A Study of the Relevant Values of Nurse-Patient Interactions As Identified By Psychiatric Nursing Personnel and Psychiatric Patients

Eleanor Charlotte Hein

University of Colorado Boulder

Follow this and additional works at: https://scholar.colorado.edu/print_theses

Recommended Citation

https://scholar.colorado.edu/print_theses/148

This Dissertation is brought to you for free and open access by University Libraries at CU Scholar. It has been accepted for inclusion in University Libraries Digitized Theses 189x-20xx by an authorized administrator of CU Scholar. For more information, please contact cuscholaradmin@colorado.edu.
Unpublished theses which have been approved for masters' and doctors' degrees and deposited in the University of Colorado Library are open for inspection. They are to be used only with due regard for the rights of the authors. Bibliographical references may be noted, but passages may not be copied from a thesis except by permission of the author. In every case proper credit must be given both to the author and to the University in all subsequent written or published work. Extensive copying or publication by some one other than the author of a thesis as a whole also requires the consent of the Dean of the Graduate School of the University of Colorado.

The University Library or any other library which borrows this thesis for the use of its patrons is expected to secure the signature and home address of each user.

This thesis by Hein, Eleanor Charlotte
2418 Geneva Street, Racine, Wisconsin
has been used by the following persons whose signatures indicate their acceptance of the above restrictions.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Address</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A STUDY OF THE RELEVANT
VALUES OF NURSE-PATIENT INTERACTIONS
AS IDENTIFIED BY PSYCHIATRIC NURSING PERSONNEL AND PSYCHIATRIC PATIENTS

by
Eleanor Charlotte Hein

B.S., Marquette University, Milwaukee, Wisconsin, 1954

A Thesis submitted to the Faculty of the Graduate School of the University of Colorado in partial fulfillment of the requirements for the Degree Master of Science

Department of Nursing

1965
ACKNOWLEDGEMENTS

This Thesis for the M.S. degree by

Eleanor Charlotte Hein

has been approved for the

Department of

Nursing

The author wishes to acknowledge the help of all those nurses and by patients who graciously gave of their time in order to participate in the various phases of this study.

Date January 18, 1965
Deep appreciation is extended by the author to Mrs. Dorothy W. Bloch and Miss Margaret Berry for the guidance and encouragement they generously gave during the course of this thesis. Special thanks is also extended to Miss Susanna Chase for her assistance with this study.

The author wishes to acknowledge the help of all those nurses and patients who graciously gave of their time in order to participate in the various phases of this study.

The research method used was the exploratory or formulative study. Data were obtained by the use of the Q-sort technique as the instrument of preference for this study. Nursing literature provided the background necessary to develop the fifty-five statements utilized in developing the Q-sort. The categories of feelings, congruency, hospital culture, availability, and limit-setting emerged in the formulation of the statements. These categories identified various aspects of nurse-patient interactions in this study. Thirty-one nurses and thirty patients performed the Q-sort.

Placements regarding each item's value were noted. Correlation coefficients were calculated in order to obtain intergroup comparisons of the interactions delineated within this study.

It was concluded that those interactions identified by their high correlations indicated the least valuable aspects of this dyad. They also indicated that these less valuable interactions were operative within this relationship. Conversely, those interactions which achieved lower correlations were identified as having value but which were not being realized in actual practice. The Q-sort
Hein, Eleanor Charlotte (M.S., Nursing)  

A Study of the Relevant Values of Nurse-Patient Interactions As Identified By Psychiatric Nursing Personnel and Psychiatric Patients  

Thesis directed by Assistant Professor Dorothy W. Bloch  

The problem of this study was to discover what interactions were considered of value to psychiatric patients as these interactions were perceived by psychiatric nursing personnel and psychiatric patients.  

The research method used was the exploratory or formulative study. Data were obtained by the use of the Q-sort technique as the instrument of preference for this study. Nursing literature provided the background necessary to develop the fifty-five statements utilized in developing the Q-sort. The categories of feelings, congruency, hospital culture, availability, and limit-setting emerged in the formulation of the statements. These categories identified various aspects of nurse-patient interactions in this study. Thirty-one nurses and thirty patients performed the Q-sort.  

Placements regarding each item's value were noted. Correlation coefficients were calculated in order to obtain intergroup comparisons of the interactions delineated within this study.  

It was concluded that those interactions identified by their high correlations indicated the least valuable aspects of this dyad. They also indicated that these less valuable interactions were operative within this relationship. Conversely, those interactions which achieved lower correlations were identified as having value but which were not being realized in actual practice. The Q-sort...
also revealed that nurses were functioning predominantly in their traditional role. It was also concluded that psychiatric patients could participate adequately in completing the Q-sort.

Recommendations were made which encouraged further investigation of the categories used in this study. Further investigation was urged of the variables in hospitals such as mentioned in this study, which would influence the nurse's interactions with the patient.

This abstract is of about 250 words and is approved as to form and content. I recommend its publication.

Signed

Instructor in charge of thesis
# TABLE OF CONTENTS

## I. THE PROBLEM AND DEFINITIONS OF TERMS USED

- Introduction .......................................................... 1
- The Problem .......................................................... 1
- Statement of the problem ........................................... 1
- Purpose of the study ............................................... 2
- Importance of the study .......................................... 2
- Limitations and scope ............................................. 3
- Definition of Terms ................................................. 4
- Interactions .......................................................... 4
- Value ...................................................................... 4
- Psychiatric nursing personnel ................................... 4
- Preview of the Remainder of the Thesis ....................... 4

## II. REVIEW OF THE LITERATURE

- General Interactions ............................................... 6
- Dyadic interactions ............................................... 7
- Nurse-Patient Interactions ....................................... 10
- Studies Relating to Nurse-Patient Interactions ............. 12
- Summary ............................................................. 14

## III. METHODOLOGY

- Description of Method Used ..................................... 15
- Selection of Technique Used ..................................... 16

# General Overview of Placements

- General Overview of Placements ................................. 34
<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of Nurse Item Placements by Category</td>
<td>35</td>
</tr>
<tr>
<td>Feelings</td>
<td>35</td>
</tr>
<tr>
<td>Congruency</td>
<td>37</td>
</tr>
<tr>
<td>Hospital culture</td>
<td>37</td>
</tr>
<tr>
<td>Availability</td>
<td>38</td>
</tr>
<tr>
<td>Limit-setting</td>
<td>38</td>
</tr>
<tr>
<td>Description of Patient Item Placements by Category</td>
<td>38</td>
</tr>
<tr>
<td>Feelings</td>
<td>39</td>
</tr>
<tr>
<td>Congruency</td>
<td>39</td>
</tr>
<tr>
<td>Hospital culture</td>
<td>40</td>
</tr>
<tr>
<td>Availability</td>
<td>40</td>
</tr>
<tr>
<td>Limit-setting</td>
<td>40</td>
</tr>
<tr>
<td>Comparison of Nurse Placements and Patient Placements</td>
<td>42</td>
</tr>
<tr>
<td>Interpretations of Intergroup Correlations</td>
<td>44</td>
</tr>
<tr>
<td>Intergroup Correlations by Category</td>
<td>45</td>
</tr>
<tr>
<td>Feelings</td>
<td>45</td>
</tr>
<tr>
<td>Congruency</td>
<td>47</td>
</tr>
<tr>
<td>Hospital culture</td>
<td>49</td>
</tr>
<tr>
<td>Availability</td>
<td>50</td>
</tr>
<tr>
<td>Limit-setting</td>
<td>51</td>
</tr>
<tr>
<td>Cross Categorical Comparison</td>
<td>52</td>
</tr>
<tr>
<td>Summary</td>
<td>56</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>TABLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Specificity-Generality Mean Values of Items by Categories</td>
<td>25</td>
</tr>
<tr>
<td>II. Frequency Distribution of Q-Sort Items</td>
<td>26</td>
</tr>
<tr>
<td>III. Nurses' Item Placements by Category (Expressed by Their Arithmetic Mean)</td>
<td>36</td>
</tr>
<tr>
<td>IV. Patients' Item Placements by Category (Expressed by Their Arithmetic Means)</td>
<td>41</td>
</tr>
</tbody>
</table>
LIST OF FIGURES

FIGURE PAGE
1. Frequency Distribution According to Item Placement Means. 43
2. Linear Relationships of Correlation Coefficients by Category 46

Psychiatric nurses have long recognized the importance of interacting with patients. Despite this recognition, nurses have been unable to explain in precise terms what they do that is of value to the patient during these interactions. Frequently, they base their abilities on intuition or vague generalities that have not been substantiated by research.

The relationship the nurse maintains with the patients in her ward is special because she has close social and personal communion with them. Within the context of this nurse-patient relationship, answers must be found that will assist the nurse in establishing her own knowledgeable frame of reference. This study was an attempt to discover what interactions within the nurse-patient relationship are of value to the patient.

II. THE PROBLEM

Statement of the problem. This study was undertaken to discover what interactions were considered of value to psychiatric patients, as these...
CHAPTER I

THE PROBLEM AND DEFINITIONS OF TERMS USED

I. INTRODUCTION

Psychiatric nurses have long recognized the importance of interacting with patients. Despite this recognition, nurses have been unable to explain in precise terms what they do that is of value to the patient during these interactions. Frequently, they base their abilities on intuition or vague generalities that have not been substantiated by research.

The relationship the nurse maintains with the patients in her ward is special because she has close social and personal communion with them.\(^1\) Within the context of this nurse-patient relationship, answers must be found that will assist the nurse in establishing her own knowledgeable frame of reference. This study was an attempt to discover what interactions within the nurse-patient relationship are of value to the patient.

\(^1\)Maxwell Jones and Catherine Mullen, "What Psychiatric Nursing is About," *Nursing Times*, 59:701, June 7, 1963.

interactions were perceived by the psychiatric nursing personnel and psychiatric patients.

**Purpose of the study.** The purpose of this study was: (1) to ascertain what interactions psychiatric patients perceived as valuable within the nurse-patient relationship; (2) to compare these patient perceptions with perceptions of the psychiatric nursing personnel; and (3) to establish a beginning awareness of the need for further investigations of nurse-patient interactions.

**Importance of the study.** The realm of the nurse-patient relationship, though seen as vital to the continuance of the patient's mental well-being, persists as a much maligned and untenable area of nursing skill. The interactions that occur between the nurse and the patient remain areas in which intuition takes priority over precise and knowledgeable skills. Though the nursing literature provides suggestions as to what is helpful to the psychiatric patient within the nurse-patient dyad, many of these suggestions remain unsubstantiated. In other instances suggestions have been borrowed from the psychiatrists' frame of reference.

Switzer maintains that:

> It is only to be expected that there will be misunderstandings, misconceptions, disagreements, and misapplications until the borrowed theories and concepts are restudied and reformulated to fit the particular needs of nursing... which are in many ways vastly different from those... in psychiatry.

---

Since interactions are necessary in directing the nurses' approach to patients, it is essential to investigate those factors within nurse-patient interactions which are seen as valuable by both nurses and patients. Peplau charges that nurses have a paramount task in becoming aware of how they experience the participation of patients in ward situations and to find how patients experience their /nurses/ participation. 3 The technique of Q-sort was used in this study because of its amenability in eliciting the responses of both nurses and patients concerning their interactions. A comparison was made between the Q-sort placements of the patient group and the Q-sort placements of the nurse group in order that correlations could be obtained.

Limitations and scope. The collection of data in this study was limited to the patients and nursing staff of three psychiatric hospitals. They were: the Colorado Psychopathic Hospital, the Fort Logan Mental Health Center of Denver, Colorado, and the Milwaukee Psychiatric Hospital of Wauwatosa, Wisconsin. The patients and psychiatric nursing staff were tested as a whole in order to obtain a wider range of subjects. No attempts were made to compare hospitals.

The psychiatric patients involved in this study were limited to those patients having been hospitalized for at least one month. This time limit was established in order that the patients might have a sufficient amount of time to participate in the nurse-patient interactions occurring on their respective wards.

This study concerned itself with those members of the nursing staff who were in daily contact with the patient. Therefore, nursing supervisors and administrators were felt to be outside the scope of this study, because their patient contact was considered to be minimal and intermittent.

III. DEFINITION OF TERMS

Interactions. A reciprocal exchange of acts or influences between a nurse and a patient.  

Value. The estimate in which something is held according to its real or supposed worth, usefulness or importance.

Psychiatric nursing personnel. For this study, the term psychiatric nursing personnel refers to those registered professional nurses, practical nurses, aides, and orderlies, "who carry on interpersonal relations with psychiatric patients and who are responsible for their daily care."

IV. PREVIEW OF THE REMAINDER OF THE THESIS

The interaction process with its emphasis toward the nurse-patient relationship will be discussed in Chapter II. In Chapter III, the description of

---


5Ibid., p. 2332.

the methodology and the use of Q-technique will be presented. This chapter will include the various aspects involved with the construction of the instrument as well as with the data collection for this study. The results of the correlation coefficients from the collected data will be analyzed and interpreted in Chapter IV. This study's summation, and the conclusions and recommendations which will ensue are presented in Chapter V.

The literature was reviewed to investigate the various aspects of the interaction process as it affects the nurse and the patient within the psychiatric setting. The dyadic relationship of the nurse and the patient was explored in order to become aware of the diverse communications that occur within this relationship. Various communicative means which would aid the nurse in utilizing her interactions were perused in the literature. Finally, a survey of the literature was made for studies relating to nurse-patient interactions and the inclusion of patients within these studies.

Books, journals, and other periodicals were reviewed in relation to this study. Current textbooks in psychiatric nursing, psychiatry, and sociology were scanned. Nursing journals such as The American Journal of Nursing, Nursing Outlook, and Nursing Research were also investigated.

1. GENERAL INTERACTIONS

The realization of an interpersonal relationship is dependent upon some form of personal communication. The bridge between the utilization of this form of communication in order to achieve an interpersonal relationship is called social interaction. Its singularity as a human process is contingent upon the
CHAPTER II

REVIEW OF THE LITERATURE

The literature was reviewed to investigate the various aspects of the interaction process as it affects the nurse and the patient within the psychiatric setting. The dyadic relationship of the nurse and the patient was explored in order to become aware of the diverse communications that occur within this relationship. Various communicative means which would aid the nurse in utilizing her interactions were perused in the literature. Finally, a survey of the literature was made for studies relating to nurse-patient interactions and the inclusion of patients within these studies.

Books, journals, and other periodicals were reviewed in relation to this study. Current textbooks in psychiatric nursing, psychiatry, and sociology were scanned. Nursing journals such as The American Journal of Nursing, Nursing Outlook, and Nursing Research were also investigated.

I. GENERAL INTERACTIONS

The realization of an interpersonal relationship is dependent upon some form of personal communication. The bridge between the utilization of this form of communication in order to achieve an interpersonal relationship is called social interaction. Its singularity as a human process is contingent upon the
understanding of what occurs in that process. "Social interaction is the reciprocal exchange between at least two persons in a concrete situation which influences the subsequent behavior of each."¹

The humanness of this process does not infer that social interaction can be possessed or disposed of at will. Man's ability to function lies in the fact that, in addition to being a biological creation, he is also a social being. Man's survival is initially dependent upon those who bore and nurtured him through childhood. The need for clothing, food and water elicit varieties of social interactions from man to other men. Finally, his very existence requires that he perpetuate himself. This biological interaction is partially determined by man's ability to establish social contact with his mate.²

The importance of social interaction in our lives remains unchallenged. What requires more scrutiny is the perception of what transpires between people during interactions. This scrutiny involves every nuance emitted by the participants, as well as an intimate knowledge of them and the environment of which they are a part.³

Dyadic interactions. A more accessible unit for consideration in this discussion is the interacting relationship of the nurse and the patient. The


therapeutic climate requires that interactions play an important part for both
the nurse and the patient. For the patient entering into this relationship, the
resolution of his discomforts and the fulfillment of his needs are uppermost in
his mind. For the nurse entering into this dyad, the use of her professional
skills and the satisfactions she will obtain from their use are prominent in her
mind. 4

Many of the interactions seen in therapeutic settings have a destructive
flavor about them. Ruesch sees the destructive aspects of these interactions as
those, "in which individuals move either towards self-destruction or towards
breaking down the system in which they participate." 5 The patient, therefore,
enters this setting with patterns of interacting already disrupted and which affect
his interpersonal relationships. His ability to communicate effectively is
seriously impaired, not only in the disruption of his interpersonal relationships,
but in the lack of knowledge needed to communicate on a better level.

The patient's interactions with the nurse provide the setting for the
purposefulness needed to establish better interacting patterns for him. This
direction is of a professional orientation and concerns itself with helping the
patient whose problems require the aid of others possessing special knowledge

---

4 M. Audrey Kachelski, "The Nurse-Patient Relationship," The American

5 Jurgen Ruesch and Gregory Bateson, Communication (New York:
and skills. This purposeful or therapeutic nurse-patient dyad is defined by Hofling and Leininger as, "an interaction process between the two persons in which the nurse offers a series of purposeful activities and practices that are useful to a particular patient."

Both the nurse and the patient are involved in a setting which encourages a variety of participation. Such participation offers activities and experiences of a sort that will help him to interact and to communicate with others in his environment. Peplau feels that, "what is actually learned depends upon how various individuals in the situation participate and how this participation is experienced by everyone concerned."

The nurse's contribution to this interaction process is recognized as an important contribution. The success she experiences in her efforts to help other people will depend upon her ability to interact with them in a positive way. It will depend upon the interpersonal relationships she experiences and upon how she uses herself in these relationships.

But using these skills requires more than the desire or the encouragement to demonstrate them. Peplau and others purport that favorable changes in the patient's behavior during nursing situations lie in the sagacity of how and what

---


the nurse observes. The quality of such a relationship is evidenced, not only by the demonstrated awareness of what is occurring, but in the alterations, if any, made by the nurse of her own behavior in order to help the patient.\textsuperscript{10} The precision with which the nurse does observe and utilize herself as a therapeutic instrument, and her ability to do so in cooperation with the patient, places her in a position to help restore the patient's ego.\textsuperscript{11}

The ability for the nurse to become aware of her interactions with the patient is dependent upon the manner in which she and the patient see and interpret those interactions. The ensuing interpretations can be viewed as the employment of a set of proposals about the world or the individual, whose truth depends upon the person's belief in them.\textsuperscript{12} Interactions based upon the commonality of these interpretive meanings become more meaningful for the nurse and patient alike.\textsuperscript{13}

\section*{II. NURSE-PATIENT INTERACTIONS}

The commonality of meanings gained through interactions is contingent upon the types of communication used during nurse-patient encounters. Dalton proposes that communication is the key to interaction. He separates them into three types, namely verbalization, goal-directed action, and non-verbal

\begin{itemize}
\item \textsuperscript{10}Peplau, op. cit., p. 327; Hofling and Leininger, op. cit., p. 29.
\item \textsuperscript{12}Ruesch and Bateson, op. cit., p. 220.
\item \textsuperscript{13}Hildegarde Peplau, \textit{Interpersonal Relations in Nursing} (New York: G. P. Putnam's Son, 1951), pp. 283-284.
\end{itemize}
expressive acts. Ruesch views the (nurse-patient) communication as a blend of "observable facts, reportable experiences, and non-reportable emotions."

There is no doubt that, of these delineations, the most concrete form of communication is the use of verbal language.

Verbal language enables people to isolate certain aspects of events and to delineate the areas in which they wish to reach an agreement. It follows that people whose mastery of verbal communication is shaky have great difficulties in stating agreements or disagreements, and therefore they have trouble in utilizing interpersonal communication for the correction of assumptions and beliefs.

The ability of the nurse to pick up verbal cues of the patient, and utilize them for elaborating and developing the relationship, gives a feeling of prestige and significance to the patient. Peplau explains:

It makes what has been said by them take on a new meaning, for if it is important enough for the nurse to listen, the patient is more likely to pay attention to what he is actually saying. He becomes more critical of his expressions and exerts more effort to clarify them.

The attempts the patient makes to clarify his verbal communications remains only one aspect of his interactions with the nurse. It is the non-verbal element between the nurse and the patient that creates the elusive quality so difficult to note during an interaction. These non-verbal aspects, "may be

14 Dalton, op. cit., p. 52.
16 Ibid., pp. 172-173.
17 Peplau, op. cit., p. 294.
consciously employed . . . or they may be the result of unconscious
motivation." Cues may be slight or they may be imagined by the nurse who
wishes to see something that is not there. The continual interplay of verbal
and non-verbal communication during any one interaction makes the nurse's
task seem more overwhelming when she attempts to sort out one communication
from another.

The primary difficulty in achieving success in observing the various
facets of interactions lies in Ruesch's belief that:

\[ \text{we are unable fully to encompass the effects of our own actions upon others and because of our limited human perspective we are unlikely to grasp the magnitude and nature of what happens.} \]

Nevertheless, the challenge remains for the nurse to continue to
strive for precision in observing the transpirations occurring during interactions.
Both Burton and Peplau have reiterated this need. The outgrowth of the nurse's
efforts enables the patient's isolation to decrease.

III. STUDIES RELATING TO NURSE-PATIENT INTERACTIONS

The interaction process has been pursued empirically for some time
by sociologists and social psychologists. It has only been recently that such
empirical efforts have been implemented in psychiatric nursing.

18 Dalton, op. cit., p. 52.
19 Ruesch, op. cit., p. 8.
20 Burton, op. cit., p. 7; Peplau, op. cit., pp. 325-328.
Rouslin, for example, attempts to describe and analyze the process of interaction through which a patient's maladaptive patterns of response become stabilized. These stabilized patterns, if not identified, will continue to impede the patient's ability to interact in a constructive manner.  

The area of non-verbal communication has been investigated by Smoyak in a study of ideas and emotions which are transmitted through gestures alone. One conclusion of this study was that gestures were an important indicator of what patients were really communicating, despite the use of verbal language.  

Hurteau, in her efforts to restore patients' verbal communication to a better level of comprehension, Rosenblum, in trying to identify verbalizations used by the nurse and their effect on the communication of the patient, and Carter, in operationally defining the adaptive maneuvers of support during interactions, again illustrate the growing trend toward detailing the varied aspects of the interaction process.  

The literature also indicates a growing inclination in present studies to use the psychiatric patient as a primary source of information. The studies of

---


LeBaron, Sawatzky, and others, exemplify the fact that psychiatric patients should and can be utilized as a primary source of research investigations.  

IV. SUMMARY

Literature was surveyed for articles and books relating to the interaction process within the nurse-patient relationship. The dyadic relationship was explored with emphasis on what this relationship meant to the nurse and the patient. The communicative aspects which affect better interactions were discussed in addition to the nurse’s responsibility in implementing them. While recent studies have indicated a growing trend in empirically investigating nurse-patient interactions, more studies were also utilizing the patient as a primary source of information.

CHAPTER III

METHODOLOGY

The nature of this study seeks to discover, in more precise terms, the tenor of nurse-patient interactions. The procurement of new insights from such pursuits is the intent of the exploratory or formulative study. *

I. DESCRIPTION OF METHOD USED

The potential research yet to be investigated within nurse-patient interactions is awesome. The obscure nature of these interactions requires the perusal of research designs that meet the prerequisites of the problem.

Exploratory studies are a beginning step toward achieving insights. No attempts are instituted to demonstrate the problem's general applicability. The aura of discovery which stimulates the exploratory study forestalls any preconceived conclusions which might result from other types of methodology. The descriptive study for example, demands an accurate portrayal of characteristics peculiar to a group, an individual, or a situation. The conclusions achieved usually coincide with a fairly specific hypothesis which has been formulated after a good amount of empirical data have been collected. At the onset of

Selltiz and others see the exploratory study as preparing this needed foundation by providing information about practical possibilities for carrying out research in real life settings. Together with the alert receptivity of the investigator, the intensity of the study, and the investigator's ability to mesh diverse components of information into a unified interpretation, the exploratory study readily promotes the establishment of priorities for further research. The following section is concerned with a technique used for data collection.


Ibid., pp. 64-65.
peculiar to a group, an individual, or a situation. The conclusions achieved usually coincide with a fairly specific hypothesis which has been formulated after a good amount of empirical data have been collected.

Selltiz and others see the exploratory study as preparing this needed foundation by providing information about practical possibilities for carrying out research in real life settings. Together with the alert receptivity of the investigator, the intensity of the study, and the investigator's ability to mesh these diverse components of information into a unified interpretation, the exploratory study really provides a basis from which to establish priorities for further research.

II. SELECTION OF TECHNIQUE USED

The increasing emphasis upon the nurse-patient relationship has brought into view the importance of other facets within that relationship. The accoutrements accompanying the physical care of the patient were a prime source of much scientific investigation. Since the psychological and social aspects of this relationship have gained more recognition, new scientific investigations have been needed to measure and test the diverse nature of this relationship.

The classical means of scientific query has been the study of one cause and effect sequence in many people. In this type of investigation, one independent
variable (cause) is held constant while changes in one or more dependent variables (effect) are noted. The inception of the Q-sort technique brought with it the means of testing the diversity between people, and the extent of agreement between them regarding a certain problem. The Q-sort is midway between the personal and probable bias of the interview and the academic diagnostic tests which measure the subject on various scales. The Q-technique affords a "convenient means of objectifying the impressions and personality formulations of observers. By doing so, the extent of the agreement among people . . . can be assessed."  

In viewing nurse-patient interactions, this study makes no attempt to identify the causes which may or may not impede these interactions. It merely, as Mowrer states, wishes to isolate the common elements of the interactions which are considered of most value or of least value, to the nurse group and the patient group. These more common elements, once isolated, then will require more precise definitions by other investigators. 

The selection of any one of the various research techniques available is based upon the investigator's assessment of the advantages and the


8Mowrer, op. cit., pp. 343-344.
disadvantages presented by each technique. The selection of the Q-technique for inclusion in this study was based upon the relative merits it possessed which were felt to far outweigh its limitations.

In order to assess differences or agreements of interactions in the nurse-patient relationship, the subject is asked to place into two piles the total statements given him, which he considers "most valuable" and "least valuable." From these two stacks, the subject more discriminately sorts out the statements into nine smaller groupings. He is then "forced" to place his statements into a distribution which ranges from those interactions which are "most valuable" in Row 1, to those interactions which are "least valuable" in Row 9.  

The forced choice method, as in the Q-sort, (where there is only one item for every empty space) has several advantages. For example, the forced choice method offers a more penetrating manner of eliciting information. In addition, it proffers freedom from those responses that would be left in doubt in other types of methods. Despite these advantages, the forced choice method is not without its drawbacks. Murstein points out, "the weakness of some Q-technique studies lies not so much in the technique as in the misuse of it." Careless writing of items for instance, renders the results of this type of method useless.

---

9Cronbach, op. cit., p. 378.
investigation meaningless. The forced choice, too, reduces the amount of ease and comfort usually experienced by the subject, who must at times, depending on the problem, condemn himself. Because "correlation between persons is a device for translating into operations many of the current concepts of personality, social psychology, and phenomenological theory . . . the method promises to be a great contribution."12

III. CONSTRUCTION OF INSTRUMENT

In constructing this instrument, several testing methods were utilized in order that the instrument's stability and reliability would be enhanced. A discussion of the rationale, preparation and implementation of these several methods constitutes the basis of this section.

Establishing Categories

The statements used in this Q-sort were culled from the nursing literature thought to be representative in offering various suggestions regarding what was helpful to psychiatric patients in nurse-patient interactions. These statements were selected according to the following criteria: (1) each item should be written in a clear declarative manner; (2) each item should contain a


12Cronbach, op. cit., p. 377.
reciprocity of action between the nurse and the patient; (3) each item should portray true situations between the nurse and the patient; and (4) each item should be appropriate to the category for which it was designed.

Initially, the writing of these items produced 166 statements. These were reduced to 119 statements, as those items discarded were found to be repetitious and ambiguous.

During the compilation of these statements, five categories were seen to emerge. Categories were described by Whiting as a classification of behavior into a small number of general content areas which could be compared and contrasted in order to understand the varying emphases which groups and individuals put upon different general aspects of the nurse-patient relationship.

The designation of the proposed five categories were: (1) feelings; (2) congruency; (3) hospital culture; (4) availability; and (5) limit-setting.

Description of Categories

The five categories, their description and the examples of items within each category are as follows:

Feelings. This category included any and all sensations that arose as a spontaneous reaction within the patient and which could be shared between the patient and the nurse. Examples of statements relevant to this category were:

The patient feels anxious when the nurse expects too much of him.

The patient feels reassured when he knows the nurse has confidence in him.

The nurse recognizes that each patient is a separate person. The nurse explains the purpose of the medications to the patient.

The patient is concerned about knowing what to expect each day as regards such activities as daily routines and functions of the hospital ward. This included small number of general content areas which could be compared and contrasted in order to understand the varying emphases which groups and individuals put upon different general aspects of the nurse-patient relationship.13

Categories were described by Whiting as a classification of behavior into a small number of general content areas which could be compared and contrasted in order to understand the varying emphases which groups and individuals put upon different general aspects of the nurse-patient relationship.

The designation of the proposed five categories were: (1) feelings; (2) congruency; (3) hospital culture; (4) availability; and (5) limit-setting.

It was from this list that each patient when the patient wished to do so defined this category. In this category, were selected to portray availability.

The patient feels anxious when the nurse expects too much of him.

The patient feels reassured when he knows the nurse has confidence in him.

---

13 Whiting, op. cit., p. 29.
Congruency. The statements within this category referred to the manner in which the patient was received by the nurse and the genuineness of her responses to him. Examples of statements in the Q-sort which reflect congruency were:

- The patient may express himself more if he knows that the nurse will not make fun of what he says.
- The nurse recognizes that each patient is a separate person.

Hospital culture. Incorporated into this category were statements that reflected the daily routines and functions of the hospital ward. This included such activities as the administration of medications, the physical designations of the ward, and the patient activities that occurred on the ward. Statements such as:

- The patient is concerned about knowing what to expect each day as regards the routine of the ward.
- The nurse explains the purpose of the medications to the patient.

were examples of the hospital culture category.

Availability. The willingness of the nurse to communicate with the patient when the patient wished to do so defined this category. In this category, statements such as:

- Though the patient cannot always talk, he may want the nurse to sit with him.
- The nurse is always available to listen to what patients have to say.

were selected to portray availability.
Limit-setting. This category included all those statements which referred to ways in which the nurse helped the patient to control his behavior.

The control of behavior was limited to the verbal and non-verbal ways the nurse used herself in limiting the patient's behavior. Examples of statements in this category were:

- The patient realizes that the nurse will interrupt him when she thinks his behavior is depreciating to himself among the patient group.
- The nurse relieves the patient of making his own decisions until he is better able to do so.

Selection of Items

A committee of five psychiatric nurses was selected to appraise the 119 statements. (See Appendix B for the judges' instructions.) The committee was chosen in order to secure appraisals from individuals knowledgeable in psychiatric nursing. The acceptance of each statement was based upon a simple majority of the judges. In keeping with the criteria presented to them for their appraisal, ninety-four statements were found acceptable by three of the five judges. These ninety-four statements were distributed in the categories presented to the judges by the investigator. Since one of the judging criteria was that each item be appropriate to the category for which it was designed, the investigator retained the categories for inclusion in this study, on the basis that the judges had indicated their approval of the tentative categories.

The retention of the number of categories in this study was rooted in Block's premise that having more categories yielded more discriminations for the investigator. In addition, it enabled the investigator to note whether five
categories lent themselves to the ease of judgment needed in accomplishing the Q-sort. As Block points out, "... too many categories might pressure the judge to the point where he responds with great difficulty and great randomness."\(^{14}\)

**Specificity-Generality**

The judges were then asked to sort out the items regarding their specificity-generality. This measuring tool was implemented by Whiting in an attempt to control verbal statements of behavior in which judgments must be made. The evaluation of the statements on the basis of their relevant value was felt worth investigating in establishing a more creditable tool for this study.

Whiting sees specificity-generality as encompassing the following points:

1. It is possible to describe a given behavior at several different levels of abstraction;
2. There appears to be some correlation between specificity of behavior;
3. If the statements in the Q-sort do not have a stable frame of reference with respect to specificity-generality, then we are imposing an extremely difficult decision-making task upon the experimental subjects; and
4. Some aspects of the nurse-patient relationship lend themselves more easily to precise description of specific bits of behavior; others are more abstract and intangible.\(^{15}\)

The judges were asked to use a five point continuum for the specificity-generality evaluation, ranging from the "most specific" (1) to the "most general" (5). (See Appendix B.) Once completed, each of the five points on the specificity-generality value were written on separate pieces of paper. Eleven items were then randomly assigned to each category and the accompanying numerical mean for each item were calculated. In order to see if each category had approximately the same degree of specificity-generality, each accepted statement was assigned its specificity-generality value. These values were then totaled by category and their means for each category were established.

Despite their acceptance, the ninety-four statements were felt to be too large a number with which to accomplish the Q-sort in this psychiatric setting. As the availability category already contained eleven items, it was decided to utilize this figure in limiting each of the other categories to eleven items. In this way, the total number of statements used in the Q-sort was reduced to fifty-five. The congruency category meant the retention and inclusion of the Q-sort. The congruency category required three selections in order to achieve approximation with other categories' specificity-generality values. The congruency category required three selections in order to achieve approximation with other categories' specificity-generality values. Table I below shows the specificity-generality mean values before and after the reduction in the number of statements.

---

\(^{14}\)Block, \textit{op. cit.}, p. 79.

\(^{15}\)Whiting, \textit{op. cit.}, p. 36.
continuum was assigned a numerical value of one ("most specific") through five ("most general"). The arithmetical mean for each item was calculated from the values indicated for that item by each judge.

In order to see if each category had approximately the same degree of specificity-generality, each accepted statement was assigned its specificity-generality value. These values were then totaled by category and their means for each category were established.

Despite their acceptance, the ninety-four statements were felt to be too large a number with which to accomplish the Q-sort in this psychiatric setting. As the availability category already contained eleven items, it was decided to utilize this figure in limiting each of the other categories to eleven items. In this way, the total number of statements used in the Q-sort was reduced to fifty-five items. The decision to use fifty-five items meant that new specificity-generality means per category would have to be calculated. No attempts were made to alter the judges' original classifications of specificity-generality values.

Each statement from the remaining categories and the accompanying specificity-generality value were written on separate pieces of paper. Eleven statements were selected at random representing the total number of statements that would be in each category. The specificity-generality value was determined and a category mean established. The approximation of these newly established category means to that of the availability category meant the retention and inclusion of that category in the Q-sort. The congruency category required three selections in order to achieve approximation with other categories' specificity-generality values. Table I below shows the specificity-generality mean values before and after the reduction in the number of statements.
### SPECIFICITY-GENERALITY MEAN VALUES OF ITEMS BY CATEGORIES

<table>
<thead>
<tr>
<th>Category</th>
<th>Specificity-generality mean values of 94</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings</td>
<td>2.5</td>
</tr>
<tr>
<td>Hospital</td>
<td>2.49</td>
</tr>
<tr>
<td>Culture</td>
<td>2.41</td>
</tr>
</tbody>
</table>

#### TABLE I

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of statements in each category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings</td>
<td>17</td>
</tr>
<tr>
<td>Hospital</td>
<td>41</td>
</tr>
<tr>
<td>Culture</td>
<td>12</td>
</tr>
</tbody>
</table>

#### TABLE II

<table>
<thead>
<tr>
<th>Frequency Distribution of Q-Sort Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
</tr>
<tr>
<td>9</td>
</tr>
<tr>
<td>15</td>
</tr>
<tr>
<td>9</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>9</td>
</tr>
</tbody>
</table>
Development of Procedure for the Q-Sort

With the use of fifty-five items for the actual Q-sort, the distribution of items on the Q-sort board was required. A normal distribution was used in determining the placement of items on the Q-sort board, because, as Mowrer states, "A normal distribution has the advantage (for computational purposes) of automatically equalizing all means and standard deviations." The delineation of the rows and items in the Q-sort are shown in Table II.17

TABLE II
FREQUENCY DISTRIBUTION OF Q-SORT ITEMS

<table>
<thead>
<tr>
<th>Items in row</th>
<th>1</th>
<th>3</th>
<th>7</th>
<th>9</th>
<th>15</th>
<th>9</th>
<th>7</th>
<th>3</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assigned rows</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

The items of this Q-sort were sorted on a continuum from the "most valuable" in Row 1 to the "least valuable" in Row 9. More specifically, Rows 1 to 3 were viewed as items having most value. The "neutral" aspects of the participants' evaluation would incorporate Rows 4 to 6, with Rows 7 to 9 assuming the "least valuable" demarcation. In this way, the items could be viewed as to the subjects' evaluation of what was or was not of value in nurse-patient interactions.

16Mowrer, op. cit., p. 370.

Pilot Study

The pilot study attempted to ascertain whether the anticipated time limit of one hour was a sufficient amount of time in which to complete the Q-sort. In addition, the instructions were under scrutiny for clarity and aptness of thought. During this period any further problems that might arise were to be noted.

Arrangements concerning nurses' and patients' participation in the pilot study were concluded by telephone with the test ward at the Colorado Psychopathic Hospital. A suitable day was decided upon which would enable both the patients and the nurses participating to perform the test on the same day. The participants required no lengthy introduction as they had been seen previously. The first four participants (two patients and two nurses) on the investigator's lists were asked to complete the Q-sort. Since the instructions differed somewhat, the nurses and patients were not tested simultaneously. The investigator remained with all the participants during the test period.

While there were no problem areas among the patient participants, problems were noted with the nurse participants. Both nurses took one hour and fifteen minutes to complete the sort. Much of their time was spent in interpreting the words of each statement. They commented that the intangibility of the statements made sorting difficult. As the commentary progressed, it became apparent that the nurses were struggling with the incompatibility of what they should be doing in contrast to what they were doing regarding nurse-patient interactions.
On the basis of this pilot study: (1) the one hour time limit was retained for both nurses and patients; (2) the patient instructions were retained in their present state; (3) the nurse instructions were reworded in part; and (4) the Q-sort items presented no other obstacles. The results of this pilot study were incorporated within the study.

Validity and Reliability

The validity and reliability of any measuring instrument is of prime concern to the investigator. In planning the research model, the investigator begins clarifying concepts and definitions in order to determine precisely what requires measurement. In utilizing tests of validity and reliability the investigator demonstrates statistically that the constructed instrument measures what it was designed to measure. Selltiz and others elaborate:

Validity . . . is the extent to which differences in scores . . . reflect true differences among individuals, groups, or situations in the characteristic which it seeks to measure, or true differences in the same individual, group, or situation from one occasion to another, rather than constant or random errors.18

Similarly, the evaluation of the reliability of the constructed instrument necessitates determining the consistent, but independently comparable measures of the individual, group or situation.19

While the judges in this study were asked to evaluate the statements with which they were presented, the results of their evaluation provided this study

18Selltiz, op. cit., p. 155.
19Selltiz, op. cit., p. 167.
with face validity. To give statistical credence to their work and to provide this study with a more valid and reliable instrument, a test-retest situation was devised.

Five psychiatric nurses participated in the test-retest situation. They were asked in the initial testing to sort the items in response to the instructions, which asked them to choose those items which they felt were "most valuable" and "least valuable" to the patient. (See nurse instructions in Appendix A.) Approximately one week later, they performed the same test using the same instructions.

In order to determine the extent of any differences that might occur in a representative sample of the population, a statistical test of significance, namely the \( t \)-test, was utilized for this situation. The \( t \)-tests were performed on each of the five categories in the test-retest series. The results of these \( t \)-tests indicated no significance at the five percent level. On the basis of these results, it was concluded that the differences between scores were due to chance for this population. (See \( t \)-test table in Appendix C.) The constructed instrument was felt to be reliable for use in this study.

**IV. COLLECTION OF DATA**

**Selection of Sample**

Personal visits and letters were utilized in contacting the Directors of the Colorado Psychopathic Hospital, the Fort Logan Mental Health Center, and the Milwaukee Psychiatric Hospital, in order to obtain permission to use the facilities of these hospitals for this study. Similar attempts were made to
inform the Directors of Nursing. The requests were granted and confirmed by letter. All three hospitals were asked to grant additional permission in allowing their respective institutions to be identified in this study. These permissions were granted. Copies of these letters appear in Appendix D.

Ten patients were selected from each of the three hospitals used in this study. They were selected from wards thought to be most representative of the patients usually admitted to these hospitals.

The criteria used in selecting the patients for this study were dependent upon the length of hospitalization, the patient's mental status, and the patient's consent. No patients having been hospitalized for less than four weeks were asked to participate. Likewise, no tests were administered to patients who had not given prior consent. One alteration occurred in the selection of the sample. This involved the inclusion of the day patients on the ward used at the Fort Logan Mental Health Center. The low census of the twenty-four hour patients necessitated this inclusion.

The appropriate mental status of each patient was determined through a personal visit by the investigator. Often informal gatherings of patients on the ward provided ample time in which to ascertain their mental status.

All patients fulfilling the criteria of this study were assigned numbers prior to being asked to participate. Those who refused to participate in the study retained their assigned numbers, while the investigator continued down the list of patients already compiled. Of the patients asked, only two refused to participate in the study. Two patients who had consented had to be refused; one,
because her mental status had deteriorated in the week between making the appointment and taking the test; the other, when it was discovered that she could not read English.

The psychiatric nursing personnel for this study numbered thirty-one. This figure included the entire population of psychiatric nursing personnel on the wards used during the data collection.

The selection of the psychiatric nursing personnel was based upon whether they were involved in interpersonal relations with patients as well as being responsible for the patients' daily care. Arrangements were made to meet with the nursing staff of each of the three hospitals to discuss this study and enlist their cooperation. Appointments were made at the personnel's convenience.

Procedure

Prior to the actual testing, each participant was given a suitable appointment which would allow an ample amount of time to complete the sort. These appointments were arranged to permit minimal interference with the patient's scheduled activities and the nurse's responsibilities toward patient care. In other instances appointments were rescheduled to meet unexpected demands of the ward.

Provisions made by the hospitals involved in this study usually allowed for a large, well-lighted conference room. These rooms could accommodate three to four people under test conditions. When these facilities were not available a spare room on the ward was utilized by both patient and nurse participants.
Nurses and patients were not, as a rule, tested together as their instructions differed. Each participant was seated in front of the Q-sort board. Accompanying the Q-sort board were the fifty-five items and the instructions. (See Appendix A for instructions.) The participants were asked to read the instructions carefully. Any questions pertaining to the clarification of the instructions were answered after the participants had read them. At this time the participants were informed that questions which required an interpretation of the statements would not be answered.

The one hour time limit was seldom exceeded. Generally, the patients took much less time to complete the test than did the nurses. The time taken by the patients ranged from fifteen minutes to forty-five minutes; the nurses ranged from twenty minutes to one hour.

The reception accorded the investigator by the participants was genial. The patients' enthusiasm in participating in this study seemed to stem from their sincere desire to be of some help to those who, in the future, found themselves in a similar situation. In some instances patients on their own initiative sought to inform the investigator of sudden changes in their schedules which necessitated a change of appointment. Often, the investigator would be stopped to answer additional questions posed by patients regarding the purpose of the study. Even after the testing, patient interest remained high, with several patients inquiring as to when the study would be made available to the hospital.

Of particular interest to the investigator was the thematic quality voiced by patients regarding the importance of the nurse-patient relationship.
Responses from the nurses were no less enthusiastic. They generally displayed a tendency to interpret the test as a reflection of their deficiencies. Though much of this inclination toward interpretation was eliminated by rewording the instructions, some of this could not be avoided. Despite this, the nurses expressed the desire to be informed of the results of the study.

Plans for the Analysis of Data

Further utilization of the data will include the use of correlation coefficients to determine the extent of agreement between the nurse groups and the patient groups. The single number achieved when correlating the two groups expresses the amount of the relationship between these two groups.\(^\text{20}\) In this study, note will be taken on what interactions in the nurse-patient relationship are agreed upon as valuable by both nurse and patient groups.

V. SUMMARY

This chapter included a discussion of the methodology and technique used in this study. Included in this discourse was the construction of the instrument which embraced the areas of item categorization, a description of the categories, the use of specificity-generality, the pilot study and the establishment of validity and reliability. The method of procedure and plans for analysis of data were also mentioned. Interpretative and analytical material based on this study will be found in Chapter IV.

CHAPTER IV

ANALYSIS AND INTERPRETATION OF DATA

The analysis and interpretation of data under consideration in this chapter will be the determination of the presence of agreement between the nurse group and the patient group with regard to their placement of the items in this Q-sort. The position either group selected for the placement of a given item will be noted by calculating its arithmetic mean from the assigned row values on the Q-sort board. The extent to which these placements agree in value will be determined by the use of correlation coefficients. Intergroup comparisons of the correlation coefficients will be interpreted by category in the remainder of this chapter.

I. GENERAL OVERVIEW OF PLACEMENTS

Item placements were obtained by establishing an arithmetical mean for each statement as rated by each of the involved groups. In this way, the arithmetical mean provided an indicator of the value assigned to the item by that particular group. Since Rows 1 to 3 were designated as a repository for those interactions having the most value, all numerical means between 1.0 and 3.0 were classified in the same manner. Similarly, Rows 4 to 6 and numerical means from 3.1 to 6.0 assumed the cloak of neutrality. In like manner, the numerical means from 6.1 to 9.0 attended Rows 7 to 9, and were considered items having the least value.

The flavor of this interpretation depended upon the characteristics of the population involved in the study. In reviewing the results of the item placements and the interpretation of the data, a better resume of the involved population was included in the belief that it would lend more meaning to the interpretative fabric of this study. There were sixteen nurses, education, and nursing techniques in the group. Two licensed practical nurses completed the total of thirty one professionals for the study of the psychiatric nursing personnel.
manner, the numerical means from 6.1 to 9.0 attended Rows 7 to 9, and were considered items having the least value.

The flavor of this interpretation depended upon the characteristics of the population involved in the study. In reviewing the results of the item placements and the intergroup correlations, a brief resume of the involved population was included in the belief that it would lend more meaning to the interpretative fabric of this study.

Description of Nurse Item Placements by Category

The nurse population represented a cross section of professional and non-professional nursing personnel. Each of the three hospitals used in this study contributed individually in achieving its own representative cross section. Thirteen registered nurses represented the professional population in this study. There were sixteen aides, orderlies, and nursing technicians in the non-professional personnel group. Two licensed practical nurses completed the total of thirty-one participants from the ranks of the psychiatric nursing personnel.

The items reviewed by this group and placed according to their assigned value on the Q-sort board will be discussed by category. The fifty-five items of the Q-sort were listed by category in Appendix E.

Feelings. Item placements within this category were rated as generally "neutral" by this group of nurses. (See Table III for nurse item placements.) Of the eleven items in this category, only two items were rated
Table III: Nurses' Item Placements by Category (As Expressed by Their Arithmetic Mean)

<table>
<thead>
<tr>
<th>Categories</th>
<th>Least Valuable</th>
<th>Neutral</th>
<th>Most Valuable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X = 6.1 to 9.0</td>
<td>X = 3.1 to 6.0</td>
<td>X = 1.0 to 3.0</td>
</tr>
<tr>
<td>Feeling</td>
<td>ITEM: 1 = 4.4</td>
<td>ITEM: 5 = 3.7</td>
<td>ITEM: 18 = 2.4</td>
</tr>
<tr>
<td></td>
<td>ITEM: 3 = 4.4</td>
<td>ITEM: 12 = 3.3</td>
<td>ITEM: 34 = 4.2</td>
</tr>
<tr>
<td></td>
<td>ITEM: 10 = 3.9</td>
<td>ITEM: 13 = 4.9</td>
<td>ITEM: 39 = 5.3</td>
</tr>
<tr>
<td></td>
<td>ITEM: 11 = 5.2</td>
<td>ITEM: 19 = 4.0</td>
<td>ITEM: 42 = 5.4</td>
</tr>
<tr>
<td>Congruency</td>
<td>ITEM: 9 = 3.5</td>
<td>ITEM: 14 = 5.1</td>
<td>ITEM: 30 = 5.6</td>
</tr>
<tr>
<td></td>
<td>ITEM: 16 = 4.6</td>
<td>ITEM: 23 = 5.1</td>
<td>ITEM: 43 = 5.1</td>
</tr>
<tr>
<td></td>
<td>ITEM: 20 = 4.6</td>
<td>ITEM: 24 = 5.2</td>
<td>ITEM: 40 = 4.1</td>
</tr>
<tr>
<td></td>
<td>ITEM: 21 = 5.4</td>
<td>ITEM: 25 = 4.9</td>
<td>ITEM: 41 = 5.7</td>
</tr>
<tr>
<td>Hospital Culture</td>
<td>ITEM: 2 = 6.3</td>
<td>ITEM: 26 = 6.7</td>
<td>ITEM: 44 = 5.1</td>
</tr>
<tr>
<td></td>
<td>ITEM: 5 = 6.6</td>
<td>ITEM: 27 = 4.8</td>
<td>ITEM: 53 = 5.4</td>
</tr>
<tr>
<td></td>
<td>ITEM: 8 = 6.6</td>
<td>ITEM: 31 = 5.8</td>
<td>ITEM: 54 = 5.0</td>
</tr>
<tr>
<td>Availability</td>
<td>ITEM: 4 = 6.4</td>
<td>ITEM: 28 = 5.4</td>
<td>ITEM: 45 = 5.1</td>
</tr>
<tr>
<td></td>
<td>ITEM: 7 = 6.4</td>
<td>ITEM: 29 = 5.2</td>
<td>ITEM: 46 = 5.5</td>
</tr>
<tr>
<td></td>
<td>ITEM: 11 = 6.4</td>
<td>ITEM: 32 = 5.8</td>
<td>ITEM: 47 = 5.3</td>
</tr>
<tr>
<td></td>
<td>ITEM: 15 = 6.4</td>
<td>ITEM: 33 = 5.4</td>
<td>ITEM: 48 = 4.8</td>
</tr>
<tr>
<td></td>
<td>ITEM: 38 = 6.3</td>
<td>ITEM: 55 = 7.4</td>
<td>ITEM: 52 = 4.7</td>
</tr>
</tbody>
</table>

The two statements receiving the "least valuable" connotations concerned direct confrontation by the nurse to the patient in both a physical and verbal manner. (See Items 2 and 5 in Appendix B.)

The two statements receiving the "neutral" connotations concerned the insincerity of the nurse's agree or disagree statement regarding the nurse-prescribed treatment of the patient." (See Items 3 and 10 in Appendix B.)

The two statements receiving the "most valuable" connotations concerned the nurses' concern for the safety of the patient while in the hospital. (See Items 8 and 11 in Appendix B.)

The nurses' placement of this item within the "least valuable" segment of the value scale within the "neutral" segment of the value scale seems to reflect the nurses' concern for the patient's safety while in the hospital. This concern was also expressed in the nurses' refusal to administer medication in which the patient was allergic to the medication.
with any definitiveness. The two statements receiving the "least valuable" connotations concerned direct confrontation by the nurse to the patient in both a physical and verbal manner. (See Items 2 and 4 in Appendix E.)

Congruency. Generally, these item placements fell within the "neutral" area of assigned values. Nurses saw only one item as having the most value in the nurse-patient interaction. This item (18) concerned itself with the uniqueness of each patient as a separate person and achieved a numerical mean of 2.4.

The positive value placed upon this item represented one of the basic tenets of this category. Another item, 15, reflected the least value by this group of nurses in terms of the congruency needed in approaching the patient. This "least valuable" statement dealt with the insincerity expressed by the nurse to the patient. The remaining "neutral" items formed a tightly bound expression of the nurse group's concern with congruency.

Hospital culture. Though the nurses again expressed general neutrality within this category, they also rated this category with more items of least value than was the case in the other categories. Three items (26, 27 and 33) were given this negative connotation, though not with the definitiveness expected of the "least valuable" demarcation. Specific actions, such as locking the doors of the ward, were assigned this negative value. Except for these specific actions, the nurses reflected their neutrality of approximately one point of the linear range within the neutrality segment of the assigned value scale.
Availability. No item in this category fell within the "most valuable" area of the assigned value scale. The majority of the instrument's placements of items reflected the "neutral" expression of the tenets conveyed by this category. There was, however, an air of indecision about these items. Several of the item means within this segment bordered on the "most valuable" area of the scale, but not to the degree of explicitness required for their inclusion in this area. Similarly, relative indecision was displayed by the lone item (3) found as "least valuable" within this category. Neutrality was reflected more generally as the item means were meted out over a wider linear range than has been evident in the remaining categories.

Limit-setting. The consensus of neutrality was again reflected by this group of nurses. No items were rated as being valuable, nor did any item place near the parameter of that area. Explicitness was demonstrated by the numerical mean of 7.4 given to one item (55) in the "least valuable" area of Table III. This item was the only item of the fifty-five presented to this group which definitely expressed their opinion as having the least value. The statement reflected strong views regarding the negative effects which excessive permissiveness would have upon nurse-patient interactions.

Description of Patient Item Placements by Category

The age range of the patients participating in this study by hospital was:

(1) Colorado Psychopathic Hospital, eighteen years to fifty years ($\bar{X} = 35.3$ years);

(2) Fort Logan Mental Health Center, eighteen years to forty-five years
In addition, the length of their hospitalization, according to the order of the hospitals previously mentioned, ranged from: (1) four weeks to three months; (2) four weeks to six months; and (3) two months to sixteen months.

The ensuing discussion of item placements as evaluated by this group was pursued by category.

**Feelings.** Patient group consensus gave this category a "neutral" disposition. While there were no items which achieved the definite status of "most valuable," approximately half of the items in the "neutral" segment hovered rather closely to the "most valuable" parameter. Though this group expressed themselves with doubt concerning the positive aspects of these items, the number of these items within the "neutral" segment cannot be entirely discounted in relation to the piquant properties it projects. Only one item achieved the "least valuable" designation and dealt with the specific manner in which the nurse comforts the patient. (See Item 2 in Appendix E.)

**Congruency.** No item in this category achieved either a "most valuable" or "least valuable" designation by the patient group. The item (18) expressing the nurse's recognition of the patient as a separate person received a slightly lower item mean for the "neutral" portion of this scale. Despite this lower mean, however, its neutrality is reflected in the fact that the mean was much closer to the neutrality delineations than to the "most valuable" delineation.
Hospital culture. The ideology of this category met with "neutral" responses by the patient group. Three items (24, 26 and 33) eluded this evaluation and represented this group's most assertive opinions concerning the less valuable aspects of this category. While two of these statements were not eligible for the "neutral" segment of the sort, the proximity of their item means was such as to indicate an affinity with that portion of the value scale. It was the statement concerning the locked doors and windows of the ward which predicated this item's evaluation of least value by the patients. (See Item 26 in Appendix E.) There were no items placed in the "most valuable" segment as shown in Table IV.

Availability. Unanimous neutrality was allotted to this category. There were no statements in this category which could be suggestive of another segment of the scale. Patient consensus was tightly ensconced within the domain of neutrality.

Limit-setting. This category demonstrated no statements of value by item means from the patient group. One item (55) reflected "least valuable" qualities, but not with any measure of definitiveness that would be characteristic of this assigned value segment. As in the other categories of the Q-sort, the patients evaluated the statements with expressions of neutrality. The extent of this neutrality was reflected by the definite opinions concerning the statements from the patient group. This could be seen by the closeness of the item means within this segment.
<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>MOST VALUABLE</th>
<th>NEUTRAL</th>
<th>LEAST VALUABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$X = 1.0$ to $3.0$</td>
<td>$X = 3.1$ to $6.0$</td>
<td>$X = 6.1$ to $9.0$</td>
</tr>
<tr>
<td>Feelings</td>
<td>ITEM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$1 = 3.4$</td>
<td>$6 = 3.5$</td>
<td>$10 = 4.1$</td>
</tr>
<tr>
<td></td>
<td>$3 = 4.7$</td>
<td>$7 = 5.3$</td>
<td>$11 = 3.9$</td>
</tr>
<tr>
<td></td>
<td>$4 = 5.9$</td>
<td>$8 = 3.4$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$5 = 3.2$</td>
<td>$9 = 3.8$</td>
<td></td>
</tr>
<tr>
<td>Congruency</td>
<td>ITEM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$12 = 4.5$</td>
<td>$16 = 4.2$</td>
<td>$20 = 4.2$</td>
</tr>
<tr>
<td></td>
<td>$13 = 5.2$</td>
<td>$17 = 4.3$</td>
<td>$21 = 5.8$</td>
</tr>
<tr>
<td></td>
<td>$14 = 4.9$</td>
<td>$18 = 3.9$</td>
<td>$22 = 4.5$</td>
</tr>
<tr>
<td></td>
<td>$15 = 5.8$</td>
<td>$19 = 4.4$</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>ITEM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Culture</td>
<td>$23 = 4.8$</td>
<td>$28 = 5.3$</td>
<td>$31 = 5.2$</td>
</tr>
<tr>
<td></td>
<td>$25 = 5.5$</td>
<td>$29 = 5.1$</td>
<td>$32 = 5.4$</td>
</tr>
<tr>
<td></td>
<td>$27 = 5.7$</td>
<td>$30 = 5.4$</td>
<td>$33 = 6.0$</td>
</tr>
<tr>
<td>Availability</td>
<td>ITEM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$34 = 5.3$</td>
<td>$38 = 4.2$</td>
<td>$42 = 5.4$</td>
</tr>
<tr>
<td></td>
<td>$35 = 5.0$</td>
<td>$39 = 4.3$</td>
<td>$43 = 4.9$</td>
</tr>
<tr>
<td></td>
<td>$36 = 4.7$</td>
<td>$40 = 5.0$</td>
<td>$44 = 4.7$</td>
</tr>
<tr>
<td></td>
<td>$37 = 5.1$</td>
<td>$41 = 5.4$</td>
<td></td>
</tr>
<tr>
<td>Limit</td>
<td>ITEM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Setting</td>
<td>$45 = 5.4$</td>
<td>$49 = 5.5$</td>
<td>$53 = 5.1$</td>
</tr>
<tr>
<td></td>
<td>$46 = 4.5$</td>
<td>$50 = 5.3$</td>
<td>$54 = 4.6$</td>
</tr>
<tr>
<td></td>
<td>$47 = 5.2$</td>
<td>$51 = 5.6$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$48 = 5.2$</td>
<td>$52 = 5.1$</td>
<td></td>
</tr>
</tbody>
</table>
Comparison of Nurse Placements and Patient Placements

Nurses and patients found very little in the way of positive value concerning their item placements. Out of fifty-five statements, only Item 18 (see Appendix E) was evaluated by numerical mean as having the most value. This evaluation was given by the nurse group. While the patient group did not express their values in as positive a manner in all the categories, there was sufficient inclination toward assuming this in the category of feelings.

There was strong expressiveness in the placement of items in the "least valuable" segment by both groups. Item means also gave way to hesitancy by both groups to commit themselves to either end of the assigned value continuum. Though in comparing both extremes of the continuum, it was not surprising to note the ease in which negative traits or opinions were made apparent by both groups. (See Figure I for nurse-patient comparison of frequency distribution according to item placement means.) Their significance was all the more remarkable in that the item placements alluded to very obvious interactions within the nurse-patient relationship. "The upset patient feels better at times when the nurse holds his hand," is but one example of this obvious nurse-patient interaction.

Of the two groups in this study, the nurses found a more expressive outlet for their negative value judgments by demonstrating this in every category. (See Figure 2.) The commitment nurses have to become cognizant of the full range of the nurse-patient interaction is curiously absent in this Q-sort. There are very few items which can come close to the parameter of positive values, save the lone item already there.
FIGURE I

FREQUENCY DISTRIBUTION ACCORDING TO ITEM PLACEMENT MEANS
Patients also did not commit themselves explicitly, but their non-commitment was generally more in keeping with neutrality. For instance, the patient group rated the categories of congruency and availability with total neutrality. Except for the two items in the categories of feelings and limit-setting, these also would have added to this consistency of expression. (See Items 2 and 55 in Appendix E.)

The items neutrally placed by the nurses were placed in more closely aligned proximity than were the patients. This propinquity was not as approximate in the patients' placements. This would signify a more searching attitude concerning their value judgments. The nurses on the other hand, did not reflect this attitude, and indeed, in view of their willingness to be judgmental in extremes of value, they also demonstrated this judgmental attitude in their neutrality.

II. INTERPRETATIONS OF INTERGROUP CORRELATIONS

The results of the correlation coefficients necessitated the use of a guide from which to make intergroup comparisons. (See Appendix F for correlation coefficient formula.) Guilford presents such a guide in explaining the degree and strength of a relationship:

Less than .20--slight; almost negligible relationship.
.20 to .40--low correlation; definite but small relationship.
.40 to .70--moderate correlation; substantial relationship.
.70 to .90--high correlation; marked relationship.
.90 to 1.00--very high correlation, very dependable relationship.  

From these guidelines, a minimum of .40 was accepted as reliable indication of agreement between the two groups.

**Intergroup Correlations by Category**

The discussion of the intergroup correlations will be pursued by category.

**Feelings.** The correlations in this category contained a variety of "moderate" to "high" correlations. (See Figure 2.) The doubt expressed in this variety points to a paucity in the knowledgeability and awareness needed by the nurse to communicate understanding in her dyadic interactions. This was emphatically reflected by the previous item placements of both groups. While the patients voiced an inquisitiveness in the discovery and use of feelings, the nurses remained dogmatically neutral in their approach to this category, relenting only in statements which were blatantly obvious. Statements which reflected the conspicuous agreement in this category achieved correlations in the .80 to .90 range. The obvious derision received by a patient from the nurse is an example of this unique unanimity.

The statements which achieved lower correlations (.58 to .76) were those which were more apt to disclose the deficiencies of this category in its implementation within the nurse-patient interaction. These deficiencies concerned themselves with the intangible aspects of feelings. In this category, the elusive but vital elements of trust, concern, interest, and confidence were displaced into a lower echelon of agreement. This can only be interpreted as a justifiable basis for the patient's reluctance in the establishment of a meaningful relationship with the nurse.
FIGURE 2
LINEAR RELATIONSHIPS OF CORRELATION COEFFICIENTS BY CATEGORY
Such a dyad cannot be formed when only one of its members chooses to participate actively. Since the formulation of this category was based on the premise that the spontaneous reactions of both members of the dyad would be shared, the intergroup correlations lent credence to the interpretation that very little of this sharing was actually taking place.

In view of this, it must be concluded that the nurse deals strongly with those facets of her interactions with the patient that can be felt or seen. The lower correlations substantiated the patients' views that the reluctance of the nurse to deal with her feelings towards their relationship might be based on her fears of the patient and the feelings that would ensue as a result of investing in such a relationship. The extent to which the nurse influenced these responses from the patient precludes any effectiveness she may have in her future interactions with the patient.

Congruency. For the most part, this category achieved correlations in the .80 range. (See Figure 2.) The reflection of nurse inadequacies was denoted quite well in the lower correlations. In formulating the tenets of this category, the genuineness of the nurse's response to the patient and the willingness to accept the patient as a unique individual who possessed both positive and negative qualities, comprised the basic core of congruency. Yet, the statements which directly expressed this core philosophy received the lowest correlations in this category. It was the statement which propounded the nurse's recognition of the patient as a separate person which merited a .68 correlation. (See Item 18 in Appendix E.) Despite this statement's receiving the "most valuable"
connotation in the nurse item placement, the fact that the patients did not view
it in the same way reflects the confusion between the two groups regarding this
statement. It bears out the interpretation that the nurses saw this statement as
a philosophical platitude rather than a usable expression of this category. The
difficulty encountered in the actual sorting by the nurses upholds the investigator's
earlier supposition that nurses were struggling between what they were doing
and what they should be doing. In obtaining lower correlations for these items,
the congruency category renders the nurses' suspect in this attitude.
The interpretations of the correlations within this category can only
follow one course. This course is one in which the higher correlations represent
those aspects of congruency which are not being achieved in nurse-patient
interactions. In this context, the nurse was taking personal offense when a
patient expressed anger toward her; she was usurping the patient's right and
need for privacy. These are two examples of what was recognized by correlated
agreement regarding this lack of achievement. (See Items 12 and 14 in
Appendix E.)
Conversely, lower correlations were evidence of the desirable
elements in this category relevant to nurse-patient interactions. Such an
expression lies in Item 15 which achieved an .86 correlation, and which pointed
to the use and acknowledgement of insincerity as demonstrated by the nurse. In
contrast, the statement reflecting the patient's respect for any nurse who deals
with him in an honest manner, despite his distaste for being approached in that
manner, by way of its .73 correlation pointed to the unfulfillment of this tenet
in practice. (See Item 22 in Appendix E.)
The importance of actively practicing the tenets of this category in the dyadic interaction is pivotal to achieving the trust necessary for any relationship. The absence of this trust, as seen in the feelings category, remains conclusive regarding the lack of a basic congruent approach in inaugurating more positive elements within the dyadic interaction.

Hospital culture. This category achieved a larger proportion of "high" to "very high" correlations than did the other categories. (See Figure 2.) Items in this category were much more specific than the other categories, so it was not surprising to note the higher degree of correlation among the statements. The highest extent of agreement within this category emitted two interpretations. The first interpretation employed more evidence for the extent in which nurses cling to their prescribed functions and role on the ward. Items which received "least valuable" connotations in the item placements also achieved high correlations. This emphatically denoted the employment of such procedures as locked doors and the administration of medicines, not as occasional procedures, but as procedures which dominated the function and purpose of the ward.

Secondly, the domination of these procedures on the ward, delineated successfully between the stereotyped picture of the nurse and the stereotyped picture of the patient. Within the confines of hospital culture, each member of this culture has specific functions and was recognized because of them. The absence of any of these specific functions deprived the member of his status, and therefore of his recognition. In losing a specific function, loss was felt more
acutely as there was no replacement whereby this recognition could be regained. Since the correlations thus far have demonstrated a noticeable discrepancy between the tangible and the intangible aspects of interactions, it was not without reason that the stereotyped roles of the nurse, and to some extent the patient, were clung to with such tenacity. This tenacity was evident in the item (33) of this category which concerned itself with group decisions and group opinions. The employment by the nurse of group activities in which she played a controlling role was contrasted with the contradictory and confusing statement she made regarding her recognition of the patient as a separate person. Here she demonstrated one philosophy in practice; another in theory.

Though the ideology of hospital culture remains a necessary part of the psychiatric milieu, its influence upon both groups should not dominate the milieu nor discourage the culture’s participants from engaging in other recognized and beneficial therapeutic measures.

Availability. The exchange of "selves" during an interaction was contingent upon the presence of the participants. Though this category promulgated as its ideology the willingness of the nurse to communicate with the patient, when he wished to do so, the manner in which he elicited the nurse’s willingness required scrutiny. The higher correlations again revealed the amount of specificity needed by the nurse in order to function within an interaction. (See Figure 2.) Thus the nurse could function in her interactions by sitting with the patient, or by being told that he does not wish to discuss his
family with her. This ability to function was impaired when the nurse indicated this willingness from the non-verbal offerings of the patient.

This impairment was given credence in the doubt reflected by the statement (43) in which the nurse realizes that the patient has other means of indicating his need of her, rather than by asking. On the basis of this doubt, more skepticism was generated by the lower correlated statement which doubts just how available the nurse really was when a patient wished to communicate with her. The statement (36) in which the nurse tries to convey to the patient the thought that he need not feel so alone, was close enough in correlated value to the aforementioned statements so as to further substantiate the nurse's inability to function from anything but a specific base.

In order to forestall any feelings of inadequacy the nurse felt, the availability of her time could well be rationed or utilized in another area where her adequacy is not challenged. The domination of a task oriented hospital culture as seen within this study provides a great deal of speculation for the investigator regarding its applicability in depriving the patient of the nurse's time for the therapeutic productiveness of their interactions.

Limit-setting. There are a larger number of .90 correlations in this category than in the other categories. (See Figure 2.) In keeping with the interpretative aspects of this section, these correlations were centered upon a high level of explicitness. This explicitness revealed itself in those statements which utilized abrupt interruption and intervention in limiting the patient's behavior. This category views limit-setting as the way in which the nurse used
herself in order to limit the behavior of the patient. Characteristically, this was not shared by the groups in this study.

While very direct methods of setting limits were demonstrated by the extent of the strong relationship between the two groups, the statements in the .80 range reflected a waiving indecisiveness in implementing some aspects of limit-setting. Here the use of tact, discussion, and observation in setting limits were seen as possible methods to use, but they remained by means of their correlations, only tentative areas in which to venture.

In the meantime, the statement, "The patient can depend upon the nurse to protect him whenever he has feelings of wanting to hurt himself," indicated substantial doubt as to the nurse's effectiveness in protecting the patient from the ultimate act of destructiveness. The .78 correlation of this statement would make it imperative for the nurse to overcome with dispatch any indecisiveness she entertained in this area. The means with which the nurse used to control the patient's behavior were those which have been demonstrated in the hospital culture category. Since these two categories shared the larger number of "high" correlations of the five categories, this interpretation was not without foundation. The degree to which the nurse relied on the demonstrable activities of the patient more than justifies the doubt she has instilled in him regarding her dependability in this area.

### III. CROSS CATEGORICAL COMPARISON

The diversity of opinions evidenced in these correlations pointed quite noticeably to several factors operating within nurse-patient interactions. Among

*In this role, the patient had no voice, no judgment, no perceptions, and no right to perform in anything other than what would be expected in such a role. By virtue of that parity, they have been relegated to the patient a sick role.*
these, the most prominently sketched was that of the nurse. Within the scope of this study, and based upon the group data, there could be no doubt that the nurse was functioning well within the sharply delineated boundaries of her traditional role as keeper of the sick. This stereotyped role permitted little freedom of judgment or participation in the transactional treatment of the patient. In being recognized as the purveyor of the hospital culture, she was seen as implementing only those aspects of the culture which could be executed with keys, quieted with medications, or herded within this domain. She transmitted or maintained nothing which strongly influenced others by an exchange of feelings or by therapeutic use of herself. In this respect, she readily defers to the doctor. The nurse in this study has successfully conveyed to those in her keep that this was her role. To advance this percept, she carefully avoided situations, such as being available to a patient, which might alter this niche she had constructed for herself. Since she had been task oriented, she had not seen, and had failed to comprehend, anything of an intangible quality presented by the patient. She relinquished the potential she might have had because it was of an unknown quantity, and she could not afford the insecurity and threatening factors which she sensed would be her lot in such a venture.

In pursuit of the "status quo" she relegated to the patient a sick role. In this role, the patient had no voice, no judgment, no perceptions, and no right to perform in anything other than what would be expected in such a role. By virtue of his "sickness," no doubts were proffered, no suggestions advanced that would serve as an encroachment upon the nurse's implacability.
There were nurses, however, who were interested in conveying something more than the staid predictability of this present culture. These nurses were considered as alien to a role not open to change. Even more threatening, than dealing reciprocally with the patient and his feelings, was the threat that pervaded the cabal maintained by the nursing ranks, for it deigned to point out inadequacies, deficiencies and otherwise disrupted the status quo.

Changes inevitably have met with barriers designed to impede them. For the adventuresome nurse, this barrier would be apathy, the implementation of which was directed toward fiercer entrenchment of the nurse's traditional role. This attitude would be doomed to failure. Its failure rested upon the same source with which the interpersonally oriented nurse achieved success, namely the patient. This study has shown that the therapeutic use of self was recognized as having value by the patient. Though this recognition was small in effort, it nevertheless remained of value for the person to whom this care was directed. Inroads such as this, regardless of its magnitude could not be ignored.

The regrettable factor of such apathy, of course, has been the severe break in communication between the intuitive base now in use by these nurses, and the purposefulness needed to implement a more constructive end to the nurse-patient relationship. In desiring to implement herself in this therapeutic fashion, the interpersonally oriented nurse has found herself in a professional limbo between the unsubstantiated suggestions of nursing textbooks and the vital, useful application of scientifically proven aids to the nurse-patient relationship.
The strongest asset for the nurse who wished to be therapeutically effective is the realization that, however small her efforts might be, it influenced the patient in some degree. Precisely to what degree has yet to be determined. These influences were apparent in the various hospital settings of this study, and though the purpose of this study was not an interhospital comparison, the trends observed could not be ignored.

The statements in the Q-sort which indicated such a trend were considered pivotal to the categories in which they were noted. They reflected approaches which were, by way of this study, unique to the milieu of the individual hospitals. On the suspicion that these diverse responses reflected more than an anomalous quality, several of these statements were selected at random for the purpose of applying them to a statistical test of significance, the chi square. This test indicated significant differences between the hospitals regarding the extent of nurse influences upon the patient.

The type of hospital, the length of the patient’s hospitalization, his age, and the amount and extent of the nurse’s therapeutic participation encouraged by these hospitals were a few of the variables noted within this study which could affect these diverse responses, and which represented real differences in the nurse’s effectiveness in her interactions with the patient.

Though the portrait etched in this study of the nurse and her participation in dyadic interactions remains a disillusioning reality, this can be effectively

---

remedied through careful and precise investigation into those areas which continue to identify through patient corroboration, how the nurse affects the patient and what, in this affectation, directs him toward health.

IV. SUMMARY

Prevalent in this chapter was a discussion concerning the item placements of the participating groups. Comparisons of these placements were made by category. Intergroup correlation coefficients were also analyzed by category. Interpretations were projected that the nurse was being seen as functioning predominantly within her traditional role. Attempts to interact with patients on an interpersonal basis received less recognition. This was interpreted, not as having less value, but rather that these interactions had less realization in fact than had been expected.

The problem of this study sought to ascertain what interactions were considered to be of value to psychiatric patients, as these interactions were perceived by psychiatric nursing personnel and psychiatric patients. The perceptions of the psychiatric patients were compared with those of the psychiatric nursing personnel in order to determine the value both groups placed upon certain interactions. This study also sought to establish a beginning awareness of the need for further investigations of nurse-patient interactions.

The review of literature relevant to general interactions was pursued.

This survey acknowledged the importance given to nurse-patient interactions.

It also revealed that more precision was needed in order to utilize to the fullest the nurse’s therapeutic effectiveness. Various communicative aspects of the interaction process were investigated in the literature in an attempt to make known to the nurse the areas which require implementation within nurse-patient interactions. The development and use of the Q-sort technique in this study also necessitated investigation of the literature.

The statements used in the Q-sort technique were culled from the nursing literature relevant to helpful measures instituted by the nurse. Fifty-five statements were submitted to the appraisal of five judges. In appraising
I. SUMMARY

The problem of this study sought to ascertain what interactions were considered to be of value to psychiatric patients, as these interactions were perceived by psychiatric nursing personnel and psychiatric patients. The perceptions of the psychiatric patients were compared with those of the psychiatric nursing personnel in order to determine the value both groups placed upon certain interactions. This study also sought to establish a beginning awareness of the need for further investigations of nurse-patient interactions.

The review of literature relevant to general interactions was perused. This survey acknowledged the importance given to nurse-patient interactions. It also revealed that more precision was needed in order to utilize to the fullest the nurse's therapeutic effectiveness. Various communicative aspects of the interaction process were investigated in the literature in an attempt to make known to the nurse the areas which require implementation within nurse-patient interactions. The development and use of the Q-sort technique in this study also necessitated investigation of the literature.

The statements used in the Q-sort technique were culled from the nursing literature relevant to helpful measures instituted by the nurse. Fifty-five statements were submitted to the appraisal of five judges. In appraising
the statements, the judges found that they were applicable to the five categories formulated for this study. These categories were: feelings, congruency, hospital culture, availability, and limit-setting. Specificity–generality values and a test-retest situation were implemented in order to provide more validity and reliability for the tool used in this study. A pilot study was done in order to note the length of time needed to complete the sort as well as noting any changes needed in the instructions. Thirty-one nurses and thirty patients were asked to complete the sort by selecting those items they considered to be "most valuable" and "least valuable" within the nurse-patient interaction.

The data obtained from the sortings were transformed into numerical means calculated for each item. This provided an opportunity to note the placements of these items in reference to the assigned value scale delineated in the Q-sort. The extent of agreement between the two groups regarding the value of their interactions was achieved by calculating correlation coefficients. Correlation coefficients between the two groups ranged from .58 to .93. This range indicated a diversity of opinions concerning common aspects of value within dyadic interactions. Specific interactions were seen in a negative context by virtue of the high correlations between the two groups. Less specific interactions resulted in lower correlations, and indicated, in addition to their value given them by the groups, their relative absence within these interactions.

(6) This study indicated an emergence of trends which bore upon each individual hospital's differences in patient care. These differences could well...
II. CONCLUSIONS

The data obtained in this study resulted in the following conclusions:

(1) Patients and nurses, by way of their item placements, exhibited neutrality in all five categories. Very few definitive opinions were adjudged as being of most value or of least value in the categories by the involved participants.

(2) Correlations of .80 and .90 were evaluated as interactions which existed in fact, but which were judged as having the least value in nurse-patient interactions. These statements were of a highly specific content and dealt with the observed, concrete aspects of nurse-patient interactions.

(3) Correlations indicating moderate relationships of .50 to .70 were adjudged as interactions having value, but which found little realization in actual practice. These statements were much less specific and dealt with the intangible qualities of nurse-patient interactions.

(4) Nurses, in the highly correlated categories of hospital culture and limit-setting, were evaluated as functioning in their traditionally authoritarian role with very few efforts being made to interact therapeutically.

(5) The patients used in this study proved to be a perceptive primary source of evaluation. This perception indicated their wish to pursue and benefit from more effective nurse-patient interactions. They did not have the difficulty of judgment that the nurses displayed throughout the sort.

(6) This study indicated an emergence of trends which bore upon each individual hospital's differences in patient care. These differences could well
affect the way the nurse influences the patient. That these differences were significant between the hospitals was given some credence in the application of the chi square to a few of the statements displaying such trends.

III. RECOMMENDATIONS

The data obtained in this study resulted in the following recommendations:

(1) That each of the five categories in this study be more clearly investigated and tested by using the Q-sort technique on both nurses and patients.

(2) That studies being done in one or more hospitals include attempts to measure the effect of variables such as mentioned in this study, which would tend to influence nurse-patient interactions.

(3) That studies be pursued which would measure the influence a nurse has upon a patient in relation to the philosophy of the hospital which permits or does not permit the nurse to engage in an actively therapeutic manner.

(4) That patients be used in studies which objectively set out to measure nurse-patient interactions.

(5) That studies be undertaken which measure the amount of influence which is extended to patients by each of the nursing disciplines within any one hospital.
BIBLIOGRAPHY

A. BOOKS


BIBLIOGRAPHY

A. BOOKS


B. PERIODICALS


### C. UNPUBLISHED MATERIAL


APPENDIX A

INSTRUCTIONS FOR NURSES

There are many things you do with patients that are helpful.

Each of the cards on the table contains a statement which describes what nurses in similar situations have done with patients. You are asked to choose those items which, in your personal opinion, you consider of most value to the patient.

Begin by separating the APPENDIXES piles. In one pile, place all those statements you feel are of "most value" to the patient. The second pile should contain all those statements which you feel are of "least value" to the patient.

From the pile you have chosen as being of "most value", select one statement which you feel best represents what is of "most value" to the patient. Place this card in the empty box in Row 1. Then sort out the next most valuable statement. Place this card in the empty box at the bottom of Row 2. Continue selecting the next most valuable statement and place it in the next empty box. Each new row should be started from the bottom and continued to the top. Please fill in the rows from left to right.

When you have finished, take the cards which you have chosen as being of "least value" to the patient. Sort out the one card which you
APPENDIX A

INSTRUCTIONS FOR NURSES

There are many things you do with patients that are helpful. Each of the cards on the table contains a statement which describes what nurses in similar situations have done with patients. You are asked to choose those items which, in your personal opinion, you consider of most value to the patient.

Begin by separating the cards into two piles. In one pile, place all those statements you feel are of "most value" to the patient. The second pile should contain all those statements which you feel are of "least value" to the patient.

From the pile you have chosen as being of "most value", select one statement which you feel best represents what is of "most value" to the patient. Place this card in the empty box in Row 1. Then sort out the next most valuable statement. Place this card in the empty box at the bottom of Row 2. Continue selecting the next most valuable statement and place it in the next empty box. Each new row should be started from the bottom and continued to the top. Please fill in the rows from left to right.

When you have finished, take the cards which you have chosen as being of "least value" to the patient. Sort out the one card which you
feel is the least valuable to the patient. Place this card in the empty box in Row 9. Continue selecting the next least valuable statement and place it in the bottom empty box of Row 8. Proceed by placing these statements in the empty boxes remembering to work from the bottom to top. This time the rows are to be filled in from right to left. All boxes must be filled. There is only one card for each box.

There are many things done by members of the nursing staff which are helpful. Each of the cards in front of you contains a true statement describing in what way the nursing staff helps you. You are asked to choose those items, which in your personal opinion, have been of most value to you during your hospitalization.

First, the cards in front of you are to be separated into two stacks. Into one pile, put all those statements which you feel are of "most value" to you. In the other pile, place all those statements which you feel are of "least value" to you.

Next, take the cards which you have chosen of "most value" and select the one card which, in your opinion, is of most value. Place this card in the box in Row 1. Now, sort out the next most valuable statement. Place it in the box at the bottom of Row 2. Continue selecting the next most valuable statement and place it in the next empty box. Begin at the bottom of each row and continue up the row until you are ready to begin again at the bottom of a new row. Place only one card in each empty box. Work from left to right.
There are many things done by members of the nursing staff which are helpful. Each of the cards in front of you contains a true statement describing in what way the nursing staff helps you. You are asked to choose those items, which in your personal opinion, have been of most value to you during your hospitalization.

First, the cards in front of you are to be separated into two stacks. Into one pile, put all those statements which you feel are of "most value" to you. In the other pile, place all those statements which you feel are of "least value" to you.

Next, take the cards which you have chosen of "most value" and select the one card which, in your opinion, is of most value. Place this card in the box in Row 1. Now, sort out the next most valuable statement. Place it in the box at the bottom of Row 2. Continue selecting the next most valuable statement and place it in the next empty box. Begin at the bottom of each row and continue up the row until you are ready to begin again at the bottom of a new row. Place only one card in each empty box. Work from left to right.
When you have completed sorting the first stack of cards, take
the remaining pile of cards which you have selected as having the
"least value" to you. From this stack, choose the one statement which
you feel is of "least value" to you. Place this card in the box in Row 9.
Continue by selecting the next least valuable statement, and place it in
the bottom box of Row 8. Fill in the remaining boxes from bottom to
top, but this time remember that you are working from right to left.

All the boxes must be filled with one card for each box. Please
leave the cards as you have placed them. When you are finished you
may leave.

Thank you for your cooperation.

1. Some interaction is needed in each statement.
2. Statements must be understood by all those doing the sort.
3. Should statements not specifically mention a nurse and a
   patient, it must be worded so as to be applicable to both.

There are two aspects of these statements to be judged. First,
the statements are to be categorized, and second, they are to be judged
as to their specificity—generality.

CATEGORIES

You are asked to judge each statement according to whether or
not it fits into one of the following categories:

1. Feelings
2. Congruency
3. Hospital culture
4. Availability
5. Limit-setting

Each statement involves the nurse, the patient, and an interaction
that occurs between them. The term "nurse" is used to mean anyone on
the nursing staff who is involved in interpersonal relations with the
patient. Administrators and supervisors are excluded. The term
The purpose of this study is to discover what interactions in the psychiatric nurse-patient relationship are of value to the patient. To ascertain this, the technique of Q-sort (forced sort) will be used. The subjects will consist of members of the psychiatric nursing staff (from head nurse on down) and psychiatric patients. They will be given separate instructions and asked to sort the items along a continuum from "most valuable" to "least valuable."

The specific criteria for these items are:

1. Some interaction is needed in each statement.
2. Statements must be understood by all those doing the sort.
3. Should statements not specifically mention a nurse and a patient, it must be worded so as to be applicable to both.

There are two aspects of these statements to be judged. First, the statements are to be categorized, and second, they are to be judged as to their specificity-generality.

You are asked to judge each statement according to whether or not it fits into one of the following categories:

(1) Feelings
(2) Congruency
(3) Hospital culture
(4) Availability
(5) Limit-setting

Each statement involves the nurse, the patient, and an interaction that occurs between them. The term "nurse" is used to mean anyone on the nursing staff who is involved in interpersonal relations with the patient. Administrators and supervisors are excluded. The term
"interaction" is used to mean a reciprocal exchange of acts or influences between the nurse and the patient.

DEFINITION OF CATEGORIES

(1) Feelings. This category includes all statements that refer to a patient's feelings. This means, "any sensation that arises as a spontaneous reaction within the patient." The statements must refer to some expression of a feeling that occurs between the patient and the nurse.

(2) Congruency. This category includes all statements that refer to the way the patient is received by the nurse, and the genuineness of her responses to him.

(3) Hospital Culture. This category includes all statements which refer to the daily routine and functions of the hospital ward. This would include such activities as the administering of medications, the physical set-up of the ward, and the patient activities that occur on the ward.

(4) Availability. Statements in this category refer to the willingness of the nurse to communicate with the patient, when the patient wishes to do so.

(5) Limit-setting. This category includes all those statements which refer to ways the nurse helps the patient to control his behavior. This category does not include the use of medications, physical restraints, wet packs, EST or insulin shock. It pertains more to verbal and non-verbal ways the nurse would use herself limit the patient's behavior.

After you have sorted all the statements into the categories you have decided they belong, list the number of each statement within the box of the specific category. For example, Feelings

<table>
<thead>
<tr>
<th>2</th>
<th>3</th>
<th>9</th>
<th>22</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>62</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SPECIFICITY--GENERALITY

You are asked to read each statement and rank them according to how specific or how general they are. The scale you are asked to
use is a five point scale ranging from "most specific" to "most general."

The items include various kinds of statements which range from exactly what a nurse does with a patient, to vaguer generalities about what she does with a patient. For instance, a specific statement might be, "The nurse gives the patient a sleeping pill at bedtime"; a general statement might read, "The nurse is responsible for administering medications."

After you have sorted each item into its appropriate category, write the numbers that are on each item card, under the category heading. For example, should there be five statements in category #1, list the numbers accorded each statement under the category #1 heading, like so, ___#1____. Do this until you have completed all five categories. 1-22-25-37

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>$\bar{X}_F$</th>
<th>$\bar{X}_R$</th>
<th>T VALUE</th>
<th>SIGN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings</td>
<td>25.18</td>
<td>24.90</td>
<td>1.40</td>
<td>$df = 8$</td>
</tr>
<tr>
<td>Congruency</td>
<td>21.54</td>
<td>21.54</td>
<td>0.460</td>
<td>$t_{05} = 2.31$</td>
</tr>
<tr>
<td>Hospital culture</td>
<td>28.90</td>
<td>29.63</td>
<td>0.250</td>
<td>$t_{02} = 2.90$</td>
</tr>
<tr>
<td>Availability</td>
<td>23.09</td>
<td>22.90</td>
<td>0.561</td>
<td>$t_{01} = 4.03$</td>
</tr>
<tr>
<td>Limit-setting</td>
<td>26.36</td>
<td>26.00</td>
<td>0.182</td>
<td>$-$</td>
</tr>
</tbody>
</table>
### APPENDIX C

#### THE t-TEST FOR VALIDITY AND RELIABILITY IN TEST-RETEST OF FIVE NURSES

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>$\bar{X}_T$</th>
<th>$\bar{X}_R$</th>
<th>T VALUE</th>
<th>SIGN</th>
<th>df = 8</th>
<th>$t_{0.05} = 2.31$</th>
<th>$t_{0.02} = 2.90$</th>
<th>$t_{0.01} = 4.03$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings</td>
<td>25.18</td>
<td>24.90</td>
<td>1.40</td>
<td>--</td>
<td>$t_{0.05} = 2.31$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congruency</td>
<td>21.54</td>
<td>21.54</td>
<td>0.460</td>
<td>--</td>
<td>$t_{0.05} = 2.31$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital culture</td>
<td>28.90</td>
<td>29.63</td>
<td>0.250</td>
<td>--</td>
<td>$t_{0.02} = 2.90$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability</td>
<td>23.00</td>
<td>22.90</td>
<td>0.561</td>
<td>--</td>
<td>$t_{0.01} = 4.03$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limit-setting</td>
<td>26.36</td>
<td>26.00</td>
<td>0.182</td>
<td>--</td>
<td>$t_{0.01} = 4.03$</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Dr. Donald Langsley  
Director  
Colorado Psychopathic Hospital  
4200 East 9th Avenue  
Denver, Colorado  

Dear Dr. Langsley:

This is to confirm our conversation of June 4, 1964 at which time you gave me permission to use the facilities of the Colorado Psychopathic Hospital for the collection of data for my thesis study. As you recall, I will be doing Q-sorts with a selected number of patients and nurses, in order to ascertain what interactions they view as being of value within the nurse - patient relationship.

The data collected at the hospital will remain confidential. When the study is completed, I would be happy to send you an abstract of the study, should you so desire.

At this time, I would also like permission to identify the hospital by name in my thesis study.

Thank you again for your kindness in permitting me the use of the hospital's facilities.

Sincerely,

(Miss) Eleanor Hein
Miss Eleanor Hein
1027 1/2 Pine Street
Boulder, Colorado

This is to confirm my June 28th conversation with Dr. Bonn, at which time I was given permission to use the facilities of the Fort Logan Mental Health Center for the collection of data for my Thesis study. It will be quite satisfactory to me to have you administer your research instrument to a number of patients and personnel on Ward South II of Colorado Psychopathic Hospital. It is understood by both of us that any material having to do with patients and identification of patients will be handled in a strictly confidential manner and that no names or other identifying information about patients will be used. You are free to mention the fact that information was gathered at Colorado Psychopathic Hospital in your report provided that specific patients are not identified in character.

I wish to express my appreciation to Dr. Bonn, and Miss Huber for your consideration of this matter.

Sincerely --

cc: Dr. Ethel Bonn
Miss Helen Huber

(s) Donald G. Langsley

Donald G. Langsley, M.D.
Director of Inpatient Service
Colorado Psychopathic Hospital
Dear Dr. Kraft:

This is to confirm my June 24th conversation with Dr. Bonn, at which time I was given permission to use the facilities of the Fort Logan Mental Health Center for the collection of data for my Thesis study. Permission was also given at this time to identify Fort Logan by name in my Thesis study.

I will be doing Qsorts with a selected number of patients and nurses in order to ascertain what interactions they view as being of value within the nurse-patient relationship.

The data will remain confidential, but I would be happy to share any information obtained in my study with you.

I wish to express my appreciation to you, Dr. Bonn, and Miss Huber for your consideration of this matter.

Sincerely --

cc: Dr. Ethel Bonn
Miss Helen Huber
Miss Eleanor Hein  
1027 1/2 Pine Street, Apt. A  
Boulder, Colorado 80302  

Dear Miss Hein:

I am happy to give you permission to use the facilities of the Fort Logan Mental Health Center for the collection of data for your thesis. I am sure the staff will cooperate in every way they can also. The name Fort Logan may be used in any unpublished material. If it is to be published, we would like to see it before our name is used.

I will be finished with the summer sessions, August 22, and I plan to be in Wisconsin between August 25 and September 10. During this time, I plan to set aside several days to complete this data collection. The test itself requires approximately one hour of the participant's time.

Finally, I would also like to request permission to identify the hospital by name in my thesis, should permission to use its facilities be granted.

I will be happy to answer any questions you may have concerning this study.

Thank you for your consideration in this matter.

Sincerely,

(s) Alan M. Kraft  
Director  
Fort Logan Mental Health Center

AMK:gs

cc: M. Cullen Burris, M.D.  
Elaine Daeger, R.N.
Mr. Dean Roe, Administrator  
Milwaukee Sanitarium Foundation  
1220 Dewey Avenue  
Wauwatosa, Wisconsin  

Dear Mr. Roe:

I would like your permission to use the facilities of the Milwaukee Sanitarium Foundation for my thesis study in partial fulfillment of a Master of Science Degree in Nursing at the University of Colorado.

My thesis is concerned with what interactions nurses and patients view as being of value within the nurse-patient relationship. My plans would necessitate the participation of ten to fifteen patients and ten to fifteen nurses (including aides and LPN's). All participants will be informed that their identities will be kept confidential.

I will be finished with the summer session August 22, and I plan to be in Wisconsin between August 25 and September 10. During this time, I plan to set aside several days in which to complete this data collection. The test itself requires approximately one hour of the participant's time.

Finally, I would also like to request permission to identify the hospital by name in my thesis, should permission to use its facilities be granted.

I will be happy to answer any questions you may have concerning this study.

Thank you for your consideration in this matter.

Sincerely,

(s) Eleanor Hein

(Miss) Eleanor Hein

cc: M. Cullen Burris, M.D.  
Elaine Daeger, R.N.
July 2, 1964

Miss Eleanor Hein
1027 1/2 Pine Street, Apt. A
Boulder, Colorado 80302

Dear Miss Hein:

We would be happy to have you use the Milwaukee Psychiatric Hospital and staff for the purpose requested in your letter of June 26th. The only condition we would like to impose is that the amount of time the nursing staff will have to be away from their job will not be too much in excess of the one hour test which you mentioned.

We look forward to seeing you at the end of August.

Sincerely,

(s) Dean K. Roe

Dean K. Roe
Administrator

DKR:dm

Sorry I missed seeing you while you were here at the hospital. We are looking forward to reading the results of your study.
Miss Eleanor Hein  
753 1/2 Ash Street  
Denver, Colorado 80220

Dear Miss Hein:

I hereby give you permission to use the name of the Milwaukee Psychiatric Hospital for your thesis.

Very truly yours,

(S) Dean K. Roe
Dean K. Roe  
Administrator

DKR:dm

8. The patient feels reassured when he knows the nurse is interested in him.

Sorry I missed seeing you while you were here at the hospital. We are looking forward to reading the results of your study.

DKR
APPENDIX E

Q-SORT ITEMS BY CATEGORY

I. FEELINGS

1. The patient trusts the nurse and is able to confide in her.

2. The upset patient feels better at times when the nurse holds his hand.

3. The patient senses that the nurse is not afraid of him.

4. The patient feels he is being punished when the nurse derides him for his behavior on the unit.

5. The patient feels secure when he knows the nurse is truthful with him.

6. The patient feels reassured when he knows the nurse has confidence in him.

7. The patient feels anxious when the nurse expects too much of him.

8. The patient feels reassured when he knows the nurse is interested in him.

9. The patient is aware that he can talk to some nurses better than others.

10. The patient cannot always talk about his feelings.

11. The patient realizes that the nurse has feelings just as he does.
II. CONGRUENCY

12. The nurse does not take personal offense when a patient expresses angry feelings to her.

13. The nurse asks the patient to make clear those points which she does not understand.

14. The nurse tries to appreciate the patient's need for privacy.

15. The patient knows the nurse is insincere when she says one thing and by her posture indicates another.

16. The patient may express himself more if he knows that the nurse will not make fun of what he says.

17. The nurse accepts a patient exactly as he is.

18. The nurse recognizes that each patient is a separate person.

19. The nurse shows concern for the patient when he is troubled.

20. The nurse deals honestly with the patient when she expresses what she feels to him.

21. The nurse attempts to ascertain what the patient really feels about his hospitalization.

22. The patient may not always wish to be dealt with in an honest manner, but he will respect the nurse who does so.

III. HOSPITAL CULTURE

23. The nurse decreases a new patient's apprehension by explaining the rules and procedures of the ward.

24. The nurse explains the purpose of the medications to the patient.

25. There is reassurance for the patient in knowing that the nurse is competent in administering his medications.

26. The locked doors and windows of the ward help the patient feel more secure.
27. The nurse knows that playing the radio and TV loudly on the ward can be irritating to the patient.

28. The nurse encourages the patients to make decisions together concerning their ward activities.

29. Participating in the ward activities is one way the patient shows he is interested in getting well.

30. The patient is concerned about knowing what to expect each day as regards the ward routine.

31. There is great comfort in the orderly consistent functioning of the ward.

32. The nurse can observe the patient's likes and dislikes about people while he is on the ward.

33. All opinions in group decisions have equal merit.

IV. AVAILABILITY

34. Despite the patient's rejection of her, the nurse continues to visit.

35. The nurse shows interest in the patient by visiting him every day, despite his seeming rejection of her.

36. The nurse tries to let the patient know by being with him that he need not feel so alone.

37. Sitting quietly with the patient is as helpful at times as talking.

38. The nurse discusses the patient's progress with him, when he asks.

39. The nurse is always available to listen to what patients have to say.

40. The patient realizes that the nurse will not force him to talk about painful subjects if he does not want to.

41. Though the patient cannot always talk, he may want the nurse to sit with him.

42. The nurse appreciates that the patient may not want to discuss his family with her.
43. The nurse realizes that the patient has other ways of indicating his need of her rather than asking.

44. The patient knows that the nurse cares about him even though she is not with him all the time.

V. LIMIT-SETTING

45. When the patient is not in control of his behavior the nurse discusses with him the need to return to his room.

46. The patient realizes he must share the nurse's time with other patients on the unit.

47. The patient can depend upon the nurse to protect him whenever he has feelings of wanting to hurt himself.

48. The nurse uses quiet tact in limiting the patient's activity should his behavior warrant it.

49. The patient realizes that the nurse will intervene in his relationships with other patients, if it is not to his best interests.

50. The nurse relieves the patient of making his own decisions until he is better able to do so.

51. The patient realizes that when his behavior indicates that he cannot comfortably remain with the group, the nurse will ask him to return to his room.

52. The patient realizes that the nurse will interrupt him when she thinks his behavior is depreciating to himself among the patient group.

53. The patient knows that the nurse will not always agree to everything he may do.

54. Though he may not like to be observed all the time, the patient realizes that the nurses are concerned for his welfare.

55. The patient would prefer the nurse let him do anything he wants to do at any time.
APPENDIX F

CORRELATION COEFFICIENT FORMULA

\[ r = \frac{\Sigma XY - (\Sigma X)(\Sigma Y)}{\sqrt{\left[\frac{\Sigma X^2 - \left(\frac{\Sigma X}{n}\right)^2}{n}\right]\left[\frac{\Sigma Y^2 - \left(\frac{\Sigma Y}{n}\right)^2}{n}\right]}} \]