A COMPARISON OF NURSE-PATIENT PERCEPTIONS IN A PSYCHIATRIC THERAPEUTIC COMMUNITY

by

Martha Margaret LeBaron

B.S., Loretto Heights College

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

1963

This Thesis for the M.S. degree by

Martha Margaret LeBaron

has been approved for the

Department of

Nursing

by

Dorothy W. Bloch

Opal V. White

Date May 21, 1963

ACKNOWLEDGMENTS

The author wishes to express her appreciation to the members of the thesis committee, Mrs. Dorothy W. Bloch and Miss Marjorie Fields who contributed invaluable assistance through their suggestions and guidance throughout the entire study. She wishes also to thank the committee of judges, Dr. Paul Binner, Dr. Elizabeth Ross, Mrs. Dorothy Bloch and Mrs. Earldeen Jones. Special thanks is extended to Dr. Donald W. Stilson.

Without the generous permission of Dr. Alan Kraft and Miss Helen Huber to use the hospital facilities at the Fort Logan Mental Health Center this study could not have been accomplished.

Special recognition is extended to the nurses and patients whose participation was essential to the collection of data.

LeBaron, Martha Margaret (M.S., Nursing)

A Comparison of Nurse-Patient Perceptions in a Psychiatric Therapeutic Community

Thesis directed by Assistant Professor Dorothy W. Bloch

The problem of this study was to investigate the perceptions of the psychiatric nurse and the patient in the therapeutic community. Those perceptions to be studied were: (1) the nurses' perceptions of their actual role and their ideal role; (2) the patients' perceptions of the nurses' actual role; and (3) the perceptions of the nurses and patients about therapeutic community ideology.

A formulative or exploratory study was the method of research used. The instrument developed to obtain data was a Q-sort. Literature pertaining to the therapeutic community was utilized in the development of the fifty-one statements in the Q-sort. These statements related to communal ideologies involving such concepts as democratization, permissiveness, communalism, and reality-confrontation. Twenty patients and twenty nurses performed the sorts requested.

The product-moment coefficient of correlation was used to determine statistically the degree or strength relationships between the pairs of sorts. The correlation between the mean ratings for each pair of the three sorts performed by the subjects was calculated.

It was concluded that the nurse in this particular hospital was performing close to her ideal role, indicating a relatively high degree of job satisfaction. It was indicated that the nurse recognized her role and accepted the ideologies in the therapeutic community, but did not always carry them out in practice. The Q-sort was found to be effective in assessment of patient-staff communication. However, it was indicated that the communication was not always as adequate as the nurses had perceived. A basic agreement between nurses and patients about their perceptions of the ideologies of the therapeutic community was evidenced. It was also concluded that psychiatric patients could perform the Q-sort adequately.

It was recommended that objective data obtained from the Q-sort items could be utilized in evaluating job satisfaction of nurses in the therapeutic milieu. These data could also be utilized as an evaluative measure of the adaptation of the student or staff nurse to the role demanded of her in a therapeutic community setting.

This abstract of about 200 words is approved as to form and content. I recommend its publication.

Signed Dorothy H. Block
Instructor in charge of thesis

LIST OF TABLES

CHAPTER I

THE PROBLEM AND DEFINITIONS OF TERMS USED

Within the last two decades there has been a noticeable trend in psychiatric hospitals to utilize the therapeutic community approach. This "social" psychiatric approach in therapy stressed the idea of the patient becoming an active participant in the affairs of the institution. All relationships were regarded as potentially therapeutic. Many hospital staffs increasingly believed that unlimited latent possibilities existed for helping patients if interpersonal and group processes could be handled with competence. However, the nature of these processes was still not well defined and a need for further study was indicated.[1]

Experts in this field agreed that the staff must clearly understand and follow the principles of a therapeutic community to make it a successful venture. These ideologies were well described. Studies of an observational

---

[1] Milton Greenblatt, Richard H. York, and Esther Lucile Brown, From Custodial to Therapeutic Patient Care in Mental Hospitals (New York: Russell Sage Foundation, 1955), p. 11.

nature have been done and recorded.[2]

The change in the role of the nurse in the last decade was evident and her role as a staff member of the therapeutic community involved an even greater change.

> The elimination of punitive restriction measures and the reduction of disturbed, excited behavior in which she took a prominent part, slowly led to a movement away from rigid routinized practices.[3]

But, how was the nurse reacting to these changes? As Schwartz and Shockley indicated,

> . . . the nurses have been dealing therapeutically with patients for a long time, [but] the knowledge and experience they have developed has not been recorded and organized in such a way that it can be made available to others. . . . Frequently, she may not know exactly what she does.[4]

Studies which could produce objective data pertaining to the area of interpersonal relationships were minimal. This study was an attempt to gain information which might be helpful in objectively evaluating interpersonal relationships.

---

[2] Alfred H. Stanton and Morris S. Schwartz, The Mental Hospital (New York: Basic Books, 1954); William Caudill, The Psychiatric Hospital as a Small Society (Cambridge, Mass.: Harvard University Press, 1958); Robert N. Rapoport, Community as a Doctor (Springfield, Ill.: Charles C. Thomas, Publisher, 1959); Milton Greenblatt, Daniel J. Levinson, and Robert H. Williams (eds.), The Patient and the Mental Hospital (Glencoe, Ill.: The Free Press, 1957).

[3] Greenblatt, et al., op. cit., p. 168.

[4] Morris S. Schwartz and Emmy L. Shockley, The Nurse and the Mental Patient (New York: Russell Sage Foundation, 1956), p. 15.

I. THE PROBLEM

Statement of the problem. It was the problem of this study to investigate the perceptions of the psychiatric nurse and the patient of the therapeutic community. These perceptions to be studied were: (1) the nurses' perceptions of their actual role and their ideal role, (2) the patients' perceptions of the nurses' actual role, and (3) the perceptions of the nurses and patients about therapeutic community ideology.

Purpose of the study. It was the purpose of this study to attempt to gain objective, quantitative data which could be used to evaluate the changing role of the psychiatric nurse functioning in a therapeutic community. This evaluation might be used as an indicator of the effectiveness of the nurses' interpersonal relationships and job satisfaction in the therapeutic milieu.

It is possible that the tool (the Q-sort used in this study) could be utilized by psychiatric nursing instructors teaching in basic collegiate programs as an evaluative process for the student's experience in the therapeutic community. Further, it might be possible to utilize the tool as a pre-test given to psychiatric nurses entering the therapeutic community, then repeated at a later date to gauge her adaptation to the new nursing

role.

Justification for the problem. The therapeutic community is rapidly evolving as a replacement of the traditional setting for the care of patients in psychiatric hospitals. Since many experts in this field agree that the success of the therapeutic community rests on the ability of the staff to develop a therapeutic climate,[5] it seems relevant that some research be made to evaluate objectively the ability of the personnel to adapt their traditional role to this new one. Some studies have been done concerning the roles of personnel in the therapeutic community setting, but the investigator discovered none which attempted to see how the psychiatric nurse perceives herself in the setting.

The technique, Q-sort, used in this study provided a means of more objectively studying the role of the nurse. The Q-sort placements made by a group of patients was compared to the Q-sort placements made by the nurses so that correlation coefficients could be obtained.

Limitation and scope of the problem. The data

---

[5] Leigh M. Roberts, "Group Meetings in a Therapeutic Community," Research Conference on Therapeutic Community, ed. Herman C. B. Denbar (Springfield, Ill.: Charles C. Thomas, Publisher, 1960), p. 145.

collected for this study were obtained from one therapeutic community, the Fort Logan Mental Health Center. Whether or not there would be similar correlation in other mental hospitals was beyond the scope of this study. Twenty nurses and twenty patients were used as the sample.

II. DEFINITION OF TERMS USED

Nurse. In this study "nurse" will refer to a graduate nurse functioning as a therapeutic member of a team in the care of the patients in the therapeutic setting.

Role. ". . . a pattern or type of social behavior which seems situationally appropriate to him [a person] in terms of the demands and expectations of those in his group".[6]

Nurse Actual Role. The role which the subjects perceived as being performed by the nurse.

Nurse Ideal Role. The role which the subjects conceived as closer to the ideal (or perfect) performance of a nurse.

---

[6] S. S. Sargent, "Conception of Role and Ego in Contemporary Psychology," Social Psychology at the Crossroads, ed. J. H. Rohrer and M. Sherif (New York: Harper and Brothers, 1951), p. 360.

III. PREVIEW OF THE REMAINDER OF THE THESIS

In Chapter II pertinent literature pertaining to the therapeutic community, its evaluation, current trends toward its utilization in psychiatric hospitals, and the role of the nurse in the therapeutic community is reviewed and summarized. A description of the therapeutic community in the hospital in which the study was made is included. In Chapter III the methodology, the tool and the procedure for the study is described. Description and results of the pilot study are presented. Chapter IV includes the analysis and interpretation of the data. The summary, conclusions and recommendations based on the findings are found in Chapter V.

CHAPTER II

REVIEW OF LITERATURE

The literature was reviewed for this study to investigate the evolution of the therapeutic community and the current trends toward utilizing the therapeutic community in psychiatric hospitals. The role of the nurse in the therapeutic community was explored. Through the review of literature an attempt was made to learn whether studies had been done to measure objectively the perceptions of the nurse and the patient about the nurses' role. Literature regarding methodology and analyses was reviewed and was integrated into Chapters III and IV.

A survey of the literature included the majority of books written describing or relating to the therapeutic community. Many of the current texts in psychiatry, psychology, psychiatric nursing, and nursing were reviewed for material relating to the study. Periodicals which were reviewed included Nursing Research, The American Journal of Nursing, Nursing Outlook, Psychiatry, American Journal of Orthopsychiatry, The Journal of Consulting Psychology, The International Journal of Social Psychiatry, American Journal of Psychotherapy, and Mental Hygiene.

I. THE DEVELOPMENT OF THE THERAPEUTIC COMMUNITY

The name "therapeutic community" came into prominence with the work done in England by Maxwell Jones.[1] Many of the concepts which have been designated as basic premises upon which the therapeutic community was developed are actually as old as mental hospitals themselves. However, these ideas of liberalism, humane treatment and democratic approach were undeveloped and rudimentary and it was not until recently that "a world-wide trend of unprecedent scope had gotten under way."[2]

Each particular hospital experimenting with therapeutic milieux has taken a different form, but there appeared to be prevailing themes which were common and integral to all. Jones summarized these under three headings: (1) study of real life situations of the patient, (2) reorganization of the original hierarchy of the hospital to a more democratic setting, and (3) the patients' role in hospital society.[3] Schwartz and Shockley described the patterning of the milieu as consisting of three concepts:

---

[1] Maxwell Jones, The Therapeutic Community (New York: Basic Books, Inc., 1953).

[2] Henry Brill, "Historical Background of the Therapeutic Community," Research Conference on Therapeutic Community, ed. Herman C. B. Denbar (Springfield, Ill.: Charles C. Thomas, Publisher, 1960), p. 11.

[3] Jones, op. cit., p. 14.

(1) social structure of the institution, (2) interactions that are engaged in, and (3) goals which the staff are trying to achieve with the patient.[4] Brown described socialization, therapeutic use of interpersonal relations and group processes, and alteration of staff roles as key concepts in creating a therapeutic environment.[5] Rapoport encompassed these themes in his identification of four ideologies; democratization, permissiveness, communalism, and reality confrontation. Democratization focused around the view that each member of the community should share equally in decision-making of the affairs of the community. Permissiveness referred to the belief that all members of the community should tolerate a wide range of behavior. It also implied a diminution of institutional regulations. Tight-knit, interconnected, warm and intimate systems of relationships embodied the communalism ideology. Reality-confrontation referred to the belief that patients should be continuously presented with interpretations of their behavior as it was seen by others.[6]

---

[4] Morris S. Schwartz and Emmy R. Shockley, The Nurse and The Mental Patient (New York: Russell Sage Foundation, 1956), pp. 130-132.

[5] Milton Greenblatt, Richard H. York, and Esther Lucile Brown, From Custodial to Therapeutic Patient Care in Mental Hospitals (New York: Russell Sage Foundation, 1955), pp. 5 et seqq.

[6] Robert N. Rapoport, Community as Doctor (Springfield, Ill.: Charles C. Thomas, Publisher, 1959), pp. 54-64.

Caudill working as a concealed observer in a psychiatric hospital reported the psychodynamic functions from the viewpoint of an anthropologist. In his book, The Psychiatric Hospital As a Small Society, he convincingly presented the hospital as a small society which affected the behavior of the people who made it up.[7] His investigation directed hospital administrators to a careful and thoughtful analysis of the hospital social system and toward a clarification of social roles.

The collaborative work of Stanton and Schwarts which developed the hypothesis that covert disagreements between authority figures result in pathology in the patient is well known. This comprehensive study which related the importance of staff interrelationships has been widely accepted as a social psychiatric approach. "Administrative psychiatry" has been an approach given to this therapeutic milieu described in their book. They described administrative psychiatry as an attempt to integrate patients' hospital lives outside the specific therapy session with the overall goals of treatment and rehabilitation.[8]

---

[7] William Caudill, The Psychiatric Hospital as a Small Society (Cambridge, Mass.: Harvard University Press, 1958).

[8] Alfred H. Stanton and Morris S. Schwartz, The Mental Hospital (New York: Basic Books, 1954), pp. 9 et. seqq.

Dreikurs in describing the "third revolution" taking place in the psychiatric field said that this social psychiatric approach involves the use of administrative psychiatry, multi-person involvement [or group methods] and a milieu therapy.[9] Rapoport pointed out the therapeutic importance of communications channeling, authority, social class norms and other institutional social structure aspects as the operative elements.[10]

In all of the literature describing the new trends in psychiatry and the therapeutic community, in particular, the authors were alert to the significance of the patient and staff interactions. As Rapoport stated ". . . the total social organization is seen as affecting the patients' therapeutic outcome."[11]

II. THE NURSE IN THE THERAPEUTIC COMMUNITY

In the last decade many changes have occurred in the nurse's role.

> To create and maintain a warm supporting environment and to help patients gain positive benefit from it is the immediate responsibility of all members of the staff who work directly in the ward or group situation. In order to achieve this goal, the roles, particularly

---

[9] Rudolf Driekurs, "Group Psychotherapy, and the Third Revolution in Psychiatry," International Journal of Social Psychiatry, 1:23-32, Spring, 1956.

[10] Rapoport, op. cit., p. 11.

[11] Ibid., p. 22.

of nurses and attendants, will have to be changed . . .[12]

Greenblatt, et al, continued to define this change as one in which the nurse leaves behind the custodial-type nursing to spend as much of her time as possible in social interaction with the patients.[13] Schwartz and Shockley emphasized the nurse's role in stating, ". . . we hold that the nurse has a central role to play in the improvement of the patient's mental health."[14]

There were problems in this metamorphasis into a new role for the nurse. Rapoport described, at length, some of these problems for the nurses in their new role. They must work in a different environment in which discipline, orderliness, routine, and set channels of communication were subordinated. They gave up elements of authority because of the equalitarian participation set-up in a therapeutic community. Since the patient had some decision-making powers, the staff now had to reconcile their work to go along with this. However, the fact remained

---

[12] Leigh M. Roberts, "Group Meeting in a Therapeutic Community," Research Conference on Therapeutic Community, ed. Herman C. B. Denbar (Springfield, Ill.: Charles C. Thomas, Publisher, 1960), p. 145.

[13] Milton Greenblatt, Richard H. York, and Esther Lucile Brown, From Custodial to Therapeutic Patient Care in Mental Hospitals (New York: Russell Sage Foundation, 1955), p. 417.

[14] Schwartz and Shockley, op. cit., p. 245.

that some things, such as handling of drugs, remained an authoritarian precept. The nurses too, were hampered by scheduling problems and administrative duties which had to be fulfilled.[15] The confusion that might have existed from such contradictions was commented on by most of the writers. Caudill further commented on the confusion of the nurse about which aspects of her behavior and role were considered therapeutic.[16] Jones defined the nurse's role as a combination: authoritarian, social and therapeutic. "Her role is more to interpret or transmit the Unit [therapeutic milieu] culture to the patient; the more she has accepted this culture, the more readily and completely can she fulfill her role."[17] Furthermore, Jones placed great responsibility on her, ". . . more than any other member of the staff [the nurse] can be said to transmit the culture of the unit to the patient."[18]

Peplau and Tudor pointed out that the nurse must become aware of the changes occuring in the field of psychiatric nursing and adapt their roles to fit these

---

[15] Rapoport, op. cit., p. 122.

[16] Caudill, op. cit., p. 336.

[17] Jones, op. cit., p. 36.

[18] Ibid., p. 158.

changes.[19] Nurses have the paramount task to become aware of how they experience the participation of patients in ward situations and to find out how patients experience their participation.[20] Evaluation of these changes or how effective they are seemed to be in question. Roberts pointed out that individual distortions by staff members when they attempted evaluation occurred because of their emotional investment. He suggested that subjective evaluations of the patients were subject to similar distortion.[21] Because of such premises, many investigators of the effectiveness of the milieu approach made use of research techniques such as questionnaires, check-lists, critical incident evaluation, structured interviews, projection techniques and scaling techniques such as the Q-sort and semantic differential.[22]

---

[19] Hildegarde Peplau, Interpersonal Relations in Nursing (New York: G. P. Putnam's Sons, 1952), p. 70; Gwen Tudor Will, "Psychiatric Nursing Administration and Its Implication for Patient Care," The Patient and the Mental Hospital, ed. Milton Greenblatt, Daniel J. Levinson, and Robert H. Williams (Glencoe, Ill.: The Free Press, 1957), pp. 237 et seqq.

[20] Peplau, op. cit., p. 259.

[21] Roberts, op. cit., p. 137.

[22] A. F. Meszaros, "Principles of Research in a Therpeutic Community," Research Conference on Therapeutic Community, ed. Herman C. B. Denbar (Springfield, Ill.: Charles C. Thomas, Publisher, 1960), p. 11.

III. THE THERAPEUTIC COMMUNITY IN WHICH THE STUDY WAS CONDUCTED

The Fort Logan Mental Health Center, the area in which this study was made, is the second state hospital in Colorado. The Fort Logan plan was set up on a community-oriented approach in that a specific unit of the hospital serves a specific geographic area.[23] The following concepts of a therapeutic community were unified into their treatment program:

1) a strong reliance on "transitional services;
2) permanent assignment of each patient to a particular therapy team, from admission to discharge;
3) a community-oriented program wherein specific units of the hospital serve specific geographic areas;
4) minimum security;
5) emphasis on using the therapeutic milieu as a treatment modality in its own rights;
6) use of family-care homes for patients requiring prolonged custodial care.[24]

It was planned to operate as a "virtually completely open psychiatric institution."[25] The patient group was to

---

[23] Frederick A. Lewis, Jr. and Alan M. Kraft, "Fort Logan: A Community-Oriented Program," Mental Hospitals, 13:154, March, 1962.

[24] Ibid., p. 154.

[25] Ibid.

serve as a therapeutic modality to the individual. A deliberate effort was made to "blur" the conventional roles of the professional staff members. Geographic designations were made according to the community served. These were called "units"; each unit was subdivided into the teams, the functional divisions of the staff. The patient was treated by the team. The members of the teams included a psychiatrist, psychologist, social worker, nurses, and technicians (or psychiatric aides or attendants). Other hospital resources were available to all the teams. In the philosophy of the Fort Logan Mental Health Center, it was emphasized that "the most important therapeutic tool of a hospital program is the relationships between the patient and the staff with whom he comes in contact."[26]

IV. STUDIES RELATED TO THE PROBLEM

Although in the report Action for Mental Health definitive research was questioned, there are books and articles published which indicated interest in qualitative and quantitative studies of interpersonal mechanisms and object relationships.[27] References have been made in

---

[26] "Philosophy of Fort Logan Mental Health Center" (Mimeographed information sheet, n.d.).

[27] Joint Commission on Mental Illness and Health, Action for Mental Health (New York: Basic Books, Inc., 1961), p. 187.

Chapter I to some of these outstanding studies and reports. Greenblatt, et al., confirmed the need to keep attention focused on social experimentation as a positive means for helping staff move toward higher levels of patient care and more satisfaction in their work.[28]

Gillis reported a study done in the therapeutic milieu in Johannesburg, South Africa, using participation on the part of the patient as a measurement of clinical change in the patient. This participation centered around: (1) interpersonal relationships and interactions with members of the staff, (2) involvement of the patient in his own treatment, and (3) increasing interest in occupational therapy, recreational therapy and group activity. Gillis concluded that the quantity of participation is used by the staff to judge improvement in the patient.[29]

Irvine and Deery investigated problem areas relating to the therapeutic community concept. They specified problems in the areas of communication, authority, patient-responsibility, and patient-role expectations. They inferred that particular attention given in these areas was needed in order to implement the creation of a social

---

[28] Greenblatt, York and Brown, op. cit., p. 25.

[29] Lynn Gillis, "Participation - Its Measurement and Relationship to Clinical Change in Psychiatric Illness," International Journal of Social Psychiatry, 6:288-301, Autumn, 1960.

environment which would have therapeutic effects on the patient.[30]

The tool, Q-sort, was used by Gralnick and D'Elia to check the concept of the patient's individual freedom versus his responsibility to the group. They recommended that further study of the new role of the patient be made to understand how this role promotes improvement. They found that factors which affected feelings and attitudes of the patient were determined by behavior, tradition, mores, and moral values of the hospital community.[31]

Parloff in his study used a Q-sort to analyze the nurse's role in relating to patients. He concluded that success in establishing a ward milieu program may be sharply limited by the extent to which the nursing role is initially congenial to the staff.[32]

Whiting has reported on several studies involved with evaluation of interpersonal relationships. In a recent study with Murray, Whiting hypothesized that if the

---

[30] Laverne F. Irvine and S. Joel Deery, "An Investigation of Problem Areas Relating to the Therapeutic Community Concept," Mental Hygiene, 45:367-73, July, 1961.

[31] Alexander Gralnick and Frank D'Elia, "Role of the Patient in the Therapeutic Community: Patient-Participation," American Journal of Psychotherapy, 15:63-72, January, 1961.

[32] Morris B. Parloff, "The Impact of Ward-Milieu Philosophies on Nursing Role Concepts," Psychiatry, 23: 141-151, May, 1960.

network of relationships built up in any hospital allows for mutual satisfaction of patients' needs and hospital staffs' needs, then patient care was effective.[33] "If these needs are not satisfied, then in the long run, patient care deteriorates."[34] He presented his study as aimed at developing "a genuinely scientific theory of hospital social structure."[35] In another study Whiting emphasized the efficacy of the Q-sort as a technique to be used to increase understanding of how ". . . interpersonal relationships are perceived by nurses themselves and by other people outside nursing."[36]

In a study on social structure and the value systems of psychiatric patients, Caudill, et al., found that the values and beliefs of the patients and staff were incompletely known or understood by the other. The two groups viewed one another in terms of sterotypes which impeded

---

[33] J. Frank Whiting and Marian A. Murray, "Toward a Theory of Hospital Social Structure Based on Objective, Quantitative Data," The International Journal of Social Psychiatry, 7:173-180, Summer, 1961.

[34] Ibid., p. 173.

[35] Ibid., p. 180.

[36] J. Frank Whiting, "Q-sort: A Technique for Evaluating Perceptions of Interpersonal Relationships," Nursing Research, 4:70, October, 1955.

an accurate evaluation of social reality.[37]

Wilmer reported the "need to identify, define and study significant elements of the therapeutic milieu as objectively and accurately as possible." This recommendation was made as a result of his study which was focused on a definitive description of the therapeutic community.[38]

V. SUMMARY

In this chapter, the therapeutic community and the nurse's role in this milieu have been described. Included was a description of the hospital in which the study was made. The research studies and reports indicated the interest in the significance of staff and patient interrelationships. The use of the Q-sort as a tool for measuring role concepts was evidenced. However, no studies which involved both nurse and patient in an objective, quantitative evaluation of how the nurse perceives herself in the therapeutic community were apparent.

---

[37] William Caudill, Fredrick Redlick, Helen Gilmore and Eugene Brody, "Social Structure and Interaction Processes in a Psychiatric Ward," American Journal of Orthopsychiatry, 22:314-334, April, 1952.

[38] H. A. Wilmer, "Toward a Definition of the Therapeutic Community," American Journal of Psychiatry, 114[2]: 824-833, March, 1958.

CHAPTER III

METHODOLOGY

In attempting to gain new insights into the phenomenon of the perceptions of the nurse and patient, the study-maker must use a method of research which is relevant to this concept. This method of research falls into the broad grouping of a *formulative* or *exploratory* study.[1]

I. DESCRIPTION OF METHOD USED

> Few well-trodden paths exist for the investigator of social relations to provide clear guidance for empirical research. In these circumstances, exploratory research is necessary to obtain the experience that will be helpful in formulating relevant hypotheses for more definitive investigation.[2]

Objectivity in evaluation of interpersonal (and group) relationships is in an area of speculation and little, if any, research has been done that relates to it. The research worker entering the area is not in a position to advance any precise hypothesis for investigation. The task becomes one of reviewing available material and collecting data with a sensitivity to the emerging hypothesis that

---

[1] Claire Selltiz, Marie Jahoda, Morton Deutsch, and Stuart Cook, *Research Methods in Social Relations* (New York: Henry Holt and Company, 1958), p. 50.

[2] *Ibid.*, p. 52.

may be derived from it. Selltiz, et al., warned that this type of research must be flexible and suggested that the method of study may vary but should be an intensive study of selected instances in which one is interested.[3] There are specific features of this approach needed to make it an appropriate procedure: (1) an alert, seeking attitude of the investigator, (2) the intensity of the study of the individuals or group involved (the individuals may be treated as informants about the object rather than being themselves the object of intensive analysis), and (3) the ability of the investigator to integrate the information into a unified interpretation.[4]

II. DESCRIPTION OF TECHNIQUE USED

To find a technique which provided a convenient means of assessing the extent of agreement among people about the way concepts are employed led the writer to an investigation of the Q-sort technique.[5]

Stephenson supported the Q-technique as a method by which man's attitudes, his thinking behavior, his personality, his social interaction, his self, his psychoanalytic

---

[3] Ibid., p. 60.

[4] Ibid.

[5] The prefixing letter Q has no special significance. By historical accident, the method came to be identified this way.

mechanisms and all else objective to others or subjective to himself can be studied scientifically. "This," he said, "can be done without any formal scales or measuring instruments of any kind with which psychology is familiar."[6]

Block described the Q-sort method comprehensively but more simply, pointing out its relevance for personality and psychiatric research.[7] In the Q-sort method, the evaluator is given a set of statements or items previously developed or fixed upon. This set of statements constitutes the entire vocabulary the evaluator is permitted to employ. The procedure can be used with any number of statements. Any statement can be used in the sorting, depending upon the problem. The items included are put in the order of significance for the evaluation, those most characteristic of him (or the person being scored) given high score, while those least characteristic are scored low.

Certain principles to be employed in writing Q-items are: (1) each item is written in a theoretically, neutral form, (2) each item is written to suggest a continuum, (3) each item is written to express a single psychological

---

[6] William Stephenson, The Study of Behavior, Q-Technique and Its Methodology (Chicago: University of Chicago Press, 1953), p. 5.

[7] Jack Block, The Q-Sort Method in Personality Assessment and Psychiatric Research (Springfield, Ill.: Charles C. Thomas, Publisher, 1961), pp. 7-12.

element to avoid "double-barrelled" phrasings, (4) only variables that are conceptually independent of each other are included, (5) items may include related but not equivalent variables, (6) redundant words may be used since logical or verbal opposites are not necessarily psychological opposites; and (7) value judgments should be prevented by composing items in a neutral and unevaluative form; however, some evaluative terms are unavoidable.

Conventionally, the Q-items are printed separately on cards, a convenience which permits easy arrangement and re-arrangement of the items until the desired ordering is obtained. The evaluator must order the Q-items with an assigned number placed in each category. This is the "forced choice" method. The prescribed distribution is a symmetric one with a fixed but sensible number of judgment categories. Most psychologists assume that the Q-distribution must be normal or Gaussian but there are other possibilities.

After the sorting, the placement of each item is recorded on a record sheet. The data are now ready for analysis and the cards can be reshuffled, preparatory to another sorting. The treatment of Q-sort data can be approached in several ways; the most common are: (1) the comparison of item placements in one Q-sort with item placements in another Q-sort and (2) the comparison of Q-sort placements in one group of individuals with Q-item placements

in another group of individuals.

III. METHOD OF PROCEDURE

Approval for the study. A personal visit was made to the medical director of the Fort Logan Mental Health Center to discuss tentative plans for the study to be conducted in that hospital. Preliminary planning was also done with the director of nurses. A formal letter was written to the medical director to confirm the permission which had been granted in the oral interview. A copy was sent to the director of nurses. It was decided at a later date to identify the hospital in the study so written permission was requested and granted for this additional request. Copies of these letters appear in Appendix A.

Construction of the instrument. Items for the Q-sort were constructed using statements and descriptions of the ideologies expressed by many of the leading authorities in the therapeutic community.[8] These were found to be compatible and inclusive of the ideologies which were in effect at

---

[8] Maxwell Jones, The Therapeutic Community (New York: Basic Books, Inc., 1953); Robert N. Rapoport, Community as a Doctor (Springfield, Ill.: Charles C. Thomas, Publisher, 1959); Alfred H. Stanton and Morris S. Schwartz, The Mental Hospital (New York: Basic Books, 1954); Milton Greenblatt, Daniel J. Levison, and Robert H. Williams (eds.), The Patient and the Mental Hospital (Glencoe, Ill.: The Free Press, 1957).

the Fort Logan Mental Health Center.[9]

Fifty-two items were submitted to a committee of four judges composed of a psychiatrist working in a therapeutic community setting in a local psychiatric institution other than the Fort Logan hospital, a research psychologist at Fort Logan, a psychiatric nurse specialist, and a lay person. They were asked to review the items for ambiguity, clarity, and relevancy. The instruction to the committee are reproduced in Appendix B.

An attempt had been made to subdivide these statements into categories of four important and prevalent ideologies: permissiveness, democratization, communalism, and reality-confrontation.[10] It was anticipated that the categories would be difficult to isolate definitively since there is great overlapping of ideas from one category to another. The above committee did not agree on the study-maker's original placement. Further evaluation to see if the items would be identified and placed under the four categories was done by a group of six psychiatric nursing specialists. No agreement on the categorizing of these items was effected, so this portion of the problem was

---

[9]Federick A. Lewis, Jr. and Alan M. Kraft, "Fort Logan: A Community-Oriented Program," Mental Hospitals, 13:154-157, March 1962; "Philosophy of Fort Logan Mental Health Center" (Mimeographed information sheet, n.d.).

[10]Rapoport, op. cit., pp. 51-64.

discarded.

Fifty-one statements were accepted as Q-sort items with minor revisions made in wording and terminology. These statements as revised and used are listed in Appendix C.

The Q-sort items were typewritten onto construction-paper cards, 1" x 3", one statement on each card. A total of ten packs were prepared. Ten poster cards were prepared by drawing blocks the size of the cards on them.[11] Nine categories were designated with an assigned number of items placed in each category. The number placed in each category was determined by a normal curve distribution. Table I shows this distribution.

TABLE I

NUMBER OF CARDS IN EACH ROW ON SORTING POSTER CARDS

Number of cards	1	2	5	11	13	11	5	2	1
Row number	1	2	3	4	5	6	7	8	9

Selection of sample. Restricted random sampling was done to obtain the twenty nurse and twenty patients subjects

[11] Philip Howe Chase, "Concepts of Self and Concepts of Others in Adjusted and Maladjusted Hospital Patients" (unpublished Doctor's dissertation, The University of Colorado, Boulder, Colorado, 1956), p. 32.

[12] Block, op. cit., p. 80.

who were to do the Q-sorts. The restriction in patient selection was to limit the sample to include day-care or twenty-four hour patients only. This restriction was made because the attendance of patients under "Out-Patient" care was so irregular. The restriction in nurse selection limited the sample to include those nurses working in a team situation.

A list of all the patients who fit into the above designation was made and they were given consecutive numbers. Random digits from a table of random numbers[13] were assigned to this list of 215 patients. The patients with the twenty lowest digit numbers were chosen.[14]

Since the nurse population was smaller, another technique was used. A random number from a random number table was placed opposite each name and the twenty with the lowest number were used as the sample.[15]

Any patients who had been discharged in the interim were replaced with alternates chosen in the same manner as in the original sampling. Nurses who left employment before the study-maker contacted them for the sorting were

---

[13] W. Allen Wallis and Harry V. Roberts, Statistics, A New Approach (Glencoe, Ill.: The Free Press, 1956), pp. 334-5.

[14] Ibid.

[15] Ibid.

replaced with alternates chosen in the same manner as in the original sampling.

Collection of data. The subjects were contacted as their name appeared on the random sample list, and they were asked to participate in the study. If they were available at this time, the sort was done; if not, appointments were set up at their convenience.

Nurses and patients did not perform the sorts at the same time since the instructions for the two groups were different. However, as many as five of the subjects did perform the sorts at one time.

Two sorts were done by the nurses: the first, the nurse-actual role; second, the nurse-ideal role. The patient did only one sort, patient-perceived-nurse-actual role. Following is the description of the sorts as they were performed by the subjects. Nurse-actual--in this sort the nurses sorted the Q-sort items as they perceived themselves actually doing, behaving or believing. Nurse-ideal--in this sort the nurses sorted the Q-sort items as they perceived they would do, behave, or believe if it were an ideal (or perfect) situation. Patient-perceived-nurse-actual--in this sort the patients sorted the Q-sort items as they perceived how the nurse was actually doing, behaving or believing. The nurses were requested to perform two sorts so that her actual role could be correlated

with her ideal role in order to derive an index of agreement. The patient was asked to perform one sort, his perception of the nurse's actual role. Information from the correlation of this sort with the nurses' sorts might indicate the degree that the nurse communicated her role to the patient.

The physical setting needed for the procedure included privacy, relative quiet, table large enough to hold poster, chairs, and adequate lighting. The study-maker utilized many areas in the hospital in order to make it convenient for the subjects and expedite collection of data.

The subject (or subjects) was seated at a table with the poster card and pack of shuffled cards. The instructions were read to the subject and illustrated as was indicated. Instructions for the patient and nurse are reproduced in Appendix D. Any questions were answered by the investigator which concerned the technique of sorting, but any attempt to interpret the Q-sort item was avoided. There was no time limit for the sorting.

Since the nurses were involved in two sorts, as soon as the first one had been completed the poster cards with the Q-sort item cards in position was removed and replaced with another poster and another pack of shuffled cards. Additional instructions were given. The range of

time for the first sort by nurses was thirty to forty minutes; for the second, fifteen to twenty minutes. The time taken by the patients varied more; there was a range from twenty minutes to one hour.

The sorted cards were picked up from the blocks on the poster card systematically so that they could be tabulated on a data sheet. (See Appendix E.) Any time this compilation was not done immediately, the packs were carefully kept in order with a rubber band, adequately identified, and the data transposed at a later time.

The investigator was received cordially by the subjects, and on the whole, the subjects were enthusiastic about performing the sorts. One patient requested that the investigator wait until the next day until she "felt better". Another patient refused to perform the sort one day, but willingly complied the second day upon a repeated request. One patient having heard the term "Q-sort" was unwilling to submit to any more "I.Q." tests. When the procedure was explained, she readily agreed to perform the sort.

Many patients approached the investigator and requested permission to do the sort. Some expressed their disappointment at not having been included in the random sample. Comments from some of the patient participants showed a variety of interests. One young man questioned

the technical use of the "forced-sort" technique. Another patient commented, "It is nice to get to evaluate, rather than always being evaluated". Another commented that even though it was an arduous task, she would complete it if it would help in any way for the patients to get better care. Still another remarked about the difficulty of sorting based on the idea of how she perceived the nurses as behaving, "I have to keep remembering this isn't how I feel, but how I think the nurses see it".

The nurses most frequently voiced opinions that the events of the particular day would possibly have bearing on their sorting of the items. Unanimously, they requested to be informed of the results of the study.

Tabulation of data. The items were recorded on the score sheet (see Appendix E). Each item was given the score of the number of the row in which it had been placed for that particular subject's sort (e.g., if the statement was placed in the fourth row, it received the score of 4). These scores were then transferred to a large ruled score sheet to facilitate finding the mean score of each card, as well as to have the scores readily available for correlation coefficient calculation. This is shown in Appendix E.

Statistical data. Mean scores for each item in each different sort done by the nurses and patients were computed.

These are shown in Appendix C. Intergroup comparison was made by computing a Pearson's product-moment coefficient of correlation. The coefficient relating each pair of sorts was found to be significant at the .01 level in every case.

Plan for analysis of data. The Q-sort items had been sorted in a continuum from "most likely" or "positive" to "least likely" or "negative". These cards were ranked according to the mean score given them by the group. It is recognized that by the item's placement, the subject is expressing his evaluation of whether or not the item provides a central theme and is defined as a decisive item.[16] An arbitrary supposition was made that the items placed in rows one to four would be positive statements, six through nine would be negative, and row five would indicate neutrality. It was then possible to say what the subjects' perceptions were or were not about the nurses' role in the therapeutic community.

IV. THE PILOT STUDY

Preliminary planning. The study-maker was acquainted somewhat with the facilities and some of the personnel at the hospital, however, she spent a week before she started

---

[16] Block, op. cit., p. 87.

her study with the staff and patients in the various cottages. During this time, she was introduced in group meetings and her project explained to the patients. She wore street clothes as did the nurses in the hospital. She identified herself as a graduate nurse student whenever the occasion arose.

The purpose of the pilot study. The pilot study was conducted to pretest the data-collection instrument. A secondary purpose was to check the method of administration. The study-maker wished to find out if the use of a code number on the reverse side of the Q-sort item would be of concern to the patients or interfere with the subjects's placement of the card. If there were any other difficulties in administering the sort, the pilot study would focalize these.

Procedure for the pilot study. The first four subjects from both lists (the patient list and the nurse list) were used in the pilot study. A test re-test method was selected to obtain reliability coefficients for the different sorts. A period of four days elapsed between the first sort and the re-test. Description of the actual collection of data is given on page 29.

Findings of the pilot study. Reliability coefficients were computed for each subject who performed the sorts in

the test-retest pilot study. The coefficient of correlation is an index number and does not demonstrate percentage of relationships.[17] However, Guilford further explained that the degree or strength relationship can be described roughly as follows for various "r's":

Less than .20	Slight; almost negligible relationship
.20-.40	Low correlation; definite but small relationship
.40-.70	Moderate correlation; substantial relationship
.70-.90	High correlation; marked relationship
.90-1.00	Very high correlation, very dependable relationship.[18]

From these criteria above, the minimum of .40 was accepted as an indication of reliability. The graphic representation of the correlations in Table II points out that most of the coefficients were in the classification of "moderate" or "high" correlation.

A coefficient of .354 would have been significant at the .01 level of significance and a coefficient of .273 would have been significant at the .05 level.[19] All the coefficients were above the accepted reliability and the

---

[17] J. P. Guilford, Fundamental Statistics in Psychology and Education (New York: McGraw-Hill Book Company, Inc., 1956), p. 145.

[18] Ibid.

[19] Henry E. Garrett, Statistics in Psychology and Education (New York: Longmans, Green and Company, 1947), p. 466.

.01 significance levels.

TABLE II

TEST-RETEST RELIABILITY COEFFICIENTS

Nurses	Actual-role	Ideal-role
1	.678	.824
2	.774	.900
3	.927	.900
4	.871	.953

Patients	Perceived-nurse actual-role
1	.479
2	.632
3	.707
4	.707

The pilot study was included as part of the sample for the overall study. This decision was made on the basis that: (1) the correlation coefficients computed for the test-retest subjects indicated substantial relationship, (2) no change was indicated as necessary in the administration of the Q-sort, (3) no Q-sort items needed revision or omission, and (4) the coding technique was usable.

V. SUMMARY

In this chapter, the methodology and technique used in the study were discussed. The plan for the development of the study included information about the construction of the instrument and the collection of data. Plans for the statistical analysis of the data were discussed. The pilot study, in its entirety, was explained. The interpretation and analysis of the total study will be found in Chapter IV.

CHAPTER IV

ANALYSIS AND INTERPRETATION OF DATA

Since the problem of the study was to investigate the perceptions of the nurse and the patient in the therapeutic community, the analysis was based on data obtained from the three sorts: the nurse-actual sort and the nurse-ideal sort performed by the nurses and the sort done by the patients, the patient-perceived-nurse-actual sort. (These are defined on page 29.) The interpretation of the data was done by a descriptive comparison of (1) the nurse-actual role and the nurse-ideal role, and (2) the patient-perceived-nurse-actual sort with the two sorts done by the nurses.

I. STATISTICAL ANALYSIS OF DATA WITH INTERPRETATIONS

Correlation coefficients for intergroup comparison were computed. The correlation between the mean ratings for each pair of the three sorts performed was calculated. The correlation coefficients which are given in Table III were made by computing a Pearson's product-moment coefficient of correlation. This statistical analysis was computed to measure the degree or strength relationship between the

pairs of sorts. (The details of this statistical analysis have been elaborated on in Chapter III, page 33.)

TABLE III

CORRELATION COEFFICIENTS OF INTERGROUP AND INTERSORT COMPARISONS

Nurse-actual with nurse-ideal	.836
Nurse-actual with patient-perceived-nurse-actual	.714
Nurse-ideal with patient-perceived-nurse-actual	.566

Interpretation of nurse-actual and nurse-ideal comparisons. The high correlation of .836 (see Table III) between the nurse-actual and nurse-ideal role suggested two possibilities. First, that the nurse working in the therapeutic community is actually performing very close to what she might perceive as the ideal role. Second, this high correlation could suggest satisfaction in her role as has been indicated by Caudill and Rapoport. Caudill indicated in his extensive study a pessimism and lack of determinancy on the part of nurses (more pronounced than in other staff members) and related it to a somewhat more poorly defined role for the nurse.[1] Rapoport spoke of the

[1] William Caudill, The Psychiatric Hospital as a Small Society (Cambridge, Mass.: Harvard University Press, 1958), pp. 159-161.

dilemma arising from "built-in contradictions" between the two sets of role conception, i.e., the idea of equalitarianism and the formal highly differentiated authority and responsibility.[2] He suggested that minimizing the discrepancy between "idealogically prescribed behavior and role behavior prescribed in the conventional system" might be a valuable postulate for staff organization.[3]

Interpretation of nurse-actual and patient-perceived-nurse-actual comparisons. The correlation (r = .714) between the nurse-actual with the patient-perceived-nurse-actual may well reflect the ability of a psychiatric patient to be involved in more complex tasks such as Q-sorts. This is in contradiction to the opinions expressed by Whiting and Murray ". . . since our research techniques [use of 100 item Q-sort] call for complex judgments, the very nature of the psychiatric patients' illness precluded obtaining reliable data from them."[4] More in line with this study-maker's opinion was Allport's suggestion

---

[2] Robert N. Rapoport, Community as a Doctor (Springfield, Ill.: Charles C. Thomas, Publisher, 1960), p. 276.

[3] Ibid.

[4] J. Frank Whiting and Marian A. Murray, "Toward a Theory of Hospital Social Structure Based on Objective, Quantitative Data," The International Journal of Social Psychiatry, 7:174, Summer, 1961.

> . . . if you want to know how people feel what they experience and what they remember, what their emotions and motives are like, and the reasons for acting as they do--why not ask them?[5]

This correlation took on special significance in consideration of the fact that the nurse might perceive herself as doing, behaving or believing in such a way but was it communicated to the patient in such a way? Will advocated, as one of the keys to therapeutic functioning on the part of the nurse, a need for her to be aware and alert to the mutual nature of the nursing process.[6] The correlation ($r = .714$) suggested that the patient was aware of how the nurse was functioning and that it had been communicated to him.

Interpretation of nurse-ideal and patient-perceived-nurse-actual comparisons. The correlation ($r = .566$) between the nurse-ideal and the patient-perceived-nurse-actual role suggested that the patient had realistically and factually sorted the Q-sorts items as to what he

---

[5]Gordon Allport, "The Use of Personal Documents in Psychological Science," Social Science Research Council, Bulletin 49 (New York: S.S. Research Co., 1942), p. 57.

[6]Gwen Tudor Will, "Psychiatric Nursing Administration and Its Implications for Patient Care," The Patient and the Mental Hospital, eds. Milton Greenblatt, Daniel Levison, Richard H. Williams (Glencoe, Ill.: The Free Press, 1957), p. 239.

observes. This lower correlation suggested again that the patient was aware of communication through the nurse's behavior and somewhat accurately gauged a situation as it was perceived by other people. It could be hypothesized that a higher correlation in this sort would indicate that the patient did not report what he perceived as the actual role but perhaps had projected his wishes or needs into the sorting.

II. DESCRIPTIVE INTERPRETATION OF THE DATA

The statistical analysis of the data obtained in this study has shown the significance of agreement between sorters in describing a set of subjects. The descriptive interpretation of the data which follows will be less scientific and somewhat presumptive on the part of the study-maker. However, such interpretations were given some validation by Cronback who stated

> . . . The Q profile is halfway between the idiosyncratic, highly personalized sketch a clinician might write, and the formal diagnostic profile from the Wechsler or some other test which 'measures' the person on a limited number of scales.[7]

Mowrer substantiated this idea further,

---

[7]Lee J. Cronback, "Correlations Between Persons as a Research Tool," Psychotherapy Theory and Research, ed., O. Hobart Mowrer (New York: The Ronald Press Co., 1953), p. 377.

> . . . [Q-sort technique] leads to an over-all, integrated conception of psychological inquiry which systematically relates and unifies the more strictly experimental methods with specifically 'clinical' approaches.[8]

Descriptions and comparisons of the nurse-actual and nurse-ideal roles. The positive statements agreed upon in both the nurse-actual and nurse-ideal sorts were those which clearly expressed or defined ideologies of the therapeutic community. (The mean scores of the items of all sorts are shown in Appendix C.) The statement, "The family should be involved in the patient's treatment plans" was rated most positive (mean 2.65 nurse-actual role and mean 2.55 nurse-ideal role). Placement of this item suggested the nurses' acute awareness of the community and family oriented program.

Other positive statements clearly pointed out the nurses' recognition of permissiveness. Such items as "The nurses respect the right of the patient to act differently," "The nurse listens to and carries out suggestions from the patients," and "Discipline is necessary to control a patient when he is abusive or destructive in the hospital" are included in the positive statements. This indicated a therapeutic conception of permissiveness.

---

[8] O. Hobart Mowrer, "Q-Technique - Description, History and Critique," Psychotherapy Theory and Research, ed. O. Hobart Mowrer (New York: The Ronald Press Co., 1953), p. 375.

Further awareness of the nurses' understanding of permissiveness used as a therapeutic rationale was indicated by the negative scoring of such items as "Freedom means to do as one pleases," and "The nurse permits the patient to do anything he wants as long as it is not dangerous." Complete freedom for the patient would indicate a chaotic situation with no controls. The limit-setting inferred in the latter statement implied the utilization of therapeutic intervention by the nurse.

The ideology of democratization was indicated by the positive scoring of items describing the involvement of patients in group therapy and in decision-making, the blurring of staff roles, and in the sharing of responsibility. The nurses suggested their adoption of the democratic ideology by negating their position as authority figures. However, they appeared reluctant to place any great emphasis on the item, "We are all equals; the staff can be as uninformed or confused about things just as patients sometimes are," and have scored it neutrally. The highest negative mean score (mean 8.15) in the nurse-ideal sorting was the item "Most of the rules in the hospital are for the patients' benefit." This might have indicated some strong feelings about the origin of rules. Are rules established by the staff to use for patient control or are they democratically established by all

(patients included) to be used for the benefit of the patient? The possibility of this heavily-rated item reflecting discomfort or difficulty in limit-setting by the nurses was considered.

Emphasis on the hospital as a miniature society where the hospital and community are closely interrelated was shown by the nurses' scoring of some items. "Psychiatric hospitals should provide a change from ordinary life where one can rest and escape stress," was given a negative scoring. "The hospital is a place to forget outside problems," scored negatively, indicated the emphasis the nurses feel should be placed on reality-confrontation. "Nurses in street clothes are more approachable," was scored positively and the item, "Nurses in uniform seem more like 'helping' people," was given a high negative scoring.

The scoring of some of the Q-sort items indicated a departure from the traditional nursing role by the nurses engaged in nursing in a therapeutic milieu. The traditional role of emphasizing physical care was negated by the scoring of pertinent items. "It is important to see that a patient has enough sedative to allow him to get a good night's sleep" was scored neutrally (nurse-actual 5.30 - nurse-ideal 5.25). "Patients should eat every meal" was scored neutrally, as was the item, "It is better that some doors in the hospital are kept locked."

The nurse in the authoritarian role has been thoroughly trained to accept the physician as the authority; in the therapeutic milieu the nurse assumes more responsibility and relates on a more collaborative basis with the doctor. Her acceptance of this philosophy was indicated by her placement of these items. "Nurses do as much participating in group therapy as other staff members," was rated positively. Negative scoring of "The nurse frequently refers the patient to the doctor to get help in solving problems" indicated her acceptance of responsibility in decision-making and problem solving.

The new role requires permissiveness and need fulfillment regarding patient care. Numerous items were scores in areas which indicated the nurse accepting this ideology. Some of these have been elaborated on earlier in this chapter (see page 44). Further indication that the nurse places prime value on fulfilling patients' needs was seen by the positive scoring of such items: "Patients are encouraged to express their feelings," "The nurse is frequently aware of how the patient feels," "The nurse recognizes that the patient can make his own decisions," "The nurse spends the majority of her time with the patients," "A patient should have some time to himself," "The patient could be a leader in group therapy," "Everyone should know what is expected of him." A negative scoring

of the item, "What a patient thinks or feels is nobody's business but his own," further stressed their involvement in the patients' emotional needs.

The nurse's role as an authoritarian figure was minimized in the therapeutic community. An indication of this was seen by the positive scoring of the items, "A group decision made by patients can be a valid one." This suggested that the nurse devalued her old role of disciplinarian and custodian. Further reflection of this philosophy was suggested by the positive scoring of "The patient has a right to choose his own friend, either male or female." Neutral scoring of "Nurses should see that patients obey the regulations" indicated the nurse sees the patient as responsible for his own behavior rather than the nurse acting as an enforcer of rules. The involvement of patients in decision-making was suggested by the positive scoring of "Patients should help to decide how their fellow patients should be treated." The nurses did not accept the close supervision and direction of patients as a prerogative of their nursing role. The nurses scored the item, "Patients are usually more comfortable being with other patients rather than staff members," neutrally. This appeared to indicate that the nurses perceived that the patients had accepted the nurses' involvement in reality-confrontation.

Descriptions and comparisons of the patient-perceived-nurse-actual with the nurse-actual and nurse-ideal roles. Although the majority of the items placed in the positive area were the same as the nurses' sorts, there were significant variables. The patients scored the item, "Mentally ill patients should be cared for in psychiatric hospitals," positively. The nurses in both the ideal and actual sorts scored it neutrally. "Psychiatric hospitals should provide a change from ordinary life where one can rest and escape from stress," was scored neutrally by the patients, but heavily negative by the nurses. It could be assumed that by the scoring of these two preceding items the patients perceived the nurses as viewing the hospital somewhat in the old traditional manner. "Cleanliness and orderliness are necessary for the patients' comfort," was scored positively by the patients; the nurses placed it neutrally. "Nurses should see that the patient obey the regulations," is scored positively by the patients and neutrally by the nurses. The placement of these items in the patients' sorting suggested that the patients still perceive the nurse and hospital as protective and somewhat authoritarian. A somewhat different perception of the nurse than her own perception was indicated by the positive scoring of the item, "The nurse has many activities which prevent her being with the patient." The patients suggested that the nurses do not spend as much time with

them as the nurses perceived that they do. There was further validation of this by the patients' neutral scoring of the item, "The nurse spends the majority of her time with the patient." The scoring by the nurses was heavily positive.

The patients sorted the items relating to authority and status much the same as the nurse. Many of these items were scored neutrally in all three sortings suggesting that a relatively low degree of importance was assigned to these items.

The item, "Patients are unpredictable and sometimes dangerous," was scored heavily negative by the nurses suggesting strong feelings about the cliches attached to mental illness. The patients, however, de-emphasized the importance by scoring this item neutrally.

The patients scored fewer items negatively than the nurses, but they were in agreement with those which were included. "What a patient thinks or feels is nobody's business but his own," was scored most heavily negative (mean 7.00) suggesting that the patients perceived the nurses as being highly concerned about the patients. Further validation of this situation was suggested by heavy negative scoring of item, "The staff is friendly because they are paid to be like this."

The patients perceived the nurses as being most

concerned about the item, "My behavior will affect other people," this was given a positive mean score of 3.55 (the most positive of the patients' item scoring). The patients scored the item, "The family should be involved in the patients' treatment plans," positively, but with less importance attached to it than the nurses perceived. This might suggest that the nurses have not communicated the importance of the therapeutic aspect of family participation of the patients as they might have anticipated.

The nurses' perceptions that patients should participate in decision-making and made to feel responsibility for their own behavior was verified by the patients scoring positively the following statements: "A group decision made by patients can be a valid one," "Patients can help one another in understanding a problem," "The nurse recognizes that the patient can make his own decisions," "The patient could be a leader in group therapy," and "Patients should help to decide how their fellow patients should be treated."

III. SUMMARY

A statistical analysis was made of the data obtained from the three sorts: the nurse-actual and the nurse-ideal sort performed by the nurses and the sort done by the patients, the patient-perceived-nurse-actual sort. Correlation

coefficients were computed for intergroup sorts. The coefficients were all above the 0.40 which had been accepted as an indication of reliability.

Interpretative comparisons of the statistical data from the three sorts were made. There was an indication that the nurse was performing close to her ideal role; this could be seen as an indication of good job performance and a high degree of job satisfaction.

Descriptive interpretation of the data was made through the use of comparative mean scores of each item by the groups. (See Appendix C.) It was found that there was a basic agreement between the nurses and patients about their perceptions of the ideologies of the therapeutic community.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

I. SUMMARY

The problem of the study was to investigate the perceptions of the psychiatric nurse and the patient of the therapeutic community. These perceptions to be studied were: (1) the nurses' perceptions of their actual role and their ideal role, (2) the patients' perceptions of the nurses' actual role, and (3) the perceptions of the nurses and patients about therapeutic community ideology. The primary purpose of the study was to attempt to gain objective, quantitative data which could be used to evaluate the changing role of the psychiatric nurse functioning in a therapeutic community. Another purpose was to construct Q-sort items which could be used as a tool for evaluating student and staff nurses' psychiatric experiences in the therapeutic community. It would be utilized as one measure of adaptability to the role expected of nurses in this milieu.

To review the development of the therapeutic community and the role of the nurse in the therapeutic community, pertinent literature was surveyed. The survey of literature revealed a need to study the role of the nurse to determine

if the nurse, not only accepted the ideologies of the therapeutic community, but communicated them to the patients through her actual nursing activities. Literature pertaining to the Q-sort technique was used in the development of the technique employed in this study.

The Q-sort items were originated by the study-maker who drew from the current literature describing the therapeutic community. Rapoport's four fundamental characteristics of democratization, permissiveness, communalism and reality-confrontation included the essential elements of all of the other therapeutic community ideologies which were reviewed. However, the items were drawn from a universe of statements made by authors in the literature reviewed in Chapter II. The fifty-one items were sorted by twenty nurses and twenty patients selected by random sample from the population of a local psychiatric hospital. Both groups used the same set of items which described the ideologies of the therapeutic community and the role of the psychiatric nurse functioning in this setting. The nurses sorted the items twice; first, describing the actual role of the nurse, and second, describing the ideal role of the nurse. The patients sorted the items only once, describing the actual role of the nurse as they assumed she would perceive herself.

The data obtained from these sortings were converted

into mean scores for individual items and them compared for absence or existence of agreement. This was achieved by using the Pearson product-moment method of correlating paired items to obtain correlation coefficients. Descriptive comparisons of the three sorts were obtained by ranking the items along a continuum from "most likely" to "least likely" according to the mean scores of the subject group or groups.

The correlation coefficients were above the .01 level of confidence. They ranged between .566 and .836. There was strong agreement between the nurse-actual sort and the nurse-ideal sort. The least agreement was between the patient sort and the nurse-ideal sort.

The descriptive comparison of the inter-group sorts indicated that the nurse was performing close to her ideal role. There was basic agreement between the nurses and patients about the ideologies of the therapeutic community. The nurses and patients were not always in agreement in describing the nurses' actual activities in the therapeutic community.

II. CONCLUSIONS

On the basis of the data obtained in this study, the following conclusions were made:

1. The correlation coefficient of the nurse-actual

sort and the nurse-ideal sort was .836. This high correlation indicated that the nurse-actual role and the nurse-ideal role as seen by the nurses were in close harmony. This suggested a relatively high degree of job satisfaction. The indication was that the Q-sort in this study could be utilized as a technique for checking the degree of job satisfaction.

2. The correlation coefficient of the nurse-actual sort and the patient-perceived-nurse-actual sort was .714. This correlation also indicated marked or high relationship. This suggested that the patient was aware of how the nurse was functioning and that it had been communicated to him. It was concluded that the Q-sorts were effective in assessment of patient-staff communication. This same correlation indicated that the patients sorted the items in moderate agreement with the nurses. It was concluded that the psychiatric patients were able to perform the Q-sort adequately.

3. The correlation ($r = .566$) between the nurse-ideal and the patient-perceived-nurse-actual role indicated the patient perceived the nurse functioning closer to her actual role than to an idealized one. It was concluded that the patient could realistically gauge the situation. This preceding conclusion again indicated that the patients sorted the items with adequate proficiency.

4. Descriptive interpretation of the data indicated that the nurse showed an acute awareness of the community and family oriented program. She recognized the therapeutic community ideologies of permissiveness and democratization. However, there was some confusion indicated by the nurse in her acceptance of her role in limit setting. This led to the formulation of a hypothesis that nurses accepted the ideologies but in actual performance did not always put them into practice.

5. Both patients and nurses indicated that the nurse did not function as an authoritarian person in this therapeutic community. The nurse was perceived by both patients and nurses as a democratic, permissive person. Whether or not the nurse had changed <u>from</u> an authoritarian person <u>to</u> a democratic, permissive person could not be concluded from this study.

6. The descriptive interpretation indicated that from the lack of agreement by the patients and nurses in some therapeutic aspects, interpersonal communication was not as adequate as the nurses perceived. Inadequate communication then, it was concluded, can be a barrier which deters the patients' return to health. Rapoport described this communication pattern,

> Patients are linked by a system of communication bridges with other patients and with staff. Whenever in our system we make communication easier, we

improve the opportunities for patient recovery, and staff happiness."[1]

III. RECOMMENDATIONS

On the basis of the data obtained in this study, the following recommendations were made:

1. That the Q-sort items used in this study be performed by team members, other than nurses, to determine if similar statistical relationships exist.

2. That the tool used in this study be utilized as an objective, evaluative measure of the adaptation of the student or staff nurse to the changing role demanded of her in a therapeutic community setting. The sorts could be given before the nurse enters this service and repeated at a later time to assess the degree of change in attitudes, expectations and opinions about the therapeutic community.

3. That the nursing service administration at Fort Logan Mental Health Center utilize the data obtained in this study to review the job effectiveness and job satisfaction of its nurses.

4. That in any similar studies, a conjunctive

---

[1]Milton Greenblatt, "The Psychiatrist as Social System Clinician," The Patient and the Mental Hospital, eds. Milton Greenblatt, Daniel J. Levinson, and Robert H. Williams (Glencoe, Ill.: The Free Press, 1957), p. 319.

interview of the subjects be used to elicit additional data which might be used to substantiate interpretative descriptions.

5. That a study using the tool employed in this study be made comparing the role of the nurse in a traditional psychiatric setting with the role of the nurse in the therapeutic community setting.

BIBLIOGRAPHY

BIBLIOGRAPHY

A. BOOKS

Block, Jack. The Q-Sort Method in Personality Assessment and Psychiatric Research. Springfield, Illinois: Charles C. Thomas, Publisher, 1961.

Caudill, William. The Psychiatric Hospital as a Small Society. Cambridge, Massachusetts: Harvard University Press, 1958.

Denbar, Herman C. B. (ed.). Research Conference on Therapeutic Community. Springfield, Illinois: Charles C. Thomas, Publisher, 1960.

Garrett, Henry E. Statistics in Psychology and Education. New York: Longmans, Green and Company, 1947.

Greenblatt, Milton, Daniel J. Levinson, and Robert H. Williams (ed.). The Patient and the Mental Hospital. Glencoe, Illinois: The Free Press, 1957.

_____, Richard H. York, and Esther Lucile Brown, From Custodial to Therapeutic Care in Mental Hospitals. New York: Russell Sage Foundation, 1955.

Guilford, J. P. Fundamental Statistics in Psychology and Education. New York: McGraw-Hill Book Company, Inc., 1956.

Joint Commission on Mental Illness and Health. Action for Mental Health. New York: Basic Books, Inc., 1961.

Jones, Maxwell. The Therapeutic Community. New York: Basic Books, Inc., 1953.

Mowrer, O. Hobart (ed.). Psychotherapy Theory and Research. New York: The Ronald Press Co., 1953.

Peplau, Hildegarde. Interpersonal Relations in Nursing. New York: G. P. Putnam's Sons, 1952.

Rapoport, Robert N. Community as a Doctor. Springfield, Illinois: Charles C. Thomas, Publisher, 1959.

Rohrer, J. H. and M. Sherif (eds.). Social Psychology at the Crossroads. New York: Harper and Brothers, 1951.

Schwartz, Morris S. and Emmy L. Shockley. The Nurse and the Mental Patient. New York: Russell Sage Foundation, 1956.

Selltiz, Claire, Marie Jahoda, Morton Deutsch, and Stuart Cook. Research Methods in Social Relations. New York: Henry Holt and Company, 1958.

Stanton, Alfred H. and Morris S. Schwartz. The Mental Hospital. New York: Basic Books, 1954.

Stephenson, William. The Study of Behavior, Q-Technique and Its Methodology. Chicago: University of Chicago Press, 1953.

Wallis, W. Allen and Harry V. Roberts. Statistics, A New Approach. Glencoe, Illinois: The Free Press, 1956.

B. PERIODICALS

Caudill, William, Fredrick Redlick, Helen Gilmore and Eugene Brody. "Social Structure and Interaction Processes in a Psychiatric Ward," American Journal of Orthopsychiatry, 22:314-334, April, 1952.

Driekurs, Rudolf. "Group Psychotherapy and the Third Revolution in Psychiatry," International Journal of Social Psychiatry, 1:23-32, Spring, 1956.

Irvine, Laverne F. and S. Joel Deery. "An Investigation of Problem Areas Relating to the Therapeutic Community Concept," Mental Hygiene, 45:367-73, July, 1961.

Gillis, Lynn. "Participation - Its Measurement and Relationship to Clinical Change in Psychiatric Illness," International Journal of Social Psychiatry," 6:228-301, Autumn, 1960.

Gralnick, Alexander and Frank D'Elia. "Role of the Patient in the Therapeutic Community: Patient Participation," American Journal of Psychotherapy, 15:63-72, January, 1961.

Lewis, Frederick A. and Alan M. Kraft. "Fort Logan: A Community-Oriented Program," Mental Hospitals, 13:154-7, March, 1962.

Parloff, Morris B. "The Impact of Ward-Milieu Philosophies on Nursing Role Concepts," Psychiatry, 23:141-151, May, 1960.

Whiting, J. Frank. "Q-sort: A Technique for Evaluating Perceptions of Interpersonal Relationships," Nursing Research, 4:70-78, October, 1955.

_____ and Marian A. Murray. "Toward a Theory of Hospital Social Structure Based on Objective, Quantitative Data," The International Journal of Social Psychiatry, 7:173-180, Summer, 1961.

Wilmer, H. A. "Toward a Definition of the Therapeutic Community," American Journal of Psychiatry, 114[2]:824-833, March 1958.

C. BULLETIN

Allport, Gordon. "The Use of Personal Documents in Psychological Science," Social Science Research Council. Bulletin 49. New York: S.S. Research Co., 1942.

D. UNPUBLISHED MATERIAL

Chase, Philip Howe. "Concepts of Self and Concepts of Others in Adjusted and Maladjusted Hospital Patients." Unpublished Doctor's dissertation, The University of Colorado, Boulder, Colorado, 1956.

"Philosophy of Fort Logan Mental Health Center." Mimeographed information sheet, n.d.

APPENDIX A

Copies of Letters

8520 West 54th Place
Arvada, Colorado
October 29, 1962

Alan M. Kraft, M.D.
Director
Fort Logan Mental Health Center
Post Office Box 188
Fort Logan, Colorado

Dear Dr. Kraft:

This letter is to confirm our conversation of October 16, 1962, at which time you consented to allow me to use the facilities of the Fort Logan Mental Health Center for the collection of my data for my thesis study.

As you will recall, I will be doing Q-sorts with a selected number of patients and professional nurses in an attempt to correlate their perceptions of the psychiatric nurse in the therapeutic community.

The data collected will remain anonymous, but I would be happy to share any conclusions that such an exploratory study might produce.

I am enclosing a self-addressed envelope so that I might obtain your written permission. Thank you again for your interest and for your kindness in permitting me to work with the personnel and patients.

Sincerely,

Margaret LeBaron

cc: Helen Huber

STATE OF COLORADO

FORT LOGAN MENTAL HEALTH CENTER

Denver, Colorado

October 31, 1962

Mrs. Margaret LeBaron
8520 West 54 Place
Arvada, Colorado

Dear Mrs. LeBaron:

I am happy to give you permission to use the facilities and records 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.

Sincerely,

/s/ Alan Kraft

Alan M. Kraft, M.D.
Director
Fort Logan Mental Health Center

AMK:gs

8520 West 54th Place
Arvada, Colorado
April 8, 1963

Alan M. Kraft, M.D.
Director
Fort Logan Mental Health Center
Post Office Box 188
Fort Logan, Colorado

Dear Dr. Kraft:

Following our telephone conversation of last week, I am writing to request written permission from you to identify the Fort Logan Mental Health Center in my research study as the hospital in which the study was conducted. Originally, this was not my intent; but as the research data were developed, it became apparent that identification of the hospital was indicated.

I would like to express my appreciation again to you and the entire patient-staff groups who were so cooperative and who participated so enthusiastically.

Sincerely,

Margaret LeBaron

enc: envelope

STATE OF COLORADO

FORT LOGAN MENTAL HEALTH CENTER

Denver, Colorado

April 12, 1963

Mrs. Margaret LeBaron
8520 West 54th Place
Arvada, Colorado

Dear Mrs. LeBaron:

This is to authorize the use of the name "Fort Logan" in the articles you are preparing for publication.

As we agreed over the phone, you will be making this material available to us prior to its publication.

Sincerely,

/s/ Alan Kraft

Alan M. Kraft, M.D.
Director
Fort Logan Mental Health Center

AMK:gs

APPENDIX B

Instructions to Committee of Judges

An Exploratory Study of the Perceptions of the Psychiatric Nurse and Patient in a Therapeutic Community

The aim of this study is to attempt to gain objective, quantitative data about the perceptions of the psychiatric nurse and patient in the therapeutic community.

1. Will the psychiatric nurse in the therapeutic community see what she is actually doing (actual role) as being closely correlated to what she feels she should ideally be doing (ideal role)?

2. Will the patient see the nurse as functioning closer to her actual role or her ideal role?

The technique used for the collection of data will be the Q-sort technique. The subjects will be patients and professional nurses at a local hospital which is set up as a therapeutic community. The nurses will sort the Q-sort items twice, (1) actual-role sort (as she perceives what she is really doing) and (2) ideal-role sort (as she believes she should be doing). The patient will sort only once, sorting the items as he perceives what the nurse is actually doing.

Subjects will be requested to place the fifty-one Q-sort items into nine spaces (forced-sort) spaced along a continuum ranging from "most likely" to "least likely."

The items have been constructed with the expectations that they will be characteristic of the idealogy of the therapeutic milieu. They have been classified into four categories: democratization, permissiveness, communalism, and reality-confirmation. These follow Rapoport's ideologies[1] but are inclusive of the ideologies expressed by the majority of other influential leaders who follow that discipline.

Specific instruction for judging of the items will be found at the beginning of the item list.

---

[1] Robert N. Rapoport, Community as a Doctor (Springfield, Ill.: Charles C. Thomas, Publisher, 1959), pp. 54-66.

Instructions to the Committee of Judges

Instructions: Please check the items for the following:

1. Ambiguity. If the item is not clear or vague place an "A" in front of it.

2. Relevancy. If the item does not seem pertinent or descriptive of the category place an "R" in front of it.

Democratization:

These items should relate to: (1) an equalitarian state of affairs, (2) feelings toward authority, (3) patient participation in therapy, and (4) social adjustment.

1. Patients should help to decide how their fellow patients should be treated.

2. Nurses should see that patients obey the regulations.

3. Patients can help one another in understanding a problem.

4. A group decision made by patients can be a valid one.

5. The nurse is more of a participant than an observer.

6. The patient could be a leader in group therapy.

7. Nurses do as much participating in group therapy as other staff members.

8. It is sometimes difficult to know who is a patient, nurse, doctor or technician.

9. The staff is friendly because they are paid to be like this.

10. Good leaders can follow as well as direct.

11. Most of the rules in this hospital are for the patients' benefit.

12. We are all equals; the staff can be as uninformed or confused about things just as patients sometimes are.

Permissiveness:

These items should relate to: (1) removal of excessive emphasis on regulations and orderliness, (2) understanding and acceptance, and (3) respect for patients' autonomy and integrity.

13. Discipline is necessary to control a patient when he is abusive or destructive in the hospital.

14. Everyone should know what is expected of him.

15. It is important to see that the patient has enough sedative to allow him to get a good night's sleep.

16. Cleanliness and orderliness are necessary for the patients' comfort.

17. Patients are unpredictable and sometimes dangerous.

18. The nurses respect the right of the patient to act differently.

19. Hospitalization takes away many of a person's rights.

20. The nurse permits the patient to do anything he wants as long as it is not dangerous.

21. The nurses listen to and carry out suggestions from the patients.

22. Freedom means to do as one pleases.

23. The nurse tolerates aggressive behavior.

24. The patient has a right to choose his own friend, either male or female.

25. Patients should restrain some of their feelings.

26. Reduction in the number of rules leads to insecurity.

27. The nurse recognizes that the patient can make his own decisions.

Communalism:

These items should relate to (1) inter-relationships, (2) inter-communication, and (3) the team concept.

28. It would be a good idea if the nurses entered into all the activities with the patients.

29. It would be a good idea if the nurses supervised and directed the patients' activities.

30. The nurse is impartial to all patients.

31. The nurse expresses personal opinions frequently.

32. The nurse is frequently aware of how the patient feels.

33. The nurse frequently refers the patient to doctor to get help in solving problems.

34. The nurse is uncomfortable if criticized.

35. Patients are encouraged to express their feelings.

36. What a patient thinks or feels is nobody's business but his own.

37. All patients should be expected to enter into the same activities.

38. Patients feel free to express any thoughts or feelings they may have.

39. My behavior will affect other people.

Reality-confirmation:

These items should relate to (1) interrelation of hospital and community, (2) "real-life-like" environment, and (3) presentation of reality situation.

40. Nurses in street clothes are more approachable.

41. Nurses in uniforms seem more like "helping" people.

42. Psychiatric hospitals should provide a change from ordinary life where one can rest and escape from stress.

43. The hospital is a place to forget outside problems.

44. Mentally ill patients should be cared for in psychiatric hospitals.

45. The family should be involved in the patients' treatment plans.

46. Patients should eat every meal.

47. It is better that some doors in the hospital are kept locked.

48. The nurse spends the majority of her time with the patients.

49. The nurse has many activities which prevent her being with the patient.

50. Patients are usually more comfortable being with other patients rather than staff members.

51. A patient should have some time to himself.

APPENDIX C

Q-Sort Items with the Mean Scores for the Three Sorts

Q-SORT ITEMS WITH MEAN SCORES FROM THE THREE SORTS: NURSE-ACTUAL, NURSE-IDEAL, PATIENT-PERCEIVED-NURSE-ACTUAL*

Items	Mean Scores N.A.	N.I.	P.P.N.A.
The family should be involved in the patients treatment plans.	2.65	2.55	4.50
Patients can help one another in understanding a problem.	2.80	3.35	4.20
Patients are encouraged to express their feelings.	3.10	3.20	3.70
My behavior will affect other people.	3.20	2.85	3.55
A group decision made by patients can be a valid one.	3.20	3.35	4.00
Patients should help to decide how their fellow patients should be treated.	3.60	3.65	4.95
The nurse recognizes that the patient can make his own decisions.	3.75	3.85	4.30
The nurse is frequently aware of how the patient feels.	3.85	3.85	4.15
The nurse spends the majority of her time with the patients.	3.90	3.25	5.70
Good leaders can follow as well as direct.	3.90	3.40	4.05
Nurses do as much participating in group therapy as other staff members.	4.10	3.95	4.95
Everyone should know what is expected of him.	4.15	3.60	5.05
The patient could be a leader in group therapy.	4.15	4.10	4.90

Items	Mean Scores N.A.	N.I.	P.P.N.A.
The nurse is more of a participant than an observer.	4.15	4.10	4.90
Nurses in street clothes are more approachable.	4.40	4.50	4.65
It is sometimes difficult to know who is a patient, nurse, doctor or technician.	4.45	4.65	5.10
The patient has a right to choose his own friend, either male or female.	4.50	4.55	4.35
It would be a good idea if the nurses entered into all the activities with the patients.	4.50	5.60	5.10
Most of the rules in this hospital are for the patients' benefit.	4.55	8.15	4.05
The nurses respect the right of the patient to act differently.	4.55	4.90	4.65
The nurse listens to and carries out suggestions from the patients.	4.60	4.30	5.30
Patients feel free to express any thoughts or feelings they may have.	4.70	3.80	4.25
Patients should restrain some of their feelings.	4.85	4.85	5.55
Discipline is necessary to control a patient when he is abusive or destructive in the hospital.	4.90	4.40	4.20
A patient should have some time to himself.	4.95	4.65	4.50
We are all equals; the staff can be as uninformed or confused about things just as patients sometimes are.	5.10	5.20	3.90

Items	Mean Scores N.A.	N.I.	P.P.N.A.
Nurses should see that patients obey the regulations.	5.10	5.35	4.60
The nurse is uncomfortable if criticized.	5.15	6.15	6.05
Mentally ill patients should be cared for in psychiatric hospitals.	5.20	5.40	4.20
Cleanliness and orderliness are necessary for the patients' comfort.	5.25	5.35	4.25
The nurse has many activities which prevent her being with the patient.	5.30	6.25	4.45
It is important to see that the patient has enough sedative to allow him to get a good night's sleep.	5.30	5.25	5.10
Patients are usually more comfortable being with other patients rather than staff members.	5.35	5.45	5.80
The nurse tolerates aggressive behavior.	5.40	5.35	5.90
The nurse expresses personal opinions frequently.	5.60	5.10	5.35
Reduction in the number of rules leads to insecurity.	5.60	5.70	5.45
Patients should eat every meal.	5.65	5.55	5.45
All patients should be expected to enter into the same activities.	5.75	5.50	5.85
The nurse is impartial to all patients.	5.85	5.45	4.80

Items	Mean Scores N.A.	N.I.	P.P.N.A.
It would be a good idea if the nurse supervised and directed the patients' activities.	5.90	5.60	5.10
It is better that some doors in the hospital are kept locked.	6.00	6.05	5.75
Nurses in uniforms seem more like "helping" people.	6.05	5.90	6.05
Patients are unpredictable and sometimes dangerous.	6.10	6.15	5.15
The nurse frequently refers the patient to the doctor to get help in solving problems.	6.20	6.10	5.75
Hospitalization takes away many of a person's rights.	6.30	6.95	6.00
The nurse permits the patient to do anything he wants as long as it is not dangerous.	6.50	6.50	6.50
Psychiatric hospitals should provide a change from ordinary life where one can rest and escape from stress.	6.80	7.15	5.95
What a patient thinks or feels is nobody's business but his own.	6.90	6.80	7.00
The staff is friendly because they are paid to be like this.	7.10	7.35	6.75
The hospital is a place to forget outside problems.	7.35	7.20	6.13
Freedom means to do as one pleases.	7.40	7.00	5.90

*This mean score of each item in the three sorts is listed. The scores within the range of 1.0 to 4.9 are considered

"positive" items; the scores within the range of 5.0 to 5.9 are considered "neutral"; and the scores within the range of 6.0 to 9.0 are considered "negative".

APPENDIX D

Instructions for Patients and for Nurses

Instructions for Patients

You are asked to describe how you believe the nurses feel, think and do in this hospital. Look at the pack of cards in front of you. Each of the cards has a sentence on it describing a hospital situation which involves the staff, the patients or the environment. As you read the cards, remember that you are sorting them according to how you think the nurses behave or believe.

Now separate the cards into two (2) piles. Into one pile, place the cards which you think would best describe how the nurse behaves or believes. In the other pile, place the cards which you see as those which least describe how the nurse behaves or believes.

Now, take the cards which "best describe" the way the nurse behaves or believes and pick out the one card which you think is most true. Place it in the box in Row 1. Now sort out the next most true statement. Place it in the box at the bottom of Row 2. Continue selecting the next most true statement and place it in the next blank box. Each time you work from bottom to top as you fill a new row. Put only one card in each box.

When you have finished, take the pile of cards that have statements which "least describe" how the nurse

behaves or believes. Sort out the least true statement and place it in the box in Row 9. Continue selecting the next least true statement and place it in the next blank box in Row 9. Continue selecting the next least true statement and place it in the next blank box. You still work from bottom to top, but fill the rows from right to left. If the middle row is not filled, place the remaining cards ("least describes") in order from top to bottom.

Instructions for Nurses

Sort I

You are asked to describe how you see your nursing role in this hospital (how you see yourself doing, behaving and thinking). Each of the cards has a sentence on it describing a hospital situation which involves staff, patients, or environment.

To sort the cards, separate into two piles: in one, place all of the cards with statements which you feel "best describes" the situation; in the other pile, place all of the cards which you feel "least describes" the situation. Take the pile which best describe the situation. Sort out the one card which is most true and place it in the box in Row 1. Then sort out the next most true statement. Place it in the box at the bottom of Row 2. Continue selecting the next most true statement and place it in the next blank box. Each time you work from bottom to top as you fill a new row. You continue filling the rows from left to right.

After sorting the cards which "best describe" the situation, take the pile of cards which "least describe" the situation. Sort out the one cards which is the least true statement and place it in the box in Row 9. Continue selecting the next least true statement and place it in the next blank box. You still work from bottom to top, but

enter the rows from right to left. If the middle row is not filled place the remaining cards ("Least describes") in order from top to bottom.

Sort II

In the first sort, you were asked to sort the cards according to what you actually saw as best describing your nursing role. This time you are asked to sort the cards as you believe the ideal situation would be. Follow the same procedure as before, but keep in mind it is now to sort the "ideal" role rather than the "actual" role.

APPENDIX E

Data Sheet and Score Sheet

DATA SHEET

Nurse_____ Patient_____

Area_____

Actual Role

1. ___
2. ___ ___
3. ___ ___ ___ ___ ___
4. ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
5. ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
6. ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
7. ___ ___ ___ ___ ___
8. ___ ___
9. ___

Ideal Role

1. ___
2. ___ ___
3. ___ ___ ___ ___ ___
4. ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
5. ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
6. ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
7. ___ ___ ___ ___ ___
8. ___ ___
9. ___

SCORE SHEET

Subjects	Items			
	1	2	3	 51
1				
2				
3				
.				
.				
.				
.				
.				
.				
.				
.				
.				
.				
.				
.				
.				
.				
.				
.				
.				
N				
Mean Scores				