AN INQUIRY INTO THE INFORMAL ORGANIZATION OF ADMINISTRATIVE NURSES
IN A SELECTED COMMUNITY HOSPITAL WHICH HAS RECENTLY
ESTABLISHED A PSYCHIATRIC DIVISION

by

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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
1960
This Thesis for the M.S. degree by
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Date 3 February 1960
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An Inquiry Into the Informal Organization of Administrative Nurses in a Selected Community Hospital Which Has a Recently Established Psychiatric Division

Thesis directed by Associate Professor Leona Jackson

General hospital care for the mentally ill is increasing. In this study, a community hospital that has recently established an open psychiatric unit was investigated on the dimension of informal organization among nurse administrators: director of nursing service, supervisors, head nurses, and charge nurses.

Attitudes toward mental illness and the mentally ill held by general nurses are not, according to available studies, consonant with those of psychiatric nurses. The problem posed was the effect on attitudes of general nurses after they had worked in a psychiatric division as manifest by their integration (or isolation) in the informal organization described above.

Sociometric measures revealed a spread from nearly complete isolation of some staff to nearly complete integration of others. Factors not related to work in the psychiatric division appeared to be significant in affecting inter-group structure. These were status in the formal hierarchy and, in accord with the hospital's religious and moral precepts, a passive acceptance of direction. Similarly, the negative aspects of informal organization and communication were well known, while the positive aspects relating to its use and function appeared outside the awareness of certain key persons in the test group.
This abstract of about 225 words is approved as to form and content. I recommend its publication.

Signed [Signature]

[Signature]
ACKNOWLEDGMENTS

The writer wishes to acknowledge her indebtedness to Mrs. Leona Jackson and Mrs. Dorothy Block for their support and guidance. Special thanks are due Dr. Robert Gasser who gave freely of his time and specific knowledge during the preparation of this thesis.
... for the inmost growth of the self is not accomplished, as people like to suppose today, in Man's relation to himself, but in the relation between the one and the other, between men, that is pre-eminently in the mutuality of the making present—in the making present of another self and in the knowledge that one is made present in his own self by the other—together with the mutuality of acceptance, of affirmation and confirmation.

"Man wishes to be confirmed in his being by man, and wishes to have a presence in the being of the other. The human person needs confirmation, because man as man needs it. An animal does not need to be confirmed, for it is what it is, unquestionably. It is different with man: sent forth from the natural domain of species into the hazard of the solitary category, surrounded by the air of a chaos which came into being with him, secretly and bashfully he watches for a Yes which allows him to be and which can come to him only from one human person to another. It is from one man to another that "the heavenly bread of self-being is passed."

Martin Buber
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CHAPTER I

THE PROBLEM AND DEFINITION OF TERMS USED

Psychiatric divisions in general hospitals, integrated with the more traditional services into a functioning whole, are a rather recent phenomenon. Presently, "... about 11 per cent of all general hospitals in the country have facilities for the treatment of mental patients," representing 1 per cent of the beds available to them.¹

Many authorities in the fields of mental health care subscribe to the idea of the general hospital as suitable, if not preferable, for the treatment and rehabilitation of the mentally ill.² A new dimension is being added to the treatment "armamentum," a dimension that shows a healthy vigor. "The trend is clear. There is a rapid increase in the availability of psychiatric beds in general hospitals and this trend shows no sign of abating."³

Inasmuch as this trend is a new and evolving one, those general hospitals which institute psychiatric divisions necessarily proceed largely on the basis of untested hypotheses. To build up a body of definitive information which will help to guide and direct those responsible for the patient's nursing care thus becomes a salient task.

²"Mental Wards Urged in General Hospitals," The Denver Post, 9 October 1959, p. 2.
³Albee, op. cit., p. 43.
One aspect of this area concerns the structure of the informal organization among nurses who carry formal administrative responsibility in the nursing service. Two recent studies that have become standard references in the hospital care of the mentally ill indicate throughout the crucial effect of informal and covert relationships with regard to nursing care.\(^4,5\)

I. THE PROBLEM

--- Statement of the problem. It was the purpose of this study to investigate the informal relationships among nursing service personnel who carry formal administrative responsibility in a selected community hospital which has recently established a psychiatric division.

Hypothetical postulates were that, 1) problems peculiar to a psychiatric service tend to isolate those who have administrative responsibility for the unit from their colleagues in the traditional services, and 2) this isolation has a reciprocating effect. The psychiatric service personnel, in turn, withdraw from the rest of the hospital staff.

Importance of the study. Dr. Chester Barnard made the point that, "You can't understand an organization or how it works from its


organization chart, its charter, rules and regulations, nor from looking at or even watching its personnel. To a degree, the formal organization of an institution resembles the skeletal structure of the human body which gives form to the organism but whose function is dependent on, and independent of it. So powerful and pervasive is this functional aspect that Millett states, "(He) has seen many illustrations of changes in organizational instructions and in organization charts which resulted in no concrete evidence of change in organizational behavior."

Informal organization is the name which has been given to the carrier of function as herein described. Its crucial importance in the hospital care of the mentally ill has begun to be appreciated in recent years. Scher states flatly, "Behavior is a product of the hospital situation itself." Stanton and Schwartz subtitled their book, *A Study of Institutional Participation in Psychiatric Illness and Treatment.*

It would thus appear that a study of the informal organization constitutes an indispensable element in understanding the modus operandi of any given institution at any particular time. Its special

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9 Staton and Schwartz, op. cit.
importance and relevance in a hospital which has recently instituted so major a change as the addition of a psychiatric division can be appreciated from the above paragraph.

Need of the study. As indicated, (page 1) a good many authorities in the fields of mental health care subscribe to the idea of general hospital care for the mentally ill. This concept is currently implemented on an a priori basis insofar as the author has been able to determine.

Medical literature is replete with examples of this kind of pioneering wherein individuals proceed without a blueprint to guide them; rather, they are led by a good hypothesis, and supported by considerable courage. "If one indulged all the qualifications this or that subject deserves," little progress could be anticipated.¹⁰ Now, however, opportunity for the study of established, on-going psychiatric divisions exists. Many such studies are needed, approaching the problem from various angles, if we are to avoid wasteful trial and error methods as each individual hospital elects to "take the plunge" into this new area of service to the mentally ill.

Scope and limitations. This study had as its focus the informal organization existing among nursing service personnel charged with administrative responsibility in the nursing department. It has been stated that values held by department heads come to be the values of the department; hence the constellations in the informal

¹⁰Millett, op. cit., p. ix.
organization around these key people affect the entire department.\footnote{11} This factor lends breadth to the study.

Further, empirical evidence abounds that hospitals are more alike than they are different. The official journals, the workshops, the nursing societies, all reflect common problems and stress, success and progress, and disappointments. When knowledge of the unique elements operative in any one institution are obtained, a considerable body of administrative knowledge can be brought to bear on the particular situation. In this it is not unlike a phenomenon of the physical world. Tides can be forecast with great accuracy provided the local topography, which modifies and directs the tides, is known.\footnote{12}

The hospital which serves as the parent organization for the nursing department under study operates as a general, community, church-owned facility. All services are provided, including electroencephalography; there is equipment for deep x-ray therapy. These latter are somewhat unusual in a community hospital whose bed capacity numbers eighty-nine.

Local psychiatrists approached the hospital with the request for a psychiatric division. This was instituted about nine months before the study began with the full and enthusiastic support of


hospital owners and trustees. The hospital administrator, source of
this information, added that the institution is committed to the
greatest possible usefulness as a community resource. In view of
current thinking—that the mentally ill can be better served, in
many instances, through general hospital care—his church felt a moral
obligation to add a psychiatric division.

Some limitation grows out of this factor. Such altruistic
motivation may well preclude any conscious recognition that the ex­
periment is anything but an unqualified success.

Further limitations include these items: one hospital, in one
community, whose informal organization was studied in one aspect.
Extrapolation of findings will necessarily be limited.

II. DEFINITION OF TERMS USED*

Informal organization. A network of personal and social re­
lations which are not defined or prescribed by formal organization.

Psychiatric division. In the hospital studied, the psychiatric
division is a twelve bed, open ward, comparable in its formal organi­
zational pattern to the medical, surgical, and obstetric divisions.

Nurses with administrative responsibility. Those nursing
service personnel who have responsibility for one or more nursing
units during an assigned period in the twenty-four hours of a patient

*The sociometric terms are adapted from those given by
Dr. Robert Gasser, Director, Bureau of Nursing Research, University
day. The category includes Nursing Office personnel, Supervisors, Head Nurses, and Charge Nurses (practical and registered).

**Formal organization.** The prescribed hierarchial relationships within the nursing department.

**Clique.** Several members who commonly associate in the informal organization.

**Friendship group.** Closer relationship than clique in association and compatibility.

**Organization of the remainder of the thesis.** Chapter II presents a review of the literature beginning with early care and treatment of the mentally ill, continuing on to reform and changes in professional attitudes toward this disability, and finally to those considerations which led to the movement for general hospital care.

Chapter III deals with methods and procedures as well as a more detailed description of the clinical facility used in the study. The hospital has undergone rather extensive reorganization during the past two years, and as mentioned earlier, the management has an especial concern that it meet community needs.

The sociometric technique, with appropriate tool, has been used as the research method. The technique and tool are described.

Chapters IV and V present respectively, an analysis of the data and the writer's conclusions and recommendations.
CHAPTER II

REVIEW OF THE LITERATURE

Greek civilization knew mental illness, wrote about it, and prescribed methods of treatment. From 500 B.C. on to the present time, treatment of mental illness presents a curious paradox of progress and regress.

In this chapter, patterns of care which have set the stage for contemporary treatment philosophy are outlined. Secondly, there is a discussion of the factors which led to psychiatric divisions in general hospitals, and finally, an examination of present day attitudes toward mental illness with particular emphasis on the attitudes of nurses.

I. HISTORICAL PATTERNS IN THE CARE OF THE MENTALLY ILL

Progress in the care of the mentally ill has been extraordinarily difficult to maintain; gains in one period have over and over been lost in the next. Greek civilization represented a period of gain in which, "... therapeutic art anticipated some of the accepted principles and best practices of the present time." Patients were thought to need a calm, restful atmosphere with limited work and mild exercise available. Abberations in behavior were believed to have natural causes.

1 Mental Health Programs of the 48 States (Chicago: Council of State Governments, 1950), p. 15.
Greek civilization declined and with it the concept of mental illness as naturally caused. "The clock turned backward as the years passed." Mental illness came to be seen as punishment for sin, possession of the patient by devils, influence of the moon, and other supernatural causes. There was no treatment in the medical sense. Rather, patients were herded together in asylums under conditions of incredible pain and privation. The era of Bedlam took over, not to be dispelled until Pinel struck the chains from the inmates at the French asylum, Bicetre, in 1792.

About the same time in England, William Tuke began a concerted effort toward more humane practices there. Both he and Pinel wanted more than mere amelioration of bad conditions. They wanted hospitals which would allow for observation and study, and which would allow them to institute "moral treatment"—in essence a rebodiment of the Greek ideal.

In America, too, there appeared a similar development. Sparked by the efforts of Benjamin Rush, jails and almshouses began to be replaced by public hospitals. Progress was slow and spotty until Dorothea Lynde Dix took up the crusade in the early 1840's, and from then on, for nearly fifty years, devoted her life to improving the care and treatment of the mentally ill. She worked with considerable effectiveness—but again progress did not hold. During her lifetime

14 Loc. cit.
she saw hospitals, which she had done much to establish, later become places where suffering and neglect were rampant.

The pattern has persisted. Intolerable conditions, investigations and improvement, then deterioration. "To the person who consults standard sources on the history of state hospitals, it is soon apparent that the evolution of state care has certainly not involved cumulative additions of improvements, one upon the other. The entire development looks far more like a process of incoherent patchwork, interspersed with alternating periods of improvement and decay." 16

In the United States, eighty-six per cent of all resident cases of mental disease are treated in state hospitals. One should not presume from Belknap's statement that no changes of an enduring nature have taken place in these public hospitals. The point is rather that change is not necessarily progress although it is sometimes thus construed. According to Dr. Hunt, Director of Hudson River State Hospital: 17

Our 'humane' practice may be almost as brutalizing and degrading as those of past centuries. It is a rare patient now who suffers cruelties to the flesh, but restraints on the human spirit cannot be measured in terms of iron bars and canvas straps alone. They derive much more importantly from the attitudes of people around the patient. For too long, as Maxwell Jones puts it, we worked on the unconscious belief that 'the role of the patient is to be sick.' If he senses that we expect him to be suicidal, or to try to get away, or to be violent, he will oblige us.


II. FROM STATE HOSPITAL TO GENERAL HOSPITAL

Has the impetus toward general hospital care for the mentally ill come from dissatisfactions with state hospital treatment? It does not appear so. Rather, two quite different incidents occurring an ocean apart appear to have been major factors in alerting the mental health community to the feasibility of general hospital care.

In England, Dr. Maxwell Jones began (1947) a study of what could be done for neurotics who had experienced special difficulties with regard to employment. The treatment regime placed emphasis on social milieu within the hospital, special group techniques, cooperation with local employment agencies, and work with the patient's family group. No locked or closed facilities were used. Results were surprisingly good. A published report of the study, The Therapeutic Community, was widely read and quoted in the United States.

As public hospitals began to open their doors, with considerable success, the possibility of treating patients in unlocked, general hospitals was created. Some few physicians and administrators went ahead with psychiatric divisions, and as they became working units of the hospitals, reports filtered into the professional journals. The gist of the sentiment seems to be, as Dr. Glotfelty titled his

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18 Walter S. Maclay, OBE., MD., Senior Commissioner, Ministry of Health, England, "Experiments in Mental Hospital Organization" (address delivered to the First Canadian Mental Hospital Institute, January, 1958).
article, "Your Hospital Can Care for the Mentally Ill." This was in 1958.

The next year two more articles appeared in Hospital Management journals. Dr. Goshen outlined specifically what he had found necessary in the general hospital division; Janovitz and Sigmond emphasized the need for service rather than special facilities such as strong rooms, locks, and bars.

The second factor which we mentioned earlier as being of importance in establishing psychiatric divisions in general hospitals was available money. Funds were needed to build new wings, and in some hospitals, to refurbish existing wards for use as psychiatric wards. The hospital emphasis was down graded, the living room, hotel type room, emphasized. The latter took place in the hospital under study. The Hospital Survey and Construction Act had funds for this kind of remodeling, and it was relatively easy for hospitals to go ahead with plans for psychiatric divisions, as the act was sympathetic to such effort. The coincidence—a new idea to be implemented and funds available to do so—was fortuitous in the extreme.


22 Mental Health Programs of the 48 States, op. cit., p. 145.
III. ATTITUDES TOWARD MENTAL ILLNESS

The importance of staff attitudes toward mental illness and the mentally ill has been mentioned (page 10). It is appropriate to this study that an examination of attitudes, as they are known through the literature, be undertaken. Informal organization, that non-prescribed aspect of institutional behavior, serves as the carrier for attitudes, feelings, beliefs, and value systems. In the words of Dr. Barnard:23

The functions of informal executive organizations are the communication of intangible facts, opinions, suggestions, suspicions, that cannot pass through formal channels without raising issues calling for decisions, without dissipating dignity and objective authority, and without overloading executive positions; also to maintain cliques of political types arising from too great divergence of interests and views; to promote self-discipline of group; and to make possible the development of important personal influence in the organization.

What, then, are the attitudes about mental illness which the informal organization could communicate? Dr. John Clausen comments:24

The mental-health movement has directed much effort toward changing attitudes toward mental illness, especially stressing the fact that the deviant behaviors of the mentally disturbed are reflections of illness. These efforts seem to have been only superficially effective, according to the findings of recent research on public attitudes and knowledge. It seems fair to say that in many instances they have been based only superficially on real knowledge of the prevailing cultural orientations and functions they serve.

One major study, directed by Shirley Star for NORC, has brought home very forcefully the fact that to most American adults, mental

23Barnard, op. cit., p. 225.

illness means violent, unpredictable behavior, to be dealt with by confinement in a mental hospital. (Italics in the original). Dr. Albee assents to this. "... many of the old attitudes toward mental illness--fear, horror, and disgrace--still persist." And the Council of State Governments says the public takes an entirely different attitude toward mental illness than toward physical illness.

The above statements apply to the public at large. Are they applicable to special publics such as the nursing profession? It is not possible to give a definitive answer. No study could be found which was as comprehensive as Shirley Star's; studies which are available caution repeatedly against too wide an application. Nevertheless, they represent a considerable body of evidence from widely spaced areas in the United States and Canada.

At a workshop in 1951, Miss Redmond made this comment:

It is a surprise, but nevertheless true, that some of the faculty members of the general hospitals do not have acceptable attitudes toward psychiatric nursing. They still think of the psychiatric hospital as a 'lunatic hospital.' Others do not believe psychiatric patients are ill--they think they are 'lacking in will power.' Some faculty personnel fear mental illness and communicate these fears to the student.

Margaret Wright, in her 1954 study, found considerable evidence to support Miss Redmond's statement. Students who came to the affiliation

25Albee, op. cit., p. 10.

26Mental Health Programs in the 48 States, op. cit., p. 58.

for psychiatry were anxious and fearful indicating poor pre-psychiatric orientation. 28

In 1955, Helene Kardasz studied the attitudes of nurse educators concerning mental illness and psychiatric nursing. These nurses were faculty members in schools which sent students to Kardasz for their psychiatric experience. Responses to the opinionnaire were unfavorable to a majority of the statements, by over half of the test population. In other words, half of the educators gave responses to half the statements that were contrary to those of the coded standard. 29

Helen Gene Tillotson found that students were unable to utilize basic psychiatric nursing concepts on return to their hospitals, partly as a result of unsympathetic and indifferent attitudes in the home faculty. 30

To some extent the same situation obtains in Canada, where Jean McCrimmon reported, "... some of the fears the general nurse brings with her (to the psychiatric division) are the 'folklore of


psychiatry and are, in fact, attitudes prevalent in the community but not based on fact.\(^{31}\)

The gradual accumulation of evidence regarding attitudes toward the mentally ill on the part of general nurses prompted Miss Kathleen Black to write, "One might conclude that nursing has not moved beyond the general public so far as we might expect in repudiating the stigma associated with mental disease."\(^{32}\)

Nonetheless, and particularly at the Canadian conference which was planned as a forum for the exchange of experience and thinking in the comparatively new area of psychiatric nursing in general hospitals, some strongly positive aspects were apparent.\(^{33}\)

Mrs. Isobel MacLeod, director of nurses, The Montreal General Hospital, stated that in her experience the presence of a department of psychiatry has greatly enriched the nursing care of patients in all sections of the hospital. and

... an exceedingly important conclusion was being reached by both general and psychiatric nurses: there are more similarities than differences in the nursing of patients in general medicine and those in psychiatry.

In the day-to-day contact with mental patients, in their own communities, in a familiar hospital—perhaps here lies the key to an effective mechanism for attitude change.


\(^{33}\)McCrimmon, op. cit., p. 250.
Over time, patterns of care for the mentally ill show alternating periods of progress and regress with the gains of one era lost in the next. Currently there is an upsurge of progress with concerted effort to bring the mentally ill into the mainstream of therapeutic practice.

Long isolation of the mentally ill from this mainstream has helped to maintain attitudes about mental illness which see this disability as qualitatively different from physical illness. To some extent general nursing shares these attitudes.

There is some evidence that closer, day-to-day contact with the mentally ill in their community hospitals may be an effective means toward an attitude change on the part of general nursing.
CHAPTER III

METHOD AND-PROCEDURES

To conduct the study, a clinical facility which met certain criteria was needed. The criteria and the hospital selected are described in part I.

In part II, the research technique, tool, population, and procedure are delimited with justification for each.

I. SETTING OF THE STUDY

The study took place in an eighty-nine bed community general hospital located in a town of about 35,000 population in the Rocky Mountain area. This hospital provides medical, surgical, obstetric, and, since April, 1959, psychiatric care. The hospital is owned by a religious group who govern through a board of trustees elected from the community at large. Established in 1895, the hospital has been in continuous operation for sixty-five years. Within the past two years, with the help of a substantial legacy and Hill-Burton funds, a new wing was built and the entire hospital renovated.

Formal organization follows the traditional pattern: top administrative officer is the hospital manager (a layman) to whom department heads are responsible. In the nursing department, with which this study is concerned, the top administrative officer is the director of nursing. She has no assistant. Under her direction are supervisors, head nurses, and charge nurses. Staff level personnel
are responsible directly to head nurses and supervisors, and through them to the nursing service director.

X-ray, physical therapy, occupational therapy, dietary department, and maintenance sections each have a department chief responsible to the administrator.

The medical staff is organized with a chief of staff for each major division. There is a proviso in the formal statement of hospital policy that patients on the psychiatric division must be followed by one of the psychiatrists on the hospital staff.

The psychiatric division, twelve beds, is on the ground floor adjacent to the operating suite and to the obstetrical department. Beds on the psychiatric division make up into a sofa for daytime use. There is a ward dining room (trays are not served routinely), and a ward lounge with radio, television, piano, and other recreational supplies.

Nursing personnel consist of a head nurse-supervisor, one day staff nurse, and an afternoon and night charge nurse. The afternoon and night staff are augmented from regular nursing service personnel as the needs of the department indicate. Average daily patient census is four.

Criteria selected as significant (see Chapter II, part 2) included: (1) an open division, (2) new established, (3) fully integrated into hospital service, (4) in a community hospital, (5) available to the community on an unrestricted basis. The facility selected meets all these criteria. In addition, the treatment
II. THE RESEARCH TECHNIQUE AND TOOL

Research techniques that keep the identity of the individual in the study intact are rather few. Among them are the sociometric procedures. All of these are predicated on the assumption that, "... a social group is effective in proportion as individuals within the group spontaneously accept each other as collaborators in activities meaningful to the group." This concept accords well with the idea of the therapeutic community in which all members participate actively in the achievement of the common goal.

Definitions of sociometry vary somewhat. Calvin Schmid states a representative position:

Sociometry helps to make more explicit and precise the configurations of group relationships, the characteristics and composition of cliques and other elements in a large group, and the streams and points of influence within and among groups.

Feelings and attitudes are notoriously difficult to extract through available research techniques. In no case are they directly accessible.

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*Information contained in this section is from the hospital administrator and quoted with his permission, from written hospital policies and objectives, and from personal investigation by the writer.


to observation or measurement, but must be inferred from behavior. In the sociogram groups based on attitudes, values, and feelings are delimited without the need to go into the specific basis for the groupings. "... patterns obtained are intrinsically meaningful and do not have to be validated by reference to outside criteria."³⁶

Early writers in the field of sociometry, and particularly Moreno, who saw sociometry as a way of life rather than a research technique, were inclined to believe that re-structuring of groups was a necessary part of the technique—that cooperation of test subjects was predicated on the assumption that something would be done to alter existing configurations.³⁷ Later investigators have been less inclined to see restructuring as a necessary part of the sociometric procedure. "... (it) is only one of the many factors that determine the relation between subject and research worker, and it should not be considered an indispensible requirement."³⁸

This writer accepts the latter view. There is little evidence that problems can be solved, stresses and strains relieved, by playing checkers with group personnel. Furthermore, such manipulations are often quite impossible, while it is often possible to alter or change existing difficulties once they are known to exist. Anxieties can be expressed and support offered, frustrations and annoyances aired and

³⁶Loomis and Pefinsky, op. cit., p. 12.
³⁸Ibid., p. 408.
often resolved, participation in group work increased, and personnel helped to develop greater professional competence. (Paraphrased from Dr. Brown's article.)

Sociometry makes available to the researcher a technique from which data are obtained that lend themselves to a graphic portrayal of inter-relationships within a prescribed group. It is just these kinds of relationships, as they exist among the informal executive group, that this study wishes to identify for the purpose of ascertaining the acceptance or non-acceptance of the psychiatric division personnel in the hospital.

The research instrument for this study. The sociometric test presents the test object with a series of hypothetical situations from which he chooses—first, second, and third—those persons with whom he would prefer to be associated. The test is predicated on the assumption that persons have the ability to choose, and that they do so. In the present study, five situations were posed with three possible choices for each. (See Appendix A.)

Statements were formulated to elicit group cohesiveness (1 through 5); leadership pattern (3 and 5); clique behavior (2 and 5); friendship group (4); a public transcending clique, friendship, and leadership lines (3); and to differentiate personal from professional choice (1).

The instrument reviewed by a jury. The nature of the study precluded a pilot test in the usual sense. The total questionnaire was presented, however, to four nurse and five non-nurse graduate students with a brief summary of the study and a request that they read the questionnaire for clarity, comprehension, and to make such comments as occurred to them. Several changes in wording were incorporated as a result. Two of the students objected to Question 4 as placing undue stress on non-church member respondents. In view of the particular facility used for the study, this question was retained.

The test group. Eighteen persons comprised the test group. The criterion, more than 50 per cent of duty time in an administrative assignment, was met by all eighteen. In fact, all eighteen have an administrative assignment 100 per cent of their duty time. The 50 per cent criterion eliminated all relief personnel owing to the particular assignment system used. The nursing office personnel, supervisors, head nurses, and charge nurses relieve each other for the most part, necessitating only an occasional staff assignment to administrative duty. In this dimension, administrative assignment, the group was completely homogenous.

All services were represented, including central service, operating room, and the obstetrical unit. Nurses from these services are used as needed throughout the hospital, although each has as her regular unit a particular ward.

Three shifts, day—evening—night, were represented.
Two practical nurses, charge on the night shift, were included.

Composition of the group with regard to position, title, professional or practical nurse, regular assignment, and occasional assignment are summarized in Appendix B.

Procedure. A letter requesting permission to use the facility was first sent to the hospital administrator. On his affirmative reply, an appointment was made with the director of nursing to arrange details. Two subsequent visits, prior to the test, were made by the investigator (with the director's consent) to the hospital to become somewhat familiar with the hospital operation. One visit was arranged at the administrator's request. At this appointment, the administrator oriented the investigator to the hospital, the staff, and gave her data reported in Chapter III, part 1, pages 18 and 19.

At the Director of Nurse's suggestion, arrangements were made to give the test during an inservice education period. Personnel were notified a week in advance by the director that the time would be so used. They were excused from mandatory attendance. At this inservice period, twelve of the test population completed the survey form. No one on duty failed to come. The other six were tested during the next twenty-four hours by special arrangement with the study maker.

Following an initial appraisal of test results, each respondent was interviewed. "(The interview) provides information to supplement
other methods of collecting data\textsuperscript{40} which, in a sociometric study is needed if one is to have a basis on which to give the "why" as well as the "what" of the patterns that appear.\textsuperscript{41}

All interviews began by giving the respondent an opportunity to comment on the study itself. Trainor found in her investigation that the unusual and disconcerting procedure of making overt choices led to resistance and discomfort among the test objects;\textsuperscript{42} hence respondents were first encouraged to ventilate their feelings regarding the technique. Then each was asked, "What was it that governed your choices? Let's begin with the first statement."

No negative choices were asked for. While Jennings considered this an important dimension in her classic study, Leadership and Isolation,\textsuperscript{43} the small population in the present study (eighteen) as compared with 400 in Jenning's survey, made protection of individual identity impossible were negative choices asked of the respondents. Further, the preliminary contacts with personnel strongly suggested that a request for negative choices would have been met


\textsuperscript{41}Dr. Robert Gasser, Director, Bureau of Nursing Research, University of Colorado. Personal communication quoted with permission.


with overwhelming resistance (see Scope and Limitations, page 4).

In Chapter IV, which follows, the data are presented and analyzed.
CHAPTER IV

ANALYSIS OF DATA

Each of the five test questions are first analyzed separately relative to the particular phase of informal group relation which it was designed to elicit. The question, its orientation, and a sociogram together with interview information comprise each of the first five parts of the chapter. Part six is a sociogram of first choices on each of the five questions.

Question I. A patient on your ward is difficult to manage. From whom would you choose to get help with this problem?

This question, placed first to set a tone of serious purpose for the study, was designed to indicate overall group cohesiveness, to differentiate patterns of personal from professional choice for subsequent questions, and to ascertain the place of psychiatric division personnel in the matter of dealing with problem patients.

Inspection of the sociogram (page 28) reveals the following factors: Numbers 1, 2, 8, and 14 are key persons. In this, their formal position in the hierarchy coincides closely with that in the informal group, there are more unchosen than in any subsequent question, no respondent chose a nurse on the psychiatric division first, there were no reciprocal choices within the evening shift, two respondents chose staff doctors—the only question where this was so.
Figure 1. Sociogram for data in question I.
Respondents had the option of choosing anyone within the hospital staff. (See Appendix A.) Of 270 possible choices, 80 percent were within the test group, in itself an indication of cohesiveness.

One of two factors governed every first choice response. Either the respondent looked to supervisory personnel for help, or they chose someone in close proximity to their work situation. In the latter case, the statement was construed to mean a patient who was physically unmanageable. Night staff, particularly, so interpreted the statement. One respondent made no choices among the key persons (1, 2, 8, 14). Her preferences were all on the basis of who was closest spatially.

Second and third choices showed no pattern. A majority of respondents said they had difficulty making more than one choice on this question. Those who chose Medical B personnel did so on grounds other than their possible skill in helping with the problem.

**Question II.** With whom would you choose to talk over an ethical problem?

Ethical problems, involving as they do interpersonal relations of an intense and touchy nature, tend to become covert in the hospital situation. Authors who deal with ethical matters are apt to put the emphasis on what should happen rather than what does. In this, MacEachern, standard authority on matters of hospital organization and management, is no exception. In practice, these matters are

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Figure 2. Sociogram for data in question II.
talked over with one's most intimate and trusted friend or colleague, and only late in the day are they brought to the attention of formal authority. This area then affords a fruitful source for identification of informal ties.

In this question, ten respondents chose the nurse with greatest formal responsibility as the person they would choose first to talk with about an ethical problem. A result so contrary to observed practice raised questions in the investigator's mind. On interview, it developed that these respondents would have chosen first a husband, pastor, or friend not associated with the hospital had they had the option of doing so. Failing this, they stuck to the formal rules of reporting difficulties to the administrative head. That which "ought to be done" had taken deep root, as second choice.

Noteworthy are the reciprocal choices between persons 1 and 2, 1 and 14, and 2 and 14. The fourth person in the quartet chose 14, but was not chosen by any of the other three.

Question III. With whom would you choose to be associated on a committee?

The loosely defined category "committee" was designed to elicit leadership apart from clique or friendship ties. While most respondents interpreted the question to mean some nursing function, the choices were more scattered than on the previous two statements. The tight grouping between 1, 2, 8, and 14 is broken up. Respondent 1 indicated that she chose 7 on the basis that this nurse would have more time than others for committee work.
Figure 3. Sociogram for data in question III.
Numbers 8 and 9, long term employees and old friends, "like to work together."

Number 3, a secondary leader—that is, outside 1, 2, 8, and 14—received more choices than on any other question on the basis of her known capacity for committee work. Number 3 told the investigator she had worked at the hospital before the present employment, and that she is well acquainted in the community and with the persons in the church hierarchy of this district. This respondent's name occurred frequently in various interviews, and it is the investigator's impression that she has greater influence than the sociograms show.

**Question IV.** With whom would you choose to attend church?

The religious orientation of this hospital made the question an obvious one. Everywhere apparent are policies relating to religious tenants—personnel policies, dietary practices, respect for and obedience to authority, devotion to duty above and beyond personal considerations being among the most prominent. Hiring policy does not restrict employment, but preference is given, in key positions, to those who are members of the owning church.

Placement of personnel in the sociogram required rather extensive change, as can be readily seen by inspection. Respondent 2 emerged as primary choice, with negligible numbers choosing 1, 8, and 14.

A number of reciprocal pairs appear: 12 and 18, 16 and 17, 14 and 17, 3 and 5, 8 and 2, and 1 and 2. Apparently respondents felt more freedom in departing from the formal hierarchial structure
Figure 4. Sociogram for data in question IV.
on this statement than any of the others. Interview information
tends to support this assumption, as those chosen were not necessar-—
ily the ones with whom respondents actually go to church.

**Question V. Whose grapevine information would you accept?**

Many names are given the network of informal communication
within an organization—scuttlebutt, gossip, underground—and so on. **Grapevine** was selected as being in the public domain to a greater
extent than the others excepting gossip, which was rejected for its
obvious negative connotation.

The striking positive relationship between formal and informal
relationships is again seen in the choices to this question. All but
one respondent chose within the key group 1, 2, and 14; ten of the
first choice responses went to person 1. Respondent 12, who chose
outside the key group, picked her roommate (18) first. "She's really
the only one I know very well."

Of interest are three respondents who made no choices, and a
fourth who chose but added in parenthesis, "actually no one."
A basic assumption in sociometry is that test objects can choose and
do so. Inasmuch as these four deviated from the assumption, their
lack of response is of some interest.

On interview, it developed that all felt grapevine information
to be negative gossip. One girl stated, "I suppose if I'd believe
anyone, I'd believe Mrs.______, but I can't very well put down that
I think she gossips." When asked if she thought all informal chatter
gossip, she answered, "Well, I don't approve of that sort of thing."
Two others made assumptions that grapevine information was always negative and always to be rejected on moral and ethical grounds. The nurse who chose, but wrote, "actually no one," told the interviewer she "didn't want to spoil the study." By responding and not responding, she solved her problem.

Two of the four persons in this group are full time on the psychiatric division. One of the four, a full time psychiatric division person, was least chosen overall on the total questionnaire.

Figure 6. This sociogram was drawn from first choices only on all five questions. The close relationship between formal and informal organization shows clearly here also. Second and third choices sociogrammed (not shown) reveal a jockeying of position between the hierarchial choices selected first, and most stay within the test population (80%).

These two findings, the close relationship between formal and informal organization, and the lack of choice outside the group but within the hospital, are perhaps the most significant facts ascertained in the study. A third finding, the failure to appreciate functions of the informal organization on the part of two persons employed full time in the psychiatric division, is also important.

In the next chapter, certain conclusions are drawn from the data, the findings summarized, and recommendations made.
Figure 6. Composite sociogram showing first choices on questions I through V.
CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Change takes place over time, sometimes slowly and imperceptibly, sometimes with great vigor and rapidity. Rapid and far reaching differences in the approach to care and treatment of mental illness characterize the present era. In this study, one facet of change, that of general hospital care for the mentally ill, has been investigated through the informal intra-staff relations among nurse administrators existing in a hospital which has recently established a psychiatric division.

I. SUMMARY

The study, a sociometric measure of nurses with administrative responsibility, took place in a community hospital in the Rocky Mountain area. The hospital has had a psychiatric division for eight months.

Local psychiatrists petitioned the hospital for this facility, and the hospital responded with alacrity. The institution, church owned, has a formal commitment to optimum community service which it sees as a primary mission. Trustees became convinced that in order to fulfill this mission, they would need to participate in the movement to hospitalize the mentally ill in general hospitals. To this end, when funds became available for a general renovation, a ward of twelve beds was prepared for psychiatric patients. The unit is open,
has hotel type accommodations, and there are recreational facilities and an occupational therapy department.

Hospital policy stipulates that all patients admitted to the unit must be followed by one of the staff psychiatrists. (There are four.) This was done to provide the consistent milieu necessary for a therapeutic community. The medical approach is an eclectic one, including psychotherapy, drug, and somatic treatments.

Nursing staff were drawn from personnel already in the hospital's employment. None had special preparation in psychiatric nursing. They had, however, expressed interest in being assigned to the division. All nursing personnel are expected to work on the division as need arises—for relief, in case of illness, or when the census increases beyond the capacity of the regular staff.

A review of literature gives evidence that general nurses have not the same attitudes toward psychiatric illness and psychiatric patients as do psychiatric nurses. This poses an interesting question when psychiatric patients are admitted to general hospitals on a par with all other types of disability.

Do general nurses, working on a psychiatric division, adopt attitudes consonant with those thought acceptable by nursing authorities in this field? And does this then separate them from their colleagues in the more traditional general hospital services?

Answers were hypothesized affirmatively for the purpose of this study. A sociometric measure was then taken among a defined group of nurses who could be expected to set the tone for the rest of the nursing staff.
The group, eighteen members of the nursing staff, included all those who had formal administrative responsibility in the nursing department as their principal assignment. See Appendix B for a breakdown of the group composition with regard to title, regular assignment, length of employment, and per cent of duty time worked in psychiatry. The data form, together with instructions for the survey and the survey questions, can be seen in Appendix B.

The data from the sociometric questions were then analyzed according to previously established criteria for the purpose of ascertaining leadership, cliques, and friendships patterns (page 22). The analysis (Chapter IV) of the sociograms (one for each question and a sixth showing first choices on all five questions) showed the following:

- Informal organization closely paralleled formal organization.
- Choices were governed more by the hierarchial structure of the department than by personal preference.
- Respondents felt most free to make personal choices on a statement relating to religion.
- One full time person on the psychiatric division received lowest number of choices.
- Two full time persons on the psychiatric division were unaware of the positive aspects of a system of informal communication.

II. CONCLUSIONS

One set of operations rarely proves or disproves an hypothesis, and this study is no exception. Although two of the three full time psychiatric division personnel are somewhat isolated— one of them markedly so— evidence is lacking that this is primarily a factor of
their assignment. Nor, conversely, can the third full time person be considered solely in relation to her work on the division. Long employment, a secure position near the top of hierarchy, and confidence in her general nursing knowledge appeared to be the most significant factors when choices were made according to the interview information obtained by the investigator.

So far, the psychiatric division has had little impact on the general nursing staff. Voluntary comments about the service were rare. Interest was expressed occasionally, but the group generally did not see themselves as having a "stake" in the psychiatric division.

The data strongly suggested that this group feels little freedom to differentiate among concepts before integrating and accepting the precepts as their own. Rather, they tend to look to authority and do so on the basis of moral teaching that places emphasis on duty, order, and devotion. One can conclude from this that direction from the psychiatrists would be followed with complete fidelity but with little awareness of self and with little understanding of the covert manifestations of psychiatric illness.

III. RECOMMENDATIONS

In the investigator's judgment, a sociometric study has serious limitations in the investigation of inter-staff relations in the selected hospital. More productive, probably, would be a participant observation study in which actual, rather than reported, behavior is studied. This hospital has undertaken an important responsibility in establishing a psychiatric division, one which deserves to be
followed in the interest of this hospital, and of others which undertake a similar function.

It is recommended that another study be done, perhaps in six to eight months, when the division is more firmly established, using a participant observer technique.

Secondly, it is recommended that the in-service education program devote some time to a study of informal organization—its function, use, and its positive, as well as negative, aspects.

Further, a study of interpersonal relations generally, using perhaps Peplau as a source, is recommended. To be warm, kindly, and well intentioned is, however much one may regret it, not enough.

Thirdly, and in conjunction with the above point, it is recommended that a psychiatric nurse be added to the staff. Without skilled help, it appears unlikely that newer concepts of nursing care of the mentally ill will permeate this very tightly structured nursing staff.

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APPENDIX A

Sociometric Survey Form
NAME:__________________________________________________

TITLE OF YOUR POSITION: (underline) Director of Nursing Services •
Head Nurse-Supervisor • Charge Nurse • Head Nurse • Supervisor

NUMBER OF YEARS EMPLOYED AT THIS HOSPITAL ____________________

AREA OF YOUR REGULAR DUTY ASSIGNMENT: _______________________

ESTIMATE PER CENT OF TIME YOU WORK ON: Medical A __________
Medical B __________ Surgical Ward _______ Obstetrics _______
Central Service ___________ Operating Room _________________
Nursing Office ____________ Other (specify) _________________

PLEASE CHECK ONE: Registered Nurse _____ Practical Nurse ______

INFORMATION AND INSTRUCTIONS

You are helping with a nursing study which will assist us in learning better ways to plan and organize for nursing care.

In this study there are no "right" or "wrong" answers. Only information is sought. All replies are completely confidential with the study-maker and your identity will be protected in the write-up of the research.

On the next page are five statements posing hypothetical, "as if," situations. Read the statement. Then make your choices, by name, from among the personnel who work in this hospital. Fill in all blanks, working as quickly as you can. These are not thought questions.

If you have a question, please ask it now. No questions can be answered after you have begun on the next page.
I. A patient on your ward is difficult to manage. From whom would you choose to get help with this problem (1st) __________
(2nd) ___________________ (3rd) _______________________

II. With whom would you choose to talk over an ethical problem
(1st) ___________________ (2nd) _______________________
(3rd) ___________________

III. With whom would you choose to be associated on a committee
(1st) ___________________ (2nd) _______________________
(3rd) ___________________

IV. With whom would you choose to attend church (1st) _________
(2nd) ___________________ (3rd) _______________________

V. Whose grapevine information would you accept (1st) _________
(2nd) ___________________ (3rd) _______________________


APPENDIX B

Composition of the Test Group
### TABLE I

**COMPOSITION OF THE TEST GROUP**

<table>
<thead>
<tr>
<th>Personnel in Group Tested</th>
<th>Title Employed (Years)</th>
<th>Regular Assignment</th>
<th>Per cent of duty on MB</th>
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<td>MA</td>
<td>1</td>
<td></td>
</tr>
<tr>
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<tr>
<td>$X_3$ S 12</td>
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<td></td>
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</tbody>
</table>

**TITLE**

- S - supervisor
- CN - charge nurse
- HN - head nurse
- S·HN - supervisor and head nurse

**ASSIGNMENT**

- OR - operating room
- OB - obstetrics
- Sr - surgery
- MA - general medicine
- MB - psychiatry
- CS - central service
APPENDIX C

Letter Requesting and Letter Granting Permission
To Use the Clinical Facility
Mr. ______________, Administrator

________________________________________

My dear Mr. ______________

Miss ______________, Nurse Consultant for the Western Interstate Commission for Higher Education, informs me that your hospital has recently established a psychiatric division. With something less than eleven per cent of hospital beds available to psychiatric patients in general hospitals, this puts you in the vanguard of a new and exciting trend in mental health care.

As a long time psychiatric nurse (about sixteen years) you can understand that I would be interested. I have a further interest. In my work here at the University I have the opportunity to do an independent study of some facet in nursing service administration that interests me, and which, when completed, will be of potential interest to directors of nursing service generally.

Your situation, a new Division of Psychiatry in an established general hospital, is tailor made for these requirements. May I hear from you soon regarding the feasibility of using ______________ Hospital as a clinical facility for this study?

Very truly yours,

cc: Director of Nursing
cc: Chief, Division of Psychiatry
Mrs. Helen Graves  
University of Colorado  
Boulder, Colorado

Dear Mrs. Graves,

Your letter of September 21 has been received, and I am glad to know of your great interest in the mental health program.

We shall be pleased to have you use the __________________ facilities in connection with your study.

Feel free to contact the Director of Nursing Service, or myself, for any aid that we can give you in carrying out your study.

Assuring you of our desire to be cooperative in every way possible, I remain

Very sincerely yours,

__________________________________________
Administrator

cc: Director of Nursing  
cc: Chief, Division of Psychiatry