
<tr>
<td>---</td>
<td>------</td>
<td>----------------</td>
</tr>
<tr>
<td>41. The nurse moves calmly and unhurriedly.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42. The nurse sits quietly with patient.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43. The nurse sits with patient in the dining room.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>44. The nurse encourages patient to make decisions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45. The nurse encourages patient to do things on own as using campus privileges.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46. The nurse encourages patient to go to the dining room.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>47. The nurse assists with group activities and asks patient to join in.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>48. The nurse tells patient she wants to help him.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49. The nurse reminds patient that he came to the hospital to be helped and indicates that this is what she is trying to do.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50. The nurse tells patient what behavior is expected of him.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX D

INSTRUCTIONS TO PERSONNEL

ACCOMPANYING CHECKLIST OF NURSING BEHAVIOR

The writer is engaged in research for a doctoral dissertation concerning the ways in which psychiatric patients might contribute to nursing education. You are asked to participate in the research by completing checklists of the nursing behaviors you employ in relating to certain patients on your ward.

The checklist consists of fifty items describing nursing behaviors directly involving patients. There are many more behaviors which might have been included, but this limited list is used to make the task a workable one. All have been identified as acceptable nursing behaviors in this setting but it is evident that all behaviors are not appropriate for every patient. It is your task to select those you use for specified patients.

Beside each item are two blank spaces: The first column of spaces is headed Used: The second is headed Should be used. For each patient you are to check each list as indicated below:

1. If you feel you are behaving toward this patient as the item describes, you place a checkmark (✓) in the first column (under Used) beside the item.

2. If you are doing as described in the item and believe it is therapeutic for the patient, place a checkmark also in the second space beside the item (Should be used column).
INSTRUCTIONS TO PERSONNEL (CONTINUED)

3. If you are not doing as the item describes but feel it would be of value to the patient, place the checkmark in the second space (Should be used column).

4. If you do not use the behavior described and do not think it appropriate for this patient, leave both spaces for the item blank.

Example:

a. Patient Jones is aged and feeble and confused, so for Item 9, you would find that you carry out the behavior and feel it is therapeutic to do so.

The nurse intervenes when others tease patient. Used Should be used

b. Patient Smith is a submissive patient who never shows anger. You find yourself protecting him, but the plan of therapy calls for patient to be placed on his own. You would check only that you used the behavior.

The nurse intervenes when others tease patient. Used Should be used

c. Patient Brown is well respected on the ward and can take care of himself, therefore, the item does not apply to him.

The nurse intervenes when others tease patient. Used Should be used

d. Patient White is a patient who needs help in controlling his aggressive behavior. He is new to the ward and you have not spent time with him. However, you feel you should intervene as a way of giving him support.

The nurse intervenes when others tease patient. Used Should be used

For the purpose of the study, the term "nurse" is broadly used to indicate members of the nursing team, nurse, student nurse, and aide. The pronouns "him" and "her" refer to personnel or patient in context regardless of gender, that is, her usually refers to the personnel and him to the patients.
INSTRUCTIONS TO PERSONNEL (CONTINUED)

Your cooperation in this research effort is deeply appreciated.

A copy of the completed dissertation will be made available to the Institute library for the use of interested personnel.

Biographical data:

Encircle the number, word or phrase which applies to you.

1. Status........student nurse, staff nurse, head nurse, supervisor, aide, ______(indicate other).


3. Marital state..single, married, widowed, divorced, separated.

4. Children.......0, 1-2, 3-5, 6-8, over 8.

5. Education.......grade school (yrs) 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12.

college 1, 2, 3, 4

diploma or degree R.N., B.S.N., M.A., M.S.
currently enrolled, planning to enroll, no further plans.

6. Work experience in psychiatric nursing:
less than 6 mos., 7-12 mos., 13-18 mos.,
1½ - 2 yrs., 2-4 yrs., 5 yrs. or more.

7. I subscribe to: American Journal of Nursing, Nursing Outlook, Nursing Research, _______(other).

8. I have done reading in the Institute library on my field _______times in the last three months.
(fill in)

9. I have attended workshop, lecture, conference, away from the institute in my field in last six months, have not attended any.
APPENDIX E

INSTRUCTIONS TO PATIENTS
ACCOMPANYING CHECKLISTS OF NURSING BEHAVIORS

The writer is engaged in research for a doctoral dissertation concerning the ways in which psychiatric patients might contribute to nursing education. You are asked to participate in the research by completing checklists on behavior which you believe to be used by the nursing personnel who are caring for you.

The checklist consists of fifty items describing nursing behavior known to be used by the nursing personnel. Beside each item are two blank spaces: the first lies in a column headed Used; the second column is headed Should be used. You are to complete them by doing as follows:

1. If you feel the person being checked uses the behavior described in the item when caring for you, place a checkmark (✓) in the column marked Used beside the item.

2. If you feel this behavior is helpful to you place a checkmark in the second space under Should be used beside the item.

3. If the person does not behave toward you as the item describes but you believe it would help you if she did, then place the checkmark in the Should be used column beside the item.

4. If the person does not use the behavior the item describes and you do not feel it would be helpful to you, do not place a checkmark beside the item at all.
INSTRUCTIONS TO PATIENTS (CONTINUED)

Example:

<table>
<thead>
<tr>
<th>Used</th>
<th>Should be used</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. The nurse intervenes when others tease patient.  
   
   Nurse Tree usually comes to your aid when older patients tease or bother you. Following the direction in (1) you would check the first space as in example (a). If this helps you, you would follow direction (2) and fill in both spaces as in example (b). However, if Nurse Tree did not intervene, but you feel she should, you would mark the second space only as in example (c). If no one teases you or you are able to deal with teasing yourself, you would leave the spaces blank as in example (d).

b. The nurse intervenes when others tease patient.  

For the purpose of this study, the term "nurse" is broadly used to indicate members of the nursing team and may refer to graduate nurses, student nurses, or psychiatric aides; the name of the person is loosely attached to each checklist and will be removed when you finish. Your name will not be used so there will be no chance of your contributions being known to others. The writer is grateful to you for your participation and feels that regardless of the findings of the study, you, as an individual, have made a contribution to nursing education.
INSTRUCTIONS TO PATIENTS (CONTINUED)

Please fill in the following biographical data:

Encircle the word or phrase which applies to you.


2. Marital state...single, married, separated, divorced, widowed.

3. Children.......0, 1-2, 3-5, 6-8, over 8.

4. Education.......grade finished: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12.
college: 1, 2, 3, 4
graduate work: 1, 2, 3, 4
APPENDIX F

CASE SUMMARIES

In the following section the pertinent case information and data collected through the several methods have been summarized for each of the patients in the study group. While fictitious names have been used, the factual data for each patient has been accurately reported.

Mr. Pride, a 44 year old Caucasian, had been admitted to the hospital from the Mental Health Clinic 33 days before the interviews with a tentative diagnosis of Anxiety Reaction, chronic, with depressive features. There was no one to give an early developmental history; the social worker learned from Mrs. Pride that both her husband's parents had been treated in mental hospitals and that his mother had been hospitalized continuously since 1948. She reported that during their 20 years of marriage the patient has had numerous episodes of restlessness, nervousness and depression, accompanied by numerous somatic complaints. This information had been reported in the team meeting by the social worker and conveyed to the nursing team by the head nurse. The complete written social history had not yet been received on the ward.

While Mrs. Napes, the head nurse, had admitted him to the ward, the data collected through participant-observation indicated that Mr. Pride interacted most often with the student, Miss Squire, who had selected him for her nursing care study, and who may, therefore, have initiated many of the contacts. He also spent a good deal of time with
the male aides on the ward, playing cards and talking. His interactions with other patients were very restricted at first but at the time of the interviews, he was participating well with others in both on and off ward activities. The nursing notes recorded a preoccupation with his physical condition: he asked that his pulse be taken; he reported headaches, dizziness and strange feelings, frequently.

Dr. Ray had indicated that treatment would consist mainly of supportive psychotherapy and milieu therapy. His progress notes indicated that he felt Mr. Pride was improving under this regime. He reported that the patient had had suicide thoughts during his early illness and had had episodes of confusion and withdrawal in addition to his somatic complaints. He felt, according to the record, that the patient was a very dependent person who had a need to please others. This was indicated in his behavior on the ward; he tended to be the pacifier and the mediator when there was friction, and to intercede on behalf of the personnel generally.

The interview with Mr. Pride revealed that he had no pre-conceived ideas about his hospitalization. He expected to be provided for - that is, to get food and shelter, and to see the doctor. He was pleased to find that there was recreation and occupational therapy, as well and felt that these had been helpful to him. He described the personnel in three categories but also stated that "Everyone is very nice. The nurses run the place; they give medication and see that we do what we're supposed to. The students are like hostesses. They keep us entertained when they're around. The aides help us with our personal hygiene and the practical things." He could not mention anything negative about
personnel but reiterated, "Everyone is nice." He was non-committal.

While his overall marking of the checklists confirmed the interview findings, there were some interesting sidelights. His agreement scores were highest for the students on the Social-Recreational items; on the Therapeutic category, his agreement scores with the aides, Mr. Ames and Mr. Astor, were greater than those with some of the nurses but the behaviors identified were different, falling into the category of technical behaviors. The behavioral items perceived in agreement with the nurses were administrative and therapeutic in nature. The agreement of the patient with all personnel regarding the Emotional Support items was the same, but he misperceived additional supportive behaviors in students. Every behavior that he checked as used, he also checked should be used, except in one instance. On item #37, which had to do with explanation of unit regulations, Mr. Pride indicated that Miss Nap had not done this but should have. He also checked incorrectly that both the student, Miss Squire and the aide, Mr. Ames, had done this. Both Miss Nap and Miss Nob had indicated on their checklists that they had given such explanations to Mr. Pride during the period of data collecting.

Mr. Prose was a 23 year old man who had been on the ward 40 days at the time of the interviews. In his own words, "I have trouble talking to people - getting the words out, I block!" His social history did not disclose anything significant in his developmental history; his parents felt that he was a normal child until the beginning of his speech difficulties around the age of 12. He was the only child of a farm couple and had few playmates. He did well scholastically; even though handicapped by his speech problem, he completed high school. Since then
he had remained at home, helping out on the farm; he had recently be­come increasingly concerned over his lack of social contacts and sought help in overcoming the speech difficulty as a result.

Dr. Ray indicated in his first notes that the patient had early asked if he might tape record his material for the doctor as he experi­enced difficulty in the direct interview. His request was denied as the doctor felt this was a crutch the patient would lean on rather than work out the problem. At the time of the study, the doctor felt that patient was improving in his ability to communicate. The nurses' notes verified this and stated that Mr. Prose was beginning to initiate contacts with nurses, especially students, despite his difficulty in talking with them unless engaged in some activity as card playing, shuffleboard or croquet. It was noted that he was able to talk more easily with his fellow patients and was beginning to join them in visiting the women's ward for evening social activities, interacting mainly with the patients of his own age.

The nursing care plan for Mr. Prose read:

Self-conscious; has much difficulty in expressing self -
Relate non-verbally first. Talks well about farming.
Meet needs without asking. Show him you are aware of
his presence.

The participant-observation data produced evidence that the last item above was needed. The patient consistently tended to remain un­noticed on the fringe of things. He could not verbally compete with the other young men on the unit; personnel tended to respond to these verbal people and overlooked him. Five personnel recognized this behavior in themselves while completing the checklists, verbalizing sur­prise at their limited interactions with patient and with some others.
While all twelve personnel filled out checklists for Mr. Prose, they checked fewer behaviors used or should be used for him than for any of the other male patients.

This writer was unable to complete an interview with Mr. Prose. An appointment for the interview had been made and the writer had just begun when the doctor interrupted to take the patient off the ward. He was not able to resume the conversation upon his return and avoided any further attempts. He reported with the rest of the patients to complete the checklists. He completed checklists on nine of the twelve personnel by checking every behavior for every person in the should be used columns and all but three for every one in the used columns. The unchecked items all had to do with anxiety. Item #39 "The nurse talks with patient alone about what makes him anxious," was not checked at all by personnel, but he considered that it should have been. Item #7, "The nurse stays close to the patient who is anxious," was checked by only two personnel; Mr. Prose indicated that no one used it but all should have. Two personnel checked Item #42, "The nurse sits quietly with patient," in both columns; Mr. Prose perceived the behavior in these two, but indicated that all should have used it.

This indicated to the writer that whereas the patient perceived himself as anxious and requiring specific behaviors from the personnel to alleviate his anxiety, the personnel had little or no perception of that anxiety. This despite the fact that his diagnosis was listed as Psychoneurosis, anxiety reaction with blocking.

(The question arises as to whether the personnel were so anxious about dealing with this low-verbal person that they screened out the
anxiety he was showing or whether it was actually not very evident.)

Mr. Pate had been in the hospital longer than any other patient in the group studied, 79 days. He was 37 and had had previous hospitalizations in another state. He was diagnosed as Paranoid Schizophrenic. His social history indicated severe stress in early childhood relationships and more recently in his marital relationship. He had two children. While he had had two years of college, he had been employed as a long distance truckdriver for the past few years. Upon admission, he had expressed delusional ideas about communists being active in his community. He was suspicious of others and rather withdrawn but later became somewhat euphoric. During the period of the interviews and the checklists, he was considered to be free from delusions and was able to leave the hospital over weekends. In addition to psychotherapy and milieu therapy, he was receiving daily doses of Chloropromazine. The nurses' notes recorded that he was socializing more and becoming more active with other patients in recreation and occupational therapy. His written nursing care plan was concise:

"Include in unit activities. Support him!"

In the interview situation, Mr. Pate's first comment was:

"I'd been in a state hospital before. I didn't expect to get so much attention here. I thought we'd just sit around all day and maybe see the doctor, and get medicine."

He further indicated that he expected to do everything in groups - "Line up, you know!" He felt that all personnel spent time with him. The students "kept him entertained." He commented on the business of the staff nurses who "have to run the ward. They are busy passing out
medicines and carrying out orders." He stated that he could talk man-
to-man with the aides who "helped me a lot." He knew the supervisors
and felt they were interested in him as a person. He also indicated
that the ward clerk was friendly and helpful to him. His only critical
comment indicated his worry over finances.

"Here, they bill you no matter what your finances. In -- (his
home state) if you didn't have much money, they didn't bill you."

Mr. Pate proceeded to mark the checklists rather cautiously,
seeking the support of the writer by asking if he was doing them properly.
His cautiousness was reflected in the marking; he checked the used column
only on most personnel. The three items he checked should be used were
#6, 7 and 23, all items having to do with anxiety. He checked these on
seven of the ten lists completed and did not indicate that the behaviors
had been used in any case. Only one of the persons checked by the pa-
tient had indicated that he felt the behavior should have been used.
Actually, at the time of the checking, the patient was considered quite
well by all personnel and the feeling most prevalent was that he was now
quite self-sufficient and a good example for the sicker patients.

In the Social-Recreational category, the patient agreed with
students more than with nurses or aides on the behaviors used; in the
other three categories, the amounts of greatest agreement were with the
nurses. This seemed at first to contradict his interview statement that
he could talk man-to-man with the aides. He did have a high agreement
score with Mr. Astor. Mr. Ames had just returned from vacation and had
not interacted with Mr. Pate much; therefore, there was little chance
for a high agreement, and as Mr. Pate was sleeping well, he had had
little interaction with Mr. Ajax, the night attendant on the ward.

Mr. Pill was a 51 year old man who had been hospitalized for 20 days at the time of the interview. He had been restless and depressed for several months and was bordering on exhaustion when he was admitted. His social history revealed that he had been a sober, hard working family man with few other interests. He had recently borrowed money to build a home (his first venture into debt) and had worried continuously since about his ability to repay the loan. He had two children, a girl 20 and a boy 15 and expressed many doubts about his ability to continue to provide for them and for his wife. He stated that he was "finished" and that he "didn't deserve his family." He felt that he had done them a grave wrong in borrowing money at his age and that he had saddled them with a heavy burden of debt. Actually, he had already made several payments ahead and was in good financial shape.

The doctor's notes recorded a diagnosis of Involutional Melancholia with depression and indicated a hopeful prognosis. His progress notes indicated that the patient began to show improvement about a week after hospitalization. The treatment was a combination of psychotherapy with milieu therapy. A tranquilizer had been ordered but the dosage was cut down to the minimal amount when the patient continued to improve.

The nurses' notes indicated that the patient had been tearful and clinging during his first few days on the ward. He "snagged onto personnel" according to Mrs. Napes and seemed to fear being alone. His nursing care plan included the statements below:

"Stay with patient. Show him you are concerned about him. Let him know you feel he is worthwhile."
In the interview Mr. Pill revealed that he could not remember much about his admission; he knew he had been sick and that his doctor had sent him for care. He had no idea what to expect and felt that all personnel were very helpful. He became quite tense at this point because of an incident between two other patients which occurred in our presence and was unable to complete the interview.

When asked the next day, he felt the interview had been completed and would not continue.

Two days later, Mr. Pill participated with the group in doing the checklists. He knew ten of the twelve personnel; he was one of the few who knew the night nurse and attendant and his agreement scores with the former on the Interest and Concern and the Therapeutic categories were higher than any others. This was consistent with the nursing reports; at this time he was awake much of the night and spent a good deal of time with the night personnel.

His highest agreement scores in all four categories were with the staff nurses and the student, Miss Shore, who was especially interested in him. In general, he tended to perceive many more behaviors in the personnel than they perceived themselves actually carrying out. In the Therapeutic category, item #11, "The nurse, in telling the patient to stop his attempts at physical contacts, indicated she likes him but not the behavior" was marked as used by all ten of the personnel he knew; while all personnel were aware that he literally clung to them when talking with them, they perceived this as a part of his need for support at this time and made no verbal remonstrance about it to him. Item #33 "The nurse reminds patient of the hospital rules about smoking, visiting, etc."
in private when patient is violating them" he also checked as used by all personnel, but only one person, Miss Needle, the night nurse, had had occasion to do this when she found him smoking in bed.

Mr. Pale was a 48 year old former salesman who had been admitted 50 days before his interview with the writer. He had left his sales job following the surgical removal of a cancerous growth from his larynx which reduced his voice to a rasping whisper. He worked for a time in a tool factory but became increasingly concerned over his voice loss, began drinking heavily and finally quit working. A married man, he told his doctor on admission that he was concerned that the loss of his voice had resulted in a decrease in his earning power. He indicated that he felt less desirable to his family and became depressed. His diagnosis was Depressive Reaction in a cyclothymic personality.

At the time of admission the nurse found the patient outwardly very gay and active but noted that his face looked sad in repose. He avoided getting serious about his illness. In the group meetings he regularly joined Mr. Burt and Mr. Boxer in their verbal harassments of the head nurse but after several minutes he usually switched over and began to attack the two men in defense of the nurse. Mrs. Napes indicated that his maneuvering in this way sometimes caused her to become confused in her functioning with the group. At other times, when there was group discussion in process, the patient attempted to draw the head nurse into a private one-to-one discussion. At first Mrs. Napes was easily drawn into this trap; she expressed her reluctance to "hurt his feelings" but after a time, she firmly but kindly reminded him of the group purpose and asked him to see her later. This was effective.
In his relationships on the ward, Mr. Pale was usually gay and outgoing. He teased some of the younger male patients but seemed to relate more maturely with those of his own age group. He acted as a protective father toward the student nurses; on one occasion he almost came to blows with a younger patient over his suggestive comments to Miss Shore and at another time he was observed to move into group conversation with Miss Shoop and Mr. Bloom when he noticed that the discussion was becoming too personal for the student. Student comments indicated that he did this on four other occasions at least.

The nursing care plan for Mr. Pale included a terse outline of some of the dynamics involved and one suggested approach:

"Concerned about loss of voice - not able to earn as much. Flirty! - to prove masculinity? - Show appreciation of his interests and abilities."

Dr. Riley had, in addition to indicating the use of psychotherapy and milieu therapy, prescribed a tranquilizer for the patient early but it had been discontinued at the time of the interview. Mr. Pale stated that he had been too ill to have any expectations about treatment when he came in. He further added that "everyone has been nice. The students keep up the social activity. The staff nurses are always busy with medicines and stuff. The aides are a swell group." He could not be more specific about personnel and their helpfulness. He did not know the supervisors or the ward clerk and carefully avoided any statements which might be called critical. He had no answers for the two final interview questions.

On the day he was to complete the checklists, Mr. Pale was in an
expansive mood. He completed the forms on all personnel, marking an average of 46 items for each and checking each item in both the used and should be used columns. At the end of the checklists for Mr. Ames and Mr. Astor he wrote in the following comments.

1. For Mr. Ames:
   "Tops in his job. The best and very understanding."

2. For Mr. Astor:
   "A great asset to the unit."

In the analysis of his lists, it was found that his highest agreement scores in each category were with Mr. Astor (I-8) (II-9) (III-7) and (IV-13). His agreement scores for students and aides were higher than for nurses in all categories, with students standing first in Category II and aides first in the other three categories. Mrs. Napes and Miss Nob had agreement scores of 8 and 7 respectively with him on the Therapeutic category. The personnel averaged a lower number of items checked for this patient than for others (11 used; 16 should be used).

Mr. Point was a 41 year old, divorced man, who had been hospitalized 70 days at the time of the interview. He marked his checklists the same day that he was to be discharged. It had been recommended to his family that he be committed to a state hospital for further treatment. He had been a tubercular patient in a veterans' administration hospital for four years (1941-45). His social history revealed that he had been a lonely child, somewhat overprotected by his mother and never much of a mixer. His first marriage had ended in divorce because of his inability to relate closely and a recent love affair had "gone on the rocks" just prior to his admission. By the end of two weeks he felt
himself to be in love with the nurse who had admitted him (now assigned to another ward) and had indulged in several episodes of anger when she told him she was "only one of his nurses" and could be nothing more. His diagnosis was Schizophrenia with depression and he was undergoing psychotherapy and milieu therapy. There were no progress notes written but his doctor had suggested verbally that the nurses not be too insistent on interacting with him but that they let him approach them. There was, likewise, no written nursing care plan but, if the patient acknowledged them, the nurses responded as appropriately as possible. The nursing notes recorded that he was socializing well with other patients on the ward and occasionally with personnel, usually aides. He went eagerly to all off-ward activities in the hope that he might see the nurse with whom he was enamored.

The participant-observation study revealed little about this patient. He remained alone in his room or engaged in small group games with a few patients. He avoided personnel unless he had a specific request.

During the interview, he was obviously uncomfortable and equally uncommunicative. His reply to all questions was a hesitant "I can't say." He agreed to do the checklists, however, and filled them out for six of the twelve personnel, checking an average of 12 items per person in the used column only. His agreement scores were low but were greatest with aides. He, like Mr. Pale, seemed to perceive best the therapeutic behavior of Mr. Astor, having scores of 5, 7, 1, and 4 respectively in Categories I, II, III and IV. His highest agreement score with this person came in the Social-Recreational
category, indicating the reliance on doing things as a way of relating.

Mr. Fender had been in the hospital 28 days at the time of the interview. He was 22 and married, and had been a night watchman in a small town for the past several months. He had been referred to the hospital from the Mental Health Clinic in his community because of religious preoccupation. The detailed social history was not yet available but information to date indicated that he and his wife belonged to a minor religious sect which was very rigid; also, his life to date had been one of restriction and deprivation. Dr. Ray's admission note indicated that the patient exhibited "guarded behavior, laughs inappropriately. 'I can't speak up; they can hear me!' He thinks he has committed the unpardonable sin."

Two days later he had an episode of crying during his psychotherapeutic interview which he said was due to his feelings of hopelessness.

The doctor indicated that his diagnosis was Schizophrenic Reaction, Acute Undifferentiated.

The nurses' notes indicated that patient remained aloof and evasive after admission. His nursing care plan indicated a "real need to establish relationships - superficial now - we must make him feel comfortable with us."

The participant-observation data revealed that this patient had stayed aloof from most personnel during his stay on the ward. Indeed, he seemed always to be just on the fringe of things. His religion forbade him to play cards, so he watched. He was inept at active sports but enjoyed observing them. He avoided female personnel. When he was
approached by the writer for an interview he became quite distressed and it was evident that he could not proceed. He was not urged. His name was posted with the group and he appeared with the others to do the checklists. He did not seem too ill at ease when in the group. He marked only five of the twelve personnel - two of three students, two of six staff nurses and one of the three aides. It was not surprising that his agreement scores were highest with students and of these, highest in the Social-Recreational category. His agreement scores were fairly low (three or under).

Mr. Paxton, a 61 year old father of one son, had been readmitted 60 days before the interview. His diagnosis was Manic Depressive, with depression. He was a quiet, withdrawn person who remained either on or near his bed most of the time. His early history was not known; his wife said that she knew little of his background before marriage but indicated that he had always been quiet and reticent since she had known him, and seldom confided in her. This was his second episode of depression.

Dr. Ray had written few progress notes since noting the patient's readmission and diagnosis. The nursing notes indicated that he had been staying in or on his bed most of the time, that he avoided other patients and was guarded in his conversations with personnel. His nursing care plan stated:

"Cannot tolerate long contacts; make them brief. Do things for him. Not able to interact with others comfortably; don't pressure him to do so."

Participant-observation data confirmed the nurses findings.
Mr. Paxton, in the group meetings, came in late and sat on the fringe of the group. He did not enter into discussion until the very end of the study period, when he remonstrated about the use of the pool table by some of the patients while it was partially dismantled for repairs. He felt they would damage it beyond repair. He was, during that time, participating in card games and other activities with Mr. Pride, Mr. Pate and Mr. Printer and was observed on four days in a row in sustained conversations with Mr. Place, who was one of his roommates. This was unusual. He was also able to interact more with personnel. Miss Nob, one of the staff nurses who was especially interested in Mr. Paxton, described her interactions with him:

"It's like a game we play. I ask him every day to go for a walk, or to come play cards, or to join us in another game. Usually, he refuses, but ever so often he does it. And then I let him rest; I don't pester him for a day or so."

A day or so later the observer was sitting with Mr. Paxton when Miss Nob asked him to go walking. After he had refused and she left, he turned to me, smiled and said:

"She didn't really expect me to go; I went yesterday. I do things with her once in a while and then she lets me alone for a while. It's a way of keeping her satisfied."

The students indicated that whereas earlier the patient had avoided them, he now accepted them, although he did not initiate any further verbal exchanges. The aides felt he interacted with them as much as other patients did. The observer's data confirmed this.
The interview with Mr. Paxton took place at a time when he was improving.

Since he had been a patient in the hospital before, Mr. Paxton had had certain expectations on this admission. He expected a regular routine, pleasant personnel, social activity and he knew there would be other people as "sick as myself." All of these, he felt, helped him to keep busy and forget his problems.

He looked upon the students as persons who "helped with the housekeeping chores and pulled me into activities." He further stated that they explained treatments to him, referring specifically to his electroencephalogram. As for the staff nurses, they were the bosses; they gave orders and ran the ward. "I know there's someone to depend on. They don't stand for silliness. If you need help, they get it for you." The aides were different, he said. "I can talk one-to-one with the men. They give different understanding. They help with personal things."

He didn't know the supervisors, but was able to identify the ward clerk as "the girl who brings the canteen and the mail." He said this in a neutral way, expressing neither warmth nor animosity.

When asked if there was anything in the situation which interfered with his recovery he commented:

"I've had experience with the give and take of army life. I've learned 'familiarity breeds contempt.' I don't get too personal with anyone."

Thus, he indicated the limits he himself imposed on therapeutic intervention by nursing personnel. He made no further comments or suggestions for increasing the therapeutic effect of the ward.
The markings of the checklists took place the next day. Mr. Paxton knew 8 of the 12 personnel. He did not know 2 of the students, the night nurse or the night aide. His highest agreement scores in all categories were with Miss Nob. Their little "game" had apparently increased his awareness of her therapeutic functioning. Mr. Paxton marked the used column only for most items. Of the few items which he checked should be used but not used, Item #24 (The nurse introduces patient to other patients) was significant. He perceived the head nurse, Mrs. Napes, carrying out this behavior and felt the other nurses should have done so. However, the nurses did not seem to feel he needed this attention; no one checked it for him. Mr. Paxton also perceived himself as the recipient of and/or needing behavior #11 (The nurse, in telling patient to stop his attempts at physical contacts, indicated she likes him but not the behavior). Although no personnel checked this for him, he checked the item for all but the student nurses, indicating that Mrs. Napes, Miss Neal and Mr. Ames should have used the behavior and that he perceived Miss Nob, Miss Nap and Miss Nun using it. Again, here was a patient who seemed to perceive himself as being much more aggressive toward personnel than they saw him.

His mean agreement scores by categories seemed to bear out the interview statements. His highest agreement score in Category I was with the aides; in the other three categories, with the nurses. His mean agreement scores in general were low.

Mr. Pitcher, a 20 year old college sophomore, had been on the ward 64 days at the time of the interview. He was a tense, anxious young man who carried himself rigidly erect. Dr. Ray's admission notes
stated that "patient says mind is retarded. Has one thought at a time. Has ideas of influence and reference and exhibits catatonic posturing. Schizophrenia, Undifferentiated."

The nursing care plan in addition to the statement "listen to him - reassure," spelled out his behavior somewhat:

Delusional - thinks he talks in sleep. Thinks others are talking about him. Believes he is going to a state hospital. His rigidity makes personnel uncomfortable. He leaves activities because of anxiety.

These fragmentary notes have provided a thumbnail sketch of the patient's interactions on the unit.

The participant-observation data revealed that Mr. Pitcher spent a good deal of time alone, on or off the ward, during the early part of his hospitalization. After a few weeks he was able to participate with others in social activities for increasingly longer periods but withdrew to his room frequently. He was a member of a card-playing group which included Mr. Prose, Mr. Bloom, Mr. Bales, Mr. Pride and Mr. Printer. Some of this group were usually to be found playing cards at almost any hour.

In the weekly unit meetings, Mr. Pitcher remained quiet until someone asked him a question; his slow precise reply was usually impatiently cut in on by others. As he became more comfortable in the group, he occasionally volunteered for party duty or made an unsolicited comment. It was observed that he rarely sought out personnel other than Mrs. Napes, the head nurse, but would willingly engage in any activity initiated by personnel. As the nursing care plan indicated, such activities even at the time of the interview after 64 days, were usually
short, for personnel as well as the patient became anxious and sometimes they had to terminate the interaction first.

Mr. Pitcher indicated to the writer that he wanted to help her as much as he could but he really didn't know what he could contribute. His only expectation of the hospital was to be helped. "My doctor told me it would help." He expected the hospital "to be like a general hospital but it isn't." He could speak of the personnel helping him only in terms of "they" - "they are always at hand when they're needed. They talk to me, get things for me and play cards with me." He would not specify what nurses, students and aides respectively did for him. He had no comments about persons or events blocking his progress, and had no suggestions for making the ward more therapeutic.

Mr. Pitcher appeared with the others to mark the checklists at the appointed hour. He completed lists for ten of the twelve personnel, stating he didn't know Mrs. Needles, the night nurse and Mr. Ajax, the night attendant. He worked slowly and meticulously and, since he was committed to play softball with the others, had to be given time the next day to complete the task.

Since personnel perceived Mr. Pitcher as one of the sickest patients on the ward, they checked a larger number of behaviors as used or should be used for him, a mean number of 33 per person. He also checked a mean number of 24 per person which was a greater number than most patients checked. There were two items of behavior which he perceived in personnel or checked should be used which they had not indicated doing. One was Item #32 (The nurse removes things from the environment when patient is destructive). This patient had not been
considered destructive to himself or to others, yet he indicated on his checklists that four personnel correctly used this behavior toward him and that the others should have used it. The other item which he checked and which personnel did not check was #33 (The nurse reminds patient of the rules about smoking, visiting, etc., in private when patient is violating them).

The agreement scores of Mr. Pitcher were higher for nurses than for aides or students except for Category II, the Social-Recreational items. His agreement scores on all categories were highest for Miss Nob and Mrs. Napes; these were the two nurses who spent most time with him in carrying on administrative duties.

Mr. Player, a 45 year old colored man, married but separated from his wife, had been in the hospital 36 days at the time of the interview with the observer. He had suffered a whiplash shoulder injury four years before and had been in and out of hospitals since, complaining of black-out spells and pain and, more recently, engaging in loud arguments with his doctors. Dr. Riley listed these complaints in his admission notes and suggested the diagnosis of Paranoid State. The nursing notes recorded that he avoided personnel and always seemed busily engaged in some activity with other patients. His nursing care plan read:

"Thinks he's in for a rest. Ready to argue. Very socially active; avoids one-to-one contacts with personnel. Suggest that he has some disability which has to be accepted and plans made to go on from there."

The participant-observer data showed that Mr. Player was always surrounded by other patients and that he moved away from personnel into
such groups. He avoided such persons as Mr. Pill and Mr. Briscoe who were exhibiting rather bizarre behavior and also Mr. Bliss, whom he knew and with whom he tended to argue. He said of Mr. Bliss:

"He's the sick one and should be here. I only have a bad back."

Mr. Bliss, on his part, stated on several occasions that Mr. Player's back was "O.K. He's sick, like the rest of us, in his mind."

In the early weeks of his hospitalization, Mr. Player took little part in the unit meeting discussion. As he became more at ease, he began to participate, usually by following the lead of some of the more aggressive patients who were verbally harassing the nurses, Mr. Bloom, Mr. Boxer and Mr. Bert. It was observed that when other patients intervened and called for a halt, Mr. Player would immediately subside while the others continued their verbal attacks. At the time of the interviews, Mr. Player had begun to be more constructive and cooperative in the unit meetings. He still avoided being alone with personnel and sought the safety of groups on occasion.

In the interview he showed his denial of an emotional illness by indicating that he expected to have his back examined and to be treated for that physical ailment. He laughed bitterly and said, "My doc hasn't even examined my back. He said he saw the X-rays. He ought to send me home. I don't belong here. They just talk to me!"

He stated that the students were very pleasant and entertaining "but I don't need nursing care." The aides were "real good Joes" and "the nurses run the ward."

When asked if anyone or anything was blocking his progress, he reiterated his denial of being mentally ill and said "I'd be better
off at home. I'm not sick like the rest, but I will be if I stay here."

Mr. Player was among the group who arrived early to do the checklists on the appointed day. He knew everyone but Mrs. Needles, the night nurse. He marked a mean number of 15 items per person as used but the actual numbers ranged from 24 for one student to 2 for an aide. He marked 3 should be used items for 3 students only. Miss Nob and Mr. Astor indicated that they used the greatest number of behaviors with this patient with 35 and 44 respectively. The others marked an average of 9 items as used but averaged 16 items checked should be used. Mrs. Napes, Miss Neal and Miss Nun all commented, while marking the checklists, on how little interaction they had with the patient. Many of the behaviors which personnel checked should be used were checked as used by them by Mr. Player, indicating that he felt they were functioning toward him in more therapeutic ways than they felt they were.

In his agreement scores with personnel, Mr. Player was among the low scorers; his highest agreement score was with the students in Category II (4) while in the other categories, he agreed more with the "good Joes" - the aides, than with the students or staff nurses.

Like Mr. Player, Mr. Pearce denied his illness at every opportunity. He had been hospitalized 29 days at the time of the interview and marking the checklists. He did the latter early as he was to be transferred the next day. He was a 51 year old farmer, married, with one son, who had always been quite religious and who had recently become more strict and even delusional. He had also been showing poor judgment and some memory loss. Just prior to admission he had threatened his family with a loaded gun. Dr. Riley felt there may have been some organic
changes and indicated in his admission notes that he would attempt to establish whether the patient had an organic illness or was a Paranoid Schizophrenic.

The nurses' notes gave evidence that Mr. Pearce was quite angry at his family for having brought him to the hospital and that he kept to himself on the ward, reading his Bible or the many papers, news-clippings and magazines that he somehow accumulated. He blamed his family for bringing him to the hospital and repeatedly said he had needed a rest but was well enough to go home. He had almost come to blows with Mr. Briscoe, on one occasion. Mr. Briscoe was quite psychotic and flared up easily. After this incident, Mr. Pearce remained in his room most of the time.

The nursing care plan for Mr. Pearce stated: "Do not argue with him about religion. Be friendly, give attention." Most of the personnel found it difficult to be with him since he did always seem to bring the conversation around to religious ideas and became very emphatic. One student said: "He makes me feel as though I'm a terrible sinner." After his encounter with Mr. Briscoe, the personnel were somewhat relieved that Mr. Pearce did remain in his room; they felt that this was a way to avoid actual violence. They were also upset when plans were made to transfer Mr. Pearce to a state hospital and his doctor indicated he did not intend to tell the patient until the time of the transfer. They felt Mr. Pearce should have been told and were apprehensive that he would become resistive.

Knowing the plans for Mr. Pearce, the writer interviewed him early in the week and asked him to do the checklists. The interview
was not very productive, but he was pleasant and cooperative and also completed checklists on 6 of the 12 personnel.

When asked how he expected to be helped, Mr. Pearce denied his need for help. "I didn't need to come here. I just needed a rest. The doctor talked me into it." He denied that personnel were helpful, saying "I don't need their help. I let them help those who are sick." He didn't know the supervisors or the ward clerk. He said, when asked if anything or anyone blocked his improvement, "I don't need to be here; it's all right for some one like that Mr. Briscoe, who is sick."

On the checklists, Mr. Pearce carried out his denial to illness pattern, marking an average of 6 items per person used. These were the most general behaviors. Personnel marked an average of 15 items per person as used for him. The resulting agreement scores were low. His highest agreement was with Miss Nob; by categories, he had mean agreement scores of 1 with students, nurses and aides in I and IV. In Category II, the Social-Recreational items, he had a score of 3 with students. For Category III, the Emotional Support items, he had no agreement with any group or with any individual.

The patient seemed to bring an atmosphere of tension into the ward. This terminated on the day of his transfer to another hospital.

This was the third time Mr. Printer had been hospitalized for episodes of Psychoneurotic Depression. He had been on the ward 46 days at the time of interview. He was 38, married and the father of three children. He was said by his doctor to have depressive ideas, feelings of guilt and inadequacy and was further described as an inadequate, passive, dependent individual. He had attempted suicide after his most
recent hospitalization. He was soft-spoken, self-effacing and seemed to move quietly among the other residents of the ward and was seldom noticed. He rarely sought out personnel but responded to their overtures. The participant-observation data indicated that he never contributed anything directly in the unit meetings; on one or two occasions he made a remark to a neighbor who then verbalized it for him.

The nurses' notes revealed that the patient remained concerned with his feelings of guilt and his depressive ideas. The nursing care plan read:

   Help to feel worthwhile. Make supportive non-threatening contacts. Sit quietly with him. Be sure he has good personal hygiene and that he eats.

   Shortly after admission, the patient was given a series of electrowave treatments. At the time of the interview, these had just been concluded and he was beginning to show more alertness and interest in the ward happenings. However, on the interview day he was unable to respond at any length to the questions. He did say that he came to the hospital with the expectation of being cared for. He indicated he had been too depressed to think about it.

   By the end of the week when the group marked the checklists, Mr. Printer was able to participate. He knew 11 of the 12 personnel and showed overall higher agreement with personnel on behaviors used than any of the other male patients. His agreement scores with students were higher than with nurses or aides. His agreement score on Category II with students was 6; this was consistent with participant-observation data which showed that students were spending a great deal more time with him than with others.
Mr. Printer's highest individual agreement scores in all four categories were with Miss Nob: I-4, II-6, III-5 and IV-11. It was noted that this patient in general perceived the nursing behaviors as the personnel did more consistently than any of the other male patients studied. This may have been due to the number of previous experiences he had had within the same institution.

Mrs. Puhl was a 51 year old widow who had been hospitalized for 21 days at the time of the interview. The social worker had not yet obtained any information about her background; Dr. Rose had tentatively defined her illness as Paranoid Schizophrenia. She was abrupt, noisy and quarrelsome, and frequently out of contact, staring into space and ignoring what went on around her. Both patients and personnel tended to avoid her, the observer noted from her data. To date no nursing care plan had been written, although there were daily conferences among personnel about her behavior and how to deal with it. Dr. Rose had initiated electro-wave therapy earlier in the week of the interview; Mrs. Puhl was somewhat hostile and easily distracted and her responses were not relevant. When the writer got up to terminate the interview, the patient indicated that she was aware that her responses had not been adequate but that she had not been able to do better. In the week following the interviews, Mrs. Puhl seemed to be more aware of her environment and made some efforts toward social interaction; these were accepted quite warily by other patients who remained a little frightened by her bizarre behavior. She appeared with the others to mark the checklists, indicating her need to be a member of the group through her anxious question: "You do want me to do this, don't you? I'll do better than before!" She knew only
three nurses of the 14 personnel but her individual agreement scores with two of them were fairly high; for Miss Nest, I-3, II-6, III-4 and IV-3 and for Miss Nun, I-4, II-7, III-5 and IV-3. She knew Mrs. Nagle but had agreement scores of 0-0-1-1 with her, marking far fewer items used and several should be used in her case. This was consistent with the data collected through participant-observation: Mrs. Puhl on three occasions had directed verbal tirades against this nurse.

Miss Pax had also been on the ward 21 days at the time of interview. She was an 18 year old whose diagnosis was Schizophrenia of Adolescence associated with lumbar scoliosis. The participant-observation data showed that she was most often alone on her bed; when present on the fringe of the group she was silent and seemed apart and unnoticed. Little of her background was known at this time but the nurses' notes revealed that she expressed a good deal of hostility toward her mother and her older sister. Personnel, as a group, were uncomfortable around this silent, hostile "child" as they termed her but attempted to implement her nursing care plan:

Feels ugly, worthless, unsuccessful. Very threatened in one-to-one contacts. Hostile toward personnel. Engage in simple activities in which she can succeed. Contact for limited periods in small groups. No demands.

An attempt was made to interview Miss Pax but while she agreed to participate in this and in the checklists, she was unable to respond to the questions. When the writer attempted to rephrase the question she found the patient became restless and tense and decided to terminate the interview. On the day the group of women patients marked the checklists, the writer did not expect Miss Pax to appear, but she arrived
in the dayroom with the others, took her folder and sat at the table
with Mrs. Puhl, Mrs. Peg and Mrs. Plane. After about 10 minutes she
asked permission to take her lists to her room to complete. She re-
appeared a few minutes later to ask the meaning of one of the words of
an item, then returned to her room where she completed the lists for 9
of the 14 personnel. While the mean number of items marked by the pa-
tient and by personnel was the same, 22, the range of items marked by
personnel was from 9 to 44 while the patient marked from 12-36 items for
personnel.

Her mean agreement scores with students were greatest in Categor-
ies I, II and III, 2 each, but the score of 4 with nurses was the high-
est for Category IV, the Therapeutic items. Miss Pax had the higher
over-all individual agreement scores (3-6-5-11) with Mrs. Nagle who had
admitted her to the floor and who maintained an active relationship with
her, even when rebuffed repeatedly.

Of all the patients studied Mrs. Pole was the one whom personnel
said they knew the least. She was a 29 year old mother of three who had
completed three years of college. A diagnosis of Schizophrenia, Undif-
ferentiated, had been made by Dr. Ritz, her therapist, who had written
no further progress notes. There was no current nursing care plan
written for this patient at the time of the interview, 38 days after
admission. The nursing notes were sparse and indicated minimal necessary
interaction as giving of medications or treatments. Personnel indicated
their feelings of "not getting through to this patient" in the group
meeting when they marked the checklists and again on the day the patient
went home.
In the interview situation Mrs. Pole was polite but distant. She did not reply directly to the question on how she expected to be helped through hospitalization but said "I get to know things from other patients, and there are lots of social activities." When the question was rephrased she replied, "I didn't know what to expect, really." She did not differentiate among students, nurses or aides, when asked how these people helped her but said "They let me in and out and get me things." When asked if they helped her when she was anxious, she answered, "No, but the other patients do." She did not know the supervisor or the ward clerk. When asked what things interfered with her getting better she commented, "I've had to take an awful lot of tests. I guess it's all right if you have to be here." (She was a subject for one of the studies being done by the research department.)

The writer learned that Mrs. Pole was to be discharged the day before the group of women were to mark the checklists, so she asked the patient to do this ahead of the scheduled time. Mrs. Pole sighed, "More tests?" but when the writer started to move away she took them, listened to the instructions and completed the checklist for Mrs. Nagle only, indicating this was the only one of the personnel she knew. The participant-observation data and the remarks of the personnel validated this fact. Also, while twelve personnel marked checklists on the patient the marked three times more items should be used than they marked items used. Mrs. Nagle had marked 29 items used for Mrs. Pole but the patient perceived only 8 items used and agreed with Mrs. Nagle on the items in each category as follows: I-2, II-1, III-1, IV-2.

When she returned the checklists, Mrs. Pole restated in a rather
apologetic way, "I really got more help from the other patients. I don't know these people (the personnel) very well."

Mrs. Price had been admitted for the second time 21 days before the interview. This 35 year old schizophrenic mother of five had a history of marked deprivation and rigid upbringing. She married a man who had proved to be an improvident wanderer and had had to work at times to support herself and the children. Her first illness had occurred shortly before the birth of her fifth child; now she was again ill. She had been fearful and suspicious on admission; at the time of interview she was tense and anxious and when near a nurse tended to cling to her fearfully. She was undergoing electro-wave therapy but had had the treatment before and accepted it matter-of-factly as a helpful necessity. She experienced periods of panic in which she would seek out a "real" nurse, not a student, to stay with her. On one occasion she rushed past the writer, who was in street-clothes, looking for a nurse; she wheeled suddenly, grabbed her arm and said, "I'm so frightened, you're a real nurse. Stay with me!" It was forty-five minutes before she was relaxed enough to say when a student entered the room, "I'm better now. I'll be alright with her. Thank you for staying." During that time she sat tensely holding the writer's hand, saying few words, seemingly, not hearing anything which was said to her. This was a frequent pattern of behavior during the early part of her hospital stay. She was careless in dress and personal hygiene and other patients viewed her with alarm. They revealed to the observer that they considered her much sicker than they. The nursing care plan was more detailed than those for other patients on the ward.
Urge better physical hygiene; help her with her hair, etc. She is afraid of people, confused and suspicious. Make your contacts warm and friendly, give simple directions; no questions. Engage in simple activities in a non-challenging atmosphere.

The participant-observer data showed that students were fairly successful in working with Mrs. Price when she was not too anxious. She related very little with aides except when their duties brought them in contact with her. She was aware that her increase in anxiety provoked anxiety in the students and would leave them precipitately to seek out a staff nurse, as described above.

In the interview, which occurred a week after the start of her treatment series, Mrs. Price said of her expectations from hospitalization, "I was so afraid. I knew they (nurses) would take care of me. I'm not afraid of them. They do my hair and everything." She could remember no other expectations than to be taken care of. This was also the terms in which she spoke of the personnel helping her; she could not spell out anything specific for student, nurse, and aide at this time. She didn't know the supervisors or the ward clerk. When asked if anything interfered with her improvement, she said, "I don't approve of dancing, the others can do it but they don't need to expect me to." This rather hostile statement grew out of an incident in the unit meeting earlier in the day. The ladies were planning a party for the men's ward. They had decided that they would go to meet the men in the hall and each choose an escort for the evening of dancing and games. Mrs. Price had been asked to do so and had replied: "No, you can pick a man that way but I won't. I've got one at home. That's enough!" Her remarks in the interview supported the writer's idea that she had been quite upset by the
event. After the party, she told the writer she had attended but hadn't picked a man, danced or played cards. "That's not the way I was brought up. I'm a religious woman."

The ladies completed the checklists about two weeks after they were interviewed. On the appointed day, Mrs. Price was just emerging from a very confused episode of several day's duration which followed a visit home. The writer doubted that she could follow the instructions or that she would be able to identify personnel correctly. The patient, however, proved to be more oriented to personnel than others in the group and helped these persons to firm up the identity of various personnel. She herself marked 9 of the 14 checklists, indicating that she knew who the others were (3 aides and 2 staff nurses) but that they had not done anything for her in the period of time involved.

While both patient and personnel checked more items per checklists, the resulting mean agreement scores by types of the personnel were no higher than in instances in which patients and personnel checked fewer items. Mrs. Price's mean agreement scores with students, nurses and aides respectively by categories were: I (2-2-2), II (4-3-1), III (3-2-1) and IV (4-5-3). Her highest agreement scores were with Miss Nest, Mrs. Norge, the supervisor, and with Mrs. Alton, the night aide whose reports revealed that she had devoted a good deal of time to this wakeful patient. She also checked more items should be used than did any other patient, particularly for Miss Nixon (12 used, 37 should be used).

Mrs. Pug, 33, married and the mother of two children, had been hospitalized for 42 days at the time of the interview. Dr. Ritz had made a tentative diagnosis of Manic Depression, Manic, and had placed
her on a drug regime which had been effective in conjunction with the milieu therapy. There had not been much background information available on the patient; she herself was more willing to find out about others than to reveal information about her own self. This "streak of curiosity" had caused some patients to avoid her and she was observed to relate to only a few patients on the ward. Personnel also found her irritating; their avoidance pattern was spelled out in the participant-observation notes and was verbalized in nursing team meetings. She was looked upon as a hostile person; in turn she viewed the personnel as hostile people as the following record shows.

She could not recall any expectations she had of her hospitalization; "I was pretty sick - too sick to know what to expect." When asked how personnel helped her she made these statements: "Student nurses? They play games and talk with me and take me on group walks. They keep me busy...aides? - they spend time with me too. Nurses - they don't do much of anything!" The last statement was made quite vehemently, but she would not elaborate on it. She knew the supervisor and felt that she "checked to see how I'm getting along." When asked if anyone interfered with her getting better she again became hostile and positive: "That Miss Nixon hardly speaks to us patients - she thinks she's too good for us. She spends more time with the men patients than with us. She lets those kids dance in the halls too and that bothers me." At this point she called over to another patient who joined her in castigating Miss Nixon. The writer thanked her for her cooperation and withdrew, letting them carry on their verbal harangue.

When the group assembled to mark the checklists a week later,
Mrs. Pug took up her harangue against "the high and mighty Miss Nixon" and included Mrs. Nagle, who was also in disfavor at the moment for "treating us like dirt." Mrs. Plum supported her in her statements but Mrs. Penn intervened in a humorous way and suggested that they let the researcher explain what they were to do. Mrs. Pug marked 8 of the 14 checklists; she "couldn't tell the aides apart" and did not know Miss Nun or Miss Nest. While personnel marked a mean number of 18 items per person used, Mrs. Pug marked them using a mean of 35 items. Her mean agreement scores were for students, I=1, II=4, III=2 and IV=2: for nurses, 1 in all four categories and for aides, 0. Her highest agreement scores were with Miss Nixon who she so vehemently berated: I=3, II=5, III=1 and IV=4. One might speculate that her hostile attitude was a blind for the positive feelings she was really experiencing in the interactions with Miss Nixon.

There was no written nursing care plan for Mrs. Poke, a 49 year old divorcee with one child, who had been admitted 32 days before the interview with a diagnosis of Involutional Reaction with Drug Addiction. Her history indicated an insecure, unhappy childhood; she had worked before and after her marriage and when this failed began having increasing episodes of physical complaints which led to drug addiction. Her feelings of worthlessness, her acute depression and her physical debilitation led to this, her second hospitalization. She said that her earlier hospitalization had led her to expect to be helped by personnel and that she also expected benefits to result from association with other patients. Specifically, she looked forward to social and recreational activities, psychotherapy and a schedule to follow.
In describing how personnel were therapeutic for her, she again stressed the social aspects, "Exchanging ideas with others means a lot. Nurses encourage and plan activities." She did not specifically mention students and aides but indicated she felt the goals of all personnel were to help her improve. She did not know the supervisors or the ward clerk, and stated that no one blocked her progress. She did feel that the ward situation would be more therapeutic "if occupational therapy were started earlier and if patients could have more of it. More leisure time activities are needed, too!"

The latter remark might be an indication of the need for the patient really to have a "schedule". The participant-observation data showed that she was johnny-on-the-spot for all set activities whether they were meals, walks, medications or interviews with her doctor. She expected others to be on time too and on one occasion was upset when her doctor was delayed in returning to his office for his session with her.

Mrs. Poke was on time for the marking of the checklists and required many assurances that she was proceeding properly. She marked an average of 18 items used per person while personnel marked that they used an average of 19 items. Her mean agreement scores were highest with aides, with scores of 3, 4, 2 and 3 for Categories I, II, III and IV respectively. Her lowest mean agreement scores were with students; she had a score of 2 in Category II and 1 in each of the other three categories. She had mean agreement scores of 2, 1, 1 and 3 with the nurses. Her highest individual agreement scores were with Mrs. Adler and Mrs. Alton, both aides. Mrs. Poke failed to perceive many of the behaviors which personnel said they used, according to her scoring of the
checklists but she also misperceived them doing behaviors which they did not report. This was more predominant in the Emotional Support (III) and Therapeutic (IV) categories.

With a diagnosis of Involutional Psychosis, Mrs. Plum, a 59 year-old widow with two grown children had the distinction of being the only Court Placement patient among the patients of the two wards studied. She made this fact known to the observer on five recorded occasions. She had a history of a somewhat stormy childhood with a series of family crisis, one of them the commitment of her father to a state hospital where he was still confined. She had lived with her husband and family in an isolated farm. Recently, a son had had to be hospitalized for mental illness and eventually committed suicide. Her illness followed the death of her husband, when she had become depressed and attempted suicide. Since she refused to enter the hospital voluntarily, she had been committed by the Court for treatment. At the time of the interview she had been hospitalized for 34 days, had had a series of electro-wave treatments, and was felt by Dr. Ritz to have "resumed pre-psychotic personality". She went home the day after she had marked the checklists. The nursing notes describe her early behavior as "anxious, clings continuously to personnel; expresses anxiety. She needs direction....has many physical complaints." The nursing care plan stated: "Allow to have contact (to cling). Give simple directions. Reassure her that nothing is wrong."

On the interview day, Mrs. Plum was seen shortly after Mrs. Pug. As was stated before, the two were quite close and somewhat isolated from the rest of the patients. They were both gossips, and Mrs. Plum tried, in the course of the interview, to learn what replies had been
given by Mrs. Pug. When asked what she had expected, she indicated that through her father's and her son's hospitalization, she had gained some knowledge of group aspects of ward living; she reminded the writer she had been sent here "and didn't seek therapeutic gains on her own."

She said she hadn't known that the hospital let men and women eat in the dining room together and visit back and forth on the wards. When asked how student nurses helped her, she commented on their friendliness:

"They are willing to do little things for me. They seem more sociable than the others." She said the aides taught her new card games and were sociable too. The nurses, she said "were accommodating" and wouldn't say more. She did not know the supervisors or the ward clerk. She felt that her progress had been blocked for a time by the return of a patient to the ward from the special care unit (she was afraid of her) but "now, I'm used to her." Despite all her castigation of Miss Nixon earlier with Mrs. Pug, she had no suggestions for making the ward more therapeutic but commented: "I think things go well, with so many people being here."

After her initial verbalization about the nurses with Mrs. Pug, Mrs. Plum proceeded to mark 11 of the 14 checklists she was asked to do. She marked more items per person in the Social-Recreational Category (II) than any other; this was not unexpected since she was to go home the next day and her need for emotional support and therapeutic intervention was minimal. Personnel marked fewer items in those categories (III and IV) for her than they had done for sicker patients. Her mean agreement scores for Category II were highest, 4 for students and aides and 1 for nurses. The mean agreement scores in Category I were for students, nurses and aides respectively, 2, 1, 2. In Category III the mean
agreement scores were 2, 2, 1 for students, nurses and aides, in that order. Her highest total agreement was with Miss Shull, a student. Her agreement scores with nurses were uniformly low, unlike Mrs. Pug's. She perceived most of the used behaviors as desirable for her.

Mrs. Puck, the mother of four children at 27, had been in the hospital 28 days at the time of the interview. She had had a previous hospitalization for Schizophrenia and was readmitted when she became confused, withdrawn and was seen to have hallucinations. She had a history of being a shy and withdrawn child who was never very sociable and who had led a quiet life. It was felt that she had always been somewhat inadequate and that the task of caring for a family became overwhelming.

The nursing notes and the participant-observation data showed that Mrs. Puck remained apart from others most of the time. She was often found on her bed crying; at times she had been observed listening attentively and admitted, when asked, that she had heard voices berating her. She indicated this was why she sometimes cried.

The nursing care plan was short: "Show patient you are interested in her. Stay with her. Seek her out often."

Mrs. Puck had improved considerably at the time of the interview. She said she had no expectations - her doctor had urged her to come but she wasn't aware of the need to come. She made mention of her previous admission indirectly: "I came to a new floor this time. I couldn't have matches before, but they let me keep them now."

In reply to the question "How are personnel helpful?" Mrs. Puck pointed out that students helped pass the leisure time with ping-pong, dancing and other activities. She had little to do with the aides, but
indicated she talked about her problems to the graduate nurses: "They helped me clear up my wrong thinking." She went on to say: "Some things I talk to my doctor about; some I talk about with the nurses." She did not know the supervisors nor the ward clerk. When asked what things or people impeded her recovery she replied that the complaints of other patients "like Mrs. Patton" bothered her. She also said her feelings were upset easily by some of the patients and further, "I get anxious when it gets noisy." She had no suggestions for making the ward more therapeutic.

Mrs. Puck was home on a visit the day the others marked the checklists but she completed hers the next day, marking them for 8 personnel. She was cautious in her checking, marking an average of only 8 items per person, while personnel indicated they used an average of 24 behaviors per person. There was no consistent pattern to the agreements and the items marked were the usual ones which personnel might have done for any patient. The mean agreement scores were as follows: for aides in all categories, 0, and for nurses and students, identical - I-1, II-2, III-1 and IV-2. The patient's highest agreement was with Miss Smith, I-1, II-2, III-1 and IV-2.

The youngest patient in the study, Mrs. Pegson, 17, had been in the hospital 17 days when she was interviewed. She was a divorcée, a child of divorced parents and had been a difficult child, a wilful adolescent who had experienced a good many things already. She had been living as a prostitute and had been given the choice of having therapy or being prosecuted as a delinquent. She was not fully accepted by the other patients, especially not by the younger ones.
Dr. Rose, her therapist, had not recorded a diagnosis on the chart but had indicated in the team meeting that he considered her illness to be Personality Disorder. There was no written nursing care plan; the personnel in their frequent team conferences discussed what they had learned about her and how they might approach her. In the nurses' notes it was recorded that personnel were finding it difficult to get to know Mrs. Pegson. She was evasive and bland and indicated that everything was fine with her.

On the day of the writer's interview with her, this patient had been under fire in the group meeting, accused of appropriating someone else's clothing from the laundry. A good deal of hostile feeling had been evoked before it was shown that she had inadvertently done this while removing her own belongings. Miss North succeeded in getting things straightened out and some measure of good will was restored.

Mrs. Pegson said she had expected regimentation, "lining up to do everything and being told what to do." She really did not expect to be helped. However, she said she was finding personnel being helpful by talking with her, "especially, if a patient is upset." She then said emphatically that she had not been upset but she saw others being helped at such times. She found the nurses' explanation of rules and regulations helpful. She did not know the supervisors. "I'm not involved with them." She knew the ward clerk was someone "who gets change and explains things." She could not identify any interference with her getting better. When asked for suggestions for improvement, she made a statement which seemed directly revealing for her: "Patients who are new and self-centered should be helped to learn new things." She was summoned for her
doctor's appointment before she had time to explain what she meant and the next day when asked, she was unable to elaborate.

Mrs. Pegson marked the checklists with the rest of the group. It was observed that she was being included in the conversation by the others at her table and was responding in a pleased way. She marked only five of the 14 lists, telling the others she didn't know everyone yet. Those she knew were Miss Spade, a student, Miss North, the head nurse and Miss Nest, Mrs. Nagle and Miss Nixon, staff nurses. Her agreement scores on Category I, the Interest and Concern item, were for students, nurses and aides, 0; for Category II, for students 1, and for nurses and aides, 0. Category III showed an agreement score of 1 for nurses and 0 for the other groups and in Category IV, the agreement scores were 3 for nurses and for students and aides, 0. Mrs. Pegson's highest agreement scores were with Mrs. Nagle. It was interesting to note that this evasive, bland person perceived no behaviors used which indicated interest and concern for her, although all the persons marking lists on her had indicated that they had used these behaviors in working with her.

Mrs. Patton, a 39 year old mother of three had been on the ward for 25 days at the time of the interview. Her therapist had made a diagnosis of Psychophysiologic Reaction after ruling out Conversion Reaction and Psychomotor Epilepsy. She had a history of severe headaches over a long period of time. These headaches usually prostrated her. She was a thin, timid looking woman whose main topic of conversation was her physical condition. Participant-observation data indicated that she used this to gain attention and sympathy from the other
patients quite successfully. The nursing notes also were full of examples of her use of physical symptoms to gain attention. Her nursing care plan stated:

Uses physical complaints to gain attention. Approach her first. Sit with her and let her talk. She has difficulty in expressing anger. Stay with her when she is angry. Encourage her to express it.

In the interview, Mrs. Patton indicated that she did not expect to be helped. She was urged to come, she said; she felt it would be like being locked up in jail. "I wasn't thinking - I was desperate."

When asked how personnel were helpful she said, "They explained things and helped me adjust to the ward. They talk to me when I'm low, and urge me into games. The group walks (with students) are very interesting." She further indicated that the staff nurses "around when needed, they listen to my troubles."

Mrs. Patton did not know the supervisors but said she appreciated the ward clerk's sense of humor.

Her only comment on situations which blocked her progress was, "One nurse forced me to eat." When asked for suggestions for making the ward therapeutic, she first said she didn't know of anything. Then, hesitantly, she went on: "It's noisy at times but I understand how kids feel. They do keep the record player going all day."

This was Mrs. Patton's first open expression on a controversy which had been waged for some time in unit meetings over the loud playing of the record player by the younger group of patients. She had, heretofore, not made any comment at all. After saying this to the interviewer in the morning, she was able to go to
the unit meeting in the afternoon and state it again to the group.

In the interim between the interview and the marking of the checklists, Mrs. Patton had had several X-rays and other examinations. She had been prostrate in bed the day before but encouraged by the other ladies, appeared with them to do the checklists at the appointed time. She completed the lists on 6 of the 14 personnel, stating she did not really know the others. For those she did know she checked an average of 27 items while the personnel checked an average of 17 items each as used for her. Many of the items she perceived as being used by some of the personnel, they indicated they should have used but did not. Others indicated they had used the behavior. Mrs. Patton's highest agreement scores were with Mrs. Nagle (I-3, II-5, III-3 and IV-3). Her mean agreement scores for students and staff nurses were 1 for all categories; for aides, 3-2-2-1 for Categories I through IV respectively.

Mrs. Plane, the mother of two children, was in the hospital for the second time with a diagnosis of Schizophrenia with a depressive element. She was 33 and had been a nurse before marriage. She had always been shy and seclusive and following marriage and the birth of her children she had gradually become more withdrawn and seclusive, requiring hospitalization. The current illness followed a period of stress in the home situation.

The nursing personnel expressed some uneasiness at first in having Mrs. Plane on the ward but it soon became evident to them that she was even more ill-at-ease than they. The nursing notes indicated that she was quite reserved with, and even suspicious of,
some of the staff nurses. The nursing care plan was fairly specific:

The attention of personnel causes her some anxiety.
She is now accepting attention through her ankle injury.
She is very cautious, both verbally and physically.

Mrs. Plane had sprained her ankle in a fall and seemed to enjoy
the attention she received through it; however, she limited the atten­
tion she would accept to strictly necessary procedures. She became very
tense and rigid when personnel made friendly overtures by inviting her
into social activities.

The writer was surprised that Mrs. Plane agreed to the interview
which took place 32 days after her readmission. The patient explained
that she felt it an obligation to participate in research related to her
profession, nursing. She was fairly relaxed during the first part of
the interview. To the question about her expectations of help through
hospitalization, she replied that she had been ill before and knew it
helped to get away from things. She knew there would be recreational
and social activities. "They get together more with the men than they
did before."

When asked about the helpfulness of the personnel, she referred
to the social actions of the students with patients. "I play the piano
for the sings," she said. Of the nurses, she said rather pointedly,
"I talk to some of the nurses about my problem." She cited the house­
keeping chores which the aides performed or helped her to complete, as
her washing and ironing.

She indicated that she did not know the supervisors or the ward
clerk. She was beginning to block in her speech and was becoming quite
tense but insisted that the interview continue. She had no definitive
comments to make on the last two questions beyond saying she had no suggestions. When the writer indicated that this was the end of the interview, Mrs. Plane seemed relieved. She said she hoped she had contributed to the study and indicated that she intended to complete the checklists with the others on the appointed day. She kept her word, completing 10 of the 14 checklists and checking as used an average of 12 items per person. The personnel averaged 21 items checked used for her. The items Mrs. Plane perceived the personnel using most often were the standard items of behavior as "The nurse sits quietly with the patient," "The nurse grooms herself neatly as an example to the patient" and "The nurse listens with interest to what the patient has to say."

She did not mark any item should be used only. She did, however, mark a few items as used without adding the check for should be used, indicating that she may not have needed some of the behaviors shown her. Item 7 (The nurse stays close to the patient who is anxious) was marked in this way for the students but when it was marked used by nurses it was also marked should be used. Apparently, Mrs. Plane felt students were not helpful to her when she was anxious. Personnel marked more items should be used only than they marked used. When in a group, completing the checklists, several of the personnel indicated that they felt they should do more for Mrs. Plane but she "held them off." The agreement scores were rather low then. The mean agreement scores with students by category were I-1, II-2, III-1 and IV-1. For nurses, these were I-1, II-2, III-1 and IV-2. For aides they were 1 in all four categories. The highest agreement scores were with Miss Nest, I-3, II-4, III-2 and IV-4.
Mrs. Penn had been in the hospital 36 days at the time of the interview. At 27, she was the mother of five children, and had suffered a sudden psychotic break after a period of unusually heavy stress in the home. Her early history was not immediately attainable as her family lived quite a distance away and her husband had not known her long before marriage. Dr. Rice, in his progress notes, indicated a diagnosis of Schizophrenia, Catatonic type. She had been placed on Chloropromazine and had been for a time quite lethargic and unresponsive, but the dosage had been reduced and she had become more active. The earlier nursing care plan had been removed from the record and a new one was to be written by the nursing team; the former plan had included providing physical care to the patient, protecting her from other patients (she had been quarrelsome earlier and provoked others) and making her feel wanted.

At the start of the interview, Mrs. Penn reminded the writer that she was somewhat "woozy" still, which was true. She replied to the first question by saying she didn't remember coming to the hospital so she didn't really expect anything. "I was confused when I came. I seem to be getting straightened out now."

She elaborated at length on how personnel were helpful. Mainly, the students helped through social activities, cards and other games. They took her on walks. The nurses talked to her and explained things to her. The aides helped her in bathing, caring for her clothes and also helped in socialization. She further stated, "The other patients help me, too."

The participant-observation data showed that Mrs. Penn was indeed
"looked after" by the other patients, who worried lest she doze off and fall off a chair, or lose her balance while walking.

As the interview proceeded, Mrs. Penn revealed she didn't know the supervisors but found the ward clerk "a friendly girl who stops to talk when she brings me my mail."

When asked if anyone or anything blocked her progress, she stated hostilely that one nurse "thinks she's pretty good - too good for me, I guess." She refused to say more about this and had no suggestions for making the ward situation more therapeutic.

By the next week, when she marked the checklists with the others, Mrs. Penn's drowsiness had disappeared. That she still was somewhat confused was shown by her ability to check only 5 of the 14 personnel although 13 indicated they interacted with her. She checked an average of 26 items used per person. Her mean agreement scores with nurses and aides were meaningless. She marked 2 nurses and no aides - one of these nurses indicated she did not work with her during the time studied. Her mean agreement scores with students by category were I-1, II-3, III-2 and IV-2. Her highest individual agreement scores were with Miss Smith: I-1, II-5, III-2 and IV-3. There was no significant pattern in her lack of agreement which suggested gross misperception of behavior.
BIBLIOGRAPHY

BOOKS


**ARTICLES AND PERIODICALS**


REPORTS


DOCTORAL DISSERTATIONS


OTHER SOURCES


AUTOBIOGRAPHY

I, Loretta Mae Denman, was born in Columbus, Ohio, December 9, 1913. I received my secondary-school education in the public schools of Findlay, Ohio. I received my diploma in nursing from the Toledo State Hospital School of Nursing, Toledo, Ohio, in 1935. After attending the University of Toledo for a year, I enrolled at the Ohio State University and was granted the Bachelor of Science in Education degree in 1946. I received the Master of Letters degree from the University of Pittsburgh in 1950 and remained on the faculty of the School of Nursing there, first as Assistant Professor of Psychiatric Nursing and Coordinator of Psychiatric Nursing Field Service, then as Associate Professor and Department Chairman. In 1960, I was granted educational leave to pursue doctoral study in Higher Education at The Ohio State University. After a year of study under a federal traineeship and a second year on a National League for Nursing Fellowship, I returned to my position as Chairman, Department of Psychiatric Nursing, University of Pittsburgh School of Nursing and completed the writing of the dissertation there.