BALANCING THE MANDATES AND CONDUCTING BUSINESS AS USUAL:

The Organization of Work and Communicating with Schizophrenics on a Psychiatric Ward

by

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CHAPTER I

INTRODUCTION AND BACKGROUND

Introduction to the Research Problem

Considerable agreement exists in the research literature that disturbed communication is characteristic of people diagnosed as schizophrenic (Arieti, 1974; Bleuler, 1911/1950; Bleuler, 1974; Chapman & Chapman, 1973). A plethora of research has been undertaken over the decades to describe the bizarre and abnormal language used by schizophrenic persons (Bleuler, 1911/1950; Bleuler, 1974; Kasanin, 1944). Much research has been undertaken in an attempt to analyze the content or process of schizophrenic thinking and communication in order to compare how these differ from their counterparts in normal discourse (Chapman & Chapman, 1973). The focus of much of the research, whether anecdotal case studies or experimental laboratory studies, has been specifically on persons labelled schizophrenic. Research studies in this area attempted to uncover a model of linear causality to account for the distortions of thought process and peculiar communication often found in the symptom complex of schizophrenia (Reusch, 1957). In the 1950s and early 1960s there was a shift in focus from the less complex linear model to more complex studies of family dynamics and interactions where one family member was diagnosed as schizophrenic. The family studies examined family interactions from a systems theory approach viewing communication as a dynamic circular process where each family member mutually influences the others (Bateson, Jackson, Haley, & Weak-

land, 1956; Jackson, 1968; Laing, 1961; Lennard, Beaulieu, Embrey, & Nolen, 1965; Lidz, 1973; Mishler & Waxler, 1968; Reusch, 1957; Singer & Wynne, 1965).

This shift in focus from the individual schizophrenic person to the family revealed that the entire family engaged in abnormal styles or patterns of communication. Watzlawick, Beavin, and Jackson (1967) who studied schizophrenic families and their communication suggested that all communication affects behavior and that through communication all humans define their roles and relationships with each other by either confirming or disconfirming their individual selves. In families that engage in excess use of pathological or abnormal communication, the authors say, "the parents fail to register a child's view and the child does not seem to register that his view has not been registered" (p. 92).

It is through language that thoughts are created and formulated and, as such, reflect the way people organize their experiences. Whorf-Sapir (cited in J. S. Kasanin, 1944) hypothesized that "the nature of one's language determines the nature of one's thoughts" (p. 288). Disordered thought and loose associations and expressions, long associated with schizophrenia, can reflect a person's inability to handle the task of organizing thoughts to communicate in a manner easily understood by others (Chapman & Chapman, 1973).

From the research studies of disordered thought and schizophrenic communication, certain inferences can be drawn. The schizophrenic person seems to have difficulty with cognition, perception, thinking, and interpersonal relationships (Andreasen, 1978; McGhie & Chapman, 1961). Many people with difficulties in the areas mentioned may have

problems with every-day activities of self-care and self-determination, and as a result of these difficulties they are often hospitalized for various lengths of time. About half the patients found in mental health institutions are said to carry a diagnosis of some form of schizophrenia (Kringlen, 1972). Nurses are the one group of health professionals in the hospital setting that attend these patients around the clock.

Psychiatric nurses* have traditionally been taught theories and techniques of communication as an integral part of their nursing education. These theories have historically been embedded in Sullivan's (1953) interpersonal theory and other personality theories. Assumptions and concepts "borrowed" from psychotherapeutic theories emphasize that nurses use therapeutic communication that is succinct, purposeful, and concrete. How psychiatric nurses implement this professional ideology and use communication that is therapeutic in their every-day work with hospitalized patients when confronted with genuinely aberrant communication as used by schizophrenic patients has not been addressed adequately in the literature.

Kramer (1974) in her book Reality Shock addressed how nurses in general seem inadequately prepared to balance the implementation of their professional mandates and the everyday requirements of the hospitals where they work. This process becomes even more difficult when highly specialized nurses such as psychiatric nurses are confronted with the everyday demands and work on a psychiatric ward.

Psychiatric nurses are also taught theories of the symptom complex of schizophrenia and various explanations of the schizophrenics' often

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*In this study she will be used to refer to nurses and he will be used to refer to patients.

bizarre behavior and abnormal communication. When psychiatric nurses enter the real world of everyday work with schizophrenic patients, they are faced with operationalizing and balancing the enormous ambiguity around assessing and communicating with them. Their theoretical knowledge of these phenomena do not provide them with specific explanations that they can fall back on in their everyday work with the schizophrenic patients. In addition, the nurses are confronted with the pragmatic sophistication of the institution where they work. The institution is much less concerned with the nurses' professional ideologies of establishing therapeutic and purposeful relationships with all the patients. The institutional mandates are more concerned with the pragmatics of admitting, diagnosing, treating, and discharging patients as expeditiously as possible.

The everyday work situation of the nurse involves fulfilling the institutional requirements of tremendous amounts of paper work when admitting or discharging patients, transcribing medical orders to the patient charts and medicine cards, making daily recordings in the patient charts about patient behavior and actions, preparing shift reports, etc. In between all the institutional requirements and ward business, the nurse is expected to answer the telephone, find replacements for nurses who call in sick, and assess and interact with patients whose behavior and communication are unpredictable and difficult to understand. While fulfilling the institutional requirements, the nurse must simultaneously balance her professional and clinical mandates of establishing therapeutic relationships with the patients and use communication that is purposeful.

Thus, psychiatric nurses, in addition to balancing the reality of a work situation, must also learn how to balance their knowledge of the theories of schizophrenia and the abnormal communication of schizophrenic patients with the ambiguous explanations of etiology and treatment with their professional and clinical mandates and the pragmatics of the institutional requirements.

Strauss, Schatzman, Bucher, Erlich, and Sabshin (1964) addressed this problem on a more general level. They discussed how mental health professionals, including psychiatric nurses, seem to negotiate between the professional goals and the pragmatics of everyday reality of psychiatric hospitals.

The Specific Study Problem

The present investigation was designed to explore and describe how nurses are affected by the abnormal communication used by schizophrenic patients in their everyday work on a psychiatric hospital ward located on the West Coast of the United States. In the process of exploring the specific research question through three pilot studies (Bunch, 1979, 1980a, 1980b), it became evident that to answer this question other variables also needed to be examined. This study also had to examine how nurses operationalized their professional and clinical mandates with the more pragmatic requirements of the institution and balance all of these. In other words, how the psychiatric nurse balances the structural requirements (professional, clinical, and institutional) had to be examined in order to understand how nurses are affected by the patients' peculiar communication and take appropriate action.

The Purpose of the Study

The purpose of this study was to explore and describe how nurses are affected by the abnormal communication used by schizophrenic patients in their daily work on a psychiatric hospital ward on the West Coast of the United States.

The methodology used to study this question was qualitative comparative analysis, a type of field method, where the researcher was a participant observer. In the process of analyzing the data, it was discovered that to answer the specific research question, additional questions had to be examined. These were: 1) How do nurses complete their daily work on a hospital ward according to the expectations and requirements of the institution? 2) How do nurses function as therapeutic agents and use communication that is purposeful according to their professional and clinical requirements? 3) How do nurses operationalize their professional and clinical requirements? 4) How do nurses operationalize their professional mandate with the everyday stressors of working on a psychiatric ward? 5) How do nurses survive emotionally and psychologically and balance between the professional, clinical, and institutional requirements when in addition faced with abnormal schizophrenic communication? 6) How do nurses balance the often ambiguous theories of schizophrenia and their peculiar communication in their everyday interactions with the patients? 7) What methods do the nurses use when interpreting and responding to the patients verbal and nonverbal actions?

Chapter I presents theories pertinent to the symptom complex of schizophrenia. This is to provide the reader with a general under-

standing of the complexities involved with the phenomena diagnosed as schizophrenia and how this has been viewed over the last fifty years. The chapter presents definitions of psychiatric nursing and what is generally included in the nurse's professional ideology. Communication as a means of working with psychiatric patients is also addressed. In addition, the first chapter discusses psychiatric hospitals, their treatment ideologies, and how these have changed over time. This is to provide the reader with a background for the environment in which the nurses and patients work together. The chapter concludes with a statement of the significance of the study.

Chapter II presents a review of research undertaken on schizophrenic communication. This is to provide the reader with a further understanding of the complexity of researching the phenomenon of schizophrenic communication. The second section of Chapter II presents principles that guided the researcher in the study.

Chapter III presents a section on how the research question evolved and the study setting was chosen. A section of the process of the nurse researcher is included to highlight issues related to being a nurse researcher and participant observer on a psychiatric hospital ward. A third section presents issues related to qualitative versus quantitative methods in nursing research. Section four presents a description of the design and method used in the study. The last section presents the study setting, treatment ideology of the ward, nurse and patient variables along with a description of the specific structural and functional variables of the study setting.

Chapter IV presents the findings and an analysis of the data. The professional, clinical, and institutional requirements that impact on

the nurses in their everyday work are discussed as they specifically occurred in the study setting. A social psychological framework (Schatzman, in press) is presented to help explain how the nurses seemed to interpret the patients' verbal and nonverbal gestures. The patients verbal and nonverbal gestures are discussed in terms of a noisiness scale. The last section presents the actual strategies, passive and active, that the nurses engaged in when faced with all the patients' activities in addition to the abnormal communication used by about two-thirds of the patients in the study setting.

Chapter V presents a discussion of the study findings and some limitations of the study. Future implications for nursing research, education, and in-service education are also presented.

This study was specifically designed to explore and describe how nurses interpret and respond to the abnormal communication used by schizophrenic patients on a psychiatric ward. It evolved to include a broader issue of how nurses balance the structural requirements of the institution with the professional and clinical requirements.

The next section presents theories of schizophrenia as these have evolved over the decades.

Theories of Schizophrenia

This section presents theories of adult schizophrenia viewed from historical and cultural perspectives and includes epidemiological studies. Many theories--biological, psychological, social, and cultural--have emerged to account for the process and etiology of the

symptom complex labelled "schizophrenia." This section presents the most prominent of these theories as they have evolved over the decades.

Psychiatric Theories

Classical psychiatry emphasized a medical model of etiology, illness course, treatment, and outcome. Kraepelin (1901) was among the first to describe and classify the symptoms and illness outcome of what he termed "dementia praecox" or "idiocy." Inherent in his theory was the postulate that the origins of the illness were organic and treatment therefore would be largely ineffectual. E. Bleuler (1911/1950) also believed in an organic cause, but disagreed with Kraepelin's view about the possible outcomes of the disease; he renamed it "schizophrenia", latin for "split personality." A contemporary of Freud, Bleuler explained many schizophrenic phenomena through psychoanalytic theory. Both Kraepelin and Bleuler agreed that the illness frequently occurs in early life, has progressive deterioration, and follows a distinctive course. The major criticism of Kraepelin has been that a disease should not be diagnosed by its outcome (Chapman & Chapman, 1973).

Even today Bleuler's classification of the primary and secondary symptoms of schizophrenia and the subtypes of hebephrenic, catatonic, and paranoid are used by most mental health professionals throughout the world. This classical organic view has dominated European psychiatry in particular. E. Bleuler's four As--ambivalence, autism, affect disturbance, and loose associations--are still regarded as the core symptoms of schizophrenia, although the 1980 edition of the American Psychiatric Association's Diagnostic and Statistic Manual has made schizophrenia's diagnostic criteria more precise (DSM III, 1980).

Bleuler believed loose associations and thought disorder to be the most characteristic symptoms. Even though essentially descriptive, Bleuler's theory has had a profound impact on psychiatry all over the world.

Psychoanalytic Theory

Psychodynamic clinicians were discontent with the organic etiology proposed by Kraepelin and Bleuler and emphasized instead an origin in emotional and interpersonal conflict (Meyer, 1938; Sullivan, 1953). In part, this change in perspective was due to Freud's theory of psychoanalysis. Psychoanalytic theory uses psychological explanations to account for human behavior which is thought to be understood through psychic processes. Freud's theory offered a psychic determinism whereby unconscious mental processes can be uncovered and a causal sequence be determined. Thus a person is regarded as having an illness which can be located and understood through psychological means and in many instances may be treated. Much research has used clinical data to demonstrate the validity of the assumptions underlying psychoanalytic theory, but little has been done to test these assumptions (Arieti, 1974; Chapman & Chapman, 1973). Later theorists (Meyer, 1938; Sullivan, 1953), still greatly influenced by Freudian thinking, stressed the interaction between the individual and the environment to explain the illness complex of schizophrenia. Particularly in the United States, there has been a marked departure from the still traditional organic/biological view of psychiatry found in Europe. Psychiatry in the United States has focused on social and interpersonal factors interrelated with intrapersonal phenomena to explain schizophrenia. The above theories are rooted in the medical model and use descriptive clinical data to explain and account for empirical phenomena.

Social Theories of Psychiatry

In the 1950s and 1960s sociological and family studies emerged which proposed an alternative theory of schizophrenia and mental illness (Bateson et al., 1956; Goffman, 1961; Laing, 1961; Lidz, 1973; Scheff, 1966; Singer & Wynne, 1965). They used systems theory and broad developmental principles to analyze the processes which contribute to schizophrenia. As a result, a circular view--rather than a linear one--was introduced into the understanding of schizophrenia.

Among the social and sociological investigations from this era, the best known are the social class study of Hollingshead and Redlich (1955), the Midtown Manhattan study of Srole (1962), the Sterling County study of Leighton (1963), Scheff's (1966) labelling madness theory, Goffman's (1961) total institutions, and the social resource study by Rushing (1978). The above studies placed strong emphasis on sociocultural factors (i.e., social class, social resources, social isolation, cultural conflicts) and migration "that make their impression into the personality and emerge as mental symptoms and/or mental disorder" (Dunham, 1976, p. 147). Surveys, interviews, medical records, and other statistical data were used, and these data have since been called into question. Design flaws, too hasty conclusions, and data interpretation were some criticisms named (Dunham, 1976; Weissman & Klerman, 1978).

Probably the best internationally known sociologist from this era is Goffman who developed the theory of total institutions and the detrimental effects these can have on hospitalized schizophrenics. The British psychiatrist Laing also should be mentioned for the impact he had on the so-called "antipsychiatric" movement in Europe and the United

States. Laing (1961) used clinical data and interviews with schizophrenics and their families to conclude that schizophrenia is a normal reaction to an abnormal situation. Arieti (1974b) strongly opposes Laing's view and contends that schizophrenia is an abnormal reaction to an abnormal situation. The authors of social theories and mental illness examined factors that led to people being labelled mentally ill and how they were dealt with. Yet the majority of the patients in the psychiatric hospitals at the time of their studies carried a diagnosis of schizophrenia. One result of the authors' often severe criticism of psychiatry, psychiatric hospitals, and labelling mental illness led to a change in peoples' awareness of the mental institutions at the time.

Cultural Studies of Schizophrenia

Cultural studies from the 1930s by anthropologists such as Benedict (1934) concluded that normality is culturally defined and that all behavior, whether normal or abnormal, is learned from the cultural milieu (Kiev, 1961; Montague, 1961; Slotkin, 1955). As Dohrenwend and Dohrenwend (1974) have phrased it, "diagnostic categories for schizophrenia are universal in representation, and are different in distribution and content of the illness" (p. 431). A more recent international pilot study of schizophrenia (1973) initiated in the 1960's, studied schizophrenia in 9 countries throughout the world and confirmed that schizophrenia with similar core symptoms can be found in all countries and cultures. The outcome of schizophrenia in the developing countries (India, China, Nigeria, and Columbia) was, for instance, better than for other more industrialized countries (USSR,

USA, Britain, Denmark, and Czechoslovakia). One suggested explanation for this finding was the difference in family systems in the developing countries. These societies are considered less stressful with a strong community support system (Mosher, 1978).

Dunham (1978) has presented fifteen summary statements that emerge from social, psychological, epidemiological, and cultural studies of schizophrenia. Because they question the results of earlier classical studies, the most important of these statements are: 1) selective social forces can account for the distribution differences of mental illness; 2) social class per se is not an etiological factor in schizophrenia; 3) social changes do not produce schizophrenia; 4) schizophrenia is found in every culture of the world; 5) culture can determine the content but not the form of the psychosis of schizophrenia; and 6) a lack of awareness and recognition of cultural differences can contribute to misdiagnoses of mental illnesses.

Biological Theories of Schizophrenia

Developing concurrently with the psychosocial theories of schizophrenia in the U.S., much research was done in Europe on genetic studies of schizophrenia (Kallman, 1938; Kringlen, 1972; Tienari, 1963; Slater, 1953). Results of these studies of twins indicate a concordance rate of 20% to 30% for monozygotic twins and a 10% chance for family members to develop schizophrenia themselves, whereas the incidence rate is about 1% in the general population. How this genetic factor is transmitted is still unclear.

In addition to genetic studies, a more recent hypothesis regarding the etiology of schizophrenia has been proposed (Cunningham, 1978; Kety,

1969). Research has shown that neuroleptic drugs such as dopamine are effective in reducing schizophrenic symptoms. These antipsychotic medications reduce symptoms by inhibiting or blocking motoric behavior and psychotic symptomatology. Cunningham (1978) believes schizophrenia to be a biological phenomena amenable to pharmacological treatment. Although there is strong evidence for biochemical causative factors in schizophrenia, such a view is as yet not fully supported.

Epidemiological Information

From epidemiological studies (Arieti, 1974; Bleuler, 1978; Kringlen, 1972; Weissman et al., 1978), the incidence rate for schizophrenia in the Western societies has remained at about 1% of the population during the last century (Arieti, 1974, IPSS, 1978). This is of particular interest when one considers the many advances in psychiatric technique and pharmacology which have taken place. Also, one would expect the incidence of schizophrenia to decrease because the propagation rate for schizophrenics is considered to be half that of the population in general (Bleuler, 1978). Epidemiological data from most countries in the world suggest that one person in one hundred can be expected to be hospitalized at some time during his lifetime with a diagnosis of some form of schizophrenia.

About one-third of those diagnosed as schizophrenic recover fully, one-third experience moderate recovery, and the remaining one-third become chronic (Bland, 1978). The general thinking in European and American psychiatry today is that schizophrenia is caused by a combination of hereditary and environmental factors found in particularly sensitive and vulnerable persons (Bleuler, 1978). Research

thus far has been unable to isolate any one specific factor whether biochemical, psychological, social, or cultural which causes schizophrenia.

Summary

Irrespective of the theories of schizophrenia, many people with this diagnosis are hospitalized for various lengths of time. While in the hospital these patients are cared for by psychiatric nurses. Communication is used as a means of interaction between nurses and patients. Communication is used as a means for interacting with patients to obtain information of why he is in the hospital and what he sees his needs and problems to be. The question one must raise is how nurses interpret and respond to the patients who use abnormal schizophrenic communication. What strategies does the nurse use to assess these patients' needs and implement nursing care for these patients? This question will be discussed further in Chapter IV.

The symptom complex of schizophrenia has been researched from many perspectives over the last century. Despite this intense research and many proposed theories, the etiology of schizophrenia remains an enigma. Which theory one believes is a sufficient explanation for the schizophrenic phenomenon will have consequences for the treatment process and nursing interventions one engages in with the schizophrenic patient on a psychiatric hospital ward.

This section presented theories of schizophrenia and how they can be interpreted. Because schizophrenia is open to such a great variety of theoretical interpretations, these can have enormous impact on how psychiatric nurses assess and define the patients' verbal and nonverbal

actions and subsequently how nurses act. The nurses' actions are further complicated by the professional ideologies and treatment philosophies in their background and how these are operationalized and modified in their everyday work situation on a ward.

The next section presents definitions of psychiatric nursing, professional ideologies, and treatment philosophies as they pertain to this study. This is to provide the reader with an understanding of what is generally implied by these concepts.

Definitions of Psychiatric Nursing

In the United States, nursing is defined as "the diagnosis and treatment of human responses to actual or potential health problems." This definition points to four defining characteristics of nursing: phenomena, theory application, nursing action, and evaluation of effects of action in relation to phenomena: (ANA, 1982, p. 9). A specialist in nursing practice, i.e., a psychiatric nurse, "includes in-depth studies of theories relevant to the particular area of specialization" in educational preparation (ANA, 1982, p. 23). A more specific definition of how to view the psychiatric nurse is Kalkman's statement that the nurse functions as "1) a scientific observer, 2) a creator of a therapeutic milieu, 3) a socializing agent, and 4) a psychotherapeutic agent" (1974, p. 17). Underwood (cited in Kalkman & Davis, 1980) further defines psychiatric nursing as "the interaction between nurse and patient that assists patients to cope with problems in daily living. In assisting patients to cope with day-to-day living the nurse uses the nursing process and nurse-patient relationship as well as an understanding of human behavior (p. 237).

Which theories of human behavior, personality, society, and/or biology one adopts will have consequences for the nursing role and practice. A nurse who believes in a biological causation for schizophrenia, for instance, may stress somatic therapies, whereas a psychological theory of schizophrenia would justify other interventions. Such interventions would tend to stress the developmental aspects of the individual as well as his ego strengths and weaknesses. On the other hand, beliefs in social theories may lead the nurse to examine social relationships and the impact of society on the individual.

The nursing process, as a scientific means for realizing the goals of nursing in practice, is recognized by most schools of nursing education in the United States and other Western countries. The nursing process--or problem-solving method--involves assessing, collecting data, planning, implementing, and evaluating patient problems as well as the nursing interventions deemed appropriate to patient care. A basic tool for the implementation of the nursing process is communication between nurse and patient.

One can say that psychiatric nursing has been defined from abstract perspectives as well as from operational positions that include process and function. Whether the descriptions are abstract or operational, the basic tool of psychiatric nursing either explicitly stated or implicitly assumed, is communication. This will be discussed in more detail on page 19.

The psychiatric nurse is part of an interdisciplinary team with other mental health professionals such as psychiatrist, psychologists, and/or social workers. The role of the psychiatric nurse and that of the psychotherapist are complementary; it is the nature and duration of

contact between the patient and nurse or between the patient and doctor that differ. The nurse focuses on the immediate needs of the patient and facilitates self-care and self-determination whereas the primary therapist examines the underlying dynamic processes of the patient's illness. The psychiatric nurse, in contrast to other mental health professionals, provides patient care 24 hours a day. This physical care and intimate involvement in the patient's daily life and therapy, as well as diagnostic scheduling and medicating, provide many opportunities for communication between the patient and nurse.

Professional Ideologies

Professional ideologies reflect ideal goals and are abstract rather than practical. Strauss and associates (1964) found that nurses and doctors in mental hospitals negotiated their professional ideologies to find a workable or operational philosophy that could be used in their everyday work situations with patients. The authors discovered that staff members did not discuss professional "ideologies in an abstract sense; they argued operations bearing upon real patients in real situations" (Schatzman & Strauss, 1973, p. 116). Thus the nurses and doctors did not carry out their work only according to their ideological dictates. They developed what Strauss and associates (1964) referred to as "Operational philosophies as a median ground between pure idea and the pragmatic necessities of collaborating with others of different ideological faith" (Schatzman & Strauss, 1973, p. 116).

In the same manner, nurses learn about their professional mandate as ideals, but operationalize them so they become workable to them in their everyday work with patients. Professional goals to establish

relationships with patients that are warm, sensitive, meaningful, and therapeutic and at the same time maintain the characteristics of a highly professionalized nurse that espouses emotional noninvolvement becomes a dilemma for many nurses (Gow, 1982). Professional goals and ideologies are necessary for the advancement of any profession. The question is how nurses can operationalize and implement these in the every-day reality of her work situation. Gow (1982) argues that:

> Of all the helping professionals, the nurse is the one who, at least theoretically, is assigned to "live" with her patients for a full eight-hours of duty. It can be argued with validity that this places far more strain on her capabilities in interpersonal relationships than any other profession. (p. 10)

How nurses balance and manage this "strain" when they also are confronted with the peculiar schizophrenic communication is problematic.

The professional ideology of psychiatric nursing has many parallels to that of other mental health disciplines. In the U.S., the theories of Peplau (1952) and Kalkman (1974, 1980) have dominated. Peplau stresses learning through interpersonal relationships between psychiatric nurses and patients. Kalkman defines the nurse as a therapeutic agent.

Communication

Psychiatric nurses are taught theories and techniques for communicating with patients as an integral part of their education. The cornerstone of this teaching rests on the interpersonal theory of Peplau who says:

> Social chit-chat is replaced by responsible use of words which help to further personal development of the patient. Talking with patients becomes productive when the nurse decides to take responsibility for her part in the verbal exchange.
>
> (cited in Altschul, 1972, p. 24)

Communication theory traditionally has been embedded in the interpersonal theory of Sullivan (1953) and others. The theories are theoretical rather than pragmatic and were originally developed for the psychiatrist and adapted for nurses.

Communication can be said to be part of every-day life and as such is often taken for granted. "Increasingly, professional nursing has required that our use of communication be more knowledgeable and more skilled" (Hein, 1980, p. 16). In psychiatric nursing, communication has a specific purpose of exploring, interpreting, and understanding what the patient is saying so that the nurse can assess patient needs and plan purposeful interventions for the benefit of the patient. Because of the peculiar schizophrenic communication, it is essential for nurses to understand communication as a process and learn how to use communication skillfully so that they can aid the patient in clarifying confusing thoughts, processing the difference between internal and external stimuli, and helping the patient with reality orientation. Hein (1980) says:

> The application of communication principles to professional nursing practice is called therapeutic communication. Therapeutic communication differs from everyday communication in that it is a planned approach used consciously to influence the patient in directions that serve his interest and his welfare. (pp. 16-17)

How nurses are able to incorporate therapeutic communication in their interactions with patients as part of their professional requirements and balance this with the requirements of the hospital when they are in addition confronted with abnormal schizophrenic communication is complex.

Psychiatric Hospitals and Treatment Ideologies and Their Changes Over Time

Tracing the history of psychiatric hospitals and treatment, one discovers their uniqueness and similarities throughout the Western World. This section describes the historical origins of psychiatric hospitals and treatment ideologies so as to better understand the environment and treatment of schizophrenic patients and the working conditions of psychiatric nurses of today.

Historically, psychiatric hospitals have been intended for those who otherwise are unable to manage their lives independently. The purpose of these hospitals has been to protect society and to shield the patient from society. For this reason , many early hospitals were placed in rural areas. Treatment, as we think of it today, was minimal and consisted of rest and occupational work within the hospital or farming the land surrounding the hospitals. This situation gradually changed. Particularly after World War II, there was an increase in the hospitalization rate that peaked in 1955. By 1955 the resident population in state mental hospitals in the United States had reached 559,000 (Bassuk & Gerson, 1978, p. 48) and many of the hospitals had become what Goffman (1961) labelled as "total institutions."

From being residents, the patients were now inmates under constant staff surveillance and were excluded from any mutual decision-making regarding their treatment. Goffman has described the hospitals as having very tight organizational control which emphasized rules and regulations/regimentation of daily activities. Communication between inmates and staff was minimal and primarily centered around staff telling patients what to do or not to do.

The hospitals had become large and dehumanizing warehouses which denied patients individualism and autonomy and are often referred to as the "snake pit years." Such a view was popularized in books in the early 1960s: Goffman's Asylum (1961), Green's I Never Promised You a Rose Garden (1964), Kesey's One Flew over the Cuckoo's Nest (1962) and Barnes' Journey through Madness (1971). These books revealed how psychiatric hospitals had fallen short of their original goals of treating/protecting patients and were now overcrowded warehouses.

The 1960s brought many changes through scientific and popular literature; these included an increase in social awareness in general, changes in social structure, the introduction of new technology, and medication such as psychotropic drugs; and these innovations caused a shift in the treatment of mentally ill people and the attitudes of others toward them.

The passing of two significant laws in the United States and California, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 and the Lanterman-Petris-Short Act of 1969, are examples of the increasing social awareness about the mentally ill. The movement toward deinstitutionalization of the mentally ill and advocacy of patient rights reflect this new sensitivity to the needs of the patients.

The intention of deinstitutionalization was to treat the patient in the community and away from large institutions. The Lanterman-Petris-Short Act for the first time specified by law who could be confined against their will in a psychiatric hospital and the length of confinement. The purpose was to prevent arbitrary incarceration and to protect the patients' rights to a court hearing. Partly because of

these laws passed in the 1960s, the composition of patient populations has changed in most mental health institutions of today. Patients have much shorter stays and when hospitalization is necessary emphasis is on crisis-intervention, rapid tranquilization, and disposition planning. Whether the conditions for psychiatric patients have improved any over the last twenty years might be a question for research. The point made here is that with the legal system of today and current laws and the complicated economic situation, people who are hospitalized have a much shorter stay and at times must even compete for admission. Yet, the professional mandates for nurses have not changed that much over the last decades.

Treatment Ideologies

In the United States, Freudian psychoanalytic principles and the social psychiatric view of Adler (1929/1971, cited in Wilson & Kneisl, 1979) have dominated the treatment philosophies used by most psychiatrists. In Europe, the biological emphasis of Kraepelin and Bleuler have dominated psychiatric treatment and ideologies. In both Europe and the United States, the perception advanced by Jones (1978), a British psychiatrist, of the hospital as a "therapeutic community" has been widely accepted. His assumptions are that, by creating a "community" within the hospital as similar as possible to the larger community outside it, patients will learn leadership skills, be more likely to participate in mutual decision-making about their treatment plan, and regard hospitalization as a social learning experience. As it says in the booklet given to the patients of the study unit for this research (see Appendix F):

> Participation in community life is emphasized on Unit [X]. Participation means respecting each individual's space, attending unit activities, and assisting each other. Through participation one learns about taking care of oneself and living with others both here and outside.

Everyday Reality on a Hospital Ward

The focus of this research study was how the abnormal and peculiar schizophrenic communication affects nurses in their everyday work on a hospital ward. To explain these phenomena one must understand the symptom complex of schizophrenia, what nurses bring to the setting in terms of professional ideology and technological skills, and how the psychiatric hospitals function today.

The everyday work reality of psychiatric nursing involves a considerable amount of paper work. The nurse is obliged to write admission notes, document patient behavior, sign medical orders, give medications and record medications on the patient's chart, as well as fill out consent forms for involuntary or voluntary admissions, treatment, and medications. The daily business of the nurse also involves attending scheduled activities such as interdisciplinary treatment and community meetings, nursing rounds, and patient activities such as changing bed linen and helping with showering, dressing, and meals.

The professional ideologies and teaching traditions of Peplau and Kalkman were formulated at a time when patients were hospitalized for many months and nurses had more opportunity to establish and maintain therapeutic relationships. Today, when short-term hospitalization seems to be the goal, psychiatric nurses are caught in a dilemma between their professional mission and the institutional dictates of admitting,

treating, and discharging patients as expeditiously as possible. How nurses balance and maintain their professionalism and their professional mandate to use therapeutic communication that is succinct, concrete, and purposeful, and to comply with the institutional requirements of the everyday business is complex. Put another way, how psychiatric nurses survive emotionally and psychologically, maintaining a sense of professional identity which reconciles professional ideology with everyday reality of institutional requirements when they are obliged as well to understand the frequently inadequate and abnormal communication used by many of their patients is problematic.

Significance of the Study

Most research undertaken on schizophrenic communication, whether anecdotal case studies or experimental laboratory studies, has been designed to examine and describe how schizophrenic thinking and communication differ from normal thinking and communication. In addition to this research, one also finds that professional textbooks for mental health workers apply similar designs. Emphasis is on either the patient's pathological condition or how the therapist can develop characteristics like empathy, genuineness, and warmth in the therapeutic relationship with the patient (Truax & Carkuff, 1964). There seems to be an absence in these discussions of how the peculiar schizophrenic communication directly affects the nurse. How nurses balance their professional and clinical mandates with the more pragmatic sophistication of the institutional requirements is problematic for all nurses irrespective of work setting. This becomes even more difficult

when nurses work in a specialty area such as psychiatry. Here they must deal with the enormous ambiguity involved in diagnosing and treating schizophrenic patients.

When the nurse enters the everyday reality of a hospital ward with frequently inadequate staffing, an overload of patients that can be belligerent and difficult to understand, demanding doctors, the everyday institutional business to organize and complete, she must learn to balance the many demands that impact on her in order to survive emotionally and psychologically.

This study was designed to examine and describe the problems, strategies, and conditions under which nursing gets done, given the conditions of professionalism, clinical and institutional requirements, and abnormal schizophrenic communication that all impact on the nurse and must be balanced in her everyday reality on a psychiatric hospital ward.

Summary

The first chapter presented an introduction to the research question and outlined the five chapters. Theories pertinent to the symptom complex of schizophrenia were reviewed. In addition, professional ideologies for psychiatric nursing and psychiatric hospitals were presented as they related to the study. The last section of Chapter I presented the significance of the study.

Chapter II will review research literature that relates to schizophrenic thought disorder and communication. The second section in this chapter presents principles that guided the researcher in this study.

CHAPTER II

LITERATURE REVIEW

The second chapter has two main sections--one reviewing the research literature pertinent to the study and inferences which can be drawn from those studies--and the second representing a meta-theoretical framework that has guided the researcher.

Psychiatric nurses through their academic education learn about professionalism and theories of schizophrenia and communication. To understand the complexities and ambiguities the nurse encounters when interacting with schizophrenic patients, a review of the research literature of schizophrenic thought disorder and communication is presented. This review will provide the reader with an additional understanding of the nurses' problems when interpreting and translating the patients' verbal and nonverbal actions and the strategies they engage in on a psychiatric hospital ward.

Review of Literature Pertinent to the Study

Abnormal Communication

The abnormal communication characteristic of the thought disorder of schizophrenia has been described and investigated from many perspectives including nursing, psychiatry, and psychology (Arieti, 1974; Bateson et al., 1956; Bleuler, 1911/1950; Chapman & Chapman, 1973; Laing, 1961; Peplau, 1952; Reusch, 1957; Singer & Wynne, 1965; Shannon,

1970; Sullivan, 1953; Tudor, 1952). Traditionally this literature has been organized according to disciplines. As varied as this research literature is, it can be described as having three organizational categories: studies which describe abnormal communication, studies of such communication from an interactional perspective, and studies from a transactional perspective.

A similar organizational framework, although the focus was on communication as a phenomenon, is suggested by Wilson & Kneisl (1979) who regarded communication as an act (action command), an interaction (exchange of messages) and a transaction (negotiation of meanings). This was the framework used for reviewing the research literature. Because communication as an act or command falls between the two categories mentioned above, it will, nevertheless, be included since much clinical data have been collected using this mode of communication with psychiatric patients.

Before embarking on the review of research literature, two current definitions of communication are presented. This is to show how communication is conceptually viewed today. Many of the research studies presented were undertaken prior to our present understanding of the phenomenon of communication. Yet, the presentation of earlier research is important in order to show how abnormal schizophrenic communication has been researched over the decades and the many difficulties involved in understanding this complex phenomenon.

Normal Communication

Two widely accepted definitions, one by Sereno and Mortenson (1970) and the other by Watzlawick and associates (Beavin & Jackson, 1967) are

presented to show the range of communication as a vehicle for human thought and speech.

Sereno and Mortenson identified four distinct dimensions of communication theory: systems of behavior, decoding and encoding activities, interaction and communication in a social context. Behavior, interaction, and social context can be compared to the three modes of communication suggested by Wilson and Kneisl (1979), and they vary depending on the social context in which they occur. The dimensions of decoding and encoding refer to the mechanisms of how communication is expressed and understood.

The theory of communication presented by Watzlawick and associates (1967) further delineates and complements that of Sereno and Mortenson by subdividing communication into three areas: syntactics, semantics, and pragmatics. Syntactics refers to the transmission of language, i.e., decoding and encoding, and to the grammatical properties of language. Semantics relates to the meanings of communication, and pragmatics refers to the effect communication has on behavior, i..e, systems of behavior, interaction, and social context. The pragmatics of communication as used by Watzlawick et al. includes meta-communication, that is, communication about communication, and how all humans define relationships through communication. Relationships can be further categorized as being complementary when based on differences or symmetrical when based on equality.

Sereno and Mortenson discussed communication as used by a normal population while Watzlawick et al. studied pathological communication as used by schizophrenic persons and their families. The authors of the two definitions presented use systems theory to explain the circularity

of communication and support the organizational framework for this section.

Studies Describing Abnormal Communication

The abnormal communication used by schizophrenics has been described in the psychiatric literature since the turn of the century (Arieti, 1974; Bleuler, 1911/1950; Bleuler, 1974). Yet, most of these descriptions are anecdotal case studies based on interviews with patients which describe bizarre language and thought processes. Certainly, most psychiatric nursing studies on the abnormal communication of schizophrenia fall within this category (Davis, 1963, cited in Mereness, 1971; Eldred, 1960, cited in Mereness, 1971; Hewitt & Pesznecker, 1964, cited in Mereness, 1971; Peplau, 1952; Crouch, 1972; Kroah, 1974; Shannon, 1970).

One good example of a psychiatric nursing study in this category is the doctoral dissertation of Shannon (1970). Her research design was a well controlled experimental laboratory study in which she describes how schizophrenic and depressive patients recognized facial expressions of emotions as displayed by standard picture cards. The findings clearly indicated that schizophrenics are less able than normals and depressives to recognize specific affects of fear, contempt, and disgust.

The early psychiatric studies described the often bizarre language used by schizophrenics without attempting to expound on the phenomenon. After Freud introduced psychoanalytic theory, many authors explained abnormal communications using assumptions and concepts from Freudian theory (Arieti, 1974). VonDomarus (1944) is a good example. He introduced the concept of paralogic thinking and suggested that

schizophrenics reason by different laws of logic. Arieti (1974) developed this notion further by suggesting that schizophrenics use paleological thinking very similar to the primary thought processes in the early developmental stages of childhood.

Other theories attempted to explain the schizophrenic phenomenon by suggesting there were intrapsychic disturbances in the person. This disturbance could be defective ego functioning, disturbance in the quality of thinking, or difficulty in abstraction (Ostwald, 1974; Rochester, 1978; Sullivan, 1952). M. Bleuler (1974), a Swiss psychiatrist who conducted longitudinal studies of schizophrenic patients and their families over several decades, concluded, among other things, that one is left with a subjective feeling of something being different when communicating with a schizophrenic patient.

Cameron (1940, cited in Kasanin, 1944) suggested that the schizophrenic person arrived at conclusions that the therapist or nurse cannot possibly hope to share, by logical methods they cannot follow, using words they cannot understand. The author speculated that this was due to a lack of abstract thinking on behalf of the patient.

The limitations of these descriptive studies are that their theories "are derived from speculative interpretations of anecdotal evidence," say Chapman and Chapman (1973, p. 11). Despite this rather severe criticism, these studies do provide valuable information about subjective experiences of disordered thought and often credible ways of interpreting abnormal communication which are useful for health professionals who work with schizophrenic patients.

In addition to the anecdotal case studies, there are a number of experimental laboratory studies which describe and explain schizophrenic

thought disorder and communication. Hypotheses generated from this body of research vary. There are performance deficits in schizophrenia (Kornetsky & Orzack, 1978) attention and screening deficits (Cancro, 1971; Rodnick & Shakow, 1940, cited in Chapman & Chapman, 1973; Tucker & Harrow, 1969; Zahn & Carpenter, 1978), self-editing studies (Cohen, 1978), information processing deficits, and a failure to account for the listener's needs (Rochester, 1978). Cohen suggested that schizophrenics might have a defect in a screening mechanism which might account for the inability to edit out sensored or inappropriate responses that are usually edited out of normal discourse. Other authors (Chapman & Chapman, 1973; Miller, 1978) suggested that the literal or concrete interpretations of schizophrenic discourse might be due to an inability to use weaker as well as stronger meanings of words.

Communication as an Act

Communication as an act or command may be viewed as a linear process whereby one person "commands" or tells another person what to do, not expecting a reply, but expecting the person to comply with the command (Reusch, 1957; Wilson et al., 1979). The sender of this type of communication is active while the receiver is regarded as passive. Much clinical data have been collected and reported related to this mode of communication and it is considered to be a useful approach in dealing with schizophrenic patients (Reusch, 1957, 1961). Communication as a command is rather common when parents address small children.

Abnormal Communication from an Interactional Perspective

Communication as an interactional process implies that there is a mutual or reciprocal influence on the participants and that there is an

exchange of messages between them. A good example of such an interactional perspective is the classical psychiatric nursing study by Tudor (1952). It is also a good example of a controlled study which analyzes sociopsychiatric nursing interventions to describe and explain problems of mutual withdrawal by nursing staff and patients on a mental hospital ward. Through an analysis of interpersonal relationships, Tudor identified how a process of mutual withdrawal can be encouraged or limited when viewed as an interactional rather than a linear process. Mutual withdrawal occurs when nursing staff perceive and convey a sense of hopelessness among themselves and in their interactions with patients. The result, according to Tudor, is a stabilization of the patients' mental illness and a mutual withdrawal by patients and nursing staff from one another. The major strength of Tudor's study is that she did more than just focus on the patients' pathological behaviors and she analyzed as well the circular effect of the nurse, the patient, and the social context of the hospital ward.

Family Studies

Studies which examine the schizophrenic and the schizophrenic's family look at abnormal communication from an interpersonal perspective, investigating communication styles and patterns. The underlying assumption is that communication is an interactional process. All family studies were undertaken on families having a schizophrenic member. It is not clear from these studies, however, whether the families had always used deviant communication as a part of their interaction. It is also unclear whether another family member may have exacerbated communication patterns already present or whether the

schizophrenic member may have developed a type of communication that led the entire family in adoption of a similar pattern of communicating. Longitudinal studies currently in process on high-risk families and normal families might be able to clarify some of these questions (Garmezy, cited in Wynne, Cromwell, Matthysse, 1978).

Many studies of families with schizophrenic members use systems and developmental theories to account for the abnormal communication found in a large number of the families studied (Bateson, 1956; Lennard et al., 1965; Mishler & Waxler, 1968; Singer & Wynne, 1965). Communication frequently is described in the literature on family studies as being amorphous, or fragmented, or excessively "double-binded." Double-bind communication is such that whatever a person says will be wrong. A person who grows up in such a family situation never learns to communicate honestly and effectively and is often unable to determine what other people really mean (Jackson, 1968).

The studies of Singer & Wynne (1965) on thought disorders and family relationships of schizophrenics are methodologically sound and similar to family studies by other authors (Jackson et al., 1967; Lennard et al., 1965; Mishler & Waxler, 1968). They assume that the style of attending, perceiving, thinking, communicating, and relating in family transactions are likely to promote the cognitive development of the child in certain abnormal directions. Their research focused on the links between individual schizophrenic impairment and family patterns of thinking and communicating. The studies indicated a high predictability in identifying family members from specific families according to the style or pattern of communication used by the family members when listening to taped conversations.

A well known American psychiatrist, Lidz (1973), studied styles of interaction in schizophrenic families as a means by which the members learn how to conceptualize. His studies emphasized the "transmission of irrationality" that goes on in these families in terms of how they communicate with each other and how their peculiar communication will negatively influence the child's cognitive and emotional maturity. The British psychiatrist Laing (1961) applied the notion of "mystification" that goes on in the schizophrenic families in terms of communication. According to Laing, mystification is a form of "imperviousness" or indifference often found in these families. This is a situation where the parent fails to register the child's viewpoint when communicating and where the child does not register that his view has not been registered.

Thus, the terms of double-bind, irrationality, and mystification are similar to what Watzlawick has referred to as "complementary relationships" whereby the person's self is either rejected or disconfirmed through pathological communication. (This point will be discussed more in the section on guiding principles.)

One criticism of studies of families with a schizophrenic member has been that only families which were typically middle class and intact were used. Another weakness of these studies is that they were not actually conducted in the home, but in a controlled laboratory setting, and they lacked proper control groups. Rosenthal (1969), in a study on communication in lower class schizophrenic families, questioned whether a common feature in these families such as difficulty in sharing a focus of attention and closure of expression and thought extended across class lines. The author interviewed lower class disintegrated and intact

black and white families in their homes. The results showed that in no instance was there any significant difference between the two categories of families or between racial groups.

Family studies also do not distinguish how families think, perceive, and relate to one another within the family system. Wynne (1978), for instance, indicates that "the most serious shortcoming of family studies is neglect of extrafamilial interactions of these family members with extended kin, friends, and work associates and the personnel of treatment facilities" (p. 530). This shortcoming is the very aspect which the present study explores: the effect of abnormal communication as used by the schizophrenic patient on the psychiatric nurse in a psychiatric hospital ward.

Examples of Studies of Abnormal Communication from a Transactional Viewpoint

The concept of communication as a transaction has changed over the years. In some of the family studies from the early 1960s, transaction is not clearly defined. Wilson and Kneisl (1979) suggest that "in a transaction, communication is viewed as a process of simultaneous mutual influence, rather than a turn taking event, and where messages are negotiated" (p. 105). There does not appear to be much research of abnormal communication which specifically deals with how schizophrenics negotiate meanings. Psychiatrists such as Sullivan (1953), Reusch (1957), and Rosen (1950) collected much clinical data on communication from a transactional perspective which had great potential for research with schizophrenics. It was not until some ten years later that Berne

(1961) introduced the theory of transactional analysis. Transactional analysis has been used with neurotics and in therapeutic groups.

Summary

In this section research studies on schizophrenic communication and disordered thought were presented. Regardless of their individual research designs, the focus of these studies has been on the schizophrenic or on that person's family in an attempt to identify what causes this phenomenon. Despite considerable methodological weaknesses, e.g., lack of uniform diagnostic criteria, use of chronic and acute populations in the same study, comparison of patients using psychoactive drugs and those who are not, and lack of control groups, the findings of these studies suggest that "schizophrenics show deficient behavior with regard to semantic and pragmatic processes, while syntactic processes are somewhat better preserved" (Reusch, 1957, p. 202).

The reason for reviewing the research literature of schizophrenic thought disorder and communication was to present the state of the art. Our understanding and knowledge of this phenomenon is somewhat obscure despite the amount of research on this topic. Yet, nurses must deal with the obscurity of schizophrenia and schizophrenic communication in their daily interactions with patients. The nurse must, despite the ambiguities, balance her professional mandate to establish therapeutic relationships with the patients and use communication that is purposeful in addition to the other demands that impact on her everyday work situation.

The next section presents principles that guided the researcher in this investigation that are drawn from two theoretical orientations.

Guiding Principles or Meta-theoretical Framework

The framework for this research was drawn from two major theoretical orientations: the pragmatics of communication as described by Watzlawick et al. (1967) and symbolic interactionism as defined by Blumer (1969). This section explicates the underlying assumptions from the two theories and presents the principles from these that guided this study.

All human interactions, not only communication, are social events in a social context that are continuously interpreted and re-interpreted by the participants or actors. The theory of pragmatics of communication describes one aspect of communication--namely pathological communication in schizophrenic families. This theory views the process of communication from a systems theory approach and how it affects behavior and defines roles and relationships in families with a schizophrenic member. Symbolic interactionism, on the other hand, views all human behavior from a transactional perspective; that is, meanings of social acts or events by the participants are seen through a process of interpretation which are continuously negotiated. Symbolic interactionism thus adds a more general view to all human activities and is not limited to pathological communication.

The theory of Watzlawick and associates provided guidance for how it is not possible not to communicate, how messages of communication can be exchanged through an interactive process, how communication with other humans defines our roles and ourselves, and how communication must be interpreted on a content level as well as on a connotation level.

Symbolic interactionism provided further guidance as to how all human acts, irrespective of psychopathology, can be interpreted as processes of social events based on our past and present understanding of these events and interactions. Also, how an understanding of events can be reached by negotiating a mutual understanding and how by using language symbolically one discovers and creates a present social reality. Thus, concepts from the two theories that guided the researcher in this study were: interaction, transaction, relationships, social events, the social context of communication, and the symbolic use of language.

Assumptions from the Theory of Pragmatics of Communication

All communication, whether normal or not, can be divided into three modes of message-giving: action or command, interaction or exchange, and transaction or negotiation. In the first mode, it is the content of the command that is essential. This mode is usually succinct and direct. Command communication is useful when one does not want to exchange or negotiate meanings. It is often used with children, for instance. It is communication as an interaction, however, upon which the pragmatics of communication are based. This assumption about communication perceives it to be an interaction or exchange between the communicants. Said another way, "each participant tries to perceive the world as the other perceives it in order to predict how the other will respond" (Wilson & Kneisl, 1979, p. 104). This predictability is lacking in interaction with schizophrenics. Tudor's (1952) study of mutual withdrawal between patients and nurses was based on the

assumption that behavior is an interactional process implying exchange of messages.

Watzlawick et al. (1967) have argued that: "A patient's situation is not static but varies with the interpersonal situation as well as the bias of the observer" (pp. 46-47). They proposed two axioms to their assumption that communication is interaction: 1) it is not possible not to communicate and 2) every communication has a content and relationship aspect such that the latter classifies the former and is therefore meta-communication" (p. 54). The first axiom implies that "even nonsense, silence, withdrawal, immobility (postural silence) or any other form of denial is itself communication" (pp. 50-51). This can be seen as the schizophrenic paradox, "[the patient] is faced with the impossible task of denying that he is communicating and at the same time denying that his denial is a communication" (p. 51).

Quite apart from the mere exchange of information, all humans must communicate with other humans for the sake of their own awareness and development of self. It is on the meta-communication or connotation level that Watzlawick and his co-authors believe that communication imposes behavior and a commitment that defines other peoples' roles and relationships. These relationships are defined as complementary, based on differences, or as symmetrical, based on equality. In normal relationships, personal roles emphasize equality or differences in defining the other person's self. From this perspective, pathological relationships, often found in families with a schizophrenic member, imply a rejection or disconfirmation of the other person's self. An example of this type of communication is Bateson's (1956) double-bind hypothesis in which the child's response is continuously rejected or

disconfirmed by the family. Singer and Wynne (1965) also considered communication to be amorphous or fragmented if it avoids a commitment and either rejects or disconfirms what the other person is communicating.

The meta-communication of Watzlawick et al. implies a transactional process. Pathological communication on this level can lead to what Laing (1961) labeled imperviousness or mystification about communication.

Symbolic Interactionism

Symbolic interactionism has a long tradition in American sociology and investigators include such names as Cooley, Dewey, Thomas, Mead, and Blumer (Strauss, 1977, p. 277). In Europe, philosophical emphases have derived from Husserl (1962), phenomenology, and the Hermeneutic philosophy of Heidegger (1962), and are all considered part of the interpretive tradition. In this study, Blumer's (1969) interpretation of social interactions as symbolic of all human actions, was the theoretical base.

Symbolic interactionism as presented by Blumer rests on three basic premises:

> 1) Human beings act toward things on the basis of the meaning those things have for them.
> 2) The meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows.
> 3) These meanings are handled in and modified through an interpretative process used by the person in dealing with things that are encountered.
>
> (1969, p. 2)

Blumer suggests that "Human beings interacting with one another have to take account of what each other is doing or is about to do; they are

forced to direct their own conduct or handle their situations in terms of what they take into account" (p. 8). All actions taken by the participants are considered social events, and it is these actions that must be interpreted and translated when responding to them. This must be viewed as an on-going process whereby one person attempts to interpret and translate another person's behavior and concept of self. Meanings are negotiated based on past and present understanding of these social events or interactions, or as Blumer says: "Symbolic interactionism sees meanings as social products, as creations that are formed in and through the defining activities of people as they interact" (p. 5).

In this manner, symbolic interactionism adds another dimension to Watzlawick's theory of the pragmatics of communication. Meanings of communication are viewed as meanings of social events. Because these events are processes, their meanings are ever changing, depending on the participants and the social context of the transaction.

Using language symbolically, one discovers and creates social reality. Social actions are events of interactions with other humans whereby the participants (in this study, nurses and patients) interpret and re-interpret the meanings of those events. Through this process, the nurse and schizophrenic patient on a psychiatric ward will subjectively achieve and construct meanings based on their past experiences and the present social context. Thus one can say that in any given social or cultural environment, family, community, or country, people acquire a certain shared and predictable symbol interpretation. Hammer, Makiesky-Barrow, and Gutwirth (1978) suggest that "In normal discourse there is a high social predictability because of a large

shared vocabulary. Studies on schizophrenic thought disorder and communication show reduced social predictability" (p. 531). How nurses deal with the lack of social predictability when communicating with schizophrenic patients is critical to this study.

This Study

The two theoretical perspectives of Blumer and Watzlawick provided guidance for this study of a psychiatric hospital ward, to observe communication between nurses and schizophrenic patients, and how the participants create their social reality and how the communication affects their actions.

Summary

This chapter reviewed research literature that specifically relates to schizophrenic communication. The literature was organized around a framework that cuts across the disciplines of psychiatric nursing, psychiatry, and psychology. Thus the research literature was presented from a perspective of communication as an act, exchange, or transaction of messages.

The many theories and research literature of schizophrenia and disordered thought and communication, professional ideologies, and treatment philosophies were presented since this study was designed to explore and describe how nurses are affected by these and operationalize the abstract theories that are ambiguous. In addition, the question of how this ambiguity reflects on the nurse's ability to balance the knowledge, understanding, and professionalism in daily encounters with

schizophrenic patients with the more pragmatic demands of the institution is central to the present research.

A second section presented principles from the theories of pragmatics of communication (Watzlawick et al., 1967) and symbolic interactionism (Blumer, 1969). These served as guiding principles for the research study.

The next chapter presents the research design and methodology used in this study along with issues related to the choice of design.

CHAPTER III

DESIGN, METHODOLOGY, AND STUDY SETTING

This chapter has four sections: 1) the formulation of the research question; 2) the process of the nurse researcher and the rationale for the design and methodology used in this study; 3) the methodology with illustrations from the study itself; and 4) a description of the study setting (See Appendix E).*

Formulation of the Research Question

Several sources aided in formulating the research question for this study. In-depth studies of communication theories, schizophrenic thought disorder, and research pertinent to these areas revealed the complexities and ambiguities involved in studying them for disciplines such as nursing, psychiatry, and psychology. Reviewing theories from the interpretive tradition such as symbolic interactionism (Blumer, 1969) further aided in formulating the research question and influenced the choice of research design and methodology. A review of the related literature and research revealed a dearth of research addressing how aberrant communication used by people diagnosed as schizophrenic affects nurses in their daily work on a psychiatric ward. The specific research question for this study was:

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*From now on the first person will be used instead of the third person since this convention makes for easier reading.

How does abnormal communication used by people diagnosed as schizophrenic affect the nurses in their daily interactions on a psychiatric hospital ward?

Additional questions that were examined were:

1) How do the professional, clinical, and institutional requirements impact on the nurse in everyday work on a psychiatric ward?
2) How do nurses balance the often conflicting demands of these requirements when in addition confronted with schizophrenic communication?
3) How do nurses operationalize the ambiguities of the abstract theories of schizophrenia and abnormal communication in light of the structural requirements that impact on them?
4) How do nurses conduct their "business as usual" and organize their work on a psychiatric ward when in addition faced with abnormal schizophrenic communication?
5) Under what social conditions and in what social situations do nurses and patients communicate and interact on a psychiatric ward?
6) How do nurses and patients subjectively interpret and translate the symbolic use of language and what are the consequences of these interpretations?
7) What strategies do nurses develop when confronted with abnormal schizophrenic communication in their everyday work situation on a psychiatric ward?

In this study "social context" refers to a psychiatric hospital ward where the principal actors are nurses and patients. The organizational

requirements have to do with job descriptions, rules, regulations, norms, and the institutional business and paper work of admitting, diagnosing, treating, and discharging the patients. The professional ideology and mission concern nursing's definition of its scientific goals, functions, and roles. Clinical requirements refer to the technical skills required and expected of nurses working in a clinical field, i.e., psychiatric hospital ward. The official ideology of a unit and the operational ideology of the profession are translated and balanced in the nurses' perceptions of reality in their daily work with patients. This latter reality then becomes what the nurses actually do while working within an organizational setting with its adherent functional and structural dictates.

The following three pilot studies (Bunch, 1979, 1980a, 1980b) undertaken by this investigator aided in formulating the research question and led to the choice of study setting for this investigation.

Pilot Studies and Findings

In the process of formulating the specific research question for this study, three pilot studies were undertaken (Bunch, 1979, 1980a, 1980b). Participant observation, a type of field research, was used in the collection of data.

The pilot studies provided the researcher with experience and understanding of field work as a scientific method and a nurse as a researcher and participant observer.

The first pilot study made me realize how professional ideologies can be operationalized in a real work situation. The assumption and expectation that nurses work for the benefit of the patients were

challenged and made me cognizant of how nurses balance the structural requirements in their everyday work on a psychiatric hospital ward by "symbolically tightening" (or loosening) their control vis a vis the primary therapist. How this happened is explained below.

First Pilot Study. My first experience as a field researcher and participant observer was on a psychiatric ward (Bunch, 1979). This ward is part of a large urban medical center and focuses on research and teaching of mental health professionals. The ward uses a specific nursing care model that clearly delineates nursing tasks from medical and therapy tasks. Although my observations focused on the interactions between nurses and primary therapists, the experience exposed me to field research and participant observation as a possible method for my own research study. The data analysis revealed how nurses and doctors constantly negotiated and balanced their professional and operational ideologies. The data analysis revealed how nurses maintain a perceived social control and ward order by symbolically "tightening" (or loosening) their control vis a vis the primary therapists. This was done in two ways. When there was discord among the professions regarding issues of patient treatment or job division questions, the nurses would "tighten" their control. They did this by "exaggerating" the patients' symptoms in their oral and written reports, increased use of p.r.n. (as needed) medications, and/or had the doctor on call (OD) change the medical order written by the primary therapist. When medical decisions coincided with their own observations, professional and operational ideologies, they would "loosen" their control. They did this by carefully documenting and reporting patient behavior to support the treatment decision. Through this practice of "tightening" (or

loosening) social control, "harmony" was restored among the professional groups and a sense of ward order was maintained and balanced.

Second Pilot Study. A second pilot study (Bunch, 1980a) was conducted while I was collecting data for a larger study of "Evaluation of the Effect of the Implementation of a Model of Nursing Practice on the Delivery of Nursing Care to the Chronic Mentally Ill (Underwood, 1980). Over a period of six weeks, I observed how nurses and patients communicated with each other at a large Veterans' Administration hospital on the West Coast. This particular hospital has an abundance of long-term chronic schizophrenic patients. I found that the nursing staff were rather rigid in their communication styles and preoccupied with maintaining a tight organizational control. Daily activities were regimented with few opportunities to deviate from a pre-set schedule. Their communication was primarily command-oriented and rarely involved any exchange or negotiation of meanings.

The observations from the second pilot study revealed very clearly how a large bureaucratic institution with highly pragmatic and sophisticated institutional requirements can transform professional ideologies under the umbrella of "treatment."

Conclusions from the two pilot studies. Observations from the two pilot studies suggested that the wards represented two very different approaches in the treatment for schizophrenic patients. The first ward is more therapeutically oriented because of its ability to attract many nurses with at least baccalaureate preparation. The first hospital is also, to some extent, able to determine which patients are admitted. The second hospital is unable to "choose" patients and is considered less attractive by many nurses. This latter may be due to a limited

opportunity for the nurses to influence change in a large and traditional bureaucratic institution. The chronicity of the patient population was another determining factor for not selecting this setting for my study.

Third Pilot Study. The two pilot studies suggested that a ward with many diagnosed acute psychotic patients might more clearly reveal how nurses are affected by abnormal communication as used by most of these patients. Thus I approached the director of the psychiatric nursing service at an urban county hospital (Bunch, 1980b). My purpose was to negotiate entry to observe the manifestation of abnormal communication used by patients and how nurses communicated and interacted with these patients. The possibility of doing my study on this unit was also explored.

Two days of observations and conversations with the nursing staff revealed that indeed two-thirds of the patients were diagnosed with some type of schizophrenia and used overtly and authentically abnormal communication. Their speech and behavior were unpredictable and at times difficult for others to understand. Much of their demeanor was bizarre with rapid pacing around the unit, ritualistic behavior such as lifting the limbs, and staring off into space. The observations indicated constant interaction between nurses and patients because of the patients' psychopathological conditions, poor self-care, and limited social skills.

The observations revealed the toll on the nurses of constantly modifying their professional ideologies, conducting and organizing institutional business in the name of treatment. The toll on the nurses' ability to balance the structural requirements and survive was

revealed through their pragmatic approach to very complex nurse-patient interactions, difficult cooperation, and often lacking support from the medical profession and high attrition rate among the nurses.

The experience from the three pilot studies led me to select this third psychiatric ward as the best setting for my dissertation because of the often blatant abnormal communication used by many of the patients and the manner in which the nurses attempted to balance the structural requirements in addition to interpreting the patients' verbal and nonverbal actions and the nurses' strategies for coping with this situation. Subsequently, I negotiated entry into the ward as a nurse researcher and participant observer.

The Process of a Nurse Researcher

The process of a nurse researcher is included to highlight the advantages and disadvantages of being a nurse researcher in a familiar field. At times this dual role can aid in legitimizing the presence of the researcher on the ward, yet it is also possible to overidentify as a clinician with the many problems facing the nurses in the setting--i.e., patient care, an apparent inability to improve therapeutic patient care standards because of the high attrition rate among nursing staff on this particular ward, or even the desire to provide help in routine tasks on those days when the ward was understaffed. The strategy developed to deal with this conflict was to remove myself from the setting for a few days in order to gain some temporal distance before resuming observations.

Gaining Entry to the Study Setting

Negotiating entry to the study setting was less difficult than anticipated, in large part because of the nursing administrator, supervisors, and head nurse working at that time.

Before embarking on the actual field research, I met with the nursing staff. My purpose was to explain the research and my role as a participant observer and to obtain the staff's informed consent (see Appendix A). Nurses in the setting were told that their discussions with patients would be observed and that they were to feel free to ask the researcher to leave the unit whenever their work was disrupted by my presence. Confidentiality of identity and specific details related to what they said or did to the patients also was conveyed to the nurses.

Other factors that aided in the process of establishing credibility and competency as a nurse researcher were extensive experience as a psychiatric nurse clinician and teacher, a valid California nursing license, and current part-time work as a psychiatric nurse at another facility in the city.

Establishing Credibility and Acceptance

Because many people under study feel uncomfortable being "observed and researched," it is essential to have their co-operation. The staff's acceptance of the researcher as a participant observer was therefore vital. The success of the study was dependent on their willingness to share their subjective interpretations of the social interactions and events on the ward.

Even though initial access to the study setting was uneventful, Schatzman's warning that "the experienced researcher recognizes that

entering relatively complex human organizations is a process in which he will be engaged long after permission has been granted" (1973, p. 23), eventually became clear to me. Establishing a history of credibility and acceptance among the nursing staff took more time and energy than I had anticipated. This was due in part to the high attrition rate among the nurses. In 1981 the attrition rate was 127% (data from director of nursing at this hospital). Only three nurses remained on the staff throughout the nine months I observed the unit. As a researcher, I very carefully recruited their help in legitimizing my presence on the ward and questioned their perceptions and interpretations of what happened there. The tenure of the nonnursing staff--psychiatric technicians, psychiatrists, and social workers--was more stable. They, like the three nurses, were quite helpful in the ways they asked me questions about the research study and interacted with me. In doing so, they acknowledged and accepted my presence on the unit.

Finding a Good Place from Which to Observe

In the process of locating a good place from which to observe nurse-patient interactions and communication, as many different events as possible were sampled. There were scheduled activities such as community meetings, team meetings, group therapy meetings, intake interviews, and occupational activities. Initially, much time was spent following Schatzman's suggestion to "take in the entire universe--so that [one] is assured of having observed at least once every routine event which occur in the organization" (1973, p. 43). This was a way of discovering how the ward is organized. I wanted to observe how staff interacted during scheduled events and their perceptions of what

happened during these events; and I wanted them to become accustomed to my presence. In addition to observing at all scheduled events, I observed at all times of the day and all days of the week including weekends and holidays.

I quickly learned the whereabouts of patients and staff, and it was during the initial mapping and sampling of ward events that I discovered a half-wall near the nursing station which was an ideal location from which to observe staff and patient interactions (see Appendix E). From there I could overhear conversations on a patient telephone behind me, see the door that was the main entrance to the unit, observe almost all interactions in the two dayrooms on either side of the nursing desk, and look down the hallway of the male patient dorm. Best of all, I could observe all interactions in and around the nursing station.

The nursing station was where most interactions among nurses, patients, and primary therapists occurred. In fact, one of the nurses made a typical remark while I was leaning against the wall by saying, "Here you are, loitering again" (Notes, p. 180).

The Issue of Recording Observations

How to go about writing down my observations was initially an issue. Should I openly record them, or write down only themes? Would I have to leave the unit for a "coffee break" in order to write my observations while the observations were still fresh in my memory? In the beginning I was hesitant about recording my observations; yet after a month it was easy to do so and I recorded mostly my own comments and direct quotes of what was said. Surprisingly few people questioned what I was doing. Since people at the nursing station are constantly

writing, my own activity simply blended into the rest. Two quotes from my notes illustrate the lack of emotion concerning my note taking:

> J.P. (staff) asked to see my notes and read some of what I had written and said, "That's interesting," and handed the writing pad back to me with a smile and walked away. (Notes, p. 167)

> T. (a patient) came by and was eyeing my note pad that was lying on top of the nursing station, she looks at the notes and I ask her if she wants to read them. As soon as I have said this I'm wondering what I have written about her on that page. First, she backs off, then comes back, she takes the pad, looks at the page, and says "Oh," excuses herself, and adds that her eyes are "so blurred" she cannot read too well. (Notes, p. 181)

Issue of Demeanor

As a participant observer I attempted to blend into the milieu as much as possible. The staff dressed casually in jeans, slacks, shirts, and low-heeled shoes, and so did I. While at the study setting, I always wore a name tag as did most of the staff. To many, this indicated that I "belonged" and my presence was not questioned. A new psychiatrist said to me after we were introduced, "I figured you belonged when I saw you wearing a name tag" (Notes, p. 140). At times the name tag caused some confusion for new patients, visitors, or people just passing through the unit. They would sometimes approach me as if I were a staff member. At other times, especially with patients, the name tag led to many interesting encounters. Since I appeared "available" and yet did not seem to belong, they seemed to feel freer to tell their stories. Patients would ask, for instance, whether I was a real nurse and about my name. Often they would then tell me about themselves and why they were in the hospital.

Maintaining the Researcher Role

At times my objectivity and identity as a nurse researcher were impaired. This was due to the very difficult working conditions of this ward, the severity of psychopathology, enormous social problems observed among the patient population, and the high attrition rate among the nurses. I corrected for this by observing for only a few hours at a time. Another strategy was to occasionally stay away from the unit altogether for two or three days before resuming the observations. Using these strategies, along with an awareness of the inherent danger of becoming too subjectively involved as a nurse or going native (accepting as my own the values and roles in the study setting), were useful.

Often I collaborated with the nursing staff because of phone calls for them or when the whereabouts of patients was questioned. Thus one of the nurses said one day:

> We are slowly seducing you into a staff person.

My reaction:

> It is hard to not cross over on roles; being an observer I end up with a lot of information about staff and patients, where they are and what they are doing, so staff frequently ask me. Hard to stay neutral and objective all the time. (Notes, p. 166)

Whenever a new staff person was met, I very quickly introduced myself and explained why I was there. The few times when I neglected to do this resulted in decreased cooperation from that person. One of the day nurses who became a very valuable informant was most helpful in the process. She would always take new staff members over to me, introduce us, and say: "All for research" (Notes, p. 76). However, it was very time consuming to get to know the many new nurses well enough to have

them feel comfortable sharing their interpretations and understanding of events with me, only to have them quit their positions.

I was never asked to leave the unit because my presence was thought to be disruptive, and only once was I denied access to a staff meeting. Throughout the data gathering process, the greatest difficulty I had was maintaining my objectivity and repressing my clinician identity.

The next section presents the research design and methodology in conjunction with issues related to qualitative and quantitative methods.

Rationale for Design and Methodology

In this section the rationale for the study design and its methodology are discussed. Arguments for the use of qualitative comparative analysis in nursing research, and its comparison with quantitative methods are advanced. In addition, the design and method are presented illustrating the data analysis process as it evolved in this study.

Issue of Qualitative vs. Quantitative Methods in Nursing Research

There is some contention as to the most appropriate scientific design and method for nursing research. In many graduate nursing schools, scientific quantitative research designs and methods have been the goal with the objective of encouraging research which can provide a predictive and explanatory theory of nursing phenomena. In qualitative comparative analysis, however, the goal is different. The field researcher enters the area of the participants as an observer to

subjectively understand how the actors experience, interpret, translate, and create their social reality. The anthropological studies of Mead (1933) and Benedict (1934) are examples of such a field method. More recently sociologists have used a similar approach to study social institutions (Goffman, 1964; Strauss et al., 1964; Becker, 1963; Olesen & Whittaker, 1968). In these studies, the "principle involvement is translated in the participant observer technique. The observer enters the world of these people whose experience is under study, getting as close as possible to the subject's experience before attempting to interpret them" (Oiler, 1982).

The qualitative comparative method rooted in symbolic interactionism and phenomenology "requires the researcher to understand the person's situation from his own definitional perspective so that insight can be gained into the way this perspective influences the person's behavior and self-concept" (Davis & Kalkman, 1974, p. 569). The most effective way of grounding theory is by doing field research. Zerubavel (1980) says that "field research is undoubtedly among the most useful avenues of gathering information about social life and acquiring first-hand familiarity with social reality" (p. 25). Contemporary nursing research has acknowledged that qualitative research designs are viable for nursing research as well. Munhall (1982) has argued:

> . . . data subjected to statistical analysis produces theory that is descriptive of or predictive of the average person--what gets lost in statistical analysis are alternative explanations for those individuals who reacted differently from the mean. Qualitative research methods, particularly in theory development, may be more consistent with nursing's stated philosophical beliefs in which subjectivity, shared experiences, shared language, interrelatedness, human interpretation, and reality as experienced rather than contrived are considered" (p. 177).

Qualitative comparative research has been used in recent years for a number of significant doctoral dissertations in nursing (Bozett, 1978; Chafetz, 1972; Corbin, 1980; May, 1979; Wilson, 1974). Stern (1980) says that "a strong case for the use of qualitative comparative analysis is investigations of relatively unchartered waters or to gain a fresh perspective in a familiar situation" (p. 20). The present study could be said to be prompted by both of these. How abnormal communication actually affects the participants--nurses and patients--and how this is subjectively experienced and interpreted by both belong in Stern's "unchartered water" category. Thus qualitative comparative analysis where the researcher is a participant observer was deemed the best design and method for this study.

The fact that the field method as a viable research design has survived decades of use by other scientific disciplines such as anthropology and sociology and more recently by nursing speaks for its validity. The strength of this methodology is that it permits exploration of areas not previously addressed and that it generates theory. As Wilson (1974) says, "The researcher must . . . communicate the range of data on which the analysis was made, so that both researcher and reader can make meaningful judgements about the value of the analysis in accurately representing the prominent features of the social world studied" (p. 51).

The following section presents a description of the design and methodology used for this study.

Description of the Design and Methodology

Qualitative comparative analysis is a type of field research where the researcher is a participant observer in a substantive field or area. The outcome of the analysis is a theory grounded in the empirical reality of the participants in the field. While in the field, the researcher records observations of what happens, in what social context, under what conditions, and what strategies are used by the participants as well as the outcomes and consequences. These field notes are later transcribed, coded for clusters or categories of behavioral patterns based on the empirical patterns of behavior and relationships within the data, and analyzed. Out of this analysis themes or variables emerge through an inductive process which can explain the social events and actions under investigation. The focus of field research is on the process of events and actions and not on the persons acting. In this way, the question of why something happens is replaced by how social events and interactions occur. The data can therefore be said to be grounded in or derived from the empirical field as the observer and participants experience and translate the social reality created by the actions and interactions. As Glaser (1978) said, "Thus generating a theory by developing the hypothetical relationships between conceptual codes (categories and their properties) which have been generated from the data indicators, we 'discover' grounded theory" (p. 55).

Analytical field research and qualitative comparative analysis do not follow a linear model. Rather, they are a back and forth process of observing, recording, coding, and theoretical conceptualization so that finally a formal theory is generated and written. For the purpose of

simplicity the various steps in the process will be presented as if they were sequential and illustrated as they occurred in this investigation.

Data Collection and Open Coding

Glaser (1978) suggested that "starting fresh is the best approach" (p. 28). The implication is that one should initiate field observations without a fixed set of hypotheses or preconceived concepts about the study problem in question. To do so may distract the researcher from what is really happening in the field of study. This does not necessarily mean that one should approach a substantive field without a focus. However, Blumer (1969) suggested that "sensitizing concepts can suggest directions which could provide a focus." The sensitizing concepts with which this study was begun were, for instance, communication, schizophrenia, nurses, social events, interactions, and transactions on a psychiatric hospital ward.

Sources for Data Collection

After a substantive field of study has been chosen, the researcher negotiates entry into the field and embarks upon his field observations. For this study, data were collected from approximately 150 hours of observations on a locked psychiatric ward at a Western county hospital in the United States and from four in-depth interviews with nurses from that unit. One nurse had been a clinical specialist and head nurse on the ward for more than a year and had resigned at the time of the interview. She provided much explanatory information about changes in ideology and treatment philosophy that had occurred over the years as well as organizational insight about where the ward fit into the larger

institution and the large county bureaucracy. The three other interviews were conducted from time to time during quiet periods on the unit or during breaks. An interview guide made prior to the investigation was used for the interviews with the nurses (see Appendix D).

Field observations were made during all hours of the day from early morning until midnight and on all days of the week including weekends and holidays. Through interviews, sampled events, and observations, it was possible to gain a balanced knowledge about the structure and function of the study setting and its ideologies. Demographic information, e.g., age, sex, diagnosis, ethnic background, average length of stay, number of admissions and discharges, etc. were collected from patient charts and records completed by the administration of the hospital. One morning was spent in the Psychiatric Emergency Service (PES) where all patients admitted to the unit were screened. Another morning was spent at a satellite clinic that has an interdisciplinary team directly linked to the unit. This team's responsibility included all patients admitted from a particular geographic district and served as well as liaison functions between the hospital and the district community. Patients were followed at the clinic as out-patients before admission and after discharge from the study setting.

Writing Field Notes

Field notes were recorded according to themes, direct quotes, tactics used by the participants, social context of the communications, and the consequences of the interactions. These notes were then transcribed and organized according to Schatzman's (1973) schema of

observational notes (ON), theoretical notes (TN), and methodological notes (MN). An additional fourth category was added, the process of the researcher (PR).

Open Coding

After the field notes were recorded and transcribed according to the schema, a sentence by sentence analysis was applied for identifying categories and their properties. Substantive coding, or open coding, is "the process of separating data into discrete bits and moving these to a higher level of abstraction by categorization" (May, 1979, p.21). A category is a concept, either a theme or a process, appearing in the data that seems distinct. May (1979) said: "Categories that are clearly connected may be combined into a broader category. Because this expands them to include a wider range of observations, these larger categories become increasingly abstract. They remain grounded in the data, however, because they are constantly compared to incoming data (p. 23). "First the analyst compares incident to incident with the purpose of establishing the underlying uniformity and its varying conditions" (Glaser, 1978, p. 49). While observing and coding, three questions were kept in mind:

1) What is the study about?
2) What category does this incident indicate or, in other words, what are the properties of the category and how does it relate to other codes?
3) What is happening in the field under observation? That is, what is the basic social psychological, or social structural process or problem occurring that makes life viable in this place? (Glaser, 1978, p.57)

By following this process of observation, open coding, and response to the questions above, it was possible to ground the data, i.e., use data only from the empirical field to generate conceptual codes that transcend the empirical view. By "fracturing" the data in this way, one can gain a theoretical concept of what is happening.

After some 50 hours of observations, certain themes began to emerge from the data. A typology or form of talk suggested the participants engaged in three different kinds of talking: therapy, business, and social. Within these three types of communication three modes were found: command messages, exchange messages, and negotiated messages. (The three modes of communication were discussed in Chapter II.) At this time it became apparent that there were many structural requirements like: professional, clinical, and institutional, that also impacted on the nurses. The three requirements seemed to influence how the nurses interpreted and responded to the patients' verbal and nonverbal gestures in their attempt to organize and conduct their work on the ward.

Theoretical Memos

The writing of memos is vital to generating grounded theory as they can transcend the subjectivity of the data and provide a means of examining conceptual and theoretical links that the data catalyze in the mind of the researcher. Memos are recorded ideas, themes, or other thoughts that the data have stimulated. Generally, they are written separately from the raw data.

Memos were written on all the codes and categories: it was possible to detect underlying patterns in the data and link them

together in a more conceptual way. Glaser (1978) said, "Thus the successive raising of descriptions through conceptual abstraction to categories and then theory is explicitly developed in memos" (p. 84).

Saturation of Observations

Eventually, the investigator reaches a point in observing where no new events or incidents add any additional information to the data. When a number of categories are saturated and seem to have similar conditions and properties, the researcher may simplify the theory by searching for a higher order category that will subsume smaller ones without losing explanatory power. This process of reduction enables the researcher to delimit the emerging theory (May, 1979, p. 26). The saturation stage in this study was reached after approximately 150 hours of intense observation.

Theoretical Sorting

Theoretical sorting is that phase of the process where notes and memos are literally cut up and sorted into logical piles. In so doing, many categories may be collapsed, ones that do not belong to the emerging theory being sorted out and the remaining piles being organized into a logical sequence preparatory to writing the theory.

Theoretical Coding

According to Glaser (1978), the "essential relationship between data and theory is a conceptual code. Substantive codes conceptualize the empirical substance of the area under investigation. Theoretical codes conceptualize how substantive codes may relate to each other as

hypotheses to be integrated into a theory" (p. 55). Theoretical coding was made possible by focusing observations on the social context in which the various types of talking occurred, the strategies used by the actors, and the consequences of the many interpretations of talking had on the participants' behaviors.

A theme emerged which seemed to explain that nurses must somehow learn to balance between the often conflicting structural demands that impact on them. On the one hand, they must follow their professional mandate to communicate therapeutically with the patients, and yet conduct their business as usual according to the institutional requirements. Conducting their work and balancing the requirements seemed to go on while simultaneously interpreting and responding to the abnormal schizophrenic communication.

Issues of Generalizability

The generalizability of this study to other hospital settings might be considered a limitation. Yet hospitals are usually organized along similar structural and functional components. Although the specific ideological focus of each psychiatric ward might vary, as do the specifics of the patient populations, the overall goal of all psychiatric hospitals is essential the same--to treat patients.

Yet, in any research, whether the design and method used are qualitative or quantitative, issues of validity and generalizability must be addressed. This is particularly true when the investigator has the dual role of nurse and researcher. A familiarity with working with schizophrenic patients can easily lead to analysis of the phenomena from a nursing perspective and thereby bias the observations. On the other

hand, familiarity with the field can legitimize the research protocol and the presence of the investigator on the unit. Dean, Eichorn, and Dean (cited in McCall & Simmons, 1969) speak of this dilemma: "[The field researcher] can reformulate the problem as he goes along, can usually move back and forth from data gathering in the field to analyze at his desk" (p. 23). This was what I did. When in the field, I participated in the daily events of the ward, spoke to many of the participants and heard their subjective interpretations of what I had observed, removed myself from the field, and analyzed the data by following the process outlined in this section. The last section of this chapter describes the study setting.

The Study Setting

This section presents a description of the study setting, staff and patient variables, and structural and functional components of this particular psychiatric hospital ward. It also presents the everyday reality of the nurses' work situation. Although I am presenting a specific psychiatric hospital ward, it is of importance to keep in mind that this ward does not differ significantly from many other wards in the United States or the Western world with a comparable patient population.

Theories of schizophrenia and thought disorder and diagnosing and treating these phenomena as done in the United States are no less complex and ambiguous in other countries. Interpreting and translating the patients' abnormal communication and bizarre behavior and taking action accordingly are done in much the same manner on other psychiatric

wards. The professional ideologies, treatment philosophies, institutional requirements, quantity and quality of the nurses' educational and clinical experiences may vary from ward to ward. But how the nurses balance all of the above and act toward the patients vary only with the different theoretical understandings of the phenomena and how these are operationalized in the nurses' work.

The Hospital and Surrounding Environment

The setting for this study was a county hospital affiliated with a large west coast university in the United States. It is a large modern building that opened in 1970; the original brick buildings are now used for offices, laboratories, or out-patient clinics. The section of the city where the hospital is located is predominately a working-class neighborhood with a mixed population. There are several public housing projects in the area and cheap hotels. Housing is inadequate and consists of small single dwelling homes. For many in the area, there is no permanent housing. There is an ethnic mix comprised mainly of Hispanics, Asians, and Blacks, a number of whom are recent immigrants, either legal or illegal, who speak little or no English.

The Psychiatric Ward

The psychiatric wards of this hospital are located on the top floor of the building. There are three psychiatric units: one admits clients who are predominantly of Asian origin, one is a forensic ward intended for criminal patients, and the third--the one on which the study was conducted--admits other patients in need of psychiatric hospitalization. The most striking feature of the psychiatric department, whether walking

in the hallways or in the units, is the large windows everywhere which provide a sense of space and light and a spectacular view of the city. The door to the study unit (see Appendix E) is locked and entry is gained only after ringing a doorbell. Inside there is a small hallway with an office and staff kitchen on the left. On the right is a large dayroom dominated by a color television. Further down the hall on the left is another dayroom with a radio, couch, a table, and a few chairs. Between the two dayrooms is the nursing station on either side of which is a long hallway, one for male and the other for female patients. Although the floor has a well-worn brown carpet marked by small cigarette burns and the dayroom furniture looks rather shabby with sagging springs, the walls are frequently decorated with colorful paintings made by the patients in occupational therapy.

The nursing station is where most interactions and events occur. The desk area itself is small and crowded with telephones, the patient charts, cardexes, staff mailboxes, and an assortment of loose papers. It is here that the ward secretary works, competing for space with the nurses and the primary therapists. A large portable blood pressure apparatus is at one end of the desk with a chair beside it. This is where patients' vital signs are taken. Above the nursing station a large schedule is posted showing what and when activities and meetings for staff and patients will take place. Since the patients are not allowed matches, a lighter is taped to the top of the desk. On a wall opposite the nursing desk is a big chalkboard where each patient's name, sex, team assignment, primary therapist, and legal status are recorded; in one corner of the board the daily census, number of admissions, and number of discharges are noted.

The patient rooms are actually dormitories, all sparsely furnished with two to five beds, metal cabinets for personal belongings, and a small toilet and washbasin. At the end of the two hallways is a large room with a piano and a linen closet. This room is used for community meetings and occupational activities. On either side of this room are three additional rooms; an office for the head nurse, a team meeting room, and a staff lounge. In both hallways are showers for the patients and a laundry room that can be used at specified times. In the women's section there is a seclusion room and dining room for all patients' use. The dining room is also used for staff shift reports, team meetings, or other activities. There are two vending machines in the dining room--one for soft drinks and one for chocolates.

There are two public telephones on the unit that the patients are free to use, one in the tv dayroom and the other in the women's hallway. On the male side there is also a quiet room used for open seclusion of patients.

Staff Variables

The study unit where the observations were conducted has 11 registered nurse positions, 13 licensed psychiatric technicians, three nurses in supervisory positions--one focusing on administration, one for clinical issues, and one working evenings--and one psychiatric nursing director for the department. I obtained consent forms (see Appendix A) from 16 nurses and demographic data (see Appendix B) from 13 of these. One nurse refused to sign the consent form and her interactions with the patients were not included in the data.

Among the 13 nurses, the average length of time they had worked on the unit was 7.3 months. They had worked an average of 4.5 years as psychiatric nurses and an average of 8.7 years as registered nurses. Six of the 13 nurses were males, 11 caucasian, one Hispanic, and one Philippino. The average age of the 13 nurses was 35.7 years.

As for their educational background, one nurse had a 3-year diploma degree in nursing. Six nurses had associate degrees, five had baccalaureate degrees, and one had a master's degree in nursing. Two of the nurses with baccalaureate degrees in nursing had master's degrees in another discipline, and one was in the process of obtaining a master's degree in a related field. Data supplied by the hospital indicate that during 1981 13 (127%) registered nurses and 8 (61%) licensed psychiatric technicians resigned. Between December 1980 and July 1982, when I was observing the unit, there were three different head nurses. In addition to the nursing staff, the unit had one chief psychiatrist, one full-time and one part-time psychiatrist, one psychologist, two social workers--each occupying one-half of one position, one occupational therapist, and one ward clerk. Many students of nursing, medicine, psychology, and social work as well as psychiatric technicians were on the unit. Since this study focuses on the nurse-patient interactions, these other mental health professionals working on the unit were not included in any of the discussions of this study.

Patient Variables

The study unit has 21 beds and admits patients from a specific geographical area of the city. In addition, out-of-town residents in need of hospitalization as well as any overflow from other hospitals in

the city are admitted. Before the patients are admitted to the unit, they are screened through the Psychiatric Emergency Service (PES) located on the first floor of the hospital; here a tentative psychiatric diagnosis and legal status are determined. Due to inadequate records for admission and discharge diagnoses on the patients, it was not possible to obtain this data. The nurses who worked there said that at least 75% of the patients carried some form of a schizophrenic diagnosis at any one time. The majority of patients are admitted involuntarily, diagnosed either as gravely disabled, suicidal, or homicidal. They can be legally held without their consent from 3 to 14 days. The average length of stay during the nine months I observed the unit was 6.66 days. During that interval, 630 patients were admitted and 633 discharged. Between February 1982 and March 1982, the average patient age was 33 years old with the oldest patient being 60 and the youngest 20. Two patients out of three were male. Patient ethnicity was 62% Caucasian, 23% Black, 8% Hispanic, 1% American Indian, 2% Chinese, 2% Philippino, and 2% other. Interpreters were used for the nonEnglish-speaking patient population. Some of the nurses and other staff members were bilingual. When additional interpreters were needed, the nurses called other wards to find staff members who spoke the language needed. The patients on the ward who were not English speaking were not included in the data.

Patient demeanor. Since most of the patients are admitted because of a psychiatric emergency, they arrive in whatever clothes they happen to be wearing. As a result, they may be found wandering around the unit in pajamas, "street" clothes, or hospital robes. Even though the staff tries to help the patients with at least one shower per day, many resist

and consequently appear rather disheveled. Because of the severity of mental status, the patients usually have little energy to be concerned with appearance on the unit. Just prior to discharge, transfer to another facility, or a court hearing, staff will make an effort to make the patient more presentable, with clothes that family or friends have brought or with garments from a voluntary service at the hospital.

Treatment Ideology of the Unit

The purpose of the study unit is printed in a booklet given to patients upon admission. It says, "The purpose of unit [X] is [to be] a therapeutic community that provides crisis intervention, evaluation, and treatment for clients." This is a common treatment ideology in psychiatric hospitals and wards throughout the Western world. However, the ways in which this treatment philosophy is interpreted and operationalized varies with each unit depending on the patient population, cultural and educational background of all parties, and training of the nurses and doctors.

How the nurses interpret, operationalize, and incorporate this official treatment ideology in their daily work was a principal topic in interviews with staff. The following examples are representative of what I was told. Even though these examples are rather detailed, they are included to show how very differently the nurses viewed their professional goals and how they operationalized the unit philosophy in their everyday work on the unit. Since nurses in the United States come from such diverse educational backgrounds, these examples illustrate very well the varied perspectives of nursing that they bring with them to a setting.

> When I took over as head nurse, psychotherapy was the goal, not medications. Getting the patient's past history and meeting with the patient for one hour daily to investigate that history was considered paramount. But patients on this unit do not fit this model. They need a different treatment model, so there has been a clash between ideology and reality. When I took over, I wanted accountability from the nursing staff for their actions and saw binding the patient's impulses as very crucial. They are so psychotic that we have to use expressive means to do so, to orient them to reality on a very basic level, like where they are, the day, etc. None of this was important under the old regime. Then, we are told to be therapeutic. The degree of psychopathology dictated the need for medications. Because of insufficient staffing, medications were used more. Now the nurses orient the world as much as possible around the patients. They try to indicate why, and what, is being done for the patient. (Notes, pp. 84-85)

Another nurse who had been on the unit for nine months expressed it this way:

> Individuals might have their own philosophy, but the unit does not have one any more. There used to be a clear Freudian philosophy, but not any more. Individuals have their own agenda: one doctor might be interested in families and family therapy, while another might use a more eclectic approach or behavior modification. Nursing clearly does not have one philosophy or model that they follow, and that is a big problem right now. It results in a dependence on the doctors and a more clearly custodial role. Nursing has not defined its goals, and the result is in people just working here. The treatment goal is to discharge patients as fast as possible. We probably have the sickest people in town. (Notes, p. 19)

> I don't want to be a secretary. I'm a new graduate and came here to work with patients and learn different manifestations of illness and how to identify and deal with these. (Notes, p.123)

In contrast to these examples,a nurse with many years of experience in private psychiatric hospitals but new to the unit said:

> I came here because of the teamwork: I like that, you can feed into the treatment plan. In psychiatry I can get one part of the patient's story while the primary therapist gets another part, and together we can piece

> the story together and in that way complement each other. Since this is a teaching hospital, there should be autonomy for the nurses. (Notes, p. 192)

The awareness of how the nurses balance and reconcile professional ideology, organizational demands, and the everyday realities of the ward seemed to depend on how long the nurse had worked on the unit along with her professional background. This is discussed in more detail in Chapter IV.

How patients are admitted to the unit. The standards of admitting a person to the unit are clear and partly dictated by legal criteria for involuntary confinement together with the psychiatrist's assessment of the severity of the person's mental condition. The admission procedure and accompanying paperwork are standardized once the patient has been admitted. The nursing staff is accountable for filling out a variety of papers and forms. They must search and record the patient's belongings to determine whether there are any medications or dangerous objects. Such admission procedures are undertaken for treatment and legal purposes and for the protection of the staff and institution.

Before being admitted to the hospital ward, the patient is screened at PES. This screening process is to determine the person's mental status and guidelines are written on standard forms.

People are brought to the hospital by police, family, or friends. A few will come on their own since they know from previous experience where to go for help. Those brought to the hospital by the police usually have disturbed the peace or do not seem to comply with normal social expectations of behavior. Family or friends will call the police or bring the person to the hospital themselves. Other reasons for a admittance may be that the person is a threat to himself or others, or

that the person is destroying private or public property. A professional assessment will determine whether the patient is gravely disabled or is a danger to himself or others and thus in need of hospitalization.

Admission to the unit. Prior to admitting a patient to the ward, the PES will notify staff (includes all personnel working on the unit--nurses, psychiatrists, technicians, ward secretary, students, etc.) of the pending admission by telephone. The staff will receive a temporary diagnosis, evaluation for potential management problems, risk of violence or suicide, and risk of attempt to leave the ward. While awaiting the patient's arrival, other staff members will be informed. Specific information conveyed will depend on what information has been made available by PES and how quiet or busy the ward may be at the time. The staff person accompanying the patient to the ward will repeat essential details of the patient's history, list medications, and report any change in behavior while in PES. This report is often shared with others with little attempt at privacy. A new patient is oriented to the unit depending on his condition, unit staffing, and how busy the staff is. Unit rules and regulations are pointed out and emphasized. The result is that new patients are introduced to the ward milieu in varying degrees.

How patients interpret the reason for admission. There is an official reason for admission to the unit, but in talking with the patients, the nurses often realize that the patient has a different understanding of why they are admitted. Often the patient would use a technical vocabulary intermingled with his own lay translation--i.e., "They say I am schizophrenic, but I only had a nervous breakdown,"

(Notes, p. 9) or "I am not insane, my brother could not have me any longer at his place so they called the police" (Notes, p. 161). Several times patients would say that they did not belong on the unit but were unable to explain what they meant by this.

Structural and Functional Components of the Study Ward

The structural and functional components of the study ward are closely interrelated and similar to many psychiatric hospital wards. The function of this unit is to admit people in need of crisis intervention, treatment, and disposition planning. The many scheduled activities and meetings for staff and patients are presented here to show how a psychiatric hospital functions on a daily basis.

A schedule for unit activities and meetings for staff and patients is, as previously mentioned, posted on the wall behind the nursing station, clearly visible for both staff and patients. Rules and regulations and a schedule of activities such as showering, eating, doing laundry, and watching TV are provided in a pamphlet given to each patient upon admission and is also posted on the wall in the dayrooms (see Appendix E).

Daily activities for the nurses. A typical nursing day starts when the day staff comes to work at 7:00 A.M. A written and taped report has been prepared by the night staff reporting new admissions, medications given, patient sleeping patterns, and any management problems that occurred during the night. Every morning from approximately 8:30 to 9:00 A.M., nurses from two of the three teams on the ward attempt to meet with their assigned patients on an individual basis to assess their conditions and plan various nursing interventions for that shift. Each

nurse is assigned a certain number of patients for whom she is responsible each shift. The nurse is accountable for aiding the patient with daily living activities such as showers, dressing, making beds, and eating. The nurse is responsible for taking the patients' vital signs, and alerting the nurse assigned to give all medications on the shift whether extra medications are needed for the patient. In addition, each nurse is also responsible for making daily recordings in the charts of assigned patients.

The third treatment team operates a little differently from the two others. This team functions as a liaison between the community and the hospital and operates out of a community center. This team comes into the hospital daily and on weekends to interview patients from their catchment area. They write medical orders for the entire day. This team is responsible for patients before, during, and after discharge unless that patient is sent out of the district. One nurse from the ward is assigned to this team to help coordinate the work.

Nursing rounds. Each morning patients assigned to team A or B are called into the team rooms by nursing staff so they can talk. In this morning meeting the patients are asked by the nurses about their own perceptions of their problems, why they are in the hospital, how the nurses can help them, and what plans they have for the future. One of the nurses made the following comment about these rounds:

> They give me a chance to hear what the patients see as their problem as opposed to how it has been defined by the doctor. I also hear how they think I can help and what they want help with. It gives me an impression of the patient's condition, any possible management problems, how crazy they are, and so on.
>
> (Notes, p. 132)

Community meetings. Three times a week there are community meetings for all patients and staff members on the unit. This meeting lasts from 9:00 A.M. to 9:30 A.M. and is based on Maxwell Jones' principles for a therapeutic community. When the meeting begins, the door is closed and no one is allowed in; if a person leaves, that person cannot re-enter according to rules established by the ward for this meeting. The meeting is led by an elected patient representative and a volunteer staff member. They follow a prescribed format for this meeting and the purpose is to discuss issues of living together, introduce new patients and staff, and say goodbye to patients and staff who are leaving. Despite the structured agenda, or perhaps because of it, a number of crucial issues are discussed in the community meetings. The behavior of demanding or intrusive patients is frequently introduced by other patients and possible solutions discussed. A follow-up discussion of 15 minutes allow the staff members to review the process and content of the meeting and indirectly serves as a learning and teaching meeting for staff and students.

Community meetings can serve many purposes. Ideologically one purpose is for the patients to participate in mutual decision-making about their treatments and learn leadership skills (Jones, 1978). On a more pragmatic level, the meeting provides the nurses and other staff members with valuable information about where the patients are in their illness trajectory. This can include the patient's ability to tolerate closeness with other people, level of restlessness, anxiety, coherency of speech, degree of thought disorder, disturbances in associations, etc. The nurses can observe which patients participate in the discussions, how they participate, or whether they just sit there

absorbed in their own thoughts. Community meetings also provide the nurses with information about the patients' subjective interpretations of why they are in the hospital. Many patients use this meeting to verbalize this type of information. One example from a community meeting will illustrate some of the above:

> 'The purpose of this meeting is to meet new people, say goodbye to patients and staff leaving, discuss issues of living together, make announcements about changes in the activity schedule, have an open discussion, and to elect a new chairperson among the patients.' This was announced at the beginning of all meetings. This day some patients were talking about why they were in the hospital. One said he was 'schizophrenic and suicidal and defined schizophrenia as 'chemical goes to your brain and through the blood and you become withdrawn and moody.'' Another patient said the 'hospital is a hallucinogen factory and I want more hallucinations.' Toward the end of the meeting three patients got into a verbal fight and one of them finally said, 'I did not come here to be insulted by you and fight with you. All you are is suicidal, anyway.' (Notes, p. 25)

In this meeting some patients use the opportunity to offer their lay interpretations of why they are in the hospital. Other patients feel they can voice grievances about other patients as many staff members are there to protect them in case the patient becomes assaultive.

How the nurses and staff members use the information they obtain from these meetings varies, depending on their backgrounds, the ward milieu, and staffing for that particular day.

Prior to all patient and staff meetings and activities, the nursing staff walk around the unit and urge patients to participate and remind them of the meeting. Sometimes a patient's participation, or lack of participation, will be discussed in interdisciplinary treatment meetings. Participation by the patient in ward activities as viewed by the staff members represents cooperation and actively taking advantage

of treatment opportunities available on the ward. Participation is interpreted to be so important that discharge of the patient could be made conditional to it.

Other meetings. Two of the three interdisciplinary teams meet three times a week to present and discuss each patient's history, possible diagnoses, treatment plan, progress, and disposition planning. The nursing staff are encouraged to participate in these meetings and offer their observations and comments about the patient's behavior on the ward. Because of the often insufficient staffing, participation and input from the nurses in these meetings are often limited. Often the nurse who participates has to rely on notes and observations made by other staff members. These meetings give the interdisciplinary team members a chance to discuss their ideological beliefs and differences about symptom complexes and different ways of interpreting and treating these. Information about ethnic variations and cultural interpretations of mental illness are often shared as the patients come from many different ethnic backgrounds. Institutional policies and regulations regarding patient treatments are often repeated to newer staff members.

In these meetings the nurses frequently attempt to negotiate and challenge the primary therapists regarding the patient diagnoses, types and amounts of medications, and the insufficient recognition of their documented observations and interventions with the patients.

Other meetings include group therapy for the patients which are scheduled for two mornings a week. This meeting is often cancelled because the therapist is "busy" or there are not enough patients the staff think can participate due to their restlessness. Another meeting, "current events," is popular and patients and staff sit in the dayroom

once a week to discuss what is happening in the world outside. Talking not related to current events is discouraged by the staff and is referred to the community meeting or to the primary therapist. Patients and staff wander in and out of these meetings which last for 30 minutes.

The occupational therapist offers many activities throughout the week, both during the day as well as in the evening. These can be self-grooming, music, movement, painting, or other activities of interest to the patients. These are fairly unstructured and open. Participation is voluntary, but the tv and radio must be off during these activities.

In addition to routine tasks, meetings, and activities, the nurses give the patients medications routinely four times a day. If patients need extra medication because of behavioral problems, these are given on a prn (as needed) basis.

Routine nursing tasks. There are many routine tasks in which the nursing staff engages. These include hourly checks on the whereabouts of all patients on the unit, making and stripping beds when patients are discharged, helping patients with showers, shaving, laundry, writing reports on each patient, attending meetings, and sharing information from them, giving and recording medications, checking and filling out a variety of papers and reports, answering the telephone and doorbell--the list is lengthy. These routine tasks, of which many are institutional requirements, are surprisingly time consuming. In addition to the many tasks listed above, the nurses are frequently disrupted by patients' unpredictable behaviors that need attention, new patients are admitted, or some are discharged. All this is compounded by difficult staffing conditions, a high attrition rate, and often the limited clinical

experience of the newer nurses. On top of all the above functions and daily stressors of working on a psychiatric hospital ward, the nurses also deal with the breakdown of communication with many of the schizophrenic patients.

Routine nursing tasks, though time consuming and dictated primarily by the institutional requirements, provide the nurses with valuable information about the patients' conditions. While the nurses engage in routine tasks they observe the patients' abilities such as tolerance of postponement of immediate needs, coherency of speech, level of anxiety, intrusiveness, how medications are affecting them, whether they socialized with others or are pacing around quietly, yelling and screaming, etc. How the nurses use the observations of the patient behavior and communication for therapeutic interventions seems to depend on their interpretations and translations of the patient actions and how they balance this with the many demands that impacted on the nurses at that moment.

Summary

This chapter presented four sections. The first described three pilot studies undertaken by the researcher. The process of a nurse researcher and issues related to qualitative versus quantitative methods in nursing research was presented as a second section. The process of a nurse as a field researcher was included to highlight advantages and disadvantages of researching a familiar substantive field. A third section presented a description of qualitative comparative analysis, a type of field methodology, as used in this investigation. The fourth

and last section presented a description of the study setting including patient and staff variables, reasons for admission to the unit, treatment ideologies, and structural and functional components of the ward.

The next chapter presents findings from the observational data. I will propose an explanation for how nurses can conduct their "business as usual" and balance the demands of the organization in which they work, and strategies they engaged in when faced with abnormal communication used by the patients.

CHAPTER IV

FINDINGS AND ANALYSIS

Introduction

The research question for this study had three components: 1) psychiatric nurses, 2) abnormal communication as used by schizophrenic patients, and 3) a psychiatric hospital ward. Chapters I and II presented the three components generally and specifically as they related to the nurse and the patient in the context of psychiatric hospital wards. Chapter III presented the evolution of the research question. This chapter also presented a description of the design and methodology used, qualitative comparative analysis, and a description of the study setting.

The specific study question was: How are nurses affected by abnormal schizophrenic communication in their everyday work on a psychiatric hospital ward? Analyzing the data it became clear that additional questions needed to be examined. Thus the research question had to be examined in light of the many structural requirements that impacted on the nurse in her everyday work situation. How the nurse operationalized and balanced her knowledge and understanding of theories of schizophrenia, disordered thought, and communication and the professional and clinical dictates in her daily work became another question. Since hospitals are considered to be bureaucratic organizations with a hierarchical structure, the institutional requirements had to be examined to show how these also impacted on the

nurse-patient interactions. How the nurses balanced all the structural requirements and organized and conducted their "business as usual" (daily work) with patients became a larger question within which the specific research question was examined.

One of the goals of a hospital is to provide personalized care and treatment to individual patients according to their needs. This is also a goal for the professional nurse. Her professional mandate is to establish therapeutic relationships with each patient and to use communication that is purposeful. The nurse does not work by herself in treating the patient. She is dependent on the cooperation of other professional groups to reach her goals. Thus teamwork becomes a necessity on any hospital ward in an attempt to fulfill the individual patient's needs. To balance the need of the patient and to fulfill the organizational, clinical, and professional dictates demands much organization, skill, energy, and cooperation by nurses, doctors, social workers, etc. About these efforts Georgopoulos (1966) says:

> Nursing often serves as a repository of residual functions in the system, so that when others fail to provide supplies, services, information, or supportive functions required for patient care, nurses must act and even perform functions which are not normally theirs. (p. 14)

Thus nurses are often expected to provide functions in addition to their nursing functions that are not necessarily written anywhere. The question comes to be how the nurse balances these additional functions with her professional and clinical mandates, organizes and conducts her work on a psychiatric ward, and interacts with schizophrenic patients and their abnormal communication.

Chapter IV presents five sections. The first section presents three structural requirements that impacted on the nurse: professional,

clinical, and institutional. Section two describes the ebb and flow of ward conditions and activities to show how these occurred on a daily basis for the nurses and patients in the study setting. Section three presents a social psychological framework that helped explain how the nurses interpreted and translated abnormal schizophrenic communication. Abnormal communication as used by about two-thirds of the patients in the study setting is presented in terms of verbal and nonverbal actions. Thus section four presents the patients' verbal and nonverbal actions as these occurred in the study setting. The last section presents the passive and active strategies the nurses used in light of the above sections.

The many complex processes of events of how the nurses interpreted and translated the patients' verbal and nonverbal actions, organized and conducted their business as usual, and balanced the structural requirements are not distinct and overlap. For the sake of clarity, topics of Chapter IV is presented in the following sequence:

1) The structural requirements that impacted on the nurses--professional, clinical, and institutional.
2) Ebb and flow of ward conditions and activities in the study setting.
3) A social psychological framework that helped explain the actions of the nurses and patients in terms of understanding, sensitivity, tolerance, risk-taking, and options.
4) How the nurse interpreted and translated the patients' verbal and nonverbal actions along a noiseness scale of violence, disruption, nuisance, or irrelevance.

5) The strategies the nurses engaged in (i.e., passive--observing, anticipating, predicting, forestalling; active--talking, medicating, secluding).

Structural Requirements

All organizations have structural requirements in terms of what Strauss (1978) labelled as structural contexts and negotiated contexts. He implied that even though they might seem stable, there is a temporal dimension to these requirements.

The structural requirements in this study were of three types: professional, as they related to the nurse's ideological professionalism, clinical expectations of the nurse in terms of her clinical performance and technological skills, and institutional as related to expectations the institution has of the nurse. The first two requirements are expectations of any nurse by virtue of her role as a nurse doing nursing. The institution where she occupies the role and functions as a nurse also has its expectations of her.

The structural requirements were discussed in general terms in Chapter I. Within any hospital organization there are requirements for clear labor division and functional specialization of all its employees. Yet it is not possible for any organization to specify exhaustively the content and boundaries of the functions of all its members (Georgopoulos, 1966). The hospital has as one of its goals the provision of individualized care for patients. How this can be undertaken in the everyday work reality on a busy psychiatric ward does not always coincide with the nurse's professional and clinical

requirements. Frequently, nurses are confronted with conflicting requirements in their endeavors to provide professional and therapeutic care for the patients. Each requirement is discussed below to show in more detail how the nurse learned to balance the many requirements and conduct and organize her daily work (business as usual) when in addition faced with abnormal schizophrenic communication.

Professional Requirements

The professional ideology and mandate for nurses was presented in Chapter I in general terms and specifically as they related to psychiatric nurses.

Professional requirements are a relatively abstract part of the professional ideology and goals embedded in the education of nurses. One professional nursing goal is to establish and maintain a therapeutic relationship between the nurse and patient for the benefit of the patient. This is no simple unconstrained goal. This goal becomes even more complex when one knows that as many as 630 patients passed through the study ward over a period of nine months. The average length of patient stay was no more than six to seven days. On the other hand, one must accept that there are varying degrees of a therapeutic relationship. The nurse must somehow learn to balance the dictate to work for the benefit of the patient within the everyday reality of a hospital ward which has its own set of requirements that may at times conflict with what is truly best for the patient.

As Underwood (cited in Kalkman & Davis, 1980) suggests:

> The psychiatric nurse assists the patient to cope with day-to-day living, uses the nursing process and nurse-patient relationship as well as an understanding of human behavior.
> (p. 237)

She further states that:

> A major objective is to attempt to understand the patients and to assist them in communicating their thoughts, ideas, or actions more clearly. (p. 250)

This injunction appears relatively easy to carry out when one first reads it. The nurses' theoretical knowledge of schizophrenia and patients' peculiar communication and the ambiguities of this knowledge do not always provide nurses with precise explanations that they can fall back on and use when interacting with schizophrenic patients. Underwood's suggestion is further compounded by the time factor involved in establishing therapeutic relationships and assisting the patients to communicate their thoughts, ideas, and actions more clearly. This is particularly difficult when the nurse also must attend to the many pragmatic requirements of the institution.

How the nurses operationalized their professional requirements in their daily work in the study setting was problematic. When I asked the nurses about their professional philosophies, they all answered differently. Mostly they indicated that each nurse probably had her own ideology. Some nurses were disappointed that the nursing philosophy was not more clearly stated in the ward philosophy. Other nurses said they would like to introduce the principles of primary nursing care. The thought behind this was that nursing would be more clearly delineated and thus become a more autonomous function complementing the doctors' work.

When I talked to them, the nurses often felt their documentations of patient problems, behavior, and nursing interventions were ignored by the other professions. Other nurses did not seem to mind that they primarily followed the dictates of the institution. They indicated that

the pressures on the institution to treat the tremendous numbers of people in need of psychiatric care led them to pretty much ignore the therapeutic ideologies of their profession. As these nurses interpreted the situation, it was better to treat the most blatant of the patients' symptoms and dispatch them as fast as possible to make room for another person more in need of a bed. Many of the nurses had reconciled their professional mandates and become very pragmatic and focused on getting their work done. This might be interpreted as their way of balancing the many demands and stressors and yet surviving emotionally and psychologically in a challenging work environment.

Thus, in their everyday work, the nurses somehow managed to balance their ideologies and say they had no choice to do much beyond the most routine care for the patients. When the nurses were asked individually, many voiced concern, anger, and frustration for not being able to function more according to their professional beliefs. As one of the nurses said, "We have the sickest people in town. Anyone who has worked here will get a job fast anywhere else" (Notes, p. 72). By this she meant that despite the many compromises, the nurses certainly learned how to assess patients' mental health status and to some extent learned how to treat the very psychotic people they encountered in this particular setting.

Clinical Requirements

Clinical requirements are expectations of a nurse's technological skills and ability to assess the patient's mental health status from a clinical viewpoint. Clinical interventions can include whether a nurse believed a patient should have his medication by injection, pill, or in

liquid form. Clinical judgements included whether a patient who had not eaten for several days should be force-fed or not. It could be whether a patient should be allowed to withdraw or be expected to actively participate in ward activities.

A clinical requirement could be for a nurse to notice when a patient has side-effects from medications or changes in the patient's blood pressure due to medications. There are many, many clinical requirements the nurse must deal with in addition to the patient's abnormal communication and bizarre behavior. These issues were often compounded in the study setting. The reasons for this were partly due to the number of patients passing through the ward, the lack of continuity in patient care because of the high attrition rate among the nurses, and the severity of the patients' psychopathologies and impaired self-care and self-determination.

The institution expected the nurses to conduct their work in such a way that they fulfilled the clinical requirements regardless of compounding factors. How the nurse was able to fulfill these requirements and interpret the patient's abnormal communication depended on the situation at any particular moment. One example was:

> A patient attempted to refuse a medication for a side-effect from another medication on the grounds she did not need it any more. The nurse insisted she take the medication because "the doctor had ordered it."
> (Notes, p. 105)

Perhaps if the nurse had been less pressured to complete the many other demands on her that morning, she would have taken the time to explore the issue with the patient. The nurse's judgement in this episode was to follow the doctor's orders so that she could continue with her other tasks. It seemed like the nurse interpreted and responded to the

requirements that seemed the most threatening to her at the time. If the ward was busy with many demanding, disoriented, anxious, and restless patients, the institutional requirement to conduct business seemed to take precedence over the nurses' professional and clinical requirements.

Institutional Requirements

Institutional requirements are expectations, norms, and rules of a hospital and ward that dictate staff and patient conduct. They are usually written in the treatment philosophy, job description, and ward rules and regulations.

What was named institutional business in this study was probably the requirement that was most time consuming for the nurses. This included all the paperwork nurses do. Institutional business could be writing admission and discharge reports, daily charting in the patient charts, taking off medical orders and recording these on medicine cards in the cardex, on a daily flowsheet, medication sheet, and in the patient charts. It involved obtaining medical orders for everything from a tablet of aspirin to secluding and restraining patients. Thus the hospital ideologically requires that patient rights be respected, that patient needs be treated according to the stated philosophy, that ward rules and regulations be adhered to by staff and patients, that nurses comply with medical decisions, complete the paper work deemed necessary, and work every other weekend, etc. At the same time the institution expects the nurse to function according to her professional and clinical mandates.

Not all institutional requirements are written. Some norms are based on past history or previous episodes. They can be created because the hospital's reputation is at stake in a particular situation. Two examples will illustrate how this happened in the study setting.

> A young male patient with many psychiatric hospitalizations was diagnosed as a chronic schizophrenic with a high suicide risk. Some months earlier he had eloped from the ward and was badly injured as he was running down a freeway. He was now considered well enough for transfer to another facility. His functional level and ability to control his suicidal impulses needed further assessment. It was suggested that he participate in a patient restaurant activity. The dilemma arose because sharp knives would be accessible to him in the restaurant. The staff were unsure if he was well enough to handle them safely. From a professional standpoint, he could participate in this activity, but what if he did use the knives to kill himself or others? If this happened, how would this reflect on the reputation of the hospital and the staff? A long discussion about how to handle this dilemma occurred in an interdisciplinary team meeting without a satisfactory resolution to the questions. (Notes, p. 13)

In this example the nurses and doctors on the one hand wanted to treat the patient according to their professional beliefs. Since they could not predict beyond doubt that he might use the opportunity to harm himself or others, they decided to be on the safe side and not allow him to participate in the activity. This time institutional requirement took precedence over the professional beliefs.

Another episode involved:

> . . .a young female tourist in the city who had been robbed and raped. This possibly happened because she was psychotic and confused at the time. After a few days in the hospital she was no longer considered acutely ill and was to be transferred over the weekend to a hospital in her home state for long-term treatment. Some of the doctors and nurses wanted to observe the patient on the ward without medications for a few days. They also wanted her to have unaccompanied passes out of the hospital while her transfer was being

> arranged. To justify her continued stay on the ward was not possible according to the institutional requirements. She could remain only if she was taking medications and not deemed well enough to go out on her own. An added complication was that the women had no funds of her own. She would be unable to pay for a hotel if she was discharged prior to her transfer.
>
> (Notes, p. 53)

Not all institutional requirements resulted in difficult dilemmas such as these two examples. Everyday occurrences could be those in which the patients used what was thought of as inappropriate or "foul" language, dressed bizarrely, refused to shower or change clothes for days, attempted to elope, refused to get out of bed, or refused medications.

Summary

How the nurses interpreted and translated the patients' verbal and nonverbal actions seemed to be influenced by the three requirements presented in this section. The nurses seemed to reinterpret the patients' actions in terms of one or more of the structural requirements. The one that appeared to be threatened the most at the time probably influenced the strategy taken by the nurse in that situation. The nurses had learned to balance the requirements to some extent. The high attrition rate among the nurses might be related to the inability to balance all the requirements and survive emotionally and psychologically. Nurses are expected to enhance their professional goals, organize and conduct the work on a psychiatric ward, and, in addition, interpret and respond therapeutically to abnormal schizophrenic communication. This may be an unrealistic goal the way many psychiatric wards are organized and staffed today.

The intersection of the structural requirements frequently appeared to be contradictory. The work reality on a psychiatric ward is such that at times these do pose dilemmas for the nurses. Ward order, safety of staff and patients, and institutional reputation can sometimes overrule a professional or clinical requirement. This is due in part to the hospital being a public institution and its dependence on public funds and good community relations to function adequately. The professional requirement of nurses appears to lose out most often since the nurse must get her work done, do business as usual, and push medications in the name of treatment in order to facilitate early discharge to free up a limited number of beds for incoming patients.

This was the everyday reality of the nurse's work situation. It was in the context of the three structural requirements with the many potentially conflicting demands that the nurses conducted and organized their work. In addition, they were faced with abnormal schizophrenic communication. Somehow the nurse was expected to understand and assist patients to communicate their thoughts, ideas, or actions more clearly concomitant with the other demands.

The next section presents the ebb and flow of ward conditions and activities in the study setting.

Ebb and Flow of Ward Conditions and Activities in the Study Setting

To help explain how nurses experienced and processed the patients' actions--both verbal and nonverbal--and to determine how the nurses interpreted these actions and selected a strategy, one must have an

appreciation of the daily conditions and activities in the study setting.

In Wilson's (1982) study, ebb and flow were described as heavy and light times. The nurses in the present study always talked about the ward in terms of "hectic," "tense," "stressed," "a zoo," "busy," and "quiet." I renamed these concepts ebb and flow because they seem to capture the ward ambience more in accord with how the nurses in this study setting labelled the ward conditions and activities.

When I asked the nurses about this they made comments such as the following: "As usual, it was a zoo the other day, but it is not too bad today." "It is its usually craziness. They [the patients] are all kind of fighting today. They are disorganized, can't you pick up on the tension around here?" At times when I questioned the primary therapists, their perceptions would be different from that of the nurses. They would, for instance, say, "It is really crazy and hectic here today," while the nurses' perception/interpretation of the same day could be "Not too bad today." Thus, to some extent it depended on whom I asked and their roles on the ward. The primary therapists come and go while the nurses must stay on the ward until the end of their shift. (Notes, p. 4).

Forms of ebb and flow included predictably and unpredictably busy times. Structural requirements that influenced these variables were change of shift, scheduled activities for nurses and patients, and admission and/or discharge of patients. Variables that could influence these conditions were: ability to predict, inability to predict, nurses' awareness of the patient actions, patient characteristics, whether patients were known to the nursing staff or unknown to them, number of

patients, number of nurses working, personal and professional characteristics of the nurses, and the nurses' interpretations of the structural requirements.

How ward conditions changed from minute to minute and day to day influenced how the nurses interpreted and responded to a given situation. Ward changes are partly due to types of patients present in the milieu, number of patients, and patient characteristics. Patient characteristics can be, for example, predictability of behavior, disruptiveness, violence (real or potential), or passivity. An increase in patient census and changes in patient characteristics could bring about changes in how the nurses interpreted the patients' communication and what strategies they decided to engage in. Other important variables that affected the nurse's responses and actions were her clinical experience as a nurse, professionalism, and personal attributes (i.e., intelligence, autonomy, controlling qualities, empathy, sensitivity, warmth). The nurse's understanding and knowledge of the institutional requirements such as policy, rules and regulations, and expectations of the the nurse's role and function also affected the chosen strategies. The make-up of a particular shift (i.e., numbers of registered nurses v. psychiatric technicians) and how well a particular group of nurses worked together (i.e., trusted each other, liked or disliked each other) were influencing factors impacting on the nurses' interpretations of the patient actions and consequent strategies. Below some predictable busy times on the ward are compared to less busy times.

Ward Fluctuations--Predictable and Unpredictable

By examining the organizational structure of any hospital ward, one can predict that certain times during the day will be busier than others

in terms of scheduled activities, events, numbers of people present, or noise level. Other times during a day will be predictably less busy. Busy times are change of shift--day, evening, and night--before and after scheduled ward meetings for staff and/or patients, and before mealtimes for patients. The observed increase in activity in this study was centered around the nursing station. It was due in part to an increase in the number of staff members present on the ward at these times. The greater visibility of both patients and staff members in the milieu added to the sense of bustle at these times.

Less busy times were usually during scheduled ward meetings and activities for staff and/or patients, after meals for the patients, evenings, nights, and weekends.

Change of shift. Like many hospitals, the change of shift for the nurses occurred three times each day--morning, afternoon, and midnight. Just before a change of shift the off-going nurses were busy completing their clinical and institutional requirements.

When a new shift started, there were usually many social greetings exchanged among the nurses and between the nurses and patients. Patients as these times were often seen approaching the nurses and greeting them by saying, "Hi, J. How are you? How was your day off?" Or the nurses would greet patients by commenting on how they looked or asked how they had managed while they were off duty. Most often I overheard the nurses greet the patient with a brief "Hi" and "I don't have time to talk to you now--maybe later" (Notes, p. 175).

One example of how the nurses viewed change of shift is the following: "One day I was leaving the unit just prior to shift change when one of the nurses said to me, 'Are you leaving now when all the fun

is starting?'" (Notes, p. 65). I was not quite sure what she meant and asked for an explanation. Her answer reflected a perception and interpretation of the change of shift as chaotic. It also reflected on the amount of work involved in preparing the following shift by informing them about all the events of the past shift.

For about one hour after a new group of nurses came to work, they were busy with their business work. This included orienting themselves to the status of the ward and patients, reading charts on the "old" and "new" patients, and checking medical orders and medications to be given. It included checking the patients to see for themselves and making their own clinical and professional judgements of the patients' conditions and matching this with what they were told about the patients during shift report. The more experience a nurse had, the more she seemed able to predict how busy or quiet a shift would be. For example:

> One afternoon as the evening shift came on duty I heard several of them comment on a couple of patients whom I had observed as using particularly much abnormal communication, were demanding, disruptive, and disoriented during the day. They said, "They are our headaches for this evening." (Notes, p. 172)

One of the observed patients actually ended up in the seclusion room later in the evening as he was deemed so disoriented and disruptive to the milieu. In this example the need to balance ward order and seclude the patient was interpreted as the best way of responding to the patient actions. In this manner the nurses attempted to anticipate and predict events.

At change of shift for the nurses, the unit appeared busy partly because of the greater number of staff members present. Patients familiar with the ward routine also seemed to surface at these times

just to see who worked that particular shift. This also influenced the ward ambience being "busy."

Scheduled events. Just prior to and after scheduled ward meetings and activities for patients and/or staff were predictably busy times on the ward. Staff in this context included doctors, psychologists, social workers, and various student categories. Again, the patients familiar with ward routine seemed to congregate around the nursing station at these times. The reasons could be that the patients wanted to ask the primary therapists for information, for a time to talk, requests for discharge, or just to remind them of their presence on the ward. Particularly after meetings staff gathered around the nursing station to give or seek information about patients, to socialize with each other, or to write new orders or notes in the patient charts.

It is difficult to convey the ambience on the ward at these times. It was as if everyone tried to talk with everyone else amidst the ringing of the telephone and the doorbell, patients pacing around mumbling or yelling, and maybe someone in the seclusion room pounding on the walls also wanting attention. At the same time, the nurses attempted to conduct their business and observe the patients, anticipating and predicting what may be important to respond to and what they could ignore. In all this confused, loud, and busy activity, the nurses knew from experience that this was a good time to "catch" the primary therapists for information about patients or to inform them about patient behaviors. It invariably impressed me how quickly the ward atmosphere changed at these times and how very confusing the milieu appeared. This state of affairs lasted from three to ten minutes at the most, and then the unit would most often calm down again in the sense

that there were fewer people around. The patient activities did not necessarily change much.

Some examples will illustrate these changes:

> When I entered the ward at 9:30 A.M., it was initially busy with many staff members crowding around the nursing station. The community meeting had just ended. After 10 A.M., the ward appeared relatively quiet and there were fewer staff members around. (Notes, p. 46)

> The ward seemed real quiet when I came there. One of the nurses gave me the following explanation: "When the patient census is down [there were only 16 patients that day], noise level decreases as well as the activity level of the patients and staff members." (Notes, p. 59)

Mealtimes. While anticipating meal times, the unit often tended to appear restless with the nurses and patients wandering around waiting for the food to arrive. Even though times for meals were fixed, the actual arrival of the food trays from the main kitchen within the hospital could vary from meal to meal. Common observation at these times revealed the following:

> Lunch finally arrived. Many patients were restless and asked the nurses when the food trays would come. (Notes, p. 93)

> Another day a patient wanted some coffee and was very demanding. The nurse glanced at the clock on the wall and said, "Lunch will be here any minute now. There will be coffee on the tray." Both patient and nurse smiled as the patient walked away from the nursing station. (Notes, p. 126)

The nurses had minimal control over the actual arrival time of the food trays and were frequently interrupted by patients wanting food or liquids.

Quiet times. Just as one can fairly accurately predict busy times on a ward, quiet times can to some extent be predicted. During scheduled ward meetings and activities for patients and/or staff and

just after patients had eaten seemed to be rather consistently quiet. Quiet on this unit meant that the noise level was down and fewer people were running around screaming and yelling.

During community meetings most of the staff and patients were occupied in one of the rooms and the activity level around the nursing station and ward was noticeably decreased. Patients and staff who were not participating in meetings or activities seemed to sense that this was a "quiet" time. The nurses not participating in meetings would often use the quiet times to conduct their business or help patients with their self-care needs such as showering, finding clothes, or doing laundry.

Weekends. On weekends and holidays the ward also seemed calmer and less busy. When I asked the nurses about this phenomenon, they explained that it was always calmer when the primary therapists were not present and when there were no scheduled events. At these times there were fewer institutional requirements impacting on the nurses. The number of nursing staff working on weekends is usually decreased because of fewer activities. Thus, depending on the patient census and patient characteristics, the nurses could either complete unfinished ward business or could engage in activities with patients such as playing volley ball, card games, or sing along with the patients.

A ward atmosphere has many parallels to the world outside the hospital. For instance, during business hours an office, school, or organization is bustling with life, activities, and work to be completed. After hours (about 5:00 P.M.), all activities seem to quiet down. Thus evenings, weekends, and holidays can usually be anticipated and predicted to be less busy on a hospital ward as well. One major

divergence from this parallel is that patients do not keep "office hours." They are ill around the clock and require nursing interventions and medical care at most hours of the day and night. Because of this factor, many ward conditions cannot be anticipated nor predicted. One example is the following:

> The unit was very quiet and when I commented on this the nurse answered: "Enjoy it while you can. You might never see the ward like this again." For some inexplicable reason the patient census was down, and the patients were known to the nurses and thus their behavior more predictable for the nurses.
>
> (Notes, p. 155)

Admission and discharge of patients. The study ward appeared particularly disruptive and busy when new patients were admitted and others discharged. These happened around the clock, especially admissions.

Admission of new patients always impacted on the ward. In addition to the usual business and paperwork of admitting a patient, the nurses had to anticipate and predict (and, if possible, forestall) the patient's potential for violence, disruption, nuisance, or cooperation. The nurses had to assess the patient for possible clinical interventions such as the need for medications, close observation due to lack of impulse control, or loss of sense of reality orientation. She had to observe the patient for adverse reaction to medications that may have been given to the patient while in PES. This assessment was particularly difficult when the patient's speech was incoherent, tangential, the patient thought "the devil" was after him, or was unable to say anything at all.

New admissions also impacted on the other patients on the ward. For instance, if the ward was already busy, had many demanding,

intrusive, anxious, restless, incoherent patients, another demanding patient may tip the balance. In this connection a nurse told me one day:

> We could not have tolerated admitting her (an "old-timer" who was admitted to another ward); we already have too many like her in the milieu.
> (Notes, p. 164)

The nurses who had worked on the ward for some time knew the patient from past admissions and were able to anticipate how this particular patient might impact on the milieu. Another example was: "It was kind of crazy here yesterday until a few of them were discharged" (Notes, p. 180).

Discharging a patient was also time consuming in terms of business work for the nurses. When patients were discharged, they needed information about follow-up care, how to take their medications, where to pick up prescribed medications, etc. The paperwork could include writing a discharge summary in the patient chart, making sure he had all his belongings, etc. A discharge from the hospital did not necessarily mean "going home," and could be a transfer to another facility, a board and care home, or a half-way house. Much paperwork was also involved in this type of discharge, particularly when the patient resisted transfer to a long-term facility "because he was not insane," according to him. In addition to information and paperwork that needed to be done in connection with a discharge, social obligations such as saying "goodbye" to people befriended in the hospital also had to be met. This could be with patients or staff members. Some examples of discharging patients were:

> As a patient was walking out the door, a nurse said, "There is another one for the graduating program."
> (Notes, p. 158)

> There was much joking with the patient as he was leaving. The nurses said they expected to see him back on the ward real soon as he was not willing to take medications. (Notes, p. 165)

> A patient was ready to be discharged from the ward, waved goodbye to some of the patients as well as talking to them. A nurse became impatient because she was taking so long to say goodbye and called to her, "Are you not ready to leave yet? Don't get too emotional now [with saying goodbye]." (Notes, p. 107)

Nurses have minimal control over patients admitted or discharged from a hospital ward and must be prepared and on the alert for rapid changes in the patient census. However, there is one structural control mechanism and that is the bed capacity on any hospital ward. The ward in the study setting had a capacity for only 21 beds and thus could admit no more than 21 patients at any one time. On the other hand, there were always patients who could be discharged when perceived as in less need of hospitalization than those awaiting admission.

The unpredictability of how long a patient might stay or the need to discharge a patient sooner than anticipated and predicted because of external pressures to admit someone perceived as more in need of hospitalization added extra strains on the nursing staff. This factor demanded much flexibility and ability to organize and conduct the nurse's work on the ward.

Typical comments the nursing staff made about the rapid changes of ward conditions were:

> Its kind of quiet today, but you should have been here yesterday. It was <u>real</u> crazy; we had six discharges and six admissions. (Notes, pp. 29, 121, 171)

> It has been quiet for several days now, the census is low, but we never know how long that will last. (Notes, p. 185)

> I heard the nurses call around to other units to hear how many patients they had to get a sense of how much pressure there might be on their unit to admit incoming patients. (Notes, p. 185)

These comments reflected daily changes. Another incident was likewise typical of the rapid ward changes. One day when I wanted to interview one of the nurses, she first said, "Yes, in about half an hour it should be okay." After half an hour she came back and said she could not leave the unit, that things had changed. It was rather busy, but then she returned after another ten minutes to say, "It's not so bad, after all. Let's go and talk" (Notes, p. 145).

Examples of explosive episodes. I have many notes from very explosive and sometimes dramatic and unpredictable episodes that I timed to last from 30 seconds to no more than five minutes. For example:

> One morning the nurses and patients seemed more restless than usual. There were many new patients and staffing was low. A young man kept watching the door as if her wanted to elope. One of the nurses said she did not trust him and wanted to seclude him while another said, "Let's wait and see." A few minutes later the patient ran out the door while the janitor was pushing his cleaning cart through the doorway; the patient overturned the cart in the process. Instantly a nurse ran after him yelling, "Help!" The patient was hauled back in while the nurse said, "That's it, strap him down." The whole incident happened so fast that I barely had time to catch my breath. (Notes, p. 30)

In this example one nurse predicted the patient would elope and wanted to forestall this by secluding him. Another nurse was more willing to experiment by waiting to see if he might change his mind. In this case the first nurse's predictions became a reality and a rather unpleasant episode for the nurses and patients happened. Some of the patients observing the episode were rather disturbed and kept watching him with anxious looks on their faces. One of the patients said, "That happened to me once. I do not like to be restrained" (Notes, p. 31).

It was in this context, the everyday work reality on a psychiatric hospital ward, where the nurses and patients communicated and interacted. The nurses in the study setting could anticipate and predict that certain times during the day would be more or less busy in terms of activities and work. There are fixed structural conditions and activities on any ward that makes this feasible. Structural conditions that influenced the degree of business in this study setting were scheduled events such as ward meetings and change of shift. Additional variables that impacted on the nurses' ability to anticipate and predict were patient characteristics such as degree of disorientation and disruptive behavior, census, and whether the patients were known or unknown to the nurses. Characteristics of the nurses that influenced their understanding, sensitivity, tolerance, risk-taking, and options were quality and quantity of clinical experience, number of nurses working a particular shift, and whether nursing staff liked or disliked each other. Also, how the nurses operationalized and balanced the structural requirements influenced how they interpreted and translated the patient actions and determined what strategies they engaged in.

The more experienced nurses seemed more able to expedite their institutional business and thus have more time to attend to the individual patient's needs. When this happened, the patients' restlessness, demanding behavior, and disorientation seemed to decrease. When the nurses seemed overloaded with institutional business, the patients appeared to sense this and often became increasingly loud, demanding, intrusive, and bizarre in their behaviors.

It is never possible to completely anticipate and predict how busy a psychiatric ward will be due to the nature of the patient population.

Unpredictable variables that influenced the ward atmosphere were admissions and discharges of patients along with the other variables mentioned. Particularly, new admissions could change the ward ambience to what some nurses labelled as "a zoo." New admissions created more business and possible management problems for the nurses.

When the ward was busy with many disoriented patients using abnormal communication, the nurses engaged in increased use of medications and the seclusion room. They seemed less tolerant and sensitive to the patient actions and institutional requirements seemed to take precedence over other requirements at these times. The actual strategies the nurses engaged in are discussed in the last section of this chapter.

It was in the context of the nurse's everyday experiences and structural requirements that she interpreted the patient verbal and nonverbal actions along a noisiness scale (see p. 120) and determined what strategy to engage in toward the patient. The interpretations of these verbal and nonverbal gestures were determined in part by the many requirements that impinged upon the nurse and helped create her understanding, sensitivity, tolerance, risk-taking, and options. Said another way, every act can be explained in terms of how the nurse in the context of the structural requirements and her clinical experience interprets the patient nonverbal and verbal gestures, defines them, and then acts toward them.

The following section presents a social psychological framework which helped explain the nurses' strategies.

Social Psychological Framework

The nurses in the context of the institutional, clinical, and professional requirements interpreted the patient's verbal and nonverbal actions along a noiseness scale and took action accordingly. The nurse's interpretation of the patient's actions are in part determined by all the requirements that impact on her and can be explained by a social psychological framework. In this study this framework has five components: understanding, sensitivity, tolerance, risk-taking, and options.

Understanding a situation can create sensitivity to the events and being sensitive can create understanding. Likewise, understanding and being sensitive can increase or decrease the nurse's tolerance for events. If a nurse is understanding, sensitive, and tolerant, she may be more willing to take risks. It the nurse takes risks, she must understand, be sensitive to, and/or tolerant of the events and possible consequences of the risk she takes. What options the nurse had for strategies seemed to be created by her understanding of them, sensitivity to, tolerance for, and willingness to take risks, etc. Her understanding of events are also dependent on the nurse's theoretical knowledge of the phenomena observed. The processes of these events are quite interrelated and a change in one may lead to a change in another. Each category and its forms are presented below as separate entities. One must keep in mind that they do overlap and are temporal.

Understanding

The nurse's understanding of the patients' verbal and nonverbal actions and the structural requirements are influenced by her

theoretical knowledge and clinical experience. How knowledge is operationalized will depend in part on the nurse's cognitive and emotional characteristics.

Knowledge. Nurses acquire theoretical knowledge through their formal education. The acquire knowledge about theories of human behavior, psychopathology, schizophrenia, schizophrenic thought disorders, communication, and professional ideologies and goals. Nurses are taught skills and techniques for communicating with schizophrenic patients that are considered therapeutic or nontherapeutic. These were presented in more detail in Chapters I and II. In this way knowledge can widen, for instance, the nurse's understanding of structural requirements, abnormal schizophrenic communication, and possible treatment modalities.

How knowledge and understanding are operationalized in the everyday work situation of the nurse seemed to be contingent on her ability to apply these in her clinical work. Thus, there are personal characteristics that can influence the above. Personal characteristics can be ability for cognitive abstraction and emotional maturity. By emotional maturity I am referring to empathy, warmth, sensitivity, tolerance, autonomy, controlling features, etc.

Experience. The quantity and quality of clinical nursing experience can enhance the nurse's operationalization of abstract knowledge and understanding. By working with patients, the nurse can experience various forms of schizophrenia, their differences, and their similarities. Thus the nurse's accumulated experience can widen her understanding and knowledge of the patient's actions and possible

strategies she can engage in that are useful from either a professional, clinical, or institutional viewpoint.

Through her experience the nurse can become more sensitive to the nuances in the patient's actions and more tolerant of abnormal and bizarre behavior. The nurse may learn how to manipulate and balance the structural requirements, be more tolerant of them, or be more willing to take risks. Experience can also create knowledge of options that are available and acceptable to the nurse. One example will illustrate how this happened in the study setting:

> A recent graduate nurse told me the following: "I came here to learn more how to work with patients and to learn different manifestations of mental illness and how to identify symptoms." (Notes, p. 132)
>
> One evening when the same nurse was working with another nurse who had many years of experience as a psychiatric nurse as well as on this particular ward, she said about the new graduate: "She obviously does not have much experience. She thinks she can talk him out of it [referring to a patient's disruptive behavior that was escalating]. I've seen him in action before, and he can be very explosive unless he is medicated fast." The following evening the same nurse added to the above comment: "She is rather naive and did not believe me when I warned her about how aggressive [patient's name] can be." The patient had exploded and was restrained and secluded for many hours the previous evening. (Notes, pp. 207, 208)

This example shows the nurses' quantity and quality of clinical experience created different interpretations and strategies for dealing with the situation. The less experienced nurse wanted to negotiate with the patient in an attempt to understand why he was restless, anxious, and unable to control his impulses. The second nurse based her interpretation and understanding on past experience with the patient and seemed less sensitive and tolerant of his actions and interpreted them more in accord with the institutional requirement for ward order. Her

perception was that he needed medications and that this was the only option available in light of the present ward conditions and the patient's actions. To her it was unacceptable at that moment to risk experimentation in this situation by negotiating with the patient for a mutual understanding of his actions or to contract with him for a more acceptable way of acting.

Sensitivity

Sensitivity can relate to personal attributes such as warmth, empathy, genuineness, etc. In this study I am using the concept in terms of the nurse's perception and awareness. Sensitivity in this sense can include the nurse's perception and awareness of stimuli surrounding her. A sensitive nurse can sort out what is important and less important of the stimuli that she must respond to. A nurse's sensitivity can change her understanding of why a patient is acting in a certain way and her interpretation of the structural requirements. In the same way her understanding can change her sensitivity to an event.

In the study setting, sensitivity to many events were evident when a patient was having a difficult time (in terms of reality orientation), was acting bizarrely with many body rituals, was pacing rapidly around the ward, or was making threatening remarks to the nurses or other patients. An example of this was a patient who, while pacing around, kept screaming, "It is the blood on your hands!" (Notes, p. 123). The nurses seemed sensitive to her reason for screaming and tolerated this by observing her, allowing her to pace and scream, and not engaging in an active intervention strategy. The more understanding and sensitive nurses tended to experiment more and give the patient space such as in

the situation with the woman above. The nurses allowed these patients to continue their behaviors as long as there was no threat of direct violence. At these times they would tell other staff members and patients to "leave her alone. She is having a difficult time this morning." The opposite also occurred, particularly when new nurses worked on the ward. They could be seen correcting the patients more, informing and enforcing the ward rules, etc. This decreased sensitivity at times led to further escalation of the patient's behavior. It even resulted in angry outbursts by the patients such as "Leave me alone, you bitch!" (Notes, p. 50).

Thus the quality and quantity of a nurse's experience can help create a different understanding of an event, shape the nurse's sensitivity, perception, and awareness, widen or narrow her tolerance for bizarre behavior and her willingness to take risks. In addition, it can create an understanding of acceptable options she has in a given situation.

Tolerance

The nurse's understanding and sensitivity to the structural requirements and the patient's verbal and nonverbal actions can widen or narrow her tolerance of patient behavior (i.e., noise that a patient is making). Tolerance for an event can change the nurse's understanding just as understanding can change her tolerance or sensitivity to an event.

A tolerant nurse may make allowances, endure, or be sympathetic toward the patient's actions. Tolerance of an event can be high or low, wide or narrow.

The nurses who seemed less understanding and sensitive also appeared to be less tolerant of infractions made by the patients according to their interpretations of the institutional requirements and the patient actions.

A nurse's tolerance level seemed to be related to certain cutting points in the study setting. The cutting point for the nurse's tolerance in the study setting were either situational, biographical, or behavioral. The situational cutting point seemed to depend on how busy the ward was, how demanding the patients were, how tired the nurses were, or what time of day it was (i.e., beginning or end of the shift). Biographical cutting points were usually related to the patient's history (i.e., assaultive or quiet crazy). As one of the nurses said about a very demanding patient, "He is kind of cute, so of course we tolerate more from him" (Notes, p. 109). In this example the patient had a history of being "cute" and nice and thus the nurses' tolerance for his behavior increased. Behavioral cutting points seemed to be related to the patient's behavior that was also situational. By this I mean that the nurses often negotiated and contracted with the patients for various types of behaviors. If the patient tried, within recognized limits, to keep the contract, the nurses often tolerated more infractions by him. One example of this was:

> Much of the afternoon one female patient was taking most of the nurses' attention. She kept walking around with her eyes closed, bumping into people and objects. At times she fell over tables and into beds in the hallway. The nurses tried to negotiate with her and told her to "Stop her little act." The patient seemed unable to comply and one of the nurses finally said, "[patient's name], you are going to be put in four-point restraint if you cannot control yourself." Shortly thereafter she was restrained and put on a bed in the hallway where the nurses could observe her more closely. (Notes, p. 177)

In this example the nurses attempted to negotiate and contract for the patient's behavior, but when the patient was unable to fulfill her end of the contract, a cutting point was reached where the nurses decided to restrain the woman.

Risk-taking

The quantity and quality of the nurse's clinical experience seemed to influence more risk-taking or social experimentation. Forms of risk-taking could include negotiating for a mutual understanding, contracting (negotiating) for behavior, challenging medical orders or institutional requirements, or balancing the patient's actions and structural requirements. Other forms of risk-taking could include negotiating what was at stake--the reputation of the nurse or the hospital.

Risk-taking seemed related to how sensitive a nurse was as well as to her understanding and tolerance for a particular event. A change in the nurse's estimate of her risk-taking may create a change in her tolerance, sensitivity, or understanding of an event.

Risk-taking could involve negotiating with the patients for a specific type of behavior, holding off giving a prescribed medication when the patient seemed overmedicated, secluding a patient before a doctor had written the order for seclusion in the event the nurse thought she had no other option, etc. Challenging medical orders and decisions was observed from the more experienced nurses. New nurses to the ward who were unfamiliar with the patients and institutional business rarely did this. This was partly because they did not see this as an option or they were too timid to challenge the medical decisions.

Whether the nurses wanted to engage in social experimentation or not with the patients by taking risks could also have to do with the safety for nursing staff and patients. One example was the following:

> A patient became increasingly threatening in the process of being transferred from one ward to another. The patient wanted to leave the ward, resisted having his belongings searched, and made verbal threats to the nurses. The patient, according to the nurses' interpretation, was not complying with the institutional requirements. Also, they had been told that he was no management problem. He ended up by being medicated and secluded. When the nurse explained to me why they could not risk further negotiating with him she said, "I favor staff security over patient safety. Also, it was close to the end of our shift and I did not want to pass him on to the evening people."
>
> (Notes, p. 130)

In this example the nurse was not willing to risk the patient losing control over his impulses and possibly assaulting the staff. The simplest solution as she saw it was to medicate and seclude the patient for a while. Thus risk-taking can be related to what is at stake at a particular moment: the nurse's reputation, the hospital's reputation, or the safety for the nurses and patients. A change in the nurse's perception/interpretation of the risks involved can change her interpretation of any of the other categories or vice versa.

Options

Options can include alternatives, choices, and preferences. The more options a nurse saw as being available and acceptable to her, the more she seemed to engage in experimentation with strategies. A nurse may know of alternative methods of acting in a particular situation due to her understanding and operationalization of her professional, clinical, or institutional requirements, but she may not think a particular option acceptable at that moment. In another situation the

same option may be interpreted as acceptable, but for different reasons. Thus the nurse's options for various strategies can be acceptable or unacceptable, depending on the patient act and the requirement that seemed the most threatened at the time. An example will illustrate some of these points:

> A patient was having very bad side-effects from a medication (extrapyramidal symptoms). The nurses checked the patient's medical orders to see if he had an order to counteract the symptoms and found he did not have this. One nurse said she would give the patient an injection right away and then call around to find a doctor to write the necessary order. (The patient's symptoms can appear very dramatic with tongue protruding, eyes rolled upwards, a stiff neck, and difficulty in walking upright. The antidote counteracts this picture within minutes.) Another nurse said, 'I am tired of covering for the doctors; let's call someone to come up here and write the order first.' (Notes, p. 31)

In this example the patient was "forced" to wait and suffer while a doctor was found to write the medical order according to the professional and institutional requirements. One nurse was willing to take the risk of giving the medication first and then calling the doctor. She interpreted this as a realistic option in light of the patient's symptoms. The second nurse interpreted this option as unacceptable and was not willing to cover for the doctors all the time. She also felt the institution was not providing the ward with sufficient medical coverage according to her clinical and professional beliefs. Although she understood very well the patient's symptoms and what was needed to relieve them, she was willing to tolerate observing the patient's problems for a few more minutes and not willing to interpret the institutional requirements to "cover" for the doctors.

Thus depending on the nurse's understanding/interpretation of a situation, she had choices of various options that could be acceptable or unacceptable to her. Some of the nurses seemed to prefer one option over others. Thus some nurses engaged in strategies such as medicating rather than talking to a patient or secluding rather than negotiating with a patient before he exploded as a way of forestalling an event.

Summary

The social psychological framework presented in this section can help explain how the nurses interpreted the patient's verbal and nonverbal actions and the structural requirements in terms of their understanding, sensitivity, tolerance, risk-taking, and options of events and situations.

The next section presents patient characteristics, verbal and nonverbal actions, and how these were interpreted along a noiseness scale.

Patient Characteristics

The nurses' work situation on a psychiatric ward was further complicated by the fact that they not only had to manage and balance the structural requirements, particularly the institutional business, but were also faced with a patient population who were noisy, violent, bizarre, unpredictable, and often unable to communicate their thoughts, concerns, and needs clearly.

Most of the patients in the study setting carried diagnoses of some form of schizophrenia. As presented in Chapters I and II, schizophrenia

can include disordered thoughts and abnormal behaviors. A schizophrenic person may have thought disturbances, faulty perceptions such as delusions or hallucinations, or affect disturbances such as loss of empathy for others. Mood changes can include ambivalence or inappropriate acts toward other people. Schizophrenic behavior may be bizarre, withdrawn, or aggressive. A schizophrenic person is often confused, depressed, anxious, excited, and in an emotional turmoil in addition to displaying abnormal communication. The symptom complex of schizophrenia, disordered thought, and abnormal communication can be interpreted in a number of ways as was discussed in Chapters I and II. The ambiguity of our knowledge of the phenomenon and how one interprets it will impact on how one defines a situation and acts accordingly.

Thus the patient's behavior and ability to communicate are often greatly altered, particularly in the acute phase of the illness trajectory. Since most of the patients in the study setting were considered in acute need of hospitalization, all of the above characteristics were observed. To organize the patient's communication and behavior in a comprehensible manner, these were analyzed along two categories--verbal and nonverbal actions (gestures).

The nurses did not seem to interpret the patient's actions so much in accordance to the actual speech content, but rather along a noiseness scale. The noiseness scale included the four forms of violence, disruption, nuisance, and irrelevance. Properties of noise could be degree of comprehensibility or volume.

The nurses were constantly attempting to understand, be sensitive to, and have tolerance for patient actions. The patient's actions seemed to be interpreted in terms of a noiseness scale and what strategy

the nurse engaged in seemed further determined by her understanding, etc. of the structural requirement she thought to be the most threatened in any particular situation.

Patient Activities

The verbal and nonverbal actions of patients can be seen as symbolic gestures attempting to signal "something" to the environment. This can be genuine distress, discomfort, anxiety, anger, irritability, etc. Properties of these actions can be varying degrees of volume (i.e., screaming, yelling, mumbling, whispering, etc.). There may also be degrees of comprehensibility ranging from lucid and clear speech to seemingly incomprehensible speech or mumbling.

Some examples will illustrate these points. A patient told me the following after he had cleared up somewhat after a very acute phase of his illness:

> I guess I was crazy or something. I was real scared, lonely, and anxious about the voices and people being the devil. (Notes, p. 207)

> Another patient passed by me and yelled: "What would you answer if they asked you not to throw stones on a glass house?" When I did not respond, he flared up and screamed, "The PAN AM building looks sideways at me!" (Notes, p. 24)

The first patient was able to verbalize some of his experiences while being out of touch with reality. The second patient was angry about something, and what he said was not particularly comprehensible, but was very loud. I will present two more examples as they also illustrate volume and comprehensibility and show some of the bizarre actions many patients engaged in.

> One situation involved a young man who had been walking around the unit quietly for a long time. No one seemed to pay much attention to him. Once he stopped in front of the chalkboard and said to no one in particular, "And there is an x missing in the. . .looking at you there is something missing. . .there is no zero there." (Notes, p. 66)

> A female patient was admitted one afternoon and as she walked in the door she said in a high, shrill voice, "Don't take my virginity! I don't want to take the virginity test. Do you have the right to refuse the virginity test?" The nurses pretty much ignored what she said but kept watching and observing her. Occasionally they would say to her, "You already said that," as she kept repeating the above statements. Some of the patients looked at her and then walked away. (Notes, p. 175)

The nurses did not respond to what the patient was saying, but rather to the noise the woman was making. In the first example the patient did not attract any attention from either nurses or patients. I just happened to be standing near him and overheard what he said.

Patient actions that mainly attracted the nurses' attention seemed to be either patients that threatened to disrupt the ward order or that needed medication to insure the treatment process. Verbal and nonverbal actions that fell outside these two main categories were often interpreted in terms of being irrelevant or nuisances. The verbal and nonverbal patient actions were conceptualized along a noiseness scale which is presented below.

Noiseness Scale

Violence. A potential or real violent act made by the patient was always acted upon immediately by the nurses. Such acts could include hitting another person, throwing furniture around the ward, making a gesture that may be interpreted as potentially violent. This could be lifting an arm or hand in a threatening manner or a body posture that

may be interpreted as hostile and potentially violent. Violent acts are considered the greatest threat on any psychiatric ward and the safety for staff and patients takes precedence over all other activities and are immediately acted upon by the nurses.

Whether a staff person triggers a violent act in the patient or the patient becomes violent because of some intrapsychological phenomenon (i.e., hearing voices that say other people are the devil) is rarely questioned. One example will illustrate how this occurred in the study setting:

> One day a young woman screamed, "he hit me!" None of the staff had seen what happened. One of the nurses took the woman by the elbow and led her to the seclusion room and told her to stay there for one hour. The patient continued to scream and make a lot of noise: "Why do I have to go to seclusion when it was he that hit me? Why doesn't he go?" She had been hospitalized many times and had a history of explosive episodes so the nurses never questioned in this instance who had hit whom. The nurse took her away since she was making the noise. (Notes, p. 55)

Real or potential acts made by the patients that were interpreted as violent were acted upon by the nurses by threatening the patient, medicating the patient, or secluding him.

The nurses were not always aware of or able to observe all violent acts. If they heard noise that may be interpreted as something violent happening, they would stop whatever they were engaged in and investigate the situation instantly.

Disruption. Many of the patient actions were interpreted as though they were disruptive to the ward order, intrusive to staff or other patients, or demanding when seen over time. Each act seen as an isolated incident may be interpreted as a reasonable request from the patient's point of view. When there were many, many small requests

throughout the shift, the nurses seemed to interpret many of these as disruptive to them. Many of the actions that fell within this group were questions, requests, or demands from the patients. These could be for a light for a cigarette, change for a dime, or something to drink. Another characteristic of this type of action was that they were often made by a patient who had many hospitalizations, were well known to staff, talked loudly, and were visible in the milieu.

Nuisance. Like any other patient action, nuisances may be interpreted as such by the nurse because the patient's actions were a bother or an annoyance to her at the time. This may be because what the patient was saying did not make any sense or it interrupted what the nurse was doing. Again, it did not seem so much the single action, but the accumulation of such actions over time that were interpreted as nuisances. Comments from nurses when they interpreted the patient action as a nuisance were, "I don't have time to talk to you now," or "Can't you see I'm busy; don't bother me now" (Notes, p. 109).

Irrelevance. All the concepts along the noiseness scale are closely related and yet there are fine distinctions between them. When a ward had many patients wandering around in the milieu talking, mumbling, being belligerent and demanding and there were few nurses present to interact with the patients on an individual basis, many of the patient actions seemed to be dismissed as irrelevant. This could be a way for the nurses to maintain a therapeutic distance from the patients. As long as the noise level did not change too much in volume, ward order was not threatened beyond limits, or nurses preoccupied with institutional paperwork were not bothered, many of the patient actions were not acted upon beyond observation, anticipation, or prediction. An example of this was:

> A young man was admitted earlier in the day. During the evening shift, he was for long periods of time either standing in front of the nursing station or waking down the hall. He seemed to be staring into space and was engaged in many body rituals with his hands. Occasionally he asked the nurses if her could have some eye drops for his itching eyes or for change for a dollar bill. The nurses did not seem to take any notice of his action. Many hours later when they wanted to medicate him, he refused. (Notes, p. 200)

The evening when this occurred, the nurses were very busy with much institutional business due to the many new and demanding patients. This man was only one among many the nurses had to observe and attempt to anticipate and predict how behavior would develop. The nurses engaged only in passive strategies such as observation, anticipation, and prediction. Since this patient was rather quiet and not demanding, they risked waiting. Perhaps if their understanding and sensitivity to his behavior had been interpreted more along their professional mandate, he would have acted differently when they attempted to medicate him.

Summary

This section presented the patients' verbal and nonverbal actions interpreted by the nurses along a noiseness scale of violence, disruption, nuisance, and irrelevance. How the nurses interpreted and translated the patient actions seemed to depend upon how they viewed the actions in terms of the social psychological framework and the structural requirements in the context of the ward as presented earlier in this chapter. The final section will present the strategies (actions) the nurses engaged in that were conceptualized as either passive or active in the study setting.

Nursing Strategies

This section presents the strategies the nurses engaged in when interpreting and translating the patient's verbal and nonverbal actions. These strategies were placed on a continuum from passive to active. In addition, it is necessary to summarize the structural requirements, ward conditions, and the social psychological framework from which these strategies emerged.

The conditions under which the nurses acted toward the patients seemed to depend on the ward conditions, the nurse and patient characteristics, and how the nurse interpreted these and took action accordingly. The nurse's interpretations of the above were in part determined by the structural requirements that impacted on her which seemed to create her understanding, sensitivity, tolerance, etc. Any changes in any of the above factors could precipitate change in the nurse's interpretation and consequent strategy (action).

For example, if the ward was too noisy and this seemed to be a violation of the institutional requirement, then the nurse may become more sensitive to it or intolerant of the noise and medicate, seclude, or talk to the patient. Likewise, if a patient seemed to have a hard time controlling his behavior due to poor impulse control, was pacing rapidly around the ward, and this was interpreted in terms of a clinical or professional requirement, the nurse's understanding and tolerance for his behavior may increase and cause her to engage in therapy talking with the patient. Or, the nurse may allow him to pace and tell other patients to leave him alone because "he is having a hard time" (Notes, p. 36).

If a nurse, based on her understanding, sensitivity, and tolerance of what was observed, anticipated and predicted a specific sequence of patient actions, she may move into forestalling the event by her mere presence. Other alternatives may be for her to engage in a more active strategy of talking with, medicating, or secluding the patient. Or, the nurse may engage in all of these strategies.

When the nurses were questioned about how they subjectively perceived their talking with the patients, their responses varied. Some of them said they "talked to the patients as normally as possible." They would explain to the patient why he was given medication, for instance, or how long he could expect to be secluded.

> One example of this was a young woman who was wheeled into the seclusion room on a stretcher as she was admitted to the unit. The nurse explained to her, "We do not know you yet so we will keep you in here [seclusion room] for a while. Do you think you can control your impulses? Stay here for about half an hour, and if you are all right by then, you can come out on the ward." Apparently the woman had resisted admission and acted in a violent manner while she was being assessed for admission in PES. The nurse attempted to explain to the patient the reasons for her seclusion. The staff needed to observe her behavior and determine whether she would be able to comply with the treatment regime and expected behaviors on the ward. (Notes, p. 190)

In this example the nurses were told by PES that the patient was combative and they interpreted this information according to the institutional requirement and decided to seclude the patient. Yet, when they were able to observe the patient when she arrived on the ward, the nurses predicted the patient may not need seclusion for very long. They attempted to negotiate with her more along their clinical understanding based on their observations. On the one hand, the institutional requirement dictated that the patient be secluded; but when the nurses

observed the patient, their understanding changed and they anticipated limited need for seclusion. This seemed to be created by their interpretation of the patient actions and their understanding from a professional and clinical perspective. Thus they talked to the patient, informed her of their strategies, and attempted to negotiate a mutual contract for later interventions.

The passive strategies included four forms: observing, anticipating, predicting, and forestalling. The passive strategies were placed on a continuum from "just" observing to anticipating to predicting and to the slightly more active strategy of forestalling until a cutting point was reached. Once a cutting point had been reached, the nurses engaged in more active strategies such as talking medicating, and secluding the patients. All the strategies must be viewed as overlapping and even happening simultaneously.

The active nursing strategies included talking, medicating, and secluding. Forms of talking were therapy, business, and social. Subcategories of the active strategies included negotiating, informing, requesting, threatening, correcting, challenging, reassuring, joking, and muting.

Separating the nursing strategies on a continuum from passive to active was done for the sake of clarity and may be considered somewhat artificial. Observing, anticipating, predicting, and forestalling also have elements of activity but are less active than talking to a patient, handing him a medication, or secluding him. Thus the active strategies of the nurses included an element of doing something beyond mere observing, anticipating, predicting, and forestalling patient actions.

The discussion of the nurses' strategies, their forms, properties, and relationships are presented separately to describe in more detail how the nurses interpreted and translated the patient actions in the study setting and acted accordingly. The passive strategies are presented below.

Passive Nursing Strategies

The passive strategies the nurses engaged in included observing, anticipating, predicting, and forestalling. Forms of observing included watching/monitoring and presencing. Forms of anticipating included waiting for something to happen, expecting, and foreseeing. Predicting seemed to depend on the nurse's understanding, quantity and quality of clinical experience, and the ward conditions at the time. Forestalling had an element of prevention of events. This could include the mere presence of the nurse and was very close to a cutting point where she would sometimes engage in an active strategy such as talking.

To observe a situation of events and attribute meaning and thereby determine an action, the nurses must have an understanding, knowledge, and experience about the phenomenon observed. Understanding events by observing can create sensitivity to a situation. When the nurses were sensitive and had an understanding of what was observed, they may be able to anticipate the unfolding of events based on the quality and quantity of their experiences. The nurse's understanding of and sensitivity to the patient actions may cause her to predict either an increase or decrease of the patient actions. The nurse's ability to do this seemed to depend on her past experience and knowledge about a

particular patient or a similar situation. Then the nurse might move ahead and forestall the event by her presence or engage in a more active strategy such as talking. The nurse's tolerance for the patients' bizarre behavior, abnormal communication, and noise may influence her willingness to take risks. Risks may include continued observation of the patient or a more active strategy of medicating him. The nurse's understanding, sensitivity, and tolerance of the structural requirements may increase or decrease her understanding, sensitivity, and tolerance for what was happening as well as the risks she may be willing to take. A change in any of the above categories may create a change in any of the other categories. These are all processes of social events that are temporal and change depending on the context, persons (nurses and patients) present, and how the patients' actions and the structural requirements are interpreted by the nurse.

Observing

Forms of observation as used in this study included monitoring and presencing. Properties of observing can be paying attention to what is happening, perceiving the situation as important or unimportant, or taking notice of changes or the absence of change in the patients and the milieu.

Professional and clinical nursing education and philosophy emphasize observing as a crucial skill for nurses. The quality of the nurse's observations are usually enhanced through her clinical experience with patients. It is in the clinical field that she applies her theoretical knowledge and understanding of schizophrenia and schizophrenic thought disorder and communication. In this study the

nurses observed the patients' verbal and nonverbal actions, the degree of comprehensibility, and the amount of noise they made and determined a strategy accordingly.

In ANA's Social Policy (1982), the authors suggest "[that] the nature of the phenomena to which the action of nurses are directed is ascertained by assessment in its various forms such as observation, interviewing, measurement, and the like" (p. 11). Assessment of a phenomena or situation is part of the nursing process (assessment, planning, intervention, and evaluation) and "serves as a scientific tool and an organizing framework for nursing practice" (ANA, 1982, p. 12). Investigating a phenomenon and deciding what action to implement for the patient necessitates an understanding of, sensitivity to, and tolerance for the events. Hence, observing and being perceptive and attentive to a phenomenon also means being able to put it in a context (i.e., understanding it, being sensitive to it, interpreting and attributing meaning to it).

What the nurses observed in the study setting could be patients rapidly pacing around the ward and mumbling, talking, or yelling. Nurses could observe what the patients were engaged in such as socializing, fighting with each other, quietly watching TV, or staring into space. Examples of the patients' verbal talking that the nurses observed were:

> It is the blood on your hand! Stay away from me, you bitch. (Notes, p. 43)

> Or a patient said while standing near the nursing station: "I'm a million, trillion year; I have a feminine mind. No, I don't have a feminine mind." (Notes, p. 43)

> The same day I observed two patients talking to each other and one said, "I like being 115 years because then I can be an artist. I write poetry. Do you want to see my poem?" (Notes, p. 43)

> A patient had been hospitalized several days, and I heard him say, "I had a girl friend; she made me a coin and then it broke up and I was hospitalized. Every time I have a girl friend they put me in the hospital--I hit a guy. I don't have my glasses and my ears pop, missing the connection between my ears and my eyes you know. (Notes, p. 140)

The nurses did not engage in any active strategies with any of these patients. They observed, perceived, and payed attention in an attempt to anticipate and predict what may happen, if anything.

In this way the nurses observed, monitored, and were present in the milieu, perceiving and paying attention to the patient verbal and nonverbal actions whether they acted in a quiet manner, were belligerent, demanding, or talked in varying degrees of comprehensibility. By observing the nurses could interpret and translate the various levels of noise while anticipating and predicting what may happen and determine whether they had to engage in a strategy beyond observing, monitoring, or presencing.

Monitoring. Since the nursing station was centrally located, the nurses could monitor the patients' activities while engaged in their institutional business work. If the noise level increased beyond the tolerance level of the nurses, the patients continued with their demanding and intrusive behaviors, the patients became involved in verbal fights with one another or were breaking too many institutional rules, the nurses could monitor this from the nursing station. How the nurse interpreted the patient actions seemed to depend on her understanding, sensitivity to, and tolerance for the behavior and which structural requirements she felt were the most threatened.

The nurse could move from a mere observing and monitoring of the patient actions to presencing, depending on her interpretation of the events at that time.

Presencing. Being present was a subcategory of observing. By showing her presence, either by working at the nursing station or walking around the milieu, the nurse could gain greater understanding and knowledge of the patient actions. Presencing could signal to the patients a sense of security in having the nurse present. At the same time, it supplied the nurses with knowledge about whether the patient's symptoms were escalating or not, whether medications were taking effect, and about what activities he was involved in and his whereabouts on the ward.

Presencing emerged as a central category of controlling in Wilson's (1982) study of Soteria House--an alternative treatment center for schizophrenic patients. Even though presencing can be interpreted as a means of controlling schizophrenic patient behavior, in this study it was seen as an aspect of the nurse's passive strategies. Through presencing the nurse would observe and be observed as a means of understanding, becoming sensitive to, or becoming tolerant of what was happening on the ward.

By presencing the nurses could perceive, take notice of, and watch the patient verbal and nonverbal actions and interpret them to determine whether any further strategies were necessary.

Anticipating

A second form of the nurses' passive strategies was anticipating. Anticipating can mean waiting, expecting, or foreseeing that something will happen.

The nurses in the study setting anticipated structural events to begin or end, times to give patient medications, and admissions or discharges of patients. While observing the patient's verbal and nonverbal actions, the nurses attempted to anticipate how they would unfold. This could be an exacerbation or remission of patients' disorientation, screaming, yelling, or inability to talk. The nurse's ability to anticipate was in part dependent on her understanding, sensitivity, and tolerance of the the many events, how she translated these, the quality and quantity of her experience, and her interpretation of the structural requirements at that moment.

While the nurses were anticipating a particular event to unfold, they were at the same time observing all the action around them and attempting to predict what may happen.

Predicting

The nurses' ability to predict the patients' verbal and nonverbal actions was related to their theoretical understanding, quantity and quality of clinical experience, sensitivity, tolerance, risk-taking, and which options they interpreted as acceptable in any given situation. The nurses' ability to predict was particularly noticeable when patients returned to the ward, which many of them did. A not unusual situation was the following:

> One day the unit was very busy with many new and unpredictable patients. The male staff postponed lunch breaks in case they were needed to help restrain patients or forestall uncontrollable behavior.
>
> (Notes, p. 116)

In this example the nurses knew many of the patients and observed much belligerent patient behavior and were unable to anticipate how the

events would unfold. They anticipated and predicted that something may happen where the male nursing staff may be needed. This time their mere presence seemed to prevent the unfolding of uncontrollable events.

Forestalling

Forestalling included an element of preventing an event from happening. It was a more active strategy than observation, anticipation, or prediction. Forestalling was very close to the cutting point where the nurse may engage in talking, medicating, or secluding the patient. A nurse could be observing an event and predict that something might happen and then move in to forestall the event by her presence before it actually occurred. This whole process, of course, assumed that the nurse was sensitive to and had an understanding of what was occurring at a particular moment. One day a patient became increasingly disorganized and the staff were anxious about him becoming assaultive. One way of forestalling this was by engaging in an active strategy and offering him medication. The nurse said to the patient:

> "We have medications available for you." The nurse explained that the patient was attempting to leave, was resisting staff searching his belongings, and was making verbal threats. The nurse gave him medication by injection. "We did not want to pass him on to the next shift," was their explanation when I asked about this episode. (Notes, p. 130)

In this example the nurse attempted to negotiate a mutual understanding of why the patient was resisting having his belongings searched which was necessary according to ward rules. She offered him medications as a means of forestalling what she predicted--an escalation of his behavior. The patient refused the medication and became increasingly threatening, both verbally and in body posture. The nurse anticipated and predicted

a disruption of the ward order and as she did not want to "pass him on to the next shift," as she said, she called the security guards for help in secluding and restraining him while she gave him medication by injection. Thus the nurse interpreted the patient's actions according to her clinical requirement (the patient needed medication) and the institutional requirement (ward order needed to be maintained), and had him secluded.

Other strategies the nurses engaged in when attempting to forestall events could be either consulting with other staff members about how to interpret the patient actions or merely showing their presence in the milieu. Comments such as "Do you think he will make it?" and "Do you think we should medicate him?" or "You had better try and talk to him" were often heard when a nurse was unsure of her interpretation and understanding of a certain situation and how to possibly forestall an event from escalating.

Summary.

This section presented the nurses' passive strategies and included four categories: observing, anticipating, predicting, and forestalling. The nurses' passive strategies must be seen as a translation of her understanding, sensitivity, tolerance, risk-taking, and options of how she interpreted the patients' verbal and nonverbal actions in the context of their everyday experience on the ward. The nurses' interpretation and consequent action seemed to depend on how she interpreted the ward milieu, the patient characteristics, and the structural requirements mediated by the social psychological framework.

Active Nursing Strategies

In this study the active strategies the nurses engaged in when interpreting and translating the patients' verbal and nonverbal actions were conceptualized as talking, medicating, and secluding. Forms of talking included therapy, business, or social (private). Subcategories of talking included negotiating, informing, requesting, threatening, correcting, challenging, reassuring, joking, or muting. Properties of talking could include frequency, necessity (as dictated by structural requirements), or length (short and to the point or a lengthy conversation).

Talking

Therapy talking. Therapy talking in this study included negotiating for a mutual understanding, contracting for a behavior, informing, protecting, or reassuring the patients.

When a nurse engaged in therapy talking, it was defined as using therapeutic skills according to her professional mandate. It is important to point out that how one defines therapy (i.e., treatment and what is considered to be therapeutic intervention as compared to institutional intervention/requirement) will influence how one interprets the various interactions between nurse and patient. Much of the therapy talking in this study setting occurred in scheduled meetings and what the nurses referred to as "weekly medication groups." Individual therapy sessions which the patients had with their primary therapists also focused on therapy issues. Thus much of what is referred to as "therapy talking" happened behind closed doors between

the patient and his nurse or doctor and was observed only a few times by this investigator. The more private talking the patient had with the staff in the so called "therapy meetings" can possibly explain why the nurses relatively rarely engaged in therapy talking with the patients in the milieu.

When the nurses did engage in therapy talk, it could be for only a few words or for several minutes attempting to understand the patient. At times it involved putting a reassuring arm around the patient while walking down the hall. The outcome of such talking varied--sometimes the patient appeared calmer and at other times he seemed unable to hear the nurse and his behavior escalated.

The major process in therapy talking in this study was negotiating for a mutual understanding or contracting for some kind of behavior with the patient. Negotiating, as used here, had a limited interpretation of the concept. Strauss (1978) talks about negotiating as a mode of "attaining desired ends--such as persuasion, education, appeal to authority, or the use of coercion or coercive means" (pp. 1-2). Negotiating a mutual understanding or contracting for some type of behavior with the patient can have all the elements to which Strauss refers. However, he discusses this in a much more macro sense than the concept was used in this study.

A nurse by virtue of her role as a nurse can be seen by the patient as authoritarian. At times she might be "coercing" patients to understand a phenomenon from her viewpoint. For example, she can attempt to "persuade" the patient that he is not hearing voices--that they exist only in his imagination. The nurse can also be educating a patient as to expected benefits and side-effects of certain medications

while she is "coercing" him to take the medication. Negotiation must be seen as temporal in that it changes with the people and the context.

Negotiation as used in this study reflects what Strauss (1978) terms the end product of negotiations: understanding, agreements, and contracts between nurses and patients. The nurse negotiated for a mutual understanding by asking the patients questions such as "Is this what you mean?" and repeating or rephrasing what she thought she heard the patient say or, "I'm not sure I understand what you are trying to tell me," or, "Do you hear what I am saying?" (Notes, p. 169). An example of negotiating for a mutual understanding is the following:

> A very confused male patient had not talked for many days and was standing near the nursing station repeating the same question over and over again. He needed to borrow money to buy cigarettes, and where was his mother who must surely be waiting for him downstairs in the lobby. One of the nurses attempted to reason with him by saying that he had not brought any money with him to the hospital. His mother might be waiting for the visiting hours to begin. The patient kept repeating his questions in a soft voice. Finally, another nurse who had listened to them joined the two participants. He went over every sentence the patient said, attempting to negotiate a mutual understanding by repeating and rephrasing each sentence and then added, "Is this what you mean?" The patient said, "Yes" each time but continued to ask his questions. Finally, the patient looked the nurse in the eyes, said another "yes," while he backed away and added, "God and Justice"--neither every really understood what the other was trying to say.
>
> (Notes, p. 183)

Another episode was:

> A young woman who had "heard" voices and kept up an imaginary conversation for many days. She imagined that the telephone rang and would lift the receiver and say, "Hello," and talk for some minutes before saying, "Nice talking to you. Goodbye," and hang up. The nurses kept telling her, "You must tell us what is going on," making a real effort to understand her rapid, soft-spoken words. They would acknowledge she was having a hard time and say, "What makes you afraid

> of people?" At this she paused for a fraction of a second and said, "You are all so nice to me; I do apologize for my behavior," and then resumed her "conversation." (Notes, p. 201)

In this example the nurses liked the patient because she had what they labelled "a sunny disposition." The nurses interpreted the patient's verbal and nonverbal actions as in real need of therapeutic interventions and used all their imagination and even challenged medical orders in an attempt to help her.

Negotiating by contracting with the patient for some type of behavior was a common strategy used by the nurses. This type of therapy talking seemed to fall within the institutional requirements more than the professional. One episode will exemplify this:

> A young woman was put in what the staff referred to as "open" seclusion after she apparently had hit another patient. After a few minutes in this room, she asked one of the nurses, "Can I come out now?" (She had been told she had to stay there for one hour.) The nurse replied, "Can you control your impulses now? When you get too much stimuli (from being in the milieu), you can go back in again." Some minutes later the patient came down the hall with the arm of the nurse around her shoulders, talking to her in a soft voice. As the nurse saw that "current events" (a patient activity) was in progress, she suggested, "Why don't you go and join them--it might help you." (Notes, pp. 55-56)

In this example the nurses engaged in therapy talking and attempted to reassure the patient, informed her of alternative activities, and contracted with her for more acceptable behavior according to the institutional requirements.

Another type of therapy talking could be to inform other patients to stay away from and give a patient space by saying, "Stay away from X [a patient]. We are dealing with that [referring to another patient]" or, "T [a patient] needs to be by himself for a little while; you leave

him alone. T is very upset and I don't want you to get upset. You are doing so well now, I don't want you to get upset, too" (Notes, pp. 88, 181). Another episode of protecting a patient was when a nurse said, "I want you to stay away from X. Stay as far away as possible; I don't want her to throw things at you. She cannot control herself right now" (Notes, p. 181).

Therapy talking as a purposeful intervention of a professional requirement or negotiating a mutual understanding with the patients was not frequently observed as a strategy used by the nurses. When the nurses were asked about this phenomenon, about what signals they picked up from the patients, and about what made them negotiate a mutual understanding, they had a very difficult time explaining the process. One nurse said, "I was not aware I was doing that." Another nurse put it this way: "It depends on how busy the ward is, how tired the nurses are, or what time of day it is. For instance, at the end of the shift" (Notes, p. 150). Thus ward conditions and the frame of mind of the nurse could dictate how the nurse acted toward the patients' verbal and nonverbal actions. Many of the strategies the nurses used seemed to fall within the institutional requirements and what was conceptualized as business talking in this study.

Business talking. Business talking included requesting, informing, negotiating, correcting, or threatening patient behavior. Business talking seemed to be dictated primarily by the institutional requirements and less by clinical and professional requirements. Business talking was usually to the point, short in duration, and either a command or an exchange of information. Business talking seemed to have an anticipatory and predictive quality that could include

negotiating for behavior, obtaining or giving information, requesting, threatening, or correcting the patients when they were breaking rules or not complying with expected behavior as defined by the ward rules.

Business talking took place all the time in the study setting. When the nurse completed the requirements associated with admission of a patient, she would obtain information from him about his subjective perception of why he was in the hospital, what factors led to his hospitalization, previous hospitalizations, what medication, if any, he used, if he was allergic to any medications, family relations, living and/or working conditions, etc. While the nurse obtained information in this manner, she focused on business, but at the same time she could observe the patient. She could assess, predict, or anticipate his ability to concentrate on their discussion, coherency of his speech, ability to focus his eyes, restlessness, cooperation, etc. In addition to getting information about the patient's background and assessing his current status, she would also inform him about the treatment on the ward, rules and regulations, visiting hours, mealtimes, possible medications he would get, etc. At the same time the nurse was often heard negotiating with the patient for cooperation or contracting for behavior. As one nurse said to a patient during the admission procedure, "Are you going to behave yourself or do we have to seclude you?" (Notes, p. 95).

Requesting a behavior from a patient, threatening him with something if he did not comply, or informing the patient of rules are all ways of maintaining order on the ward and continuing the treatment process.

Informing and correcting a patient were strategies often used by the nurses. This might be to inform the patient about the ward rules and norms or to correct some type of undesirable behavior he was engaged in. These are various measures for controlling patient behavior and are seen on almost all psychiatric wards. How visible the controlling of patients is depends in part on how strictly the ward rules and institutional requirements are enforced. It seems as though some rules and regulations are necessary for all patient treatment due in part to the legal responsibilities of the hospital.

Enforcing rules by threatening patients was used by the nurses when the unit was particularly busy and when the nurses were tired and seemed to have less tolerance for the patients' abnormal communication. At these times, rather minor infractions such as standing in front of the door watching people come in and out, wanting to watch TV during a scheduled ward activity, or walking down the hallway of the dorm of the opposite sex could trigger a sanctioning strategy from the nurse in the name of treatment or for the sake of ward order.

By focusing their interactions with the patients on business issues, the nurses fulfilled many of the institutional demands that impinged on them. Some of these demands are necessary. These can be taking a patient's blood pressure since so many of the medications prescribed on the ward can cause dangerous changes in blood pressure. Signing and taking off medical orders and recording medications given are important so the staff knows who ordered the medication and if and when it was given to the patient. These tasks are also important from a legal standpoint since the hospital is accountable for the patient while he is hospitalized.

I think it is the amount of time nurses spend fulfilling the many institutional requirements and how this detracts from the time they have to spend with the patient in a therapeutic way, as well as the energy it takes for the nurses to do these tasks that need to be examined. Yet, many nurses did not seem to mind the paper work. At times, it was convenient for them to be able to "hide" behind the paperwork, and it provided a legitimate distance and reason for not interacting with the patients. One nurse said she "felt like she was a secretary more than a nurse" (Notes, p. 123), while another said, "At times it is real nice to be able to concentrate on the paperwork and not have to deal with all their 'crazy' behavior" (Notes, p. 204).

While the nurse focuses her interaction with the patient on business issues, she could also be collecting valuable information about the patient's behavior (i.e., tolerance for contact with other people) which could be used in his treatment plan. Thus, how the nurse used the institutional demands for therapeutic purposes or whether she just complied with them varied among the nurses in the study setting. It seemed as though the nurses with more clinical experience were less apt to focus on the business as business and were more able to use it for the benefit of the patient.

Data from this study indicated that when there were many inexperienced nurses working a shift or many registry nurses (nurses hired from an agency for the day), there was more correcting of patient behavior and less therapy talking.

A comment from one of the patients seems to illustrate how he felt about the nurses "being so busy" all the time. He said, "Promises,

promises--that's all I hear--all I want is a cup of coffee" (Notes, p. 133).

Social/private talking. Social or private talking was a friendly strategy used by the nurses. Social talking was a way of getting acquainted with another person, liking or being attracted by, or sharing with others. This type of talking had a quality of intimacy, muting tension, or joking with each other.

Social talking between the nurses and patients took place around the nursing station, in the two dayrooms, or while walking down the halls. When the unit was quiet, the nurses could be observed socializing more with the patients. Also at the beginning of the shift there were many social greetings between the participants. At times when the unit was very tense with many new patients and/or many patients were pacing restlessly around the unit, the nursing staff used joking and kidding to mute or equilibrate some of the tension.

Social talking was particularly used by the nurse when a patient had stayed on the unit longer than average and they had come to know one another over time. Observing some of these patients revealed a marked change in their demeanor from quite confused and disoriented upon admission to being coherent and articulate just prior to discharge. With some of these patients the nursing staff would engage in social talking.

Patients that the nurses liked or were attracted to were more likely to be talked with; the nurses tended to share more information and to discuss their lives outside the hospital with them. Altschul (1972) makes the following comment: "Ordinary human relationships or liking or disliking are bound to occur and their existence needs to be

acknowledged" (p. 193). Engaging in social talk can also be seen as a way of passing time while anticipating a change such as the end of shift, waiting for meal trays to arrive, or for a patient to be admitted or discharged.

Social talk was often intermingled with business and/or therapy talking. For instance, while helping a patient with his laundry or a shower, there could be some sharing of information between nurse and patient about how they "normally" liked or did these activities.

Quite often if the nurses were engaged in small talk and standing outside the nursing station, patients would join in the conversation whether invited to do so or not. It was almost as though they wanted to share some of the intimacy of the talking. Some examples will illustrate social talking.

> A patient was complaining to some patients about diarrhea and asked them for help. They in turn directed him to the nursing station. He went over there and announced his problem to the nurses. There was much joking back and forth between the staff about the causes for diarrhea and what to do. The patient looked a little bewildered, and a nurse finally said, "No, we are just joking." (Notes, p. 74)

Comments the nurses made when they liked the patients were: "He is kind of cute: of course, I tolerate more from him," or, "she is cute, I like to kid her." When I asked one of the nurses about this she said:

> There are many parallels to life outside the hospital; some people we like and others we don't. Especially the patients that are similar to us in some ways that staff seem to like, and the ones that rebound quickly or come back to high functioning. They give the staff a lot of rewards in terms of recovery from the very regressed states they often come in with. Staff develop pets among the patients and I see that as very unhealthy and interfering with what they should be doing (therapy?), and maybe even reinforces some of their less desirable behavior. Other patients that do not rebound much become more of a nuisance that has to be tolerated. (Notes, p. 185)

The actual talking the nurses engaged in with patients can be typed according to whether it was therapy, business, or social in content.

Often the types of talking would be intermingled. The talking that I observed on the study unit was more often business-oriented than therapy or social. This can be due, in part, to the high attrition rate among the nurses, the lack of continuity in patient care, the few resources they had, and the very high turn-over rate among the patients with very short hospitalizations that do not render much time to treat patients beyond medicating and reducing some of their most prominent symptoms. Medicating and secluding patients are discussed in the following section.

Medicating Patients

When a patient was medicated, the nurses could negotiate, challenge, inform, or threaten him. Medications were used as a part of the treatment process or when the ward order was threatened. Medicating a patient, when he was acting out of control or his disorientation was escalating, was one of the most effective actions the nurses had for controlling a patient. Patients are medicated when they act out, are unable to control their impulses, become increasingly incoherent and verbally or nonverbally threatening to staff or other patients. The types and amount of medication a patient received varied depending on the diagnosis and/or the patient behavior at that time.

The issue of medication is one of controversy and has legal and ethical dilemmas. Are the medications for the benefit of the patient or are they given to make the patient more manageable for the staff? If one believes there are underlying chemical imbalances causing patients'

abnormal communication and difficult behaviors, it seems easier to defend the use of medication. The psychotropic medications that the patients receive have many unpleasant side-effects such as drop in blood pressure, drooling, dizziness, feelings of being "hung over," a numbness of emotions, etc. Until we have more knowledge about the etiology of abnormal communication and schizophrenia and how the chemicals interact with the person's psychological makeup, this issue will be debated among nurses.

Medicating patients was a prevalent strategy used by the nurses on the study unit. It can be seen as the only means they had for quickly controlling patient behavior. Patients admitted to the unit were considered very "sick," often did not know what was happening to them, had completely lost control over what is real or unreal, and had been assaultive to family, friends, or the police. From experience the nurses knew that medication would help clear up some of the patients' confusing thoughts and control their behaviors. Once the patient was medicated and sedated, he was more amenable to listening to the nurses and perhaps able to realize that he had problems that may need long-term treatment either at another facility or at an out-patient clinic.

When a patient was found to be much out of control, or when the patient had a history of assaultive behavior, he was put on what this unit called "rapid tranquilization." This involved hourly injections of a psychotropic drug until the patient slept, cleared up, or became more coherent and noncombative. A patient on rapid tranquilization had to be frequently checked through assessment of eye contact, coherence of speech, level of drowsiness, body movements in general, and blood pressure. As soon as the patients' symptoms abated, the frequency of injections was decreased.

Patients who had a history of assaultive behavior or were familiar to the nurses from previous hospitalizations were often medicated faster than new patients. With new patients the nurses would often wait and observe the patient for a while in the milieu prior to medicating him.

Only a medical doctor is authorized to prescribe medications. Often the nurses spent much time and energy finding a doctor on call or the patient's primary therapist to write orders for medications. At times the nurses would challenge the doctor(s) about the type and amount of medication given. They based their arguments on the patient behavior as they observed it over time. The nurses were dependent on good working relations with the doctors and needed to feel that their opinions were heard and respected. At times there was much bitterness from the nurses because they thought the doctors ignored their observations and would not listen to them. It was in the interdisciplinary team meetings that the nurses and doctors most often seemed to negotiate the issue of medication for patients. A typical comment was: "The Navane is not hitting his (the patient's) agitation. Ask the doctors in team meeting to change his order." Another nurse added, "There is another patient who also needs his medication changed" (Notes, p. 19).

The nurses' reactions to giving medications to patients varied. Some said outright that they hated to give medications and yet added that this was "the only way they have to help the patients fast." One nurse said it in the following way:

> I really have no problem giving medications to patients on this unit. They are needed to control their behavior and are a means of controlling the patients' impulses. I will talk very straight to the patient and explain the procedure involved. If they are

> involuntary patients, they have no choice and must take the medications; but I will still explain how it is given and why. (Notes, p. 99)

The nurses would approach the patients and say, "Here is your medication," or, "You need more medication," or, "What about some more meds?" When a patient refused medications, some negotiating would occur. If the patient refusing was a strong male, the nurse would often call the security guard in the hospital to help restrain the patient while they gave him an injection.

Patients who had been hospitalized many times seemed to refuse medication less often than the ones that were new. The ones with a longer patient career seemed to know they did not have much choice regarding medications. Many patients complained about the unpleasant side-effects from their medications. Some patients were familiar enough with the medications to alert the nurse if they had side-effects and to ask for something to help them with these.

Some comments the patients made about medications were:

> They (the medications) made me drool. When I was sick they made me do things I was not aware of. (Notes, p. 28)

> As a patient came out of the shower he approached the nurse and said, "The medications make my tongue thick. I can't swallow." Another patient acted as if he was irritable and the nurse said to him, "Maybe you need some Haldol." The patient answered in an angry tone of voice, "Maybe <u>you</u> need some Haldol. I will give you the same treatment you give me, and then you will see." (Notes, p. 186)

> A patient who had just talked to his doctor came and asked the nurse for "some medications." The nurse said to him, "You had some medications this morning. How did they affect you?" There was some negotiating back and forth and the nurse finally said, "I do not have anything against medications. Good thing you asked me. But sometimes it is important to deal with whatever bothers us before taking a pill." (Notes, p. 64)

> A patient who has had multiple hospitalizations was asking for more Stelazine (a medication), and as he was swallowing the medication he said, "It tones me down; lick the sugar off and when it gets to my stomach it goes. . .can't you see me toning down?" (Notes, p. 109)
>
> A nurse was telling how she had tried to give a female patient an injection the previous evening. The patient had refused to take it and the nurse had insisted on her taking it as she had no choice in the matter. "Then she kicked me and said it was my fault, and I guess she was kind of right." (Notes, p. 200)

At times the patients would negotiate with the nurses for medications. They seemed to be able to recognize their own tolerance levels as well as those of the staff. One episode was that of a patient who was intrusive, demanding, and pacing rapidly around while he kept asking for more Prolixin (a medication) "because I can't hold it much longer." He was given the medication and about 45 minutes later came and said he needed more. Since the nurse had to wait another hour before she could administer more, there was much social talking with him and the nurses tolerated much of his demanding behavior. When I asked her about this, she said, "They liked him and he seemed to make a real effort not to lose control completely" (Notes, p. 206).

The patients who were liked were able to attract much attention from the nurses regarding medications. The nurses seemed to be more concerned about the types and amounts of medications these patients were administered than those of the patients they liked less or knew less well.

Secluding a Patient

Reasons for secluding a patient included assaultive behavior, being out of control, or threatening staff or other patients in some way. The

nurse could negotiate, contract, inform, or threaten the patient in the process of secluding him.

Secluding a patient means placing him in a room that has been especially equipped for this purpose. The walls are reinforced, the door has no handle on the inside and has a small window through which staff can look and check on the patient's behavior. There are very specific rules for when and how long a patient can be secluded at any one time. A doctor's order is needed and a special form is used to document the reasons for secluding the patient and to note every 15 minutes the patient's behavior (i.e., sleeping, tossing around, screaming, etc.)

A patient in seclusion will often be restrained and have his arms and/or legs tied down with leather straps so he cannot harm himself or others. A slightly less restrictive way of secluding was the use of "open seclusion" as it was called on this unit. This was a room without a bed where the patient could open the door from the inside.

Patients who attempted to escape from the ward because they did not see themselves as "sick," had a history of being violent, or threatened the nursing staff or other patients verbally or nonverbally were always secluded and restrained immediately. Prior to secluding a patient, the nursing staff would most often discuss the pros and cons of seclusion among themselves. Secluding a patient practically always had elements of drama. This was because the security guards were often summoned to aid in the process and other patients were asked to move out of the area of confrontation.

Whether seclusion of some patients could be avoided by other treatment methods is a difficult question to answer. Perhaps, had there

been more and better qualified nurses, less emphasis on paperwork, the patient had been hospitalized earlier in his illness trajectory, some seclusions could have been prevented. On the other hand, many of the psychotic patients admitted to this ward were unable to recognize that they needed help, or their families were reluctant to commit the person to a psychiatric hospital because of the stigma associated with hospitalization. Also, the patients admitted to this ward were what one nurse referred to as "the sickest in town." It is not easy to explain this phenomenon unless one has seen the patients. Many of them were unemployed or had very unstable work records; many were drifters who had only temporary residence in the city; some were illegal immigrants and did not speak or understand English well. Many of the patients showed little interest in changing lifestyle; others had the interest, but seemed unable to change. Many of these saw hospitalization as a respite where the most blatant symptoms would be temporarily relieved and they would get food, shelter, and clothes before returning to the streets.

The nurses seemed reluctant to discuss this strategy and made such comments as, "We did not have much choice. There was only one male staff on duty and as women there was no way we could control him," or, "He has a history of being assaultive. I have seen him in action before. There was no need to wait until he 'blew it [lost control]'" (Notes, p. 199). Thus the nurses seemed to rely on their past experience with a particular patient or a patient that had acted in a similar manner and the ward conditions at the time (i.e., male vs. female staff present, time of day, etc.) prior to secluding a patient.

The patients themselves rarely commented on the fact that they had been secluded. Once in a while comments such as, "I had better behave

or they will seclude me again like they did last night," or, "I am sure glad they knew what to do with me. I thought they were all the devil and were coming after me" were heard from the patients (Notes, p. 202).

Medicating and/or secluding a patient can be interpreted as the most effective means of controlling patient behavior. Yet, this must be seen in the context of a particular ward at a particular time, the structural requirements of the hospital, and how these elements are balanced by the framework of understanding, sensitivity, tolerance, risk-taking, and options.

Summary

The last section of Chapter IV presented the active strategies the nurses engaged in based on their interpretations of the patients' verbal and nonverbal actions. The strategies were conceptualized as being talking, medicating, and secluding. Talking had three subcategories: therapy, business, and social.

How the nurses in the study setting interpreted the patients' actions in the context of the ward and nurse and patient characteristics and acted accordingly seemed to depend on how they interpreted and balanced the structural requirements that created their understanding, sensitivity, tolerance, risk-taking, and options.

Chapter Summary

This chapter presented five sections:

1) the structural requirements that impacted on the nurses (professional, clinical, and institutional);

2) the everyday experiences on the ward in terms of ebb and flow of activities for the nurses and patients;

3) a social psychological framework of understanding, sensitivity, tolerance, risk-taking, and options for the nurses;

4) patient characteristics in terms of verbal and nonverbal actions along a noiseness scale; and

5) passive nursing strategies in terms of observing anticipating, predicting, and forestalling and active nursing strategies in terms of talking (therapy, business, and social), medicating, and secluding.

Even though the findings are discussed in terms of the specific unit that was the basis for the observations of this investigation, the events must be viewed as similar to those on other psychiatric wards with similar patient populations.

In my observations in this study, it did not appear that the nurses engaged in much direct interpretation of the patients' abnormal communications per se. Rather, they interpreted all the patient actions in terms of the noise that could be interpreted as either disruptive, a nuisance, or irrelevant to the ward order or treatment process as defined by the structural requirements. The strategies (actions) the nurses used were observing, anticipating, predicting, forestalling, talking, medicating, and secluding.

A discussion of the study findings, limitations, and recommendations for nursing research, education, and in-service education that can be made from this study are discussed in Chapter V.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Introduction

This last chapter presents the study findings in light of the purpose of the investigation and existing body of related theories and research and is followed by a discussion of the findings. The latter part of the chapter addresses study limitations, implications of study findings for nursing research, education, and clinical practice.

This study was designed to discover how abnormal communication as used by many schizophrenic patients affects the nurse-patient dyad on a psychiatric hospital ward in the western part of the United States. Through three pilot studies (Bunch, 1979, 1980a, 1980b) and analysis of the data, it became evident that to answer the specific research question, additional areas had to be examined. The psychiatric nurse who works in a clinical area such as a hospital ward must learn to balance not only her professional and clinical mandates but also the more pragmatic requirements of the institution. Examining the everyday stressors on a psychiatric ward with much institutional business, including volumes of paperwork to organize and complete, the larger research question became: How do psychiatric nurses balance the many and often conflicting requirements of her profession and the institution and organize and conduct her business when in addition she is faced with patients using abnormal schizophrenic communication.

Reviewing theories and research pertinent to schizophrenic thought disorder and communication (Arieti, 1974; Bateson, 1956; Bleuler, 1911/1950; Bleuler, 1974; Chapman & Chapman, 1973; Jackson, 1968; Laing, 1961; Lennard et al., 1975; Mishler & Waxler, 1968; Reusch, 1957; Singer & Wynne, 1965, 1978; Sereno & Mortenson, 1970) revealed a multitude of theories, each with plausible explanations of what causes schizophrenia and the peculiarities of schizophrenic communication. The only consensus found in this review was that the etiology of schizophrenic thought disorder and communication remains an enigma (Chapman & Chapman, 1973). Also, the multitude of interpretations of this symptom complex have led to a variety of treatment ideologies for schizophrenic patients. The many ambiguities and possible interpretations of the phenomenon and treatment ideologies have consequences for nurses working with schizophrenic patients. Nurses are left with few specific explanations to fall back on when interacting with this patient population.

Findings

At the outset of this study it was thought that nurses conceptualized their knowledge of human behavior and theories of schizophrenia and schizophrenic communication and engaged in therapeutic communication in a manner that would lend itself to categorize (conceptualize) and develop into a grounded theory. It was assumed that nurses would problem-solve with patients, reality orient with them, and use corrective language when interacting with them. Findings from this study indicated that nurses either focused on the institutional business when talking to patients, medicated and secluded them. When there was "time

6left over" and the institutional business was taken care of, the nurses at times would negotiate a mutual understanding about the patient's communication. Or, they contracted with the patient for some type of behavior. If the nurse liked or was attracted to the patient, she would engage in a fair amount of social talking with him.

How the nurses in the study setting operationalized their knowledge of schizophrenic theories, abnormal communication, and professionalism and balanced these with the everyday stressors on a psychiatric ward was explained by the use of a social psychological framework. The subsequent strategies the nurses engaged in when in addition faced with the schizophrenic patients' actions seemed to be determined by the nurses' interpretation and translation of the above and by which structural requirements appeared most threatened at a particular moment. The findings revealed that the nurses engaged in more business talking, medicating, and secluding patients than in therapy talking according to their professional mandates. Thus the institutional requirements seemed to take precedence over the professional and clinical requirements much of the time.

In the study setting the attrition rate among the nurses was very high. Many of the nurses voiced great interest and a feeling of challenge in working with the patients. Yet, the stressors of balancing their professional and institutional mandates, obtaining satisfaction and continuity when interacting with the patients caused many frustrations. Some of the nurses attempted to rectify this by suggesting alternative ways of decreasing the institutional business. Others suggested allowing the nurses to work in part-time positions. This was not feasible due to the bureaucracy of the ward and the fact

that the hospital is "owned" by the city. Changing nursing requisitions was not the autonomous decision of the ward. Other nurses resigned their jobs in frustration. Despite this, some stayed on because they liked to work with the particular patient population on this ward.

When the nurses were asked about the treatment philosophy and/or the nursing ideology for the ward, their answers varied. The following are some:

> It must be written somewhere. The philosophy here seems to be to get a certain amount of work done and then get the patients out of here. (Notes, p. 27)

Another nurse was very explicit about these questions and said:

> Nursing clearly does not have a philosophy or model they push right now and that is a big problem. Nursing has not defined it's goals and that results in people just working here. (Notes, p. 19)

The answers the nurses gave are not very different from many other hospitals where the same questions have been asked. Altschul (1972) found similar results from her study in Scotland a decade ago. She said at that time: "It has proved to be impossible to obtain any picture of the treatment ideologies which prevailed among nurses" (p. 191).

The findings from this study indicated that the nurses had great difficulty operationalizing their professional mandates, knowledge, and understanding of psychopathology and balancing these satisfactorily with the institutional demands. This was evidenced by the nurses engaging in passive nursing strategies when the ward was quiet. When the ward was very busy, the nurses engaged in strategies such as business talking and medicating and secluding patients.

The findings from this study are supported in general terms in Strauss and associates' 1964 study on "Treatment Ideologies and Psychiatric Patients." Kramer's 1972 study of the nurses' reality shock

upon entering the world of working on a busy hospital ward also supports the findings from this study. (These studies were discussed in greater detail in Chapter IV.) Wilson and Underwood (1980) have a similar conclusion when they suggest that:

> All institutions are subject to public and private rules, constraints, regulations, laws, governing bodies, and inspections. Such institutional requirements often have a logic--rooted more perhaps in maintaining the institution than quality patient care. To bring about change the nurse has to know where the control rests. Only then can s/he know if the results of the control are negotiable. (p. 260)

To balance the many requirements that impact on them, nurses must somehow learn where the controls lie and how to manipulate these better. The above becomes even more complex when nurses in addition are confronted with abnormal schizophrenic communication as discussed in Chapter IV of this study.

A somewhat spurious finding from this study was how much the nurses' liking and attraction for many patients seemed to influence their tolerance for belligerent behavior and bizarre communication from these patients. Conversely, patients that frequently returned to the ward and had histories of assaultive behavior and management problems were often seen as less attractive by some nurses. This latter group were more frequently medicated and secluded as well.

Tudor's (1952) study demonstrated a correlation between staff withdrawal from patients with biographical histories of hopelessness, unresponsiveness, or assaultiveness. Tudor found that the nurses, though unconscious of their actions, continued to avoid contact with these patients. Hall (1976) reviewed studies on social attraction among staff and patients and found that ". . .surprisingly few studies concentrated on staff-patient attractions" (p. 76). She goes on to say

that "A liking between a patient and a staff member may occur when each sees the other as similar in some important characteristic" (p. 77). Hall's statement in conjunction with Tudor's findings was confirmed by many of the nurses in this study setting as well. This finding was presented in more detail in Chapter IV under social talking as a nursing strategy.

One explanation for the finding that the nurses engaged in more passive strategies (observing, anticipating, predicting, and forestalling), business talking, and medicating and secluding can be the shift in focus from long-term treatment to short-term treatment of psychiatric patients. When patients are hospitalized for an average of six to seven days, as in the study setting, it might be unrealistic to expect nurses to balance the institutional requirements with their professional mandate to establish a relationship with the patients that was purposeful, meaningful, and therapeutic. When hospitalization for a patient is very short, and in addition as many as 630 patients pass through a ward in nine months, it is not easy to get to know all the patients. Peplau (1952) suggested that "the corrective language the nurse uses will directly affect the language of the schizophrenic individual and that this in turn will have a positive effect on his thought processes and behavior" (p. 14). This argument might have been more realistic when patients were hospitalized for longer periods of time than was customary in the study setting.

When there are many and conflicting requirements impinging upon the nurses, their ability to balance these becomes exceedingly difficult and will take its toll on the nurses and their patient care. The extent of the toll on nurses will reflect in their job satisfaction and what is

today popularly labelled "burn out syndrome." It will also reflect on the nurses' performance expressed through job dissatisfaction and an increased use of sick leave. High attrition rate is another way of expressing dissatisfaction and frustration when nurses are unable to balance the many requirements and yet work therapeutically with patients.

The value of the findings from this study is less in novelty than the documentation of the magnitude of ambiguities involved in working as a nurse on a psychiatric hospital ward where about 75% of the patients are diagnosed as schizophrenic. The observed difficulty by the nurses in this study to balance the structural requirements and establish therapeutic and meaningful relationships with patients can reflect on how bureaucratic organizations stifle the nurses' endeavors to do this. The difficulty in balancing the many requirements and organizing and conducting ward business can also reflect on the nurses' education. Perhaps the educational preparation for nurses does not supply them with sufficient knowledge and skills to manage this task.

Limitations of the Study

Several limitations of this study which are pertinent to the study design, the study setting, and the patient population are presented below.

Validity

How valid the findings from this study are and how generalizable they can be to other psychiatric wards and hospitals may be an issue.

(Some of these questions were discussed in Chapter III.) My empirical experience from many hospitals in this and other countries indicates that there are many similarities in hospitals throughout the world. This view, of course, has not been tested. Oiler (1982) suggests that: "If the phenomena described and compared can be recognized by others, they are valid" (p. 181). The data from this study was grounded in empirical reality of everyday events as they happened to nurses and patients in the study setting. This is another way of saying what Schatzman and Strauss (1973) refer to: "An essential prerequisite to establish credibility with any audience is the researcher's conviction that what he (she) is saying is so" (p. 133).

Despite the limitations of this study, there was one significant factor that as a researcher I also have clinical experience from similar work situations and could relate to many of the observed phenomena. Gow (1982) makes a similar contention when she says:

> . . .related to my particular background in hospitals, I could demonstrate a backstage understanding of the life and activities of a nurse, and from my own direct experience in working with patients, I was in a position to understand the complexities of the situational factors involved. (p. 311)

The setting. The psychiatric ward that was used for my observations had some unique features. It is part of a large county hospital and as such is highly bureaucratic. It must admit patients in need of acute hospitalization whether they have hospital insurance or not, are residents of the city or not, as well as illegal immigrants. Most patients on the ward were involuntary and committed by law to stay there from three to 14 days. Disposition planning was often difficult as the patients either did not consider themselves sick, had a poor work record, if any, and limited financial resources. Many patients had no

family nor any type of social network to support them after discharge from the hospital. Thus generalizability of findings from this study to other wards, unless they have similar constellations and patient populations, must be considered a limitation.

The patients. The focus of this study was on the nurses and how they interpreted and responded to abnormal communication as used by many of the patients. The patient's subjective experience of the many social events on the ward was not directly obtained which must be seen as a limitation.

It was decided at the outset of the investigation that to obtain an informed consent from all the patients to interview them would be beyond the framework for this investigation. Also, consent from the patients would probably be rather difficult to obtain due to the acuity of their illnesses and short stay at the hospital. The data and findings may have been richer if the patients' interpretations of the events could have been included.

At times the patients would tell me how they viewed the nurses either as helpful or less helpful. Or the patient complained how busy the nurses were all the time. I think the patient who made the comment, "Promises, promises. That's all I hear around here." was at times a pretty accurate assessment of the ward conditions. Some patients volunteered their personal interpretation of why they were in the hospital, or how they thought they did not belong there. This information was given more because I seemed available and not engaged in routine tasks as were the nursing staff. Thus I indirectly obtained many subjective interpretations from the patients regarding events, the patients' view of the nurses, and their feelings about their patient

roles. If it had been feasible to obtain their consent to participate in this study, the data and findings may have been richer and may have added other interpretations to the many social events and processes on this particular ward.

The Nurses. Limitations of the study findings related to the nurses were the high attrition rate and the frequent use of registry nurses working one shift at a time, creating a lack of continuity of patient care. I conducted five in-depth interviews with the nurses; this small number may be considered low and another limitation.

Only three nurses remained on the ward during the entire nine months when I was a participant observer there. The remaining nurses were there from three weeks to seven months. Five of the nurses were interviewed in-depth following an interview guide that was made prior to the onset of observations (see Appendix D). Most of the other nurses were questioned on the site as the various episodes occurred. Thus all the nurses were to some extent involved in validating my own observations and findings to ensure that they were shared by more than me as an observer. In addition to the staff nurses, one nursing supervisor and the director of psychiatric nursing service supplied much statistical information about the patients, nurses, and the hospital in general which was helpful.

The high attrition rate among the nurses and the high usage of registry nurses might have contributed to the nurses' rather heavy emphasis on the institutional requirements and business aspects when interacting with the patients.

Recommendations

Many recommendations from this study can be made for future nursing research, education, and in-service programs for all mental health workers in psychiatric hospitals and any other hospital setting.

Nursing Research

The grounded theory of balancing the mandates, organizing and conducting business as usual, and communicating with schizophrenic patients on a psychiatric hospital ward can generate many propositions. The findings from this study also indicate possibilities for future nursing research. Some areas for future research generated from the present study are listed below.

Communication and job stressors:

1) A clearer statement of professional and clinical mandates could increase the job satisfaction and therapy talking by the nurses when responding to the patients' verbal and nonverbal actions (see Chapter IV). Conversely, the less clear the professional and clinical mandates are stated, the greater could be job dissatisfaction (expressed by high attrition rate and use of sick time) and the less therapy talking by the nurses when responding to the patients' verbal and nonverbal actions (see Chapter IV).
2) The less rigid and restrictive the institutional requirements are could decrease attrition rate among the nurses and increase job satisfaction expressed by an increase in therapy talking when responding to the

patients' verbal and nonverbal actions (see Chapter IV). Conversely, rigid institutional requirements could increase attrition rate among the nurses, decrease job satisfaction, and increase the use of active nursing strategies (i.e., business talking, medicating, and secluding)(see Chapter IV).

Communication and nurse-patient interactions (relationships):

3) The stronger the professional identification of the nurses could lead to an increase in therapy talking when responding to the patients' verbal and nonverbal actions (see Chapter IV). Conversely, a decrease in the nurses' professional identification could lead to a decrease in the nurses' therapy talking when responding to the patients' verbal and nonverbal actions (see Chapter IV).

4) An increase in the patients' noiseness could lead to an increase in business talking and medicating and secluding strategies by the nurses (see Chapter IV). Conversely, a decrease in the patients noiseness could lead to an increase in passive strategies by the nurses (observing, anticipating, predicting, and forestalling)(see Chapter IV).

5) An increased liking of and attraction to the patient could lead to an increase in social talking by the nurse (see Chapter IV). Conversely, the less the nurse likes and is attracted to the patient could lead to a decrease in social talking with the patient.

Problem areas for future nursing research:

1) The nurses' response to a patient's abnormal communication depends on her understanding and operationalization of her professional mandates, quality and quantity of education, clinical experience, and amount of ward activities and institutional business.

2) The quantity and quality of nursing education and clinical experience will influence the nurses' ability to balance the structural requirements more satisfactorily and thereby engage in more therapy talking when interacting with schizophrenic patients.

3) Hall (1976) suggests that: "The entire area of staff-patient attraction would appear to be a fruitful research question for nursing" (p. 77). I support her suggestion based on the findings from this study.

4) Other areas nurse researchers may want to explore are: the amount and degree of institutional requirements and how these influence the nurses' 1) ability to incorporate professional mandates and engage in therapy talking with schizophrenic patients in a hospital setting, 2) job satisfaction, 3) attrition rate, and 4) work environment (controlling v. autonomous).

Other suggestions could be made from the study findings for future nursing research. I have mentioned only a few to indicate some areas that may be fruitful to explore.

Education

The findings from this study can have implications for nursing education as well as nursing research. Some areas are presented below.

The nurses in the study setting were well educated and some had many years of clinical experience working with psychiatric patients from other hospitals as well as in the study setting. Yet, when questioned individually, they voiced great concern and frustration over the amounts of institutional business they engaged in and the limited opportunities to establish purposeful and therapeutic relationships with the patients. Styles (1982) says that: "As professions and organizations have interacted and evolved together in increasingly complex ways, client [nurse] identification which is a basic necessity for ethical and autonomous practice, has become more difficult" (p. 20). She argues that "the professionalism of nursing will be achieved only through the professionhood of its members" (p. 8). The author defines "professionhood" as the characteristics of the individual as a member of a profession while professionalism emphasizes the composite character of a profession (p. 8).

Perhaps in the course of their education, nurses must be taught more clearly what is meant by "nurses' professionhood." How can nurses learn professionalism and professionhood and balance these with the increasingly complex organizations as Styles discusses may need to be addressed more clearly in the educational curricula for nurses.

The findings from this and other studies certainly indicate a great need to supply nurses and the organizations where they work with alternative methods of balancing the mandates if they want to improve job satisfaction, decrease attrition rates, and improve the quality and continuity of patient care.

Schools of nursing may need to re-examine the communication theories, skills, and techniques taught in today's graduate schools for nurses. The emphasis on short-term hospitalization demands a different type of relationship with psychotic patients than what Peplau described. The strain of being assigned to psychiatric patients for eight hours a day as Gow speaks about seems to create a most difficult situation for nurses to function therapeutically according to their professional mandate.

Nurses may benefit from learning more about how emotions do affect the nurse and, consequently, patient care. Gow (1982) addresses the practitioner's dilemma of ". . .being required to be warm, open, sensitive, willing to share and risk themselves in meaningful relationships (and at the same time) they are reminded that one of the distinguishing characteristics of the mature, highly professionalized practitioner is emotional non involvement; effective neutrality" (p. 1). This conflict may be a purposeful area to address more clearly in the education of nurses.

Another finding from this study indicated a lack of knowledge by the nurses of the boundaries of their nursing function v. managerial and therapist functions. Perhaps the implementation of nursing models such as Orem's (1971) self-care principles in nursing education may influence a clearer delineation of the nurse's role and functions. This may be helpful for the nurse when she enters the reality of work on a psychiatric ward.

In-service Education

Many of the recommendations mentioned earlier could also be used in in-service programs for nurses and other mental health professionals.

If nurses on any ward examined their job descriptions, the ward rules and regulations, the amount of time spent on paper work, the nurses might acquire a clearer picture of how their time is used on a hospital ward. Some areas that may be helpful to explore for the clinical nurses in a hospital setting are listed below:

1) What is the treatment philosophy on this ward; how is it implemented in practice and what are the consequences for:
   a) the patients in terms of treatment and nursing care,
   b) the nurses in terms of job satisfaction and continuity of patient care,
   c) the ward in terms of ward atmosphere--controlling or autonomous?
2) How is psychiatric nursing defined on this ward and what are the consequences for:
   a) patient care,
   b) clarity in delineating the role and functions of the nurse,
   c) job satisfaction for the nurses?
3) What are the institutional requirements in terms of business for the nurses and what are the consequences for:
   a) amount of time the nurses spend on organizing and conducting these,
   b) the nurses in terms of job satisfaction,
   c) patient care in terms of the nurses balancing the institutional requirements with their professional and clinical mandates.

Examining the structural requirements (professional, clinical, and institutional) and how these are balanced on a hospital ward may be fruitful for the nurses. This type of examination may more clearly delineate the nurse's role and functions, increase job satisfaction, and uncover where some of the institutional controls lie as Wilson and Underwood (1980) suggested.

Summary

This last chapter presented the study findings in light of the study purpose in conjunction with study limitations pertinent to the design, setting, patient population, and nurses. The latter part of the chapter suggested areas for future nursing research, education, and clinical practice that can be generated from the study findings.

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APPENDIX A

CONSENT FORM

CONSENT FORM FOR STAFF TO PARTICIPATE IN RESEARCH

ON THE EFFECT OF DEVIANT COMMUNICATION ON THE NURSE-PATIENT DYAD

Approval No.: 930113-01

Eli Haugen Bunch, RN, doctoral candidate, has explained to me she is doing a study to discover how nurses and patients communicate.

If I agree to be in this study, the following will happen to me:
I will answer questions on a demographic check list once.
I will be observed while she is on the ward for about 200 hours.
I will answer questions she might ask me about how and why I do certain nursing procedures and how I understand what the patients are saying to me and if this affects my behavior toward them.

The observations will be done on this ward.

I understand that the observations will have no direct risk or discomfort to me. I have been told that I can at any time decline from answering questions, withdraw from the study, or ask her to leave the ward if deemed necessary for my work.

All answers and observations are confidential and known only to the investigator and will be used only for data analysis. No individual information will be shared with other personnel. Any published work resulting from this study will report on a group, not on one person.

I understand that this study has no immediate benefit to me, but that it might help develop teaching skills to nurses about communication and nursing interventions for future patient care.

This information was explained to me by the investigator, Eli Haugen Bunch. I understand she will answer any questions I may have concerning this research at any time. I may reach her at any time at (415) 681-0281.

I understand that my participation in this study is entirely voluntary and that I may decline to participate at any time without jeopardy to my present or future job at this hospital.

I understand I will not receive any compensation for my participation. I have been offered a copy of this consent form.

_____ _____

Date Subject's Signature

APPENDIX B

DEMOGRAPHIC CHECK LIST

DEMOGRAPHIC CHECK LIST

NAME: _____

AGE: _____

SEX: _____

RACE: _____

HIGHEST DEGREE IN NURSING:

_____ DIPLOMA

_____ ASSOCIATE DEGREE

_____ BS

_____ MS

_____ OTHER

NUMBER OF YEARS IN NURSING: _____

NUMBER OF YEARS IN PSYCHIATRIC NURSING: _____

NUMBER OF YEARS ON THIS WARD: _____

JOB TITLE: _____

OTHER JOB EXPERIENCES (LIST YEARS AND TYPE OF WORK): _____

_____

_____

APPENDIX C

PRESENTATION TO STAFF AND COMMUNITY MEETINGS

A brief outline of what will be presented to staff and community meetings

Community Meeting

I am Eli Bunch, a nurse researcher. I will be on this ward for the next few months during the day and evening shifts. I am interested in how nurses and patients talk to each other. I will not ask you any questions unless you approach me first, and I will be happy to answer any questions you might have. If you do not want to be observed, let me know and I will not make observations of your interactions. This study will hopefully provide nurses with information on how they can better understand you and help you. It will provide information nursing teachers can use when they teach nursing students. No names or personal information about you will be used so your right to confidentiality will be protected.

Staff Meeting

More or less the same as above. In addition, I will go through the consent form, demographic check list, and interview guide. Their right to ask me to leave if deemed necessary for whatever reason will be stressed along with their right to decline to answer any questions. All information gathered and the confidentiality of this will also be stressed.

Bulletin Board Notice

Eli Haugen Bunch, a nurse researcher, will be on this ward from _____ (date) to _____ (date) to observe how nurses and patients talk to each other. If you have any questions about this project you can ask her directly or tell one of the staff members you want to talk to her and they will tell her.

APPENDIX D

INTERVIEW GUIDE

Areas to be explored in semi-structured interview

For each question discussed, elicit thoughts, perceptions, and understanding of situation and behavior of participants. Also elicit actions considered, carried out, strategies performed, and results of these.

I am Eli Bunch, a nurse researcher. I would like to ask you some questions about psychiatric nursing, your experience and beliefs working with psychiatric patients. I am primarily interested in the way nurses and patients talk to each other.

1. I would like to know if this ward has any specific philosophy and if you can tell me about this. Does this philosophy influence the way you treat patients? Can you give me some examples?

2. Do patients come to this ward with a diagnosis? When you hear a patient is diagnosed as, for example, schizophrenic, does this influence your behavior toward him? Your expectations of him? The way you interact with him? The way you talk to him? Do you question the validity of the diagnosis? Can you give me some examples?

3. When you talk to a patient, do you ever think about his diagnosis? Do you behave or talk to him differently depending on what diagnosis he has? Can you give me some examples?

4. When you talk to a patient, do you change your language in any way, like using simpler words, avoiding medical or nursing "jargon", or is there no difference? Please elaborate.

5. If a patient tells you he is paranoid, hallucinating, or delusional, do you ever ask him how he understands these terms or do you assume he has the same understanding of these terms as you have? Please elaborate.

6. Sometimes patients will say they are not sick - or they do not need medications because they are not sick. How do you answer this patient? Can you give some examples?

7. Some patients will say they cannot eat, the food is poisoned, or "God will take care of me" or similar things. Has this happened to you? How did you handle this situation?

8. When patients tell you they hear voices, how do you respond? Can you give some examples?

9. Do you ever listen to how other staff members talk to patients so you can learn different ways of interacting with patients? Can you give some examples?

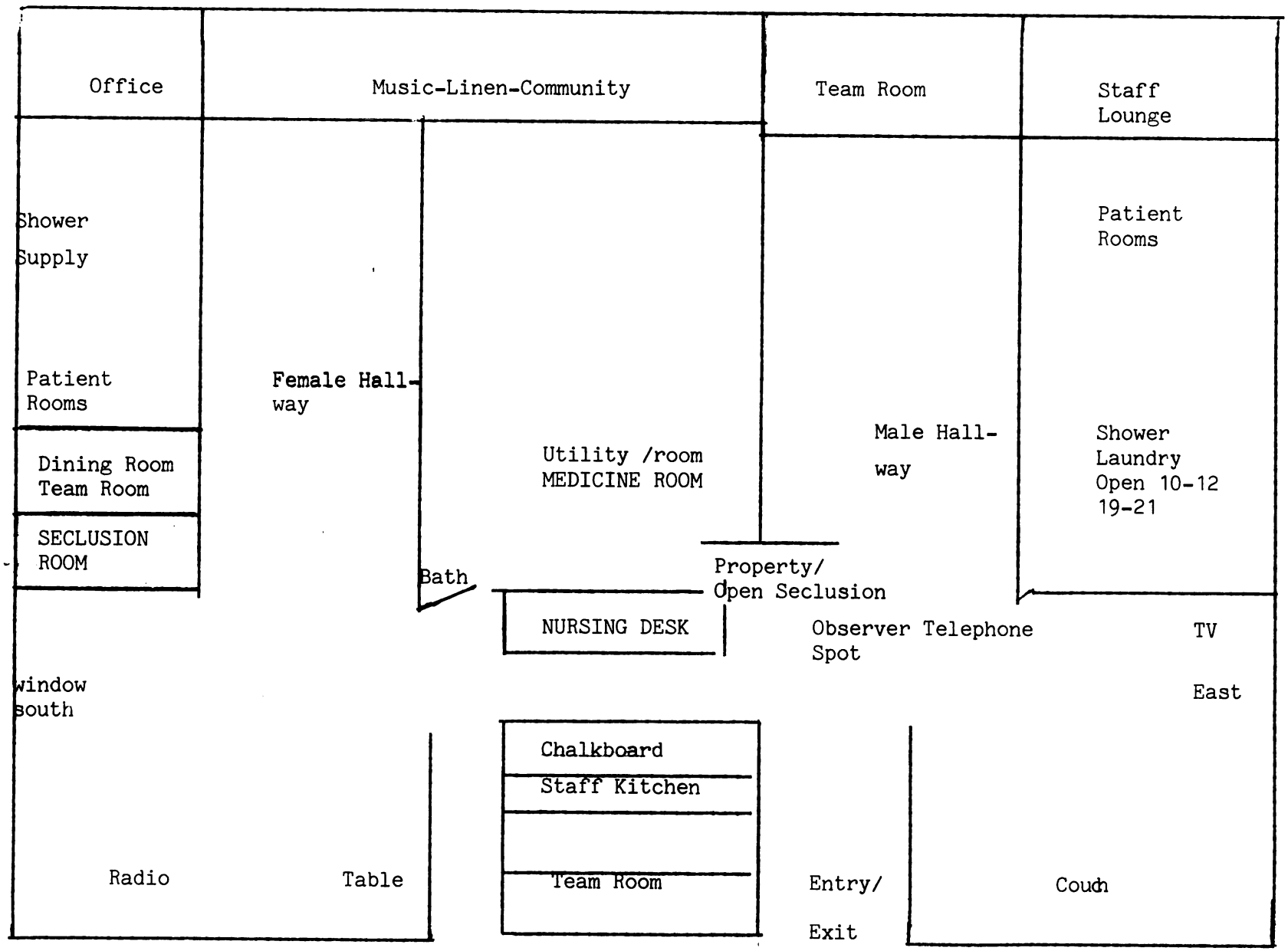
10. If you overhear another staff member talking to a patient in a way that increases the patient's frustration, anger, or psychotic behavior, what do you do? Can you give an example?

11. If you do not understand what a patient is saying to you, i.e. because he is rambling, tangential, etc., how do you respond? Do you ignore it, try and discuss it with him, discuss it with other staff members, or are there other ways of dealing with this type of situation?

12. Sometimes a patient will ask you or answer you in a very literal way, like if you suggest he take it easy or "cool it", he might say, "Do you want me to sit here?" (pointing to a chair) or "Do you want me to take a shower now?" Can you give some examples of what and why you did what you did?

APPENDIX E

WARD MAP


Office
Music-Linen-Community
Team Room
Staff Lounge
Shower
Supply
Patient Rooms
Female Hall-way
Patient Rooms
Dining Room
Team Room
SECLUSION ROOM
Utility /room
MEDICINE ROOM
Male Hall-way
Shower
Laundry
Open 10-12
19-21
Bath
Property/
Open Seclusion
NURSING DESK
Observer Telephone Spot
TV
window
south
East
Chalkboard
Staff Kitchen
Radio
Table
Team Room
Entry/
Exit
Couch

APPENDIX F

BOOKLET GIVEN TO PATIENTS ON STUDY WARD

UNIT PURPOSE

This unit is a therapeutic community that provides crisis intervention, evaluation, and treatment for clients. Participation in community life is emphasized. Participation means respecting each individual's space, attending unit activities, and assisting each other. Through participation one learns about taking care of one-self and living with others both here and outside.

ORIENTATION

1. ARRIVING ON UNIT
   a. When you arrive on the unit a staff member makes out a valuables list for you, including clothing, watch, etc.
   b. Vital signs such as blood pressure, temperature, pulse, and respiration will be taken.
   c. A room assignment will be made.
   d. The unit entrance doors are locked as some patients cannot leave without supervision.

2. CARE OF VALUABLES
   a. You are encouraged to send all valuables and large sums of money to the main property room.
   b. A small amount of money can be kept on the unit for you to use and may be locked in the medicine room.

3. GENERAL LAYOUT OF UNIT
   a. Bedrooms on the south side of the unit are designated as the female rooms, bedrooms on the north side are designated as the male rooms. Each room has a bathroom.
   b. Bedrooms can accommodate 2-5 patients. There are no private rooms.
   c. Shower and tub facilities are available on both the men's and women's hallway.
   d. Meals are served in a central dining room.

4. MEALS
   a. Meals are served at approximately 7:30 am, 12:30 noon, and 6:00 pm.
   b. Please assist at mealtimes by clearing off your place after eating.

5. COMMUNITY EXPECTATIONS
   a. Attend scheduled meetings and groups.
   b. Maintain your own living area (make bed, change linen as needed).
   c. Maintain personal hygiene by combing hair, showering, brushing teeth, etc.
   d. Visiting hours are from 2:00 until 8:00 pm. Hospital rules prohibit visitors under 16 years of age. Under various circumstances exceptions can be made through your primary therapist.

6. COMMUNITY MEETINGS
   Community Meeting is held every Mon., Wed., and Fri. from 9:00 to 9:30. These meetings are held so that staff and patients may discuss any issues concerning living and working together.

7. TEAM TREATMENT APPROACH
   Each patient is assigned a primary therapist. The primary therapist coordinates your treatment while you are on the unit. In addition to the primary therapist, a nursing staff member will be assigned to you throughout the day.

8. GROUPS PROGRAM
   Occupational therapy groups are included in the patient program to encourage self-expression and to provide learning experiences. The various activities are designed to help you gain insight about dealing with problems in a more constructive way.

UNIT RULES

1. Violence against person or property will not be tolerated.

2. We expect everyone to attend daily activities and groups.

3. No alcohol, drugs, or sharp objects allowed on the unit.

4. In order to promote a pleasant environment, all patients are expected to bathe and dress in street clothes and be responsible for making their own beds and cleaning their own area.

5. TV will be turned off during all patient meetings, groups, and activities.

6. Men and women cannot visit each other's rooms. Sexual activity between patients is prohibited.

7. Smoking is allowed only in the front two dayrooms from 6 am to 12 midnight. Patients are not allowed personal matches or lighters. Patients found smoking in unauthorized areas will have their smoking privileges restricted. If another patient gives a cigarette to a restricted patient, he/she will also lose smoking privileges.

THANK YOU FOR OBSERVING THESE RULES.

HOURS

Meals are served at 7:30 am, 12:30 noon, and 6:30 pm. After trays arrive on the unit you will have 45 minutes in which to eat.

Visiting hours are from 2 pm to 8 pm. Visitors are allowed in the two front dayrooms and dining room. All packages brought in will be searched. No children allowed on the unit.

Telephone hours are from 7 am to 11 pm. There are two public pay phones available for patient use.

Shower/tub times are 7:30 am to 12 noon and 7 pm to 9 pm. Razors will be given out during the am time.

TV hours	Sunday - Thurs.	7 am to 11 pm
	Fri. - Sat.	7 am to 12 mn
Laundry hours	10 am to 12 noon and 7 pm to 9 pm	
Bedtime	Sunday - Thurs.	11 pm
	Fri. - Sat.	12 mn

Group room will be closed at 9 pm and at other times according to staff discretion.

AS A PATIENT IN THIS FACILITY, YOU HAVE THE FOLLOWING RIGHTS:

A. TO WEAR YOUR OWN CLOTHES, TO KEEP AND USE YOUR OWN PERSONAL POSSESSIONS, AND TO KEEP AND BE ALLOWED TO SPEND A REASONABLE SUM OF YOUR OWN MONEY FOR CANTEEN EXPENSES AND SMALL PURCHASES

B. TO HAVE ACCESS TO INDIVIDUAL STORAGE SPACE FOR YOUR PRIVATE USE

C. TO SEE VISITORS EACH DAY

D. TO HAVE REASONABLE ACCESS TO TELEPHONES, BOTH TO MAKE AND RECEIVE CONFIDENTIAL CALLS OR TO HAVE CALLS MADE FOR YOU

E. TO HAVE READY ACCESS TO LETTER WRITING MATERIALS, INCLUDING STAMPS, AND TO MAIL AND RECEIVE UNOPENED CORRESPONDENCE

F. TO REFUSE CONVULSIVE TREATMENT INCLUDING SHOCK AND INSULIN COMA TREATMENTS

G. TO REFUSE PSYCHOSURGERY

PLEASE NOTE

Rights A-F listed above may be denied for "GOOD CAUSE". "GOOD CAUSE" for denying a right exists when the person in charge of this facility has good reason to believe:

1) that the exercise of the specific right would result in injury to yourself, seriously infringe on the rights of others, or cause serious damage to this facility,

and

2) that there is no less restrictive way of protecting yourself, others, or the facility.

If a right of yours is denied for "GOOD CAUSE", you must be told why the right is being denied and the reason for the denial must be entered in your treatment record.

IN ADDITION TO THE ABOVE, YOU HAVE THE FOLLOWING RIGHTS:

1. TO BE INFORMED OF THE MEANING AND CONTENT OF INFORMATION IN YOUR CHART.

2. TO BE GIVEN A COPY OF AND TO KEEP YOUR RECORDS UNLESS A PHYSICIAN OR ADMINISTRATOR RESPONSIBLE FOR YOU DECIDES IT IS NOT IN YOUR BEST INTEREST. IF YOU REQUEST A COPY OF YOUR RECORDS AND YOUR REQUEST IS DENIED, THE PERSON MAKING THAT DECISION MUST GIVE FORMAL NOTICE OF HIS/HER DECISION TO THE SUPERIOR COURT.

3. TO RECEIVE AS MUCH INFORMATION AS YOU NEED ABOUT A COURSE OF MEDICAL TREATMENT, INCLUDING A DESCRIPTION OF THE TREATMENT, ITS MEDICAL RISKS, COMPLICATIONS, AND SIDE EFFECTS, AND ALTERNATIVES TO THAT TREATMENT.

4. TO NOT HAVE SECLUSION OR RESTRAINTS USED AS A PUNISHMENT, FOR THE CONVENIENCE OF STAFF, OR AS A SUBSTITUTE FOR A LESS RESTRICTIVE ALTERNATIVE FORM OF TREATMENT.

5. TO THE LEAST RESTRICTIVE FORM OF TREATMENT: THIS MEANS THE LEAST RESTRICTIVE INVASION OF YOUR MIND OR BODY. FOR EXAMPLE: RESTRAINT MAY BE USED ONLY WHEN ALTERNATIVE METHODS ARE NOT SUFFICIENT TO PROTECT YOU OR OTHERS FROM INJURY.

6. TO BE FREE TO VOICE COMPLAINTS AND GRIEVANCES WITHOUT FEAR OF RESTRAINT OR INTERFERENCE.

7. TO TALK WITH AN ATTORNEY OR A PATIENTS' ADVOCATE AT ALL REASONABLE TIMES.

8. TO MAKE A REQUEST FOR YOUR RELEASE FROM THIS FACILITY TO ANY PERSON ON THE STAFF.

9. TO A WRIT OF HABEAS CORPUS. THIS IS A LEGAL DOCUMENT WHICH REQUIRES THIS FACILITY TO BRING YOU TO COURT AND PROVE WHY YOU SHOULD NOT BE RELEASED. YOU MAY BE HELD IN THIS FACILITY ONLY IF, AS A RESULT OF MENTAL DISORDER, YOU ARE DANGEROUS TO YOURSELF OR OTHERS OR GRAVELY DISABLED. GRAVELY DISABLED MEANS THAT AS A RESULT OF A MENTAL DISORDER YOU ARE UNABLE TO PROVIDE FOR YOUR BASIC PERSONAL NEEDS, FOR FOOD, SHELTER, OR CLOTHING.

If you believe any of the above rights of yours has been abused, withheld to punish you, or denied without "GOOD CAUSE", you have a right to file a complaint with your Patients' Advocate.

If you have any questions about your rights, or if you wish to file a complaint, PLEASE CALL:

PATIENTS' RIGHTS ADVOCACY SERVICES
2525 - 24th Street
San Francisco, CA 94110

Telephone: (415) 282-1777

An answering service will receive calls at night and on weekends.
An advocate will contact you as soon as possible.

APPENDIX G

PATIENT SCHEDULE

PATIENT SCHEDULE

MONDAY	8:00	NURSING ROUNDS	
	10:00	COMMUNITY MEETING	Day Room
	11:00	COOKING GROUP (OFF WARD)	OT Dept.
	2:00	CRAFTS GROUP	Dining Room
TUESDAY	8:00	NURSING ROUNDS	
	10:00	SMALL GROUP	Group Room
	11:00	CURRENT EVENTS	Day Room
	1:30	OCCUPATIONAL THERAPY OPEN WORKSHOP (OFF WARD)	OT Dept.
WEDNESDAY	8:00	NURSING ROUNDS	
	10:00	COMMUNITY MEETING	Day Room
	11:00	ART GROUP	Dining Room
	1:30	OCCUPATIONAL THERAPY SURVIVAL WORKSHOP (OFF WARD)	OT Dept.
THURSDAY	8:00	NURSING ROUNDS	
	10:00	SMALL GROUP	Group Room
	11:00	MEDICATION GROUP	Group Room
	2:00	MOVEMENT GROUP	Group Room
FRIDAY	8:00	NURSING ROUNDS	
	9:00	COMMUNITY MEETING	Day Room
	10:00	FRIDAY'S RESTAURANT (OFF WARD) . .	OT Dept.
	2:00	SELF CARE GROUP	Dining Room
SATURDAY	CHECK THE FRONT DESK CHALKBOARD FOR GROUPS		
SUNDAY	CHECK THE FRONT DESK CHALKBOARD FOR GROUPS		

PATIENTS ARE EXPECTED TO ATTEND ALL GROUPS. TALK TO YOUR PRIMARY THERAPIST IF YOU WANT TO ATTEND OFF WARD GROUPS.

PLEASE CHECK THE CHALKBOARD FOR CHANGES IN THE SCHEDULE.