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REALITY ON THE PSYCH UNIT:
THE ADAPTATION OF PSYCHIATRIC NURSES IN AN ACUTE CARE SETTING
by

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DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

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PREFACE

PSYCHIATRIC NURSING

IN TIME AND SPACE

In any society, past or present, there are individuals such as those we call mentally ill. These people behave in ways judged to be deviant or bizarre, according to the cultural norms of the group. Social responses to the behaviors and the performers vary. Each society deals with its disturbed, unproductive, or disruptive members in relation to its own wider community. Deviant individuals may be punished, banished, feared, encouraged as curious entertainment, pitied and protected, venerated and admired, tolerated, or simply ignored.

The approaches used in dealing with the mentally ill are affected by political and economic as well as social factors. Contemporary industrialized societies typically can afford and attempt to provide treatment. Approaches to treatment of mental illness reflect the social attitudes dominant in a given time and place. Prior to our present psychiatric era, American social responses to the mentally ill included phases of alienation, ritualized exclusion, isolation and confinement, observation and description, and diverse treatment approaches focused on work, rest, moral reshaping, and physical permutation.

The Expansion of American Asylums

Mentally ill persons in the colonial United States of America were

generally cared for within the family structure. Institutions provided custody for those without friends or family. After 1820 asylums were erected at increasing rates. These institutions removed the disruptive from mainstream society and provided self-contained sites where treatment and education might proceed in an orderly, disciplined environment.

Perpetuated by the functionalism of custodial care, asylums supplied relief to the community and care to the individual. But cure was not forthcoming. As the hope of mental cure dwindled, supporting public funds and numbers of asylum workers likewise declined. The situation was complicated by the many European immigrants who, as unprepared for adjustment to middle and late nineteenth century America as the native populace was to accept them, became institutionalized.

Poor houses and work houses eventually became unpopular. Yet the conviction grew that America's dangerous, dependent, and "defectives" required institutionalization. Asylums became large and convenient dumping grounds for acute, chronic, and well (albeit unwanted) members of society. Madness was increasingly viewed as both irrecoverable and contagious. The role of mental medicine became less to cure and more to justify social exclusion through certification of insanity.

The Development of Professional Nursing

Establishing the most appropriate way to care for the ill represents a perennial human dilemma. Nursing behaviors are ages old, but nursing as a profession is a product of the late nineteenth and twentieth centuries. Both general nursing and mental nursing, as

psychiatric nursing was known, were developed in response to a need for institutions to provide socially acceptable levels of care.

The European tradition of nursing care developed by early religious organizations nearly disappeared in the wake of the Protestant Reformation. By the nineteenth century, care was left to whatever paupers, drunkards, patients, or others who were willing to make a living at such tasks. Meanwhile, concurrent with the Industrial Revolution, health conditions in many areas deteriorated. The situation was ripe for reform when Florence Nightingale established her first school of nursing in 1862. Nursing of the physically sick and wounded proceeded to develop somewhat separately from that of the mentally ill.

The Development of Psychiatric Nursing Education

Early asylums in the U.S. provided no systematic training to their workers until 1880, seven years after the first class graduated from an American nursing school and Linda Richards went to Europe to study Nightingale's methods. Earlier attempts to establish training schools in asylums had buckled under a movement away from isolated institutions and toward general hospitals, but, as asylums became hospitals, many opened training schools. Although initiated by mental hospitals, the nursing courses provided by these institutions trained for general, not specifically mental nursing.

By 1900 there were thirty-five training schools attached to American institutions for the mentally ill. Despite this proliferation, the output did not necessarily supply hospitals with

graduate nurses. As late as the 1930s and 40s, there were large psychiatric hospitals with no trained nurses on staff.

The shift from non-professional, uneducated staff to trained and professional personnel has not been smooth. Several historical changes drained well-trained nurses from hospitals. There has been recurrent resistance to further professionalization of nursing in favor of dependence upon less expensive common sense approaches to care. Nursing has also experienced almost continuous disagreement over the training process for nurses. The first half of the century saw the development of vocational, diploma, baccalaureate, and graduate programs in nursing. Its multiple entry levels remain a divisive feature in the discipline today.

Most early nurse training programs served to provide staff for the hospitals which supported them. Essentially apprenticeships, they offered opportunities to acquire skills in exchange for staffing. As the trend toward general hospitals influenced nursing curricula in the direction of medical schools, it was decided that training should be generalized and standardized; specialization would come with post-graduate experience. All students worked for periods of time in medical, surgical, obstetrical, and mental institutions in preparation for roles that required increasing flexibility. As affiliate programs depleted staffs composed in large part of trainees, increasing numbers of graduate nurses were employed to provide staff stability and patient care. Nursing teachers, meanwhile, became instructors. They were no longer primarily role-modeling practitioners.

The Development of Psychiatric Nursing Roles

The restraining keeper role gradually gave way to that of trained nurse, albeit one who still had non-nursing chores ranging from bedmaking and linen-counting to grave-digging. Oriented toward ward management and key-keeping, the nursing role remained mechanistic, custodial, and subordinate to physicians. Nurses attended primarily to the physical needs of patients and did not attempt systematic interpersonal work with them. As new methods of treatment were developed, nursing served to implement them.

Turn of the century psychiatry was primarily descriptive. Into this passivity, Freudian psychology thrust recognition that observation of the patient was not enough. Interpersonal and emotional dimensions of mental illness began to be more vigorously explored. In the 1930s, psychoanalytic theory became part of medical school curriculum and began to be practiced on some psychiatric units. The large numbers of severely impaired patients, however, inhibited widespread therapeutic application of psychoanalysis. Other clinicians, meanwhile, conceptualized mental illness as a biological dysfunction. Encouraged by the need to treat many patients at once, new somatic therapies stimulated revision of psychiatric nursing roles, although these roles were not necessarily more active or therapeutic.

Wards became more manageable with the control exerted over patients' behavior by somatic treatments. Patients were also more available for interpersonal relationships. The focus of nursing in mental hospitals shifted from physical care to the creation of an environment which would contribute to the patient's recovery and be

amenable to the interpersonal relationships that were the focus of dynamic psychiatry. As training programs and roles changed, mental nurses had fewer menial tasks than before, yet they still had limited training in psychological nursing skills. Therapeutic roles for nurses did not develop until the Second World War propelled psychiatric nursing into higher academia.

World War II presented the shock and challenge of millions of psychiatric disabilities and selective service rejections. Mental illness gained recognition as a national problem. Military requirements prompted an exodus of trained personnel from mental hospitals, again leaving non-professionals in charge. Nurse training programs were intensified and shortened. A larger number of men entered the traditionally female profession. In 1946 the National Mental Health Act created the National Institutes of Mental Health (NIMH). With new research, training, and applied programs, graduate education became available for psychiatric nurses. Multidisciplinary teams formed, and psychiatric nursing techniques developed.

Based in large part upon Hildegard Peplau's delineation of the nursing role, nurses began to use interpersonal therapeutic techniques with individuals and groups in a variety of settings. Clinical psychiatric nursing revolved around nurse-patient relationships, therapeutic interviews, and the participant observer role. In work with patients, the idealized psychiatric nurse was active, knowledgeable, and knowledge-seeking. This individual was a scientific observer, created a therapeutic environment, fostered socialization, and functioned as a psychotherapeutic agent.

With Peplau's reconception of the nursing role as psychodynamic, nursing focused on wholeness. Social sciences began to be recognized as valued and necessary in the preparation of nurses who were to treat each patient as "a whole person." NIMH training grants stimulated the integration of mental health concepts into basic nursing training. By 1955 all undergraduate nursing programs were required to incorporate some psychiatric nursing into their curricula. Despite the optimism of the time, however, back wards proliferated and therapy remained only selectively available.

The pre-1930 trend toward expansion of state-supported facilities was sharply reversed after 1950. As the Great Depression undermined beliefs about deviant and dependent groups in the U.S., society became less enthusiastic about total institutions. Public psychiatry, demonstrating trends toward more equitable access and entitlement to services and increased patients' rights, became more sensitive to social variables. In a complicated interplay of politics, medicine, and economics, the locus of care changed from in-patient to out-patient settings. As public poor houses had once given way to large institutions, these in turn conceded to an expansion of community-based services. The community mental health movement in effect deinstitutionalized numerous nurses along with patients as the latter were shifted in location, while their numbers and needs remained unchanged.

Psychiatric Nursing in the 1980s

Nurses today are the largest single group of health professionals

in the U.S. Despite the continued trend toward health-focused care in the home and community, more than sixty percent of American nurses work in hospitals. There they provide the only around-the-clock professional presence. A relatively small percentage of these specialize in psychiatric nursing, which in the 1980s is part of a complex subculture of psychiatry and mental health.

Psychiatric deinstitutionalization followed a long history of institutional confinement and tranquilization. Operationalized through psychiatry, deinstitutionalization provided political and economic reprieve for overextended state governments. Justified as humanitarian, the new ideology held that institutionalization and custodial treatment had resulted in dependent and socially isolated patients, and, therefore, community-based care could alleviate such limitations.

The community mental health system, idealistic but in some ways unrealistic, was launched. It was soon obvious, however, that decentralization fragmented understandings of needs, goals, and means; that even social psychiatry was unprepared to resolve the deeper problems of an ethnically, racially, and economically stratified and highly mobile society; and that the movement was being imposed upon communities which remained unreceptive to the numerous individuals still labeled by psychiatry as "sick."

The system and its patients, doublebound by dependence upon a pharmaceutical "fix" which controls psychotic symptomatology but deters social acceptability, continue to be shaped by economic and legal constraints. A product of rationalistic, individualistic, and

scientific American culture, the social values reflected in the community mental health movement tend to promote patients' rights without ensuring appropriate support and protection, to perpetuate paternalistic and stigmatized low status for sick and relatively unproductive members of society, and to employ an efficient but dehumanizing mechanical approach to systemic repair in lieu of problem resolution involving individual attention, social support, and rehabilitation. Accompanying this is a swelling population of acutely ill deinstitutionalized and never-institutionalized patients who are admitted for short term care from community mental health centers to general hospital psychiatric units. Often these admissions are serial, with the hospital serving as a "revolving door" to crisis-oriented admissions and hurried discharges.

Although in-patient and out-patient facilities are components of the same community mental health system, the challenge of modifying institutional patterns and subcultural norms in well-established hospitals has resulted in social organizations that are distinct in terms of complexity, flexibility, and perspective.

Psychiatric/mental health nursing reflects these differences and others. Diverse subroles emphasize a melange of medical or psychosocial approaches to treatment and care, liaison work with a variety of disciplines and branches of nursing, mental health and/or community health as well as traditional psychiatric settings, multiple approaches to dealing with stress and adaptation, and a host of psychological and psychiatric theories. With roles focused on either acutely or chronically ill patients, nurses use tools which range from

technologically sophisticated machinery to themselves as the primary instrument in counseling, social support, and patient education.

In some institutions the substantial body of nursing knowledge developed by clinicians and researchers has led to nursing roles directly involved in patient therapy. In other settings such role expansion has not occurred. This is in part because nursing has focused its theoretical development on patient care, and not on knowledge and strategies for the exercise of leadership and authority.

Contemporary psychiatric nursing informally distinguishes itself from that based in the community and oriented predominately toward mental health rather than illness. Members of the psychiatric subdiscipline tend to follow psychiatry's lead, ideologically positioning themselves along a medical-social continuum, although the hospital-based and disease-oriented medical perspective at times rings incongruent with nursing's focus on health. More demanding than the various degrees of differentiation from mental health nursing, however, is psychiatric nursing's grapple with polarization from pathology-oriented medicine, the most powerful institution in the social organizations in which most nurses are employed. Nursing's struggles for independence and for support of a philosophy of health and care are recurrent themes in the chapters that follow.

Psychiatric Nursing: Status and Image

A young profession, nursing has always been in a state of flux. In scarcely more than a century the discipline organized and developed a diverse clinical practice; learned to generate, adapt, and

operationalize theoretical frameworks; and became involved in the movement toward equal human, civil, and women's rights.

During the late Victorian era, society was poised to replace the stereotype of the poor untutored nurse. The nursing reform movement and its surge of training schools sought to convince the world that nursing was a positive and respectable occupation and nurses a special kind of people. Nightingale emphasized the nurse's development of both knowledge and character. Descriptions of early training programs portray para-military organizations with finishing-school overtones. Nursing, both in preparation and performance, was challenged with preserving cherished attributes of femininity, while American society in general experienced rapid social and cultural change.

Psychiatric nursing's later emphasis on interpersonal relationships reinforced concerns regarding the character of nurses. Again it was put forth that the kind of person the nurse was made a significant difference in patient care. It was the responsibility of nursing and of nursing education to foster personality development and maturity in nurses. Typically this reinforced those traits traditionally considered virtuous in women. While the public was being socialized to depend upon allopathic medicine, nurses learned nonassertiveness. The traditional nursing subculture signified passivity, deference, compliance, and dependence upon others for rewards and sanctions.

The acceptability, status, and achievement of nursing roles changed for the better in the late nineteenth century with the discipline's formal organization and standardization. By the mid 1930s, psychiatric nursing was viewed as a separate and specialized part of organized

nursing. The subdiscipline evolved, benefiting from the theoretical foundations of philosophy, psychology, psychiatry, and general nursing. In 1920 psychiatric nursing's first textbook was printed; within four decades specialty journals were well established. Although numbering only about five percent of all American nurses in the 1970s, psychiatric nurses held one-third of the positions in nursing graduate programs. Model psychiatric and mental health nursing roles emerged as increasingly autonomous. The idealized new image was upwardly mobile, decisive, assertive, and defensive of individual rights. This image, however, remains tenuous due to the powerlessness of nursing in general. The handmaiden image persists in society, which has never clearly distinguished nursing care from medical treatment.

Nursing is further affected and its image confused by the discipline's multiple levels of academic preparation. Assessing a broad knowledge base as necessary to provide a variety of interventive modes, the American Nurses' Association in 1965 pronounced the baccalaureate degree as the basic educational level for all professional nurses. Distinctions between levels of nursing preparation are sometimes not made at the level of practice, however, and the discipline continues to contend with problems arising from nurses' varied levels of technical and theoretical expertise.

Nursing's public image is in large part derived from its hospital roles. What glamour the discipline projects is countered in the homogenizing media with connotations of stress, underpayment, poor working conditions, routinism, widespread dissatisfaction, diminished commitment, and traditionally feminine stereotypes. The psychiatric

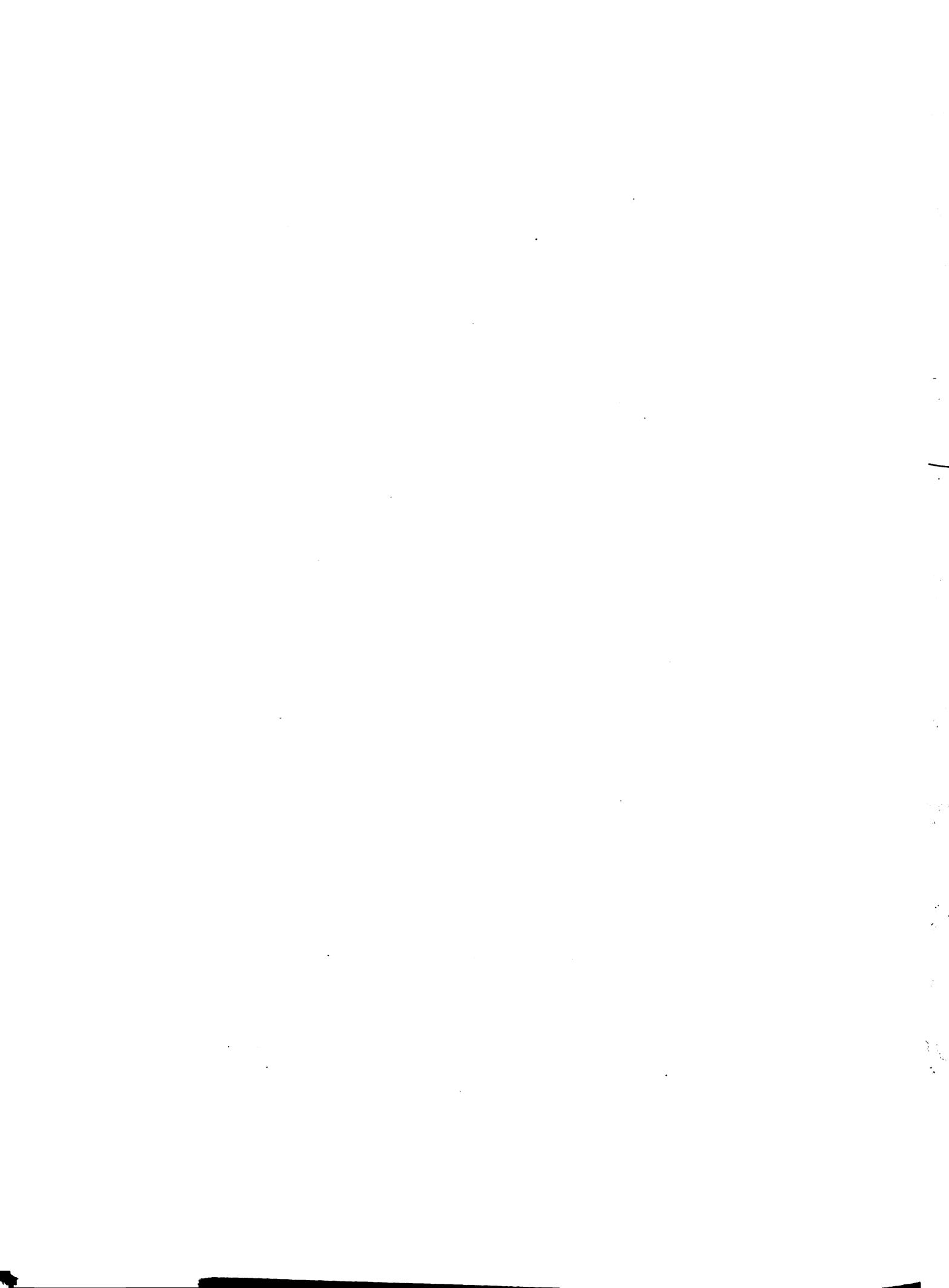
specialty lacks the clear-cut roles and life-saving drama of some aspects of nursing. Its practitioners deal often with unsettling and fear-provoking people, behaviors, and conditions. The failure of nursing to attract positive and supportive public attention is reflected in the lack of a comprehensive written history of its psychiatric subfield within the broader contexts of the mental health sciences and practices, organized nursing, and the overall health care system.

In nursing's concerted effort to upgrade its status and image, nursing history has glorified primarily the good names of the elite members of the occupation (see, for example, Buckwalter and Church 1979 and Church and Buckwalter 1980). The daily work of the average nurse at ward level is seldom acknowledged or closely examined. It is the "rank and file" of psychiatric nursing to whom, with respect and appreciation, this work is dedicated.

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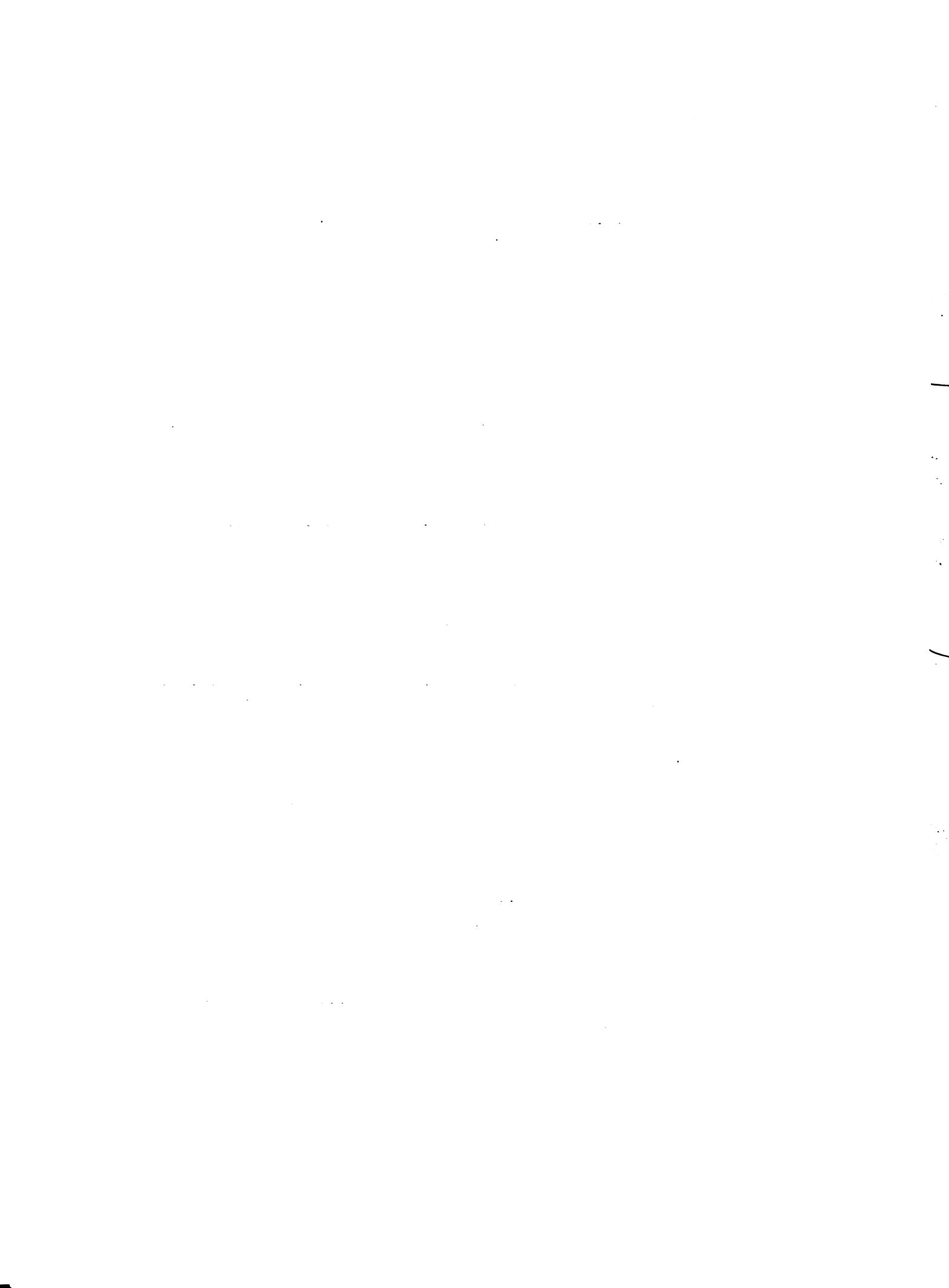
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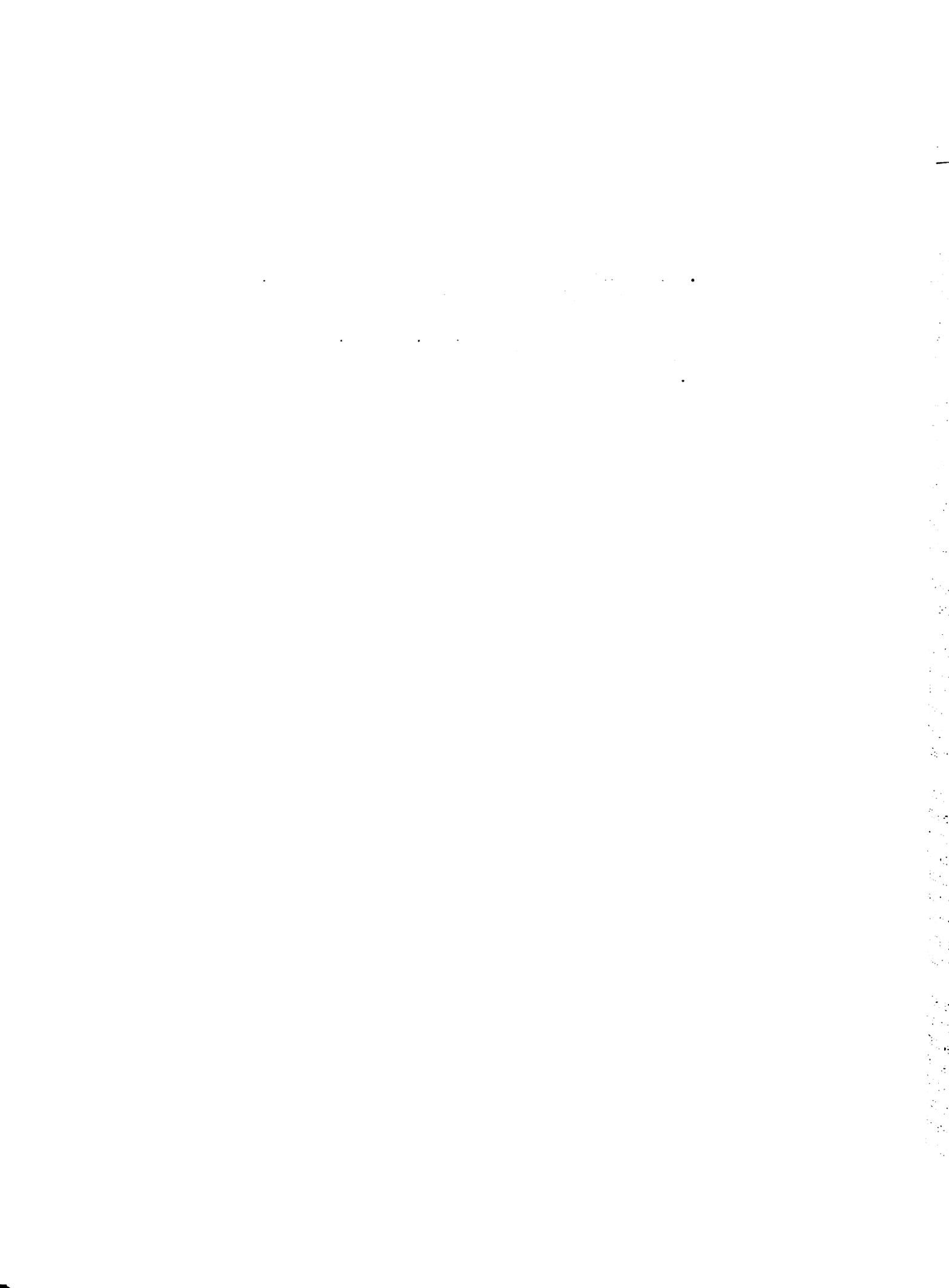


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REALITY ON THE PSYCH UNIT:

THE ADAPTATION OF PSYCHIATRIC NURSES IN AN ACUTE CARE SETTING

Kathryn Hopkins Kavanagh

Attrition, burnout, turnover, management problems, and job dissatisfaction are frequently encountered among Registered Nurses (RNs). The majority of nurses, however, do not leave the discipline. The focus of this study is the manner in which some RNs modify nursing and themselves to achieve workable balances between the public (work) and private aspects of their lives.

Data pertaining to the experience of practicing occupational nursing were elicited with an emphasis on those aspects perceived by the nurses and/or observed by the researcher to be stress-provoking and/or associated with coping and adaptation. Participant observation and in-depth, focused interviewing were the primary research methods used for an ethnographic study focused on adaptation. The qualitative strategies were supplemented with demographic statistics, attitudinal questionnaires, and network analyses.

The research setting was the psychiatry department of a large, urban, American, general hospital referred to as City and County. In this public facility, psychiatric in-patient units provide intensive care and brief hospitalizations for suicidal, homicidal, or gravely disabled adults. Staffing and resources are chronically limited. Rewards for seniority are more prominent than those for experience, competence, or education. Hierarchical and communication systems are complex and constraining. Pay is comparable with other facilities in the area, on the other hand, and above average for nursing.

Nursing of acutely ill patients is demanding. In addition to the intensive emotional involvement associated with psychiatric nursing roles, hospital-based RNs must integrate nursing's health-oriented ideology with psychiatry's orientation toward disease. Lay and professional belief systems are adapted to formulate workable explanatory models allowing operationalization of nursing roles. Explanatory models used by the nursing staff were elicited. Roles of therapists, administrators, and non-RN nursing personnel were examined in relation to those of the nurses.

Nurses are usually studied as occupants of health care provider roles and not as people who also have private lives. In this study the informants were viewed as individuals with activities, roles, and interests beyond the boundaries of their occupations and the facility by which they are employed. Ways in which psychiatric nurses at City and County integrate their public, occupational careers with their private careers were explored. Of particular interest are relationships with others in the work setting and in private life.

Approved 6/12/86
M. Margaret Clark

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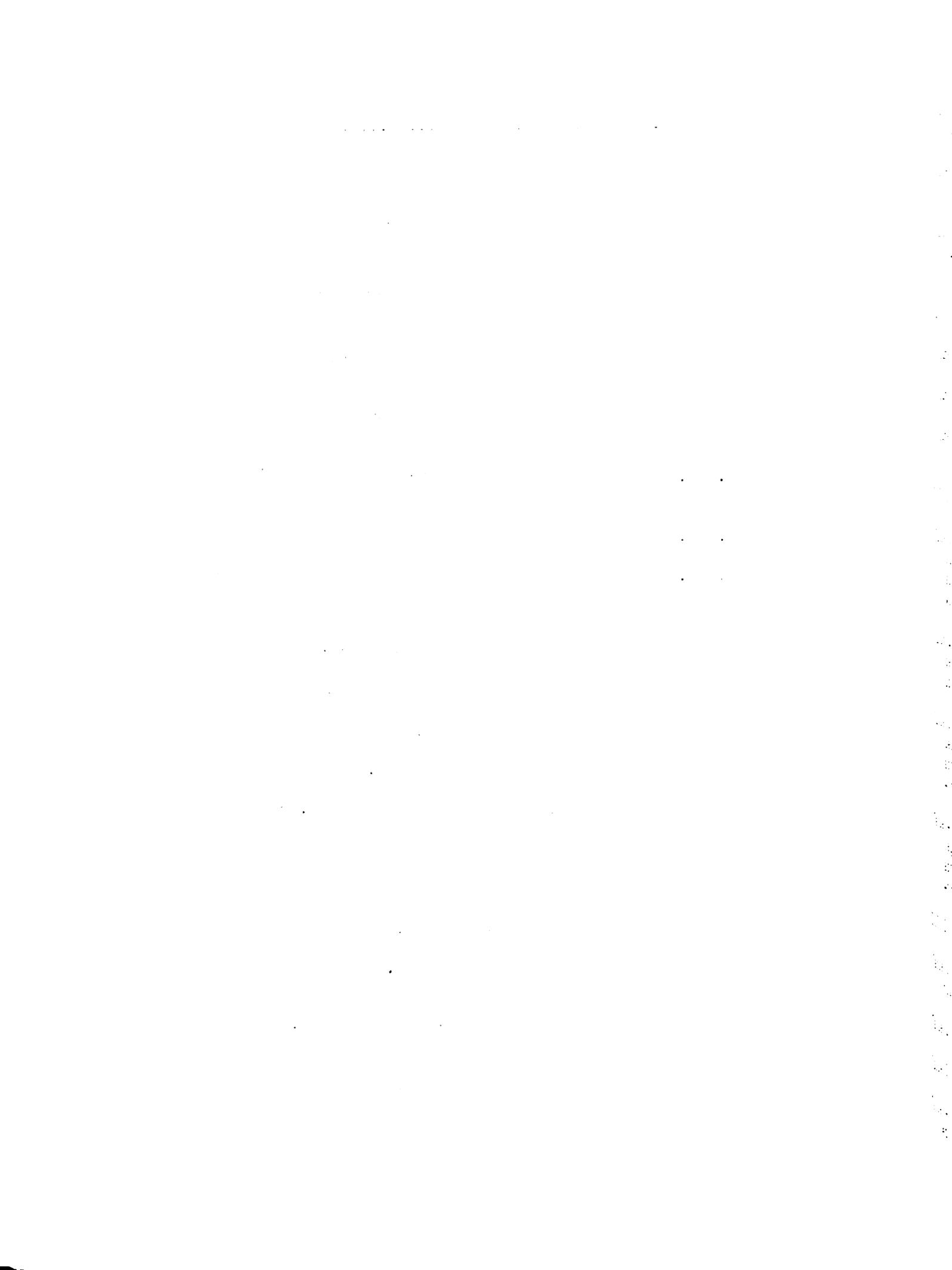


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CHAPTER 1

FRAMING THE STUDY

"Experience without theory is blind
but theory without experience is mere intellectual play."
Kant

Introduction

The traditional domain of anthropology involved societies and cultures unlike those of modern North America. In recent years, however, changes in emphasis and opportunity have encouraged the "pursuit of anthropology at home" (Messerschmidt 1981). With new interest in life in industrialized societies, many anthropological studies are now set in cities. The research approach and the goal, that is, the study of culture and society through observations in the natural setting, remain unaltered despite the change of site.

Hospitals can be viewed as distinct subcultural settings. The people within them share specific commonalities. City and County is the name given here to a large, urban, American general hospital. Within this sprawling medical complex, one department specializes in providing in-patient psychiatric services. Nursing staffmembers who work in psychiatry are hired by that department and do not work elsewhere in the hospital. The experience of individuals within this environment is the focus of the research reported here. Understanding the rules, roles, and relationships characteristic of such a setting requires analysis of the total context in which they occur.

The Theoretical Framework

Medical anthropology is almost by definition ecologically oriented (Foster and Anderson 1978). Ecology provides a background for an interdisciplinary perspective with which people are viewed as multidimensional (that is, biopsychosocial (Engle 1977)) beings who interact constantly with and within ever-changing environments. These environments may be internal or external, physical, psychological, or sociocultural. A relationship between an individual and his or her environment may involve, for example, a transaction between two or more persons, between a person and the physical situation, or between more than one intra-individual system.

Ecology implies a dynamic, changing, reciprocal impact between people and all elements of their surroundings. With consideration of multiple influences, the limitations of simplistic cause and effect relationships can be avoided. Understanding adaptation requires attention to the processes by which interactional and phenomenological responses are formulated by individuals and groups who utilize innate and learned processes to cope with, adapt to, and modify environmental constraints and opportunities.

Human communities, although not planned, are organized. Cultural beliefs and values are reflected by a group of interrelated and interdependent people (Leininger 1970) in conventional norms which constitute socially structured patterns of action (Shibutani and Kwan 1965). The study of social organization is more realistic than is that of social structure because it allows examination of alternatives among the real working arrangements of society. These include, for example,

the ways in which choices are made, resources used, and decisions rendered on a probable cost-benefit basis (Firth 1964). The underlying assumption is that each individual performs in the ways he or she assesses as most feasible.

The nurses at City and County compose a group linked by occupational ties. This provides a structured model in which specific realities can be examined through a phenomenological approach designed to describe human experience as it is lived. Of integral importance are adaptive strategies developed as responses to specific conditions. These acts of choice and decision systematically order and reorder social relations. Changes in structure and organization are the consequence of behaviorally expressed reinterpretations and modifications.

People interact in terms of the conceptions that they form of themselves and one another. Of particular relevance in this research are interpersonal dimensions as they relate to models of idealized and performed behaviors. Despite this emphasis, variables are not limited to that sphere. Human adaptation has biological and psychological as well as sociological and cultural dimensions. Relationships within the total environment create a multifaceted collage of components with dynamic qualities. Individuals, and groups, are both agents of change and respondents.

Adaptation

Adaptation involves all conscious and unconscious forms of adjustment to actual or supposed environmental conditions (Martin and

Prange 1962). In the synthesis of a tolerable fit between an individual and environmental pressures, adaptation requires coping capabilities, the motivation to meet demands and/or to utilize opportunities, and the ability to maintain a psychological state that allows energy and skills to be directed toward meeting those activities (Mechanic 1974).

Each part of the multi-dimensional individual is involved in adaptation. Physiological processes energize and mediate between interior and exterior environments. Psychological adaptation involves multiple conscious and unconscious processes related to perception, interpretation, ideation, and learning. The sociocultural level implies interrelationships with other environmental objects and events.

Adaptive measures vary widely. They include approach and/or withdrawal responses, rearrangement of systemic parts and the use of alternative functions such as conformity, and alterations of the environment. What strategy or strategies are most feasible depends on the specific circumstances of the individual and the environment. Short-term adjustment behaviors temporarily enhance the fit between an individual and an immediate situation (Daniels 1970). This allows time to be gained, but in the long run may be either positively or negatively adaptive.

Adaptive processes involve attempts to balance threatening and frustrating environmental factors with stress management and need-gratifying skills (Carroll and White 1984). Adaptive efforts and their consequences may themselves be stress-provoking. Illness, for example, is conceptualized as a breakdown in an organism's

environmental adaptation. Such episodes tend to cluster during periods perceived as stressful (Engle 1971, Frank 1974).

Humans are generally characterized by resilience, a persistent inclination toward wholeness and balance (Murphy and Moriarity 1976). Despite immense adaptability, however, adaptive potential is limited. Environments, interior and exterior, can change too rapidly for adaptive processes to keep pace (Dubos 1971). The goal, nonetheless, is to achieve and maintain a condition of dynamic but relatively stable balance between environmental resources and demands. Linkages with valued others and self-esteem as a necessity for successful handling of stress-provoking circumstances are central to understanding these phenomena (Hamburg and Adams 1967). A positive social adaptation allows, for example, meaningful and satisfying integration with and participation in society through adequate social identities and opportunities for development (Hirsch 1981). A less healthy outcome reflects an insufficient repertoire of developmentally appropriate identities and leads to failure to achieve adequate expression and support in the social environment (Hirsch 1981).

Another notable human trait is the diversity which results from wide variability among ecological relationships. Situations are differentially interpreted. This heterogeneity represents varied, equally valid definitions of the situation, rather than contradictory sets of facts (Bennett 1946, Berreman 1966).

Stress and Coping

What is important about any experience is its significance to an

individual and how he or she deals with it. A point of juncture among various biological, psychological, and sociocultural approaches, the concepts of stress and coping are relevant to the study of complex interrelationships between individuals and their environments.

A tendency persists in the literature pertaining to stress and adaptation, as well as in that describing occupational nursing, to focus on sources of problems, dissatisfactions, and maladaptation. There is a need, however, to study sources of strength, support, coping, and resilience as well. A goal of this study was to delineate factors related to coping as well as to stress in the adaptation of individuals engaged both in nursing roles within a specific workplace and in other roles elsewhere.

Stress states are conditions that are perceived as significant and at least in part beyond individual control. These are not limited to major events and include routine environmental occurrences as well. Related variables, in addition to frequency, are intensity, duration, complexity, familiarity, predictability, shape, and conflict associated with the experience (Marsella and Snyder 1979). Stress is not by definition negative; the experience is also the medium for challenge and opportunity.

The conscious or unconscious appraisal of a situation as threatening (that is, stress-producing) depends on motivational characteristics, belief and value systems, intellectual and physical resources, education and sophistication, and other individualized characteristics (Lazarus 1966). Stress-related transactions with environments are mediated psychologically through cognitive processes

such as perception, thought, and judgment. Whether originating from within or without, situations appraised as stress-provoking imply expectations of response oriented toward adaptation.

Coping refers to goal-oriented, problem-solving behaviors which are mobilized when stress-provoking experiences interrupt a plan of action. Designed to alter person-environment transactions, coping behaviors provide protection from problematic experiences by making available the means to eliminate or modify conditions (Pearlin and Schooler 1978). This may involve neutralizing their problematic characters or adjusting emotional responses (Pearlin and Schooler 1978). Such adjustments are internal and/or external. Coping styles and outcomes vary widely (eg., Glittenberg 1981, Graves and Graves 1979).

Hospital units specializing in treatment and care for mentally ill individuals present unique settings. Locked wards provide a vast potential for the experience of stress-producing circumstances and for the utilization of coping behaviors. It is traditionally nursing's task to orchestrate, within these cloistered miniworlds, what may amount to interactive cacophony. Normal everyday rules for social exchange cannot be taken for granted. Staffmembers often experience, for example, minimal or distorted reciprocity in their relationships with patients. The extent to which social realities are shared may be noticeably limited.

Predictability in the psychiatric setting is limited, while unpredictability is associated with decreased tolerance for subsequent stresses and with impaired performance (Glass et al. 1969).

Stratified rankings of participants in various hierarchical subsystems result in inequitable distributions of status and power (Berreman 1981). These factors strongly influence experiences and behaviors at City and County. They and other stress-provoking as well as coping phenomena are discussed in subsequent chapters.

Interaction: Roles

Within an ecological and adaptive framework, the study of social organization focuses on acts, meanings, roles, persons, and collections of persons acting together as units. Social science has long held that the workings of society depend upon reciprocity between its members (Mauss 1925). The differentiation of status and role (Linton 1936) built upon that basic premise. Status involves a collection of rights and duties relative to positions in patterns of reciprocal behavior. Roles are social identities that are fixed within social structure and in which behaviors are learned in reciprocal pairs. Roles represent the tasks socially allotted to each individual. As such, roles represent the dynamic aspect of status (Linton 1936).

This conception of roles provides a foundation for understanding how individuals relate to environmental systems. In conjunction with a view of identity as a social phenomenon (Mead 1967), roles came to be seen as defined, created, stabilized, or modified in the process of interaction between oneself and others. Role-taking is viewed as a process by which actors attempt to organize interactions so that each person's behavior expresses a consistent orientation. A role takes meaning from the way in which other actors deal with similar

orientations. This perspective allows a dynamic, interactional view of behavior as responsive to self-interest, and not simply obedient to societal norms. Actors tend to behave as if there are roles, yet roles involve people responding to social situations according to their own interpretations of those situations. Individuals indicate (for example, by speech and demeanor) the roles that they have in mind for themselves, although others may or may not respond in kind.

Interaction: Social and Symbolic

Viewing interaction as symbolic deals with conceptions of self and the construction of meaning in social life. Basically phenomenological, interactionism examines the relationship between meaning and behavior, and the implications of this relationship in the social construction of everyday life. Social interactions are sets of typical patterns of reciprocal behaviors within spatially and temporally structured everyday life (Berger and Luckman 1967, Schutz 1973). It is assumed that the integration that is found in individuals and society is based on ever-changing relationships, rather than on inherent tendencies of a homeostatic character (Rose 1962).

Arrangements of people interlinked in changing actions (that is, socially organized), form a framework within which social action takes place (Blumer 1969). Group process involves a build-up of joint actions. Social organization actually affects action only to the extent to which it shapes situations and supplies the symbols used for interpretation (Blumer 1969). Each individual, unique in biography and perspective, interprets and interacts in situations according to

his or her own life experiences (Berger and Luckman 1967, Natanson 1973, McNall and Johnson 1975). All social objects and events are interpreted as having meaning, that is, as "definitions of the situation" (Rose 1962). The situation is defined, for example, when there is agreement among participants regarding which activities are proper and relevant, and which expressed selves are appropriate (Braroe 1975). Socially constructed reality involves a practical agreement among individuals to act as if they share the same understanding and perspectives.

Relationships develop when role-taking occurs between persons. The participants attach to relationships values along continua from high to low and from positive to negative. George Herbert Mead called reference relationships "significant other(s)" (Strauss 1956), although that term is misleading because it does not acknowledge that the other may be oneself, or an object, or that relationships may vary widely in significance. Social reality is sustained through ongoing communication with others. This involves the ways in which an individual views him or herself and others (Berger and Kellner 1970).

Erving Goffman used theatrical performance as a metaphor for social interaction. This variant of the interactionist perspective emphasizes impression management, that is, how individuals guide and control the impressions which others form of them. Interacting individuals attempt to sustain their performances the way an actor presents a character to an audience, that is, by playing a role (Goffman 1956, 1967, 1969, 1974). Unique as an interactionist for his consideration of power relationships, Goffman examined presentation and avoidance behaviors in

social intercourse through symmetrical or asymmetrical, formal or informal, and substantive or ceremonial rules of conduct and content. His emphasis on "underlife" and "backstage" components in social interaction focused attention on previously taken for granted levels of action and organization in individual responses to social situations. Goffman also described the impact of status differentials in impression management when the willingness to give others deference may conflict with one's own self-respect (Goffman 1961, 1963). Each of these considerations is relevant to the study of psychiatric nurses and nursing at City and County.

Assessment of the Approach

An ecological perspective emphasizing adaptation presents individuals as interacting with and within internal and external environments. Generally resilient and adaptive, healthy persons attempt to achieve a tolerable fit between demanding situations and the resources available to them. At an individual level, behavior is interpreted through subjective meanings, definitions of interactive situations, and performance of interactive roles. Behavior is assumed to be self-directed and observable at both the symbolic and interactional levels. Analysis attempts to capture the symbolic meanings that emerge over time in these interactions.

This approach is logically consistent with the basic propositions of the social sciences: the psychic unity of mankind, extreme cultural variability, human creativity as well as capacities for socialization and for change, and the species' capacity to feed back complex

modifications to behavior without resorting to trial and error or conditioning (Kuhn 1964). The emphasis on the situation fits well with anthropology's focus on the contexts in which behaviors occur.

Alone, the symbolic interactionist perspective is limited in several respects. The approach neglects biogenic and psychogenic influences on behavior, and unconscious processes in behavior. Symbolic interaction is for the most part not quantifiable. It is also realistically limited to the study of small groups. Interactionism complements well, however, the broader framework within which the cultural scene, the material circumstances, social organization, and meaning are examined.

The naturalistic approach of anthropology, in combination with orientations toward adaptation and interactionism, allows the flexibility necessary to avoid narrow interpretations. Armed with such a stance, an investigator can hope to take on the challenge of defining a methodology that combines "rigor and insight, verification and discovery, accuracy and empathy, replicability and human relevance" (Berreman 1966: 350).

Significance of the Study

The time is past when "knowledge for knowledge's sake" was a sufficient rationale for social science (Spradley 1980). Contemporary anthropology links theory with action, and past experience with present needs. It is often issue-oriented or "applied" (Foster and Van Kemper 1980).

This study deals with realities of everyday nursing practice.

Surveys and numerical summaries are employed only within a framework of descriptive analysis. Although ethnographic studies of psychiatric wards have been done from a variety of approaches, none has previously communicated the experience of nurses in that type of setting.

In a sense analogous to nursing's front-line advocacy of groups otherwise overlooked, ethnography has the potential for humanizing stereotypes in a credible way (Agar 1980). Through descriptive analysis, group characteristics can be clarified and made understandable. A medium for describing nursing practice as it is viewed from various perspectives, such analyses caution against tendencies to attribute causation or to place blame for problems. When a group of people is humanized through exploration and presentation of the realities with which they live, a vehicle is provided for increased understanding by those external or marginal to those circumstances.

Problems must be identified before they can be managed or resolved. Management issues, burnout, and attrition are common in nursing. Those, like many of the phenomena examined in this study, are not peculiar to the psychiatric subdiscipline; they are prominent throughout occupational nursing. Most nurses, nonetheless, do not leave the field. It is important, therefore, to examine reasons for continuing behaviors as well as for changing them.

It is widely accepted that people take care of themselves and others in many different ways (Leininger 1978, Aamodt 1984). Little is known, however, about the self-care of the caretakers. Data reporting self maintenance mechanisms related to nursing career development and continuity, and utilized by psychiatric nurses at City and County,

are described.

In contrast to many studies of nursing, the focus here is on neither students nor recent graduates. The research population involved all RNs within a specified setting. This included the satisfied as well as the dissatisfied, and those beginning nursing careers as well as those who had been in the field for as long as three decades.

In recent years, the transition from training programs to graduate nursing has been studied and facilitated with increased attention to the actual demands of practice (Schmalenberg and Kramer 1979). Little has been done, however, to investigate long-term occupational adaptation. Analyses such as that presented here stimulate questions about the protracted adequacy of current nurse training and socialization programs.

Psychiatric nursing roles and statuses are variably interpreted, adjusted, modified, performed, and accomplished. The study of articulation between ideologies and roles includes exploration of explanatory models which are held to be central in clinical communication, management, and effectiveness (Kleinman 1980). Evidence is presented here of significant differences within and between psychiatric and psychiatric nursing staffs. Kleinman (1980) proposed that efficacious psychotherapy depends upon similarities of client and provider explanatory models. Demonstration of marked variability of clinicians' models provokes speculation of implications for relationships among the staff and between staffmembers and patients, and for patient outcome.

This study is not limited to nurses as nurses. Job-related experiences are viewed in the context of the total individual. Interrelationships between psychiatric nursing roles and other aspects of the lives of these individuals are examined.

In sum, the study of relationships between environmental responses and adaptive domains can lead to generalizations about the basic human attribute of adaptability (Mazess 1973). Knowledge of behaviors related to adaptation contributes to the predictability of relative probabilities that perceptions of stress-provoking situations and attempts at coping will follow similar lines in analogous circumstances.

CHAPTER 2

THE SPECIFICS: FIELD METHODS AND TECHNIQUES

"It is a capital mistake to theorize before one has the data. Insensibly one begins to twist facts to suit theories instead of theories to suit facts."

Arthur Conan Doyle as Sherlock Holmes

That the birds of worry and care fly above your head,
this you cannot change,
but that they build nests in your hair,
this you can prevent."

Chinese proverb

It is at the level of experience that the principles, patterns, routines, orderliness, and structures of social realities are located. Field work is the process of studying phenomena first hand in the environments in which they naturally occur (Georges and Jones 1980). Statistical or experimental methods provide supplemental tools, but the major instrument used for the collection of data is the investigator him or herself. The naturalistic researcher pays attention to the spatial, temporal, ritualistic, and interactional features (Denzin 1978) of a selected part of everyday life. Through face-to-face interaction, the characteristics, and to a lesser extent the causes and consequences, of social phenomena are examined. The data produced are primarily qualitative. They consist of detailed descriptions of situations, events, people, interactions, observed behavior, excerpts from documents and records, and direct quotations from people about their experiences, beliefs, and thoughts (Patton 1980). This

process prioritizes depth over breadth.

Anthropology is scientific because it carries out empirical observation, interprets in terms of the interrelationships of concepts pertaining to these observations, and involves the accumulation of systematic and reliable knowledge (Pelto and Pelto 1978). Reliability refers to potential for repeatability of results by another investigator. This requires the elimination, as much as is possible, of impressionistic data.

Anthropology's ethnographic approach allows examination of a situation in, as much as possible, its total context. Participant observation and focused interviewing permit the intensive study of relatively small samples. These methodologies facilitate an emphasis on qualitative aspects of relationships within the context studied. Unlike reductive analyses, which are usually the product of data gathered by studying isolated variables in simplified (for example, experimental) settings, ethnographic work is inductive. Patterns are observed in the data and described. Hypotheses are continually reformulated and refined so as to correspond with the data. This process allows relationships among data to be realistically represented. The emergent concepts, hypotheses, and theories are grounded in empirical data, rather than representative of pre-existing conceptualizations (Glaser and Strauss 1967).

To respect the social organization studied, the research situation is explicitly defined. Participant observation is used to obtain as much contextual information as is relevant. The investigator attempts to experience the situation as closely as he or she can to the way the

other person experiences it. Inferred information is differentiated from that objectively expressed (Ragucci 1972). A variety of perspectives, sources, and methods of data collection are employed to cross-validate emergent findings and to avoid narrow interpretations (Denzin 1978). In the analysis of data, the usual is separated from the unusual to allow concentration on those phenomena found repeatedly to be significant (Germain 1979).

Selecting the Research Site

The proposed research required a sizable sample of RNs (Registered Nurses) employed in one setting in psychiatric nursing roles. The search for an appropriate site began with telephone calls to each in-patient health-care facility listed for the municipal and suburban areas of the city in which I chose to work. Briefly outlining my intent, I inquired about psychiatric units, their sizes, and staffing patterns. If a facility had a designated psychiatric unit or units, I spoke with its director of nursing or a charge nurse on one or more units.

Several patterns emerged from these preliminary contacts with about three dozen institutions. Of those with psychiatric facilities, about one-third listed these separately from the medical hospitals with which they were associated. This became evident when I called what appeared in the telephone book to be different facilities, only to be connected more than once with the same place. The personnel with whom I spoke usually quickly expressed interest or disinterest in research of any kind being done at the institutions they represented. One head nurse

angrily stated that "We don't do that kind of thing here!" Most others were open to the idea, some even solicitous.

Many of the contacted facilities with the largest numbers of beds designated for psychiatric patients employed few RNs for these. (One sixty-bed facility, for example, had a total of eight RNs, five of whom were in administrative positions.) Other facilities rotated all of their RNs through the psychiatric units, having few or none employed specifically for psychiatric nursing.

My search narrowed to three large urban facilities. Each had several in-patient psychiatric units for which it employed several dozen RNs. Each was also associated with a large medical center. One of these institutions was public, two private.

Idealized psychiatric settings provide psychodynamic, open-ended, intensive therapy and deal with well-motivated and insightful patients. The reality of public psychiatry more often presents patients who resist rather than seek care and treatment, patients and caretakers who seldom have the option of choosing each other, a focus on managing symptoms rather than exploring their meanings, and a social control function rather than the more neutral posture of private therapists and caretakers (Wile 1984). Public psychiatry, on the other hand, may also be characterized by greater challenges and opportunities to create and use innovative interventions for patients viewed typically as resistant and unattractive candidates for care; by more opportunities for professional collaboration; and by increased diversity in patient population, diagnoses, and needs (Wile 1984).

Each of the three institutions was explored as a possible site for the research. The two private facilities were already engaged in numerous research projects involving the nursing staff. One devoted several entire patient care units to research. Nurses with whom I spoke there described their roles as more research than patient oriented. I met with fourteen members of the psychiatric nursing staff at the second private hospital. Their questions were many and well thought out. It soon became clear, however, that they too had little need of yet another research project in their midst, despite the interest they expressed in the current proposal. That facility was also strongly influenced by the religious group that ran the hospital. If the study was conducted in either of these relatively unique institutions, its results would have limited generalizability. As a research site, the public facility seemed both most appropriate and most amenable.

For several reasons, I have not provided City and County with a regional location. Foremost, the anonymity of the institution should be preserved. Secondly, although the patient population reflects local variance, the staff represents a mobile composite. Nationwide, nearly one-half of employed RNs are located in states other than that in which they received their nursing educations (Moses and Roth 1979). At City and County, 70% of the surveyed RNs working in the psychiatry department were trained and originally licensed in another state. At this facility, moreover, I detected no significant regional institutional characteristics relevant to this research. Not localizing the research site helps avert a tendency to assign

assumptions about facilities in various parts of the country.

Entre: Presentation of Self at City and County

I telephoned City and County's Director of Psychiatric Nursing and explained my proposed research. My fear that the nursing staff in a university-affiliated institution as large as this would be inundated by researchers proved unfounded. The director pointed out that the staff had little time for research, and few others had selected City and County.

I met the Director of Psychiatric Nursing armed with copies of the research proposal, human subjects application and clearance, and research consent form (Appendix A) that I proposed to use. Since the proposal had been approved by the university's Human Subjects Committee, the Director of Psychiatric Nursing kindly handled its consideration and acceptance at the hospital. As we toured the department's four locked units and its psychiatric emergency clinic, she introduced me to available nursing staff on each. I was invited to present my proposal at the next Nurses' Executive Meeting.

At that meeting I described the study to the psychiatry department's head nurses, supervisors, and nursing administrators. I emphasized that all information would remain confidential and identifying features would be disguised in the research results; that my interest focused on RNs, but it was not my objective to evaluate nursing care or patient outcome; and that I would be around the units thirty or more hours a week at any time of night or day for most of a year.

The presence of unacculturated individuals where there are acutely ill psychiatric patients can pose serious problems for all involved. Patients sometimes act out unexpectedly. They may be easily upset, frightened, or agitated. To allay fears that my presence would entail increased responsibility and work for the staff on the units, I pointed out my experience as a staff nurse and as a clinical nurse specialist in similar settings. Beyond normal attentiveness, the staff would need neither to protect me from the patients nor the patients from me.

Two factors influenced my initial acceptance at City and County. One was that I am a nurse. From the head nurses I heard, "I'm so glad that you are a nurse!" and "I don't like it when non-nurses try to study nurses." Such comments were repeated later by others on the units.

The second factor was the nursing staff's response to research that had been done several years earlier on one of the units by another doctoral student. That individual had also done a qualitative study. Several quantitative studies, described as having been done by "invisible researchers" and "not taken seriously by the staff," were mentioned. It was clearly to my benefit to follow a successful qualitative researcher whose time at City and County had been a positive experience for the nursing personnel. It was also clear that at least some of the nurses in the psychiatric department felt that nursing could be understood only by being there.

We decided with which unit I would start, and when to come to be introduced at its next staff meeting. I was given the customary symbol of acceptance in such settings, a key, with which I could let myself

on and off each unit. I began research at City and County in early October 1983, six weeks after my initial contact there, and finished in late July 1984 after ten months in the site.

Participant Observation

Participant observation, an unstructured procedure which is both art and science, endures as a fundamental approach in anthropology because it permits the fieldworker to relate to life as it is lived (Edgerton and Langness 1974). The participant observer looks beyond reports of behavior to observe behavior itself. Correspondence or discrepancy between the ideal and the real can then be assessed.

Participant observation involves a role, a body of techniques, and a methodology (Pearsall 1965). The role may reflect any point along a continuum: complete observation, observation as a participant, participation as an observer, or complete participation (Pearsall 1965). My role (and at times those of my informants) vacillated between observation as participant and participation as observer.

Participant Observer as Student

Each person on a hospital unit has a designated role. Typically the nature of this role is manifest on a nametag or, for patients, a wristband. Role labeling facilitates definition of appropriate responses by others. To clarify my position and to avoid expectations of clinical performance, I wore a tag with my name and "Medical Anthropology Student" printed on it. In introducing myself to nursing staff, I indicated that my background was in psychiatric nursing, but

my presence on the units was as a medical anthropologist doing research. I usually did not volunteer the extent of my clinical experience or education. I emphasized instead my student role.

Participant observation implies a learning situation. I tried to make it clear that I was there to learn from the staff, and in particular the nursing personnel. I might know already about psychiatric nursing in general, but I had been away from health care settings for several years, did not know what it was like at City and County, and was dependent upon the staff to communicate their own experiences of psychiatric nursing. Although observers exploit incompetence, there is a socially acceptable level of ignorance (Lofland 1971). I made no attempt to hide my familiarity with psychiatric settings, procedures, or jargon. To do so would have compromised both ethics and credibility.

Insider-Outsider

The researcher must always consider the potential consequences, positive and negative, of his or her observation and analysis. Traditional anthropological research assumed a cultural gap between those studying and those studied. The study of American social organizations by middle-class anthropologists who share the same culture and society poses new ethical concerns (Ablon 1977). Additional issues are superimposed when nurses study nurses within a health care setting. My primary concerns included objectivity, relationships with staffmembers, nonintervention, and reciprocity.

Objectivity

The participant observer role is ambiguous. It involves being enough of an insider to empathize and understand, and enough of an outsider to remain objective. The participant observer is, therefore, simultaneously "stranger and friend" (Powdermaker 1966).

My nursing background provided the advantage of background knowledge which would otherwise have taken months or years to acquire. Culture shock was minimized. This clinical orientation, however, also implied a likelihood of overlooking some relevant aspects of the setting due to their familiarity. I realized this potential for inattention almost immediately after starting fieldwork. At first acutely aware of the physical character of the unit, within a few days I was no longer observant of conditions that had considerable impact when I entered the setting. Becoming so soon blunted to such obvious matters, I wondered what I might miss among the more subtle.

The nurse participant observer, seeking to maintain objectivity, must periodically withdraw physically and mentally from involvement in the immediate behavioral situation (Byerly 1969). The time spent on the units was balanced by an equal amount spent processing field notes. This provided objectifying distance. Occasionally I found even simple retreat from the fray of unit activity to be helpful.

As my relationships with staffmembers developed, I realized that I was spending much of my interactive time with people who could not become significant parts of my personal support system if I was to remain objective to the system. The bulk of the rest of my time was spent completing and typing notes. I speculated that it would be more

comfortable and perhaps more productive to be part of a team with whom observations could be shared and the same degree of separation would not be necessary. Near the end of the fieldwork, I dreamed that on one unit I had remained so marginal that no one noticed when I left, while on another the staff was so distressed by my departure that I felt I must have lost my marginal status. Although neither extreme occurred, I was conscious throughout my tenure at City and County of the effort required to maintain my ambiguous insider-outsider role.

Objectivity is relative. It does not imply a lack of involvement with the setting. Many times I found myself emotionally responsive to events on the units. I was delighted to be asked to staff celebrations, angered when a therapist failed to show up for a patient's hearing, often saddened by the problems of patients. I liked and respected the staff and was grateful for their acceptance of an outsider at a time when the system as a whole was recoiling defensively in response to external pressures.

Staff-Researcher Relationships

Time was a primary factor in the data collection process. On each unit my initial focus was on rapport and relationships with the staff. During the getting-acquainted period (Pearsall 1965), I was observed as well as observing. I made myself available and engaged in visible but nonthreatening activities such as learning and mapping the physical layout of the department and the units, or perusing policy manuals. I sought to present myself as aligned with the nursing staff in general (in contrast to alignments with patients, therapists, medicine, or

administration), but tried to avoid involvement in factions.

The staff's response to my presence was generally welcoming. At times it reflected staffmembers' ideas about anthropology. One head nurse announced my impending arrival on her unit by describing me as "a nurse-anthropologist here to dig up old nurses to interview." An intern described me as "the omnipresent anthropologist passing out consent-to-be-a-research-subject forms while jotting notes on the backs of her kid's fourth grade math papers," adding that he supposed "every group needs a cultural pathologist."

Many staffmembers consistently behaved in a caring and supportive manner toward me as well as toward the research. Some were supportive even while unclear about what I was doing, despite the many times I described and answered questions about the project. An example: several months into the project, Moses Lane, a Licensed Psychiatric Technician (LPT) with many years in the system, asked me how my work was going, adding "I don't know what you are doing, but you sure are good at it." At the end of fieldwork, I attempted to complete appropriate public and personal leave-takings with each person.

Most of my interactions with the nursing staff were dyadic. Prior to the research, the staffmembers were not often asked about nursing and their own responses to it. Even brief interactions were followed frequently by comments such as "It sure is nice to have someone to talk with." As time went on, nurses and other members of the staff often checked to see if I had included particular information in my notes. They channeled items to me that they thought were appropriate, or tracked me down with some "hot news," to expand upon an issue we had

discussed, or simply to chat. Some nurses were initially wary of hidden agenda in my research. In nearly all cases, however, we established productive and I think mutually supportive relationships. On the unit on which I spent the most time, I eventually became, at least in the eyes of many, "our in-house researcher who can hear anything we have to say."

I learned about the City and County system while spending the first four months on one unit. This unit was chosen for its generalizability, since the others focused on specific ethnic groups. While maintaining less intensive contacts on the first, I then shifted my focus to two other units. By the end of the study, relationships with staffmembers on the first unit were generally more open and trusting than those on the other units. These relationships affected responses to my requests for interviews away from the hospital setting. On the unit first contacted, all of the nurses appropriate to my interview sample agreed to be and were interviewed. There were no broken appointments or last minute cancellations. On each of the other two units, some of the nurses agreed to interviews only within the hospital, and one or two nurses either "never got around to" or allowed arrangements for the interview to fall through. The length of time in the setting seemed to have as much or more impact upon individual staff-researcher relationships as actual frequency of or time spent in interaction.

The Clinical Non-Interventionist

Nurses are taught to intervene. The participant observer,

however, cannot completely participate because it is necessary to objectively consider, remember, and record everything relevant that occurs. I realized how thoroughly socialized I was to health care environments and intervention when I found it difficult to assign fictitious names to my informants. After years of training for accuracy so as not to confuse names in clinical settings, it seemed somehow bad practice to purposefully alter them in my notes, although this was necessary to protect anonymity. The use of pseudonyms affected me in another way as well. On each unit I met many people in a short time. I would afterward spend an equal amount of time with their pseudonyms in the notes. Often, by the time I returned to the unit, I had difficulty remembering which names were real.

In my role as observer, patients often viewed me, relative to busy staffmembers, as inactive and accessible. I usually positioned myself so as to minimize interactions that distracted me from my focus on the staff, but I also had many conversations with patients. As a "non-staffmember," patients occasionally shared with me information that they withheld from the staff. Confidentiality in these cases had to be balanced with clinical judgment. One well-read but deeply paranoid man about whom the staff knew very little, for example, one night related his detailed history to me because "anthropologists are inquisitive rather than interventive." We had several lengthy talks before he permitted me to communicate the information he gave me to a staffmember. On other occasions, however, I readily reported to the staff information about potentially dangerous situations.

Reciprocity

The staff understood that I was there as a researcher and not in a clinical role. Interaction implies participation, however, and participation implies interactive reciprocity. Within a short time on each busy unit, it became obvious that I could assist the staff in small ways that would not alter the environment to the extent of compromising scientific validity. I answered phones when others could not, transmitted messages, chaperoned male nurses treating female patients, let people on and off the unit, and tried generally to help out with minor tasks when the staff was busy.

Occasionally I was asked for advice about patient care. One nurse, especially helpful in my quest for information, sometimes countered my questions with "I know you aren't a consultant, but what would you do about...", filling in some patient-oriented problem with which the staff was dealing. The staff was more knowledgeable than I about the patients, but I had the advantage of freedom of movement about and between units and often of observing patients' behaviors during more than one shift. My responses to these requests usually involved discussions suggesting consideration of the issue from additional perspectives.

Although at times I provided otherwise unavailable information that could mildly influence treatment or care, queries about intrastaff matters provided less flexibility. When nurses in middle management roles sought information relevant to staff problems or unit administration, I had to reiterate my commitments to informant confidentiality and non-intervention, and decline discussion of the

suggested topic. Giving feedback is part of the research verification process, but respect of informants' rights has priority. Other information was easy to provide. Examples included contributing bibliographic references, editing legal forms, giving content summaries of missed meetings, and offering basic information about policies for new staffmembers not yet oriented to the system or unit.

On each unit nurses functioned as facilitators in various types of patient interaction groups. Interested staff on one unit discussed their group sessions at bi-weekly meetings with a consultant. As the only non-patient who attended more than one type of patient group, I sometimes contributed observations to help the staff assess the effectiveness of the formats used. I assisted other group leaders by videotaping sessions for in-hospital analysis.

The primary reciprocal function was the role of supportive sounding-board for personal and unit tensions. In listening, for example, to a nursing staffmember's response to a sexual assault incident, I learned a great deal about staff interaction and relationships with the administration. But I was also able to help the distressed individual express her feelings about the incident and to seek support from other sources. Although most exchanges were less dramatic, many of my relationships with individuals on the staff were influenced by, and in some cases founded upon, my role as supportive listener.

Recording and Other Techniques

Without persistently writing down what went on, I would be barely

more prepared than the participants themselves to analyze the social system I studied. I continuously took notes. These ranged from simple jotted outlines to verbatim accounts recorded in an abbreviated version of high school shorthand. To be coherent and complete, these notes were filled out and typed as soon as possible, a process which was as time consuming as the recording.

Originally concerned about the intrusiveness of taking notes, I soon realized that writing was not only acceptable but expected activity on the units. Members of the staff frequently are seen carrying and writing on charts and clipboards. Most pay little attention to what others are writing, and my own notetaking proved no exception to this. I learned to use pencils, however, because pens had a tendency to be borrowed by busy nursing staff and interns, leaving me disarmed. Since they connote impermanence and are unacceptable for use in patients' charts, no one borrowed my pencils.

Life on an in-patient psychiatric unit goes on around the clock. Day, evening, and night shifts equally represent psychiatric nursing. Personnel, unit routines, and staffing patterns, however, vary by shift and day. Accurate sampling, therefore, meant experiencing each unit at all times of the day and night, each day of the week and weekend, and on holidays. The length of unit visits varied from three to twelve hours. Most often these included portions of more than one shift.

I often sampled by observing and recording at peak interactive times (for example, change of shift or other staff information-sharing sessions). Notes were also taken on contextual matters and while reading unobtrusive sources of data such as patient charts, hospital

documents, and staff communication books. I attended and took notes in a multitude of meetings: team meetings, nursing staff meetings, nursing clinical meetings, community meetings, level (of care) meetings, staff meetings, in-service meetings, nursing discussion groups, nursing grand rounds, medical grand rounds, departmental meetings, and change of shift reports. I also participated, with the department's interns and trainees, in a series of visits to other types of facilities within the extended mental health system.

The field notes record observations, conversations, interviews, activities, and interactive events involving nursing personnel, patients, therapists, visitors, administrators, myself, and representatives from other agencies within the community system. In the notes I distinguished observed data from inferred, and recalled data from that recorded in situ. Each session's notes were identified with time, date, setting, participants, and themes. Cross-indexing was periodically revised as areas of significant interest formed. Eventually the indexing system was transformed into a massive computerized outline which allowed each category to be viewed in relationship to every other.

Focused Interviews

A major portion of the data came from 36 semi-structured interviews. The interview sample was limited to RNs who had worked in psychiatric nursing for a minimum of four years after completing their basic training as registered nurses. To facilitate the informant's discussion of his or her private as well as public life, I encouraged

holding the interviews away from the hospital environment. Sixteen of the interviews were done in informants' homes, nine in public places (including cafes, parks, and bars), and eleven within the medical center complex. Averaging three and one-half to four hours, the lengths of interviews ranged from three to seven and one-half hours. Nearly all were relaxed and informal in tone.

During interviews I asked open-ended questions about life history; educational, work, and migration histories; demographic characteristics; and orientation to and experiences in nursing. Although I used a list of items to be covered, this was a guide, really a series of probes, rather than an interview schedule or a questionnaire. For many informants, part of this data was collected during conversations on the unit. The interview could then serve to clarify, verify, and expand information. The topic areas were fixed, but the sequencing and wording of questions were situationally determined to promote comfortable and appropriate conversation. Accounts and narratives were recorded as much as possible in the informant's own terms.

Support Network Analysis

One variable frequently assumed to influence nursing career performance and satisfaction is the cohesiveness of the work group (Beland 1980). Social support systems are also acknowledged as important in private life. Network analyses were done with the interview sample to obtain data related to the structure and function of their non-work-related and their work-related networks of

significant relationships. Although the research project focuses on qualitative aspects of social relationships, this component also sought quantitative data about nursing and non-nursing relationships.

The nurses completed structured network maps, descriptions, density grids, and support scales (Appendix B). These allowed the determination of network characteristics such as dyadic and other interpersonal structures; network size, density, and heterogeneity; interaction type and frequency; membership dispersion; and complexity, direction, and strength of relationships. Of particular interest were the implications of the psychiatric nurses' social networks for occupational identity, ideology, and role expression. The articulation of private (non-work-related) and public (work-related) networks, the extent and affect of overlap of these, and the significance of each for individual nurses were emphasized.

Attitudinal Questionnaires

A 110-statement self-administered questionnaire was given to all willing Licensed Psychiatric Technicians (LPTs), Registered Nurses (RNs), and therapists (who included a variety of medical, psychological, and social work staffpersons and trainees) on each of the three units studied. Twenty-six LPTs, 36 RNs, and 31 therapists anonymously completed and returned the forms.

The questionnaire was used to facilitate comparison of attitudes and opinions held by City and County's nurses, psychiatric technicians, and therapists about behaviors and traits of patients; the etiology, prevention, diagnosis, treatment, and prognosis of psychiatric

problems; clinical roles; and societal concerns about mental health, mental illness, and psychiatry. Although the RNs, LPTs, and therapists worked on the same units with the same patients, it could not be assumed that they shared similar ideological frameworks.

The instrument used (Appendix C) combines two previously applied tests. Cohen and Struening's (1962, 1963, 1964; Shaw 1967) "Opinions about Mental Illness" (OMI) questionnaire was combined with Nunnally's (1961: 259-264) "Information Questionnaire" as used by Townsend (1978: 126-131). Both instruments are composed of statements representing a broad spectrum of popular and professional conceptions about mental health and mental illness. These tests have been previously subjected to extensive validation procedures.

In the composite questionnaire, each statement was followed by a seven-step "Disagree-Agree" scale. Some statements were slightly reworded to up-date and simplify. Other changes involved the refocusing of several role-related statements from psychiatry to psychiatric/mental health nursing. The statistical and descriptive methods of analysis were adapted to increase the relevance of the instrument to this research.

CHAPTER 3

CITY AND COUNTY

One of the effects of civilization (not to say one of the ingredients of it), is that the spectacle, and even the very idea of pain, is more and more kept out of the sight of those classes who enjoy in their fullness the benefits of civilization.

John Stuart Mill, Civilization

The Hospital

City and County Hospital was established in the mid 1800s as a "home for incurables." By 1870 it was also an almshouse. Its purpose being treatment and care of patients admitted through City Hall, the facility's early history was one of chronic disrepair, underfunding, understaffing, and cold, damp wards. Under the auspices of the local government, the hospital established, and long since closed, a training school to supplement its meager nursing staff. Crucial to dealing with the public health problems of the time, however, City and County continued to grow. Many of the present dozen medical center buildings originated more than a century ago.

A ten-story gray concrete mass known for the past ten years as the "new hospital" now dominates City and County's two city block area. The building serves both in-patients and out-patients. An information desk, usually manned by a volunteer or two, sits inside the front door of the building's spacious lobby. The flooring is warm-toned tile. On

both sides of the thoroughfare, carpeted areas underlie arrangements of molded plastic chairs attached to each other in threes. A small gift shop sits in back of the lobby, a splash of color and light in the otherwise subdued room. A large wooden flower-form sculpture graces part of the wall facing the front door. It is complemented by a natural wood false ceiling which serves to break up the monotony of the overhead horizontal surface, as well as to hold lighting. Four huge pillars flank the seating area.

From one cream-colored lobby side wall, a large collage dominates the room. It portrays someone's life size projection of a dark-skinned nuclear family. The depicted group wears real clothing over painted Afro-American features. The woman is scarved in an African print, the man sweatshirted. A girl, maybe ten years old, wears a feminine green dress. Little brother is in a tee-shirt and jeans. In his arms, the man carries an infant dressed in old lace and a crocheted sweater. The individuals face the room against a backdrop of city landmarks.

A bank of telephones is fixed to the adjacent wall. Numerous signs repeat themselves in English, Spanish, and an Asian dialect. The overall atmosphere is pleasant. The lobby is cool, but not cold or impersonal, calming without being boring. It is a welcoming retreat from the outside world.

The hospital is located in that part of town away from affluence and convention centers. It is where many members of minority groups also tend to locate. The patient population, not directly representative of the city's, represents roughly equal proportions of

Blacks, Asians, Hispanics, and Anglo Whites. The following description suggests the diversity characteristic of City and County.

I walked through the general emergency room area. There were about fifty people in the waiting room, about half of them Black and most of the rest brown. A few were talking to each other in low tones. Many were sleeping, sprawled over chairs or on the floor. Sitting by the main entrance of the hospital, I could see people come into the lobby and the out-patient clinics. Customized sports cars, rattletrap station wagons, and sedans both ostentatious and utilitarian pulled up to deliver people. Cabs brought infirm middle-aged Black women, heavy and with canes. Younger Black men, as well as Latinos, Anglos, and Asians are delivered by what appear to be others from their groups, or they walk in from the bus-stop. An ancient Hispanic woman in tennis shoes walks by. An elderly White couple, she in a colorful babushka, holds hands and converses in a language that I do not recognize. Hospital staffmembers, leaving for lunch, are conspicuous in their white or blue lab coats and dangling stethoscopes as they come out of the building. Casts and bandages accompany some of the often serious expressions of people going in. A Japanese doctor's quick steps contrast with the slow pace of a heavily pregnant Latino woman.¹

A hospital is both an organization designed for stated purposes and an organization with covert functions not necessarily even perceived by its personnel (Strauss 1981). City and County serves many functions, some well beyond overt health care. An integral part of the community, it is a meeting place, a park, and a work place, among other things. Although people there seem generally alert to others around them, the atmosphere is one of busyness, tolerance, and safety.

The parking lot by the emergency room (ER) and the psychiatric emergency clinic has about a dozen children playing in it this Friday evening. The weather is warm and nice. The evening shadows lend contrast to the gray walls and sidewalks, and the black asphalt pavement. It is nearly

¹ Unless otherwise indicated, quotations and single-spaced, indented passages are excerpts from fieldnotes collected during the research.

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nine o'clock but not yet dark. Little children, toddlers in the care of slightly older children, climb on the long benches attached to the side of the building. Occasionally an adult comes through the ER door far enough to see where they are and to speak to them in Spanish. A boy of perhaps ten pushes a baby in a stroller between parked cars, trucks, ambulances, and police vehicles in the parking lot. On the grassy hill by the ER drive, two small Black boys of maybe six and seven throw around a football with a White girl of ten or so. The smaller children scurry out of the way when an ambulance and a police car arrive. They stop running around and watch wide-eyed as the medics unload the ambulance. No one speaks to them and they stay out of the way.

Two groups of adolescent boys use the unlocked patio on the tenth floor. (The patio is locked only when the patients use it.) For the boys, the space is a playground. They play football with a foam ball, or just horse around, or sit and listen to the huge radios they bring. On sunny days when the patio walls block the breeze, they take off their shirts, spread them on the cool concrete, and lie in the sun. Tonight a group of Latino boys came up. They left just as it got dark. Sometimes I see a group of Black boys up here. Although I have seen the same two groups many times, I have never seen them together. Interestingly, the staff seems unaware of the boys, despite their often being there when staffmembers leave the units and take the elevators down to the cafeteria for supper. The boys are ignored, presumably since they are not doing anything that the staff feels it needs to be concerned about. The guards going to and from South (the maximum security unit) must also see them, but, although I have seen others who wandered in ushered off the floor, I have never observed anyone hassle these youths. The people who work here apparently look the other way and tolerate these informal uses of the hospital grounds.

The "new hospital" building's first nine floors are divided into those areas of medicine found in most general hospitals. There are surgical suites, nursing and medical administrative offices, and a dietary department; oncology, medical, pediatric, burn, trauma, obstetrical, gynecological, coronary, intensive care, and neurological units; family practice, family planning, and orthopedic clinics; and several other resources. The top floor, the tenth, houses the department of psychiatry.

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Psychiatry at City and County

City and County had psychiatric units long before the present department existed. Some staffmembers remember "the old wards" in what had once been a "home for wayward girls" on the hospital grounds. Originally a place to evaluate people for the courts, the psychiatric units held patients until court-appointed sanity officers (who were not necessarily psychiatrically trained) decided whether to send the observed individuals back into the community or to the state psychiatric hospital. A physician who worked there forty years ago described these wards as

"... so crowded that sometimes there were solid beds. To take care of someone on the far side, you crawled over the feet of the other beds. Sometimes there was one RN for all five floors. The press described the place as a 'Snakepit,' and then all hell broke loose."

Psychiatric personnel working at City and County in the 1950s verify such conditions. They talk about separate wards for male and for female patients, and for custodial care and for treatment.

"The treatment of the day consisted of electroshock therapy (EST) and diabetic coma therapy (insulin shock). Often treatment was a combination of EST and deep coma. Music therapy was popular on my wards until an overzealous nurse played the William Tell Overture and a patient convulsed in time to it during his EST. We didn't like the EST. If your hands were wet or you leaned too hard on the old iron beds, you got shocked along with the patients. And once in a while comas were irreversible. On the other hand, those therapies helped sometimes. Other patients were worse off."

Thorazine came into use here about 1955. Prior to that, cold packs, hot tubs, and sodium amytal were used to calm patients.

"The units were large with thirty-five to fifty patients and about six seclusion rooms. Court was held at the bedside. All the actual legal and written matters were already taken care of downstairs. The court proceeding itself

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was just a formality. Sometimes the beds were so tightly packed together in the ward that the patients could not fall out of them if they had to."

Carrie Jenkins, who worked as an RN for a brief time on "the old wards" shortly before psychiatry relocated in the new building, was "appalled, disgusted by the care, or lack of it, given there." She recalls that

"An old man bled to death in the seclusion room one day because no one bothered to check him and no one knew he had a knife wound. The ward was so crowded that there was no place for the patients to sit. Once I saw the chief of the unit kick a patient who was sitting on the floor." Carrie recounts one day finding cigarette butts floating in the hot chocolate delivered to the ward from the kitchen. She went to find something to scoop them out with. When she came back, the hot chocolate was gone. The patients had drunk it, butts and all. "Psychiatry," she states laconically, "at that time just did not seem very satisfying."

With time came many changes. City and County became one of the first hospitals in the country to integrate men and women on the same psychiatric units. With the onset of deinstitutionalization, the wards were rearranged to serve specific city districts. The staff was in large part dispersed to the various community treatment settings.

New directors tended to view psychiatry and psychology as legitimate professions, and nursing and social work as relatively unimportant. City and County's psychiatric nursing remained mediocre. The present Director of Psychiatric Nursing was hired about ten years ago. She found that "there was no real nursing administration for psychiatry at the time, no one to go to with nursing problems. It really was totally insane!"

The Chief of Psychiatric Social Work came to City and County at

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about the time the Director of Psychiatric Nursing did. He describes the old wards as

"... essentially holding units for the state hospital. Care was rotten to mediocre. Many of the staff were illiterate. The facility's resources were grossly overwhelmed by the city's needs."

The evening shift nursing supervisor states that even five years ago "You would not believe what we had to work with! Things aren't perfect now, but they sure are better!" This is a view frequently expressed by departmental administrators.

The Department of Psychiatry

Over the years there were many psychiatric programs at City and County, but none was really part of it. Finally, concurrent with construction of the new building, the Department of Psychiatry was formed. In contrast to simply being housed on City and County's grounds, psychiatry became an official department of the hospital. Contracts were also made with the state university's medical school.

The transition to the new hospital, coinciding with radical changes in the composition and organization of the new department, was not smooth. Some units were overcrowded and overstaffed. Some were based on what proved to be impractical approaches to meeting patients' needs. The department was young and changing. The administration and the staff struggled to make a viable system. Limits were placed on how many patients could be admitted at a time. The competence of the staff was increased. The head of psychiatric social work recounts with pride the department's transition from a "civil service dumping ground"

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for undesirable staffmembers, to being "the dumper." The tenth floor now has a reputation within the system for having high quality staff.

Through its affiliation with the university, the department acquired many new professional staffpersons. It also received another source of governance. In addition to the city and county administration and the hospital's internal administration, the university now had a role in running the department. Theoretically serving as a system of checks and balances, this tripartite government complicates departmental management. The chain of command is so complex that the occupants of many positions have two or three bosses to whom they supposedly answer. Communication channels are sometimes vague or even contradictory. The impracticality of the situation also allows some roles and issues to slip by with little real accounting.

The Department of Psychiatry expanded beyond the hospital as well as within. As politics and funding allowed it to do so, involvement increased with various aspects of mental health in the community. Six of the city's several dozen mental health programs are administered from City and County. From the nursing perspective, these are almost totally separate from in-patient psychiatry.

The Tenth Floor

Within the hospital, the psychiatry department is divided into four in-patient units, all locked, and a suite of offices, which remains open and accessible. One unit is a maximum security medical-psychiatric facility which is an extension of the local correctional system. This area, Ten South, is known as the prison or

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jail unit. A second unit, Ten East, admits custody patients judged to require less intensive security, as well as patients from the community. Under relatively new agreements, teams focusing on the treatment of Latino and of Asian patients coexist on the third and fourth units, Ten North and Ten West, with teams which deal with a broader spectrum of patients. Since the prison unit differs considerably in history, function, and administration, the research site was limited to the other three units, Ten East, North, and West.

A Psychiatric Emergency Clinic (PEC), located on the first floor of the same building, is the fifth major in-house component of the department. Most of the tenth floor's patients are channeled to the units through PEC. There 600 to 800 people are screened each month for their need and appropriateness for admission to the units upstairs. About a quarter of them are admitted.

Hospitalization is expensive, and community treatment generally considered to be significantly less so (Castel et al. 1982). Since its inception, the psychiatry department at City and County has provided "ultra-short-term" hospitalization and minimal in-patient stays. Licensed for fewer than 60 beds, the units experience constant pressure from PEC, jail, and the administration to "get patients out fast." Whether or not ex-patients regularly take their prescribed drugs when they are no longer directly supervised, early discharge is facilitated by psychoactive medications which decrease the incidence of florid symptoms among at least some of the disturbed (Scull 1984). With a paucity of beds designated for acutely ill psychiatric patients in the city, the immediate impetus for discharge is not so much reduction



of public expenditure as it is management of a constant stream of patients assessed as being in immediate need of hospitalization.

Although admitting only the most acutely ill, that is, those who are assessed as imminently dangerous to themselves or others, or as too gravely disabled to be incapable of basic activities of daily living elsewhere, the average length of stay on City and County's psychiatric in-patient units is less than two weeks.

The Physical Format

According to departmental legend, the tenth floor was not originally designed for psychiatry. Additional floors were to be added to the building, with psychiatry being the uppermost. When finances were exhausted, however, construction halted. No one seems to want to believe that the present format was designed for a psychiatric service.

The psychiatry floor gives the impression of newness. The walls are devoid of decoration, but clean. Shaped like a large plus sign, four wings extend from its square core. In the center of the square, the common area assessable from all sides, is an enclosed patio. On two ends of the patio are smaller squares, one with a garden, the other with a shallow, empty pool. Everything appears carefully geometric, starkly precise. Although the building's lines are diverse enough to avoid monotony, there is no pretense of softness in the concrete. There are no curves, no bends. Throughout the department, the orderliness of the architecture seems to encourage structure and organization within.

The linearity of the building continues inside the units. Each is

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U-shaped with rooms for male patients along one long hallway and for female patients along another. The nurses' desk is in the center, between two dayrooms, which have been designated as smoking and non-smoking areas (Appendix D). Facing away from the hallways, the nurses' station consists of an exposed, narrow desk about ten feet long. The physical layout limits visibility and communication. Finding someone on the unit is a challenge; contacting him or her requires going where that person is. On two units, patient's charts are kept in another room, requiring frequent trips to obtain, work in, or return them. Efficiency of footsteps is not an artifact of the new hospital's construction.

Despite nearly identical physical formats, the units varied markedly. Lighting, wall decorations, plants, and furniture framed different atmospheres. One unit was striking for its unadorned walls and lack of plants. It was on this unit which, for reasons of its generalizability and not its appearance, I concentrated the first four months of research.

Introduction to Ten East

Anyone involved with one of the psychiatric units must adjust first to its physical environment. My initial response to Ten East (to be called from now on simply East) prompted me to note:

I let myself onto East with my key. The key opens all three psych units and all of the doors within each unit, with the exception of the medication rooms. East is faced with a small area, perhaps five feet square, into which one walks after opening the first door and in which one stands while relocking that door. None of the doors opens or locks automatically. They are an old type that long-ago gave way to

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more complex technology in many such institutions. Although the building is new, many of the trappings of high cost technology have not been a part of its construction.

After relocking the first door, I turned around again to unlock the second. Only East and the jail unit have these double doors; the others, not housing forensic patients, have single doors of the same type. East's second door allows entry onto the unit. Locking the door behind me required turning my back toward the unit to face the door long enough to enter the key and turn it a full revolution until I felt and heard the tumblers fall into place. Since the inside door is no longer lined up evenly, this is tricky. The ward as I entered was quiet. No one was near the door, and the door is within sight of the desk. I noticed a short time later, however, that the desk is not always manned. The staff told me that the unit just happens to be unusually mellow right now.

I felt as though I had walked into a large computer with people as its many internal parts. The sterility of the place seemed somehow to force order upon its occupants. There were no signs of life other than people, people locked together in a small, square corner of the world. I wondered if humans could be so inherently social that they need only other people to orient them. Everything else seemed the same in each direction I looked.

One of the most immediately striking aspects of Ten East was its badly soiled and stained orange tweed carpet. Five years old, this carpet was facetiously reputed by the staff to harbor organisms which defy identification. The physician in charge of the unit wryly attributed the carpet's existence not to bureaucratic lethargy, but to the notion that its long-requested removal would require permission from Congress and handling by the humane society due to the rare species that might be endangered. Members of the staff suggested that the carpet could be documented only with "audio-video in living color" for "we are talking serious wildlife here!" I saw little reason to doubt this, and immediately noted "sense of humor" as an outstanding and necessary coping strategy on East. When, after a few days on the

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unit, I realized that I was no longer aware of its striking and odoriferous flooring, I felt one really could become oblivious to almost anything.

Interaction With The Physical Environment

Lori Eichelberg, the daytime charge nurse on East, one morning commented on an outgoing letter she had noticed in the basket beside the unit door when she came to work the day before. It was still there the next day. Someone asked whether the people who pick up the mail were the same ones who transported the urine specimens to the laboratory. Lori mused, "I wonder how they distinguish between a mail carrier and a urine carrier." "Easy," Curt Kinsdorf, an RN on East, replied, "by which kind of specimen they lose." I quickly found this attitude, negativity and sarcasm cloaked with humor, predominant among the staff.

At City and County people make do. There are no resources for luxuries. On weekends the linen cart does not always come back full, so there can be a shortage of bedding. Light switches may or may not work. Medications, in open-stock bottles, sit in rows on a bookcase in the medication room. Controlled substances and liquids for injection are kept in the medicine cabinet. The cabinet shelf holds a card warning against using the attached sink, which holds boxes of surgical gloves, for it has no drain. With the florescent tube missing from the top of the medicine cabinet, the medication room is lit by a single flickering ceiling fixture.

Sometimes the units are hot, sometimes cold. Usually the air

temperature is within an adaptable range. Water temperature is less predictable, except that it is never hot. Behind the nurses' desk one quickly learns to listen for the tubes coming through the vacuum message system. They arrive with a crash that pushes open the door and hit anyone lacking the foresight to move out of range or to hold the cover closed.

Without the ongoing efforts of the occupational therapists, there would be few, if any, supplies for patient activities on the unit. I watched the magazines and paperback books that I left there disappear with porters, janitors, and, occasionally, staff members. Now and then hospital volunteers brought a book cart through the units.

Every unit has some rooms in which traffic noises are prominent. On two units the television set is on most of the day, and often the radio or stereo as well. Each unit has an average and full census of nineteen fully-admitted patients. Each usually also has one to three additional patients held briefly for observation. There is, in addition to the patients, a nearly equal number of staffmembers. Despite the acoustical tile on the ceiling, with many people in such small areas, noise levels can quickly escalate. Daily vacuuming of East's carpeting, more optimistic than effective, superimposed further auditory assault.

As on many psychiatric units, matches and lighters are controlled items. Patients light their cigarettes, often rolled from a box of loose tobacco and wrappers, on a wall lighter. The cover for this appliance is about the size of the backing for a light switch. In it are a button and three holes. To use the lighter, one must push the

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button at the same time he or she puts the cigarette into one of the holes and inhales. Since the holes are barely larger than a commercial cigarette, a loose or thick self-rolled one meets with disaster and either falls apart or gets stuck. Taking considerable coordination, the patient with tremors, who cannot see well, or who is too short must get his or her cigarette lit by someone else. Since the lighters work only part of the time, a package of matches is usually taped to the top of the nurses' desk.

For the first three months I was at City and County I did not see a box of facial tissues. Only all-purpose rolls of toilet paper were available. This revelation came to me one day when I noticed an impeccably dressed young psychiatrist with a cold blowing her nose, paper tails waving in the breeze of the open window. The rolls of toilet paper seemed symbolically degrading on interviewing room desks. Eventually a short-lived supply of boxed tissues arrived.

Patients' cigarette papers and tobacco, toothpaste and toothbrushes, combs, and clothing came from the hospital volunteers. An old dashiki I left with the volunteers was worn every day for four weeks by a patient on East. Lori was shocked one morning to walk through the emergency room and find a man sleeping on a gurney in her husband's old suit. Due to the volunteers, many patients leave City and County in more appropriate clothing than they arrive.

Interacting Parts of the System

A system is an assemblage of parts, persons, and/or objects that are united in some form of relationship, and which indicate

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interdependence in their functioning as an organized unit or whole (Leininger 1970). In hospitals, many subsystems are linked together, each affecting the others. Disturbances can occur at any point, and a disturbance in one area calls forth adaptive or maladaptive defenses from the others (Caudill 1964).

At City and County, psychiatric nursing's coordination with other services within the hospital ranged from supportive to detrimental. The messenger service, for example, might not pick up a specimen until it was too late in the day for the laboratory to process it. Supplies to replenish the emergency cart kept in the treatment room may or may not arrive. Special diets were sometimes created with considerable license. An order for a low-calorie, salt-free diet, for example, produced two trays, one low-calorie and one salt-free. A vegetarian diet included ground beef, a bland diet taco sauce. The medicine requested from the pharmacy at times did not match that received. Numerous personal communications might be needed to verify substitutability or to exchange items.

At times one day's apparently adaptive behavior ultimately proved problematic and the results of past decisions and actions haunted the units. East's one seclusion room, for example, was finished with an orange wall covering. Although hardly a calming color, and now dingy and dirty, new paint would not adhere to these walls. Eight days after Halloween I noticed that several patients still had glitter in their hair from the occasion. In addition to that, paper corners remained on the walls where the decorations had been. It turned out that glue rather than tape was used to attach these.

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City and County's system is not particularly unprepared to maintain its physical resources. Maintenance personnel respond when the shower overflows onto the carpet, for example, or someone plugs a toilet with his shoes. In a small area in which twenty people live and as many or more work, however, the physical environment is strained and the subsystems which support it are significantly challenged. When none of the institution's rug shampooers work, or other aspects of the material culture need to be dealt with, repair requisitions must filter through a maze of civil service offices and public maintenance channels. Although the same requisitions no longer go through City Hall itself, the system remains complex and at times unwieldy. It is well known that public hospitals tend to be poor in allocated resources (Strauss 1981). At City and County, space and other commodities are scarce enough to challenge and at times discourage those who participate in its system.

CHAPTER 4

THE PSYCHIATRIC NURSING STAFF

"The perfect mental health worker: he or she has six boobs, a dozen arms, a heart as big as the wall, and a cast iron stomach."

The Ten West Staff

Nurses in the United States of America

Nursing's profile has changed. Registered nurses today graduate from three types of training programs. Whereas the traditional hospital diploma school emphasized role-specific behaviors and values, baccalaureate (BSN) education espouses an integrated, process-oriented curriculum focused on how to learn, application and utilization of the nursing process, and a combination of knowledge and skills (Germain 1979). The third training route involves an associate degree (ADN) emphasizing technical preparation in a two-year college.

Since 1950 the number of registered nurses in the U.S. has tripled to more than 1.62 million (Levine and Moses 1982). In the past ten years, in addition to a greater total number of RNs, and a greater ratio of employed RNs to the population, percentages of male, minority, and baccalaureate-prepared nurses have increased (Levine and Moses 1982). The median age of nurses has decreased, as has the percentage of those whose basic educational preparation and/or highest educational level is a nursing diploma. Marked increases have occurred among nurse specialists. For example, the number of masters-prepared clinical nurse specialists (CNSs) has tripled in less than ten years (Levine

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and Moses 1982).

The number of licensed nurses has grown at a rate twice that of the total population. Seventy-six percent of the total number of RNs are employed in nursing (Levine and Moses 1982). Yet it is widely held that the supply of nurses remains insufficient. Turnover and dropout rates have compelled increased attentiveness to the many factors involved in the employment and retention of nurses (Vogt et al. 1985).

Shortages of RNs reflect not numbers per se, but increased demands due to larger and more varied case loads, and greater technical and clinical complexity of care (Levine and Moses 1982). Employed nurses are increasingly unevenly distributed in a greater variety of settings. The employment of RNs in growing numbers of health and extended care facilities (Fralic 1980, Moses and Roth 1979) has contributed to a discrepancy between the demand and supply of nurses employed in traditional (that is, not technologically-intensive) institutional settings. Despite ideological movements toward home and community care, the numbers and ratio of RNs employed in hospitals has increased by more than 35% since 1977. Meanwhile, the total number of RNs has increased only 26% (Levine and Moses 1982). The majority of patients are elsewhere in the health care system, but hospitals employ more than two-thirds of all working nurses.

In 1965 the American Nurses' Association (ANA) made it clear that not all nurses need to be baccalaureate-prepared practitioners (Wilson and Kneisl 1983). To be "professionals" responsible for nursing care, on the other hand, a Bachelors degree in Nursing (BSN) is considered necessary. According to the ANA, only RNs who are BSN graduates are

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"psychiatric nurses." Here, however, the term "psychiatric nurse" is used to designate RNs employed in that role, regardless of educational background. Although non-RN nursing personnel at City and County also at times refer to themselves as "nurses," the term denotes registered nurses only.

The LPTs

There are typically two or three RNs on each of City and County's psychiatric units per shift. Licensed psychiatric technicians (LPTs), usually one or two each shift, form the non-RN component of the nursing staff. Most of the LPTs have completed eighteen months of training specific to psychiatry. Some hold academic degrees as well, although most do not. Despite the fact that the RNs spent longer in school than the LPTs, for some it was only a few months. Several LPTs stated that their training, directly applicable to psychiatry, leaves them better prepared than the RN who trained longer but learned much that is not seen as directly relevant to psychiatry.

Psychiatry seems to be conceptualized by the LPTs as inherently separate and different from biomedicine. The RN role, on the other hand, is viewed as little different from that of the LPTs. One LPT stated that the "only differences are the pay and the prestige." Another refuses to accept some responsibilities traditionally associated with RNs (for example, administering medications) "unless they pay me like one too." Many aspects of the organization of psychiatric nursing at City and County reinforce the blurring of RN and LPT roles.

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Psychiatric Nursing: Hierarchy and Exceptions

The administration of City and County is notorious for its structural complexity. For psychiatry, in-patient services provide only a part of the department's tasks and objectives (Appendix E, Figure 1). Nurse managers typically wear several hats and are aligned with more than one service. Administrators above the unit level, with one exception, have departmental as well as nursing administrative functions.

Nursing at City and County is both embedded in and deviant from the institution's traditional hierarchy of authority. Each of City and County's psychiatric units is overseen by a physician-psychiatrist, a program director, and a head nurse (Appendix E, Figure 2). On one unit the program director is prepared as a clinical nurse specialist, on another as a CNS with a doctorate in psychology, and on the third as a social worker, also with a doctorate. The program director role was created by the psychiatry department to work with nursing and the medical administration.

The nursing hierarchy (Appendix E, Figure 3) is overseen by a masters-prepared Director of Psychiatric Nursing. This individual has many years of clinical medical and psychiatric nursing experience. Directly under her authority are a masters-prepared RN in charge of clinical practice, coordination, and education; a baccalaureate-prepared managerial RN to whom the head nurses answer; and an evening and night supervisor. Each of these nurses has substantial clinical experience in psychiatric nursing.

Two units have clinical nurse specialists in addition to head

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nurses and program directors. These CNSs focus on clinical supervision and staff consultation. Rarely, a CNS will follow a patient on a therapy team. On one unit, the program director is the only CNS. She regularly conducts group therapy sessions. Each CNS, like the program directors, interprets and performs her role relatively autonomously. There is little similarity in role definition or performance. Some staffmembers interpret this variation as evidence of limited competence or role confusion.

Relationships among program directors, clinical nurse specialists, and head nurses are sometimes vague or competitive. Accustomed to a traditional hospital hierarchy, many members of the nursing staff tend to rank these positions; the results vary with occupational alignment and personal affinities.

Among the staff level RNs there is certainly no less diversity, but their roles, somewhat less autonomously interpreted, are easier to categorize. The data reported in the succeeding sections present unit-based psychiatric nurses and exclude administrators and one CNS-prepared program director who no longer identifies herself as a "psychiatric nurse."

Backgrounds: A Nurse is Not a Nurse is Not a Nurse

There seems to be a tendency during each period of history to portray nurses as a homogeneous lot. A modern profile presents instead a heterogeneous group often bound in title only (Ham 1981).

In the U.S. as a whole, nurses are predominantly Anglo-white, middle class, American females (Leininger 1976). At City and County,

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69% of the psychiatric nursing staff is Anglo-white. Seventeen percent are Black, 9% are Asian or of Asian descent, and 6% are of Hispanic descent (Appendix F, Table 1.) Eight percent were originally educated in other countries. Thirteen percent are bilingual.

About one-fourth of the nurses employed on the Tenth Floor are married. Nearly forty-three percent have never married (Appendix F, Table 2.) Seventeen percent have children with whom they live. Twenty-eight percent of the RNs are male. Nationwide, only 3% of RNs employed in 1980 were male (Levine and Moses 1982). Also somewhat unusual is that, within the research site, none of the male RNs is a head nurse or an administrator.

Prior to becoming RNs, City and County's psychiatric nurses worked in a wide variety of occupations. Thirty-six percent were Licensed Psychiatric Technicians (LPTs), Licensed Practical or Vocational Nurses (LPNs or LVNs), nurses' aides, orderlies, mental health workers, or hospital volunteers. Twelve percent were in the military as hospital corpsmen, dental technicians, military police, or linguists. Nine percent are former counselors or welfare workers.

Some came into nursing from office jobs (including banks, post offices, and other agencies), construction work, and factories. Others were bartenders, housewives, Peace Corps workers, telephone operators, cashiers, musicians, waiters, or security guards. One was a business manager and trainer. Another put himself through college working as a clown.

Education

The RNs on the staff come from each type of nursing program. Fifteen percent hold associate degrees in nursing (ADNs) from two year college programs (Appendix F, Table 3). Twenty-seven percent hold diplomas from three year hospital training programs. Forty percent hold baccalaureate nursing (BSN) degrees. Nineteen percent have masters degrees in nursing (MSNs).

In three of four areas, the above statistics differ markedly from nationwide percentages. In 1980, the highest level of nursing education achieved by 18% of RNs in the U.S. was the ADN. Fifty-five percent held diplomas and 22% BSNs as their highest levels of nursing education. Five percent held masters degrees or doctorates (Levine and Moses 1982).

The psychiatric nursing administration at City and County has made a concerted effort to increase the educational levels of its employees. They have succeeded to the extent that the nursing staff studied reflected nearly twice the national average of BSNs and four times the statistic for advanced degrees. It has half the expected percentage of nurses prepared at the diploma level.

For City and County's personnel, education is not limited to nursing. Fifteen, nearly forty percent of the total RN staff, hold additional formal degrees (Appendix F, Table 4). More than half of these are baccalaureates, and two are masters degrees in related, non-nursing fields.

In contrast to ten percent nationwide (Levine and Moses 1982), 15% of the RNs are working toward higher nursing degrees. Of the seven

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nurses who combine going to school with employment, four work full time. The three part time nurses are full time graduate students who work to maintain clinical skills and patient contact, and for the income.

Overall, a slender majority of the nurses indicated an interest in additional schooling. Slightly less than half of these say they would choose to further study nursing (Appendix F, Table 6).

Experience

With an average age of 37.5 years, City and County's psychiatric nurses are slightly older than the RNs reflected in national samples. Although the average age of diploma graduates is the same (44 years), City and County's ADN's have a mean age of 34 years in contrast to the national mean of 32 (Levine and Moses 1982). BSN graduates in the psychiatry department average nearly 35, while the national sample's mean age is 30 years.

Sixty percent of City and County's psychiatric nurses completed their training and entered the job market as RNs while they were in their early twenties. Eighty-six percent were employed RNs by the age of 30 (Appendix F, Table 7). Sixty-five percent of the total sample, and 100% of the male subsample, completed nursing school since 1970 (Appendix F, Table 8).

Amounts and types of psychiatric training and work experience vary widely among staffmembers, although most nurses come to City and County with some experience. Ranging from zero to eighteen, they average four jobs as registered nurses prior to their present positions (Appendix

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F, Table 9). Associate degree RNs, when they are hired, frequently have had more experience as LPTs than as RNs.

The high rates of disillusionment and attrition well known among recent nursing graduates are especially prominent among baccalaureate-prepared nurses. Cohen (1981) points out that most nursing students today are not prepared for the real-life technical and emotional demands of the nursing role. Neophyte BSNs frequently experience "reality shock" because of disparities between the ideal and the real, in particular between the skills learned and those rewarded in the work situation (Germain 1979). Their images of nursing, sets of values, and attitudes sometimes lead them to expect to take responsibility for tasks and aspects of patient care which do not fit into the work situations presented. Graduates of the other programs, on the other hand, are less prepared for and expectant of independence, and are more likely to be comfortable with the hospital bureaucracy (Cohen 1981).

Two BSN nurses who were not LPTs prior to becoming RNs were observed during their first year of employment as RNs. One of these quit during the research period after exactly one year in the job. The second was struggling against "burn-out, exhaustion, and destructive criticism." Despite departmental preference for hiring experienced RNs, others are at times successfully employed and retained. One student nurse was employed as a staff nurse immediately after graduation, and within five years became a head nurse.

Mobility

Staff nursing, although generally strongly associated with women,

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is both one of the occupations which persons of either sex are likely to quit and one in which stability of employment is little rewarded (Margolis 1984). High turnover among nurses has become an accepted fact in health care (Vogt et al. 1983). Eighty-five percent of nurses in the U.S. have changed jobs and employers (Donovan 1980). It is not unusual for hospital surveys to report annual turnover rates of 50%. Rates as high as 200% have been documented in urban areas (Lysaught 1980).

Of the 36 nurses at City and County for whom the information was available, the average time in their current jobs was 4.2 years. That figure tends, however, to gloss over the total situation. The nursing staff includes a stable group of long time civil service workers and a changing group of relative newcomers. Generally it is younger nurses who relocate (Moses and Roth 1979), and City and County's are no exception. In Donovan's (1980) sample of 1051 RNs, those in the 25 to 35 year age range averaged two and a half years in their current jobs. Of the nineteen psychiatric nurses at City and County in this age category, 53% have been employed there for less than a year. The nineteen averaged 2.02 years in their current positions.

While eight percent of the nurses sampled have worked at City and County for more than twenty years, 35% have been there for less than two years (Appendix F, Table 10). Nearly 80% have been employed in the psychiatry department for under five years. One unit has a reputation for high rates of turnover, another for stability and low rates. The annual turnover rate for RNs in the department is about 38%.

Some of the known causes for nurse turnover include frustration,

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boredom, and apathy (Weisensee 1979); value conflict (Beland 1980); scheduling (Schmalenberg and Kramer 1979, Kjervik and Martinson 1979); feelings of powerlessness and helplessness (Weisensee 1979, Davitz and Davitz 1980); status disparities with other health team members (Germain 1979, Logan 1980); lack of recognition and sense of achievement (Schmalenberg and Kramer 1979, Donovan 1980, Kjervik and Martinson 1979); burnout (Maslach 1976, Asken 1979); stress (Donnelly 1980, Weisensee 1979); low salaries (Hallas 1980, Kjervik and Martinson 1979, Donovan 1980); inadequate role definition (Byerly 1970); inadequate staffing and work conditions (Hallas 1980, Donnelly 1980); the observance of compromised care (Weisensee 1979) and low patient care standards (Donovan 1980); physical strain exacerbated by poor self care (Donnelly 1980); relations between nursing and medicine (Vogt et al. 1983); conflict between accountable professional performance and promotion criteria (Vogt et al. 1983); and other administrative and leadership factors (Hallas 1980). Other cited causes include poor work relationships (Beland 1980, Hay and Oken 1972); poor communication among staffmembers and feelings of lack of unity, insecurity (Hallas 1980, Donovan 1980), and poor self-concept (Schmalenberg and Kramer 1979); difficulty in dealing with cynical or negative co-workers (Maslach 1976); and vulnerability to criticism (Byerly 1970).

Interviewed RNs at City and County were asked their reasons for leaving past jobs. The explanations given included wanting to make geographic changes (13% of 91 responses) or to continue schooling (12%), systemic shifts in the locus of mental health care (eg., from in-patient to clinic settings and back) (10%), burnout (typically

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described as being "very tired" and/or "depressed") (10%), and personal reasons (eg., family moves, changes in relationships, illness, and pregnancy) (9%). By far the most common reason for quitting previous jobs, however, was dissatisfaction with work conditions (46% of 91 responses). Within this category, the greatest motivations to quit came from (in decreasing ranked order) wanting to change the type of nursing practiced (eg., to or from psychiatric nursing), disagreement with an employing institution's philosophy or policies and/or attraction to another (eg., to public psychiatry), relationships with co-workers, shortages of materials and staff, and the poor care given to patients. Only one response indicated pay or benefits as a primary reason for leaving a job. Lack of challenge and personal response to having been assaulted each explained two moves.

Time

Seventy-seven percent of the RNs employed by City and County's Department of Psychiatry work full time (Appendix F, Table 11). Twenty-two percent work part time, usually per diem as temporary nurses obtained through an in-house registry. The part time masters-prepared RNs work as staff nurses. A few nurses work half time, but that is administratively discouraged. Nationally the statistic for employed nurses working full time is 69% and for part time 31% (Levine and Moses 1982).

At City and County, while 100% of the nurses with two year associate degrees work full time (Appendix F, Table 12) (in contrast to 72% nationally), 42% of the bachelors-prepared RNs work part time

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(in contrast to 28% nationally (Levine and Moses 1982)). The fact that nearly half of the department's better prepared staff nurses work part time (and often sporadically) has a substantial impact on the experience and outcome of nursing there.

Pay

The average full time RN in 1980 earned \$17,393, the average staff nurse \$16,451 (Levine and Moses 1982). At 10.3%, average annual increases for nurses have been higher than for other non-agricultural workers in private industry or white collar workers in general, although the increases have not equaled the inflationary rate changes in the consumer price index (Levine and Moses 1982). Projecting 10.3% annual increase, in 1984 the average full time RN earned about \$21,150 and a full time staff nurse about \$20,000.

City and County Hospital is located in a city with a relatively high cost of living. Labor union pressure during the past five years has resulted in pay increases for civil service nurses of nearly 25%. At \$29,754, an RN's gross annual pay is substantially more than the national average. Whereas a nationally averaged CNS or supervisor's pay is approximately \$24,000, City and County's is nearer \$38,500. Head nurses there average \$35,022, while the national average is about \$21,550.

With the majority of City and County's nursing personnel having come from other parts of the country, the monetary benefits of working at City and County are not overlooked. Due to the format of civil service, however, pay increments are influenced more by seniority than

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education and/or experience. Income is usually a matter of complaint among the RNs only when recently-employed staffnurses with BSNs or MSNs realize that they are paid less than an employee with experience, seniority, and an associate degree. With five years experience and seniority in the civil service system, an RN, having previously invested in two years of community college to earn an ADN and "doing a few overtime shifts," can take home \$30,000 a year.

Although their other benefits might be better elsewhere, many staffmembers claim that it is the pay that gets them "through the shifts." The relative satisfaction of the nurses with their incomes does not imply general satisfaction with their roles, but, in contrast to the results of some studies of nurses, amount of pay here is not a primary problem.

Nursing Staff Communication

Communication channels are to an extent built into the psychiatric nursing system. Head nurses, for example, talk to and with staffmembers, although in widely varying manners and amounts. In the absence of a head nurse, a charge nurse fills this role. Communication books, clipboards of administrative policies, and audio-taped reports link the three shifts. Attached to the edge of the nurses desk and slipped into mailboxes, handwritten notes attempt more direct contact.

Nursing on the units is intensive and draining. Emotionally, the atmosphere is highly charged. Cognitively, the continuous interruption of nearly every endeavor by patients, staff, therapists, and phone calls challenges even the most organized and task-oriented to

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accomplish anything. There is little time to think or to communicate beyond the essentials of the job.

When staffing is "short," that is, fewer than the expected number of staffpersons are present on the unit, communication tends to become anxious, fragmented, and incomplete. With increasingly complex and time-consuming documentation expected of each staffmember, variability in the use of direct communication channels, and limited perceived intrastaff support, many staffmembers worry that they are not privy to all relevant information, that important facts are sometimes filtered and distorted, or that some available information may be unreliable. Most RNs have experienced the embarrassment of reporting erroneous or incomplete nursing data in a team meeting or other interdisciplinary situation. Trust in the communicative capacities of co-workers tends to be limited, with a few notable exceptions, to those with similar experience and education, or to specific settings (for example, sessions with a consultant who meets bimonthly with nurses on East who are interested and/or involved in facilitating patient groups).

The frequency and intensity of staff-patient interactions and the necessity of interacting with the therapists leave little energy or motivation for other than superficial relationships among nursing personnel. About one-third of the units' nurses indicated that, for them, job-related stress focuses on staff interactions. Unit and "palace Åmedical center and/or departmentalÜ politics" are typically consciously ignored or dealt with by "making things right" and "not rocking the boat." Many nurses aim to preserve "smooth interpersonal relationships" while protecting themselves from increased involvement.

A staffperson typically has limited opportunity to process his or her experiences with peers. Staff level personnel, seldom able to leave the unit or take breaks at the same time, are always subject to interruption by patients and others. When dealing with co-workers, as with patients, it is often simpler to let the clock dictate the end of a discussion than it is to see it through to a natural termination. It is also easier to deal with many superficial fragments of other peoples' situations than it is to get very involved in even a few. Part time workers lack a vehicle for direct communication and have minimal contact with administrators or other staff. They complain of seldom having the opportunity to clarify interpersonal processes and relationships.

Many nurses claim that they, their work, and the department are overly focused on patients; "There is no energy left for the staff." Patients typically dominate intrastaff relationships; many staffmembers say they feel guilty when they are not dealing with patients or patients' problems. Cognizance of patient needs frequently overshadows that of their own.

Those staffmembers most satisfied with intrastaff relations tend to be those who have positive and supportive relationships with their immediate supervisors, often a head nurse. For many this relationship is the negative or positive focal point of their feelings about their work situations.

Camaraderie, Collegueship, and Cohesiveness

As an occupation, nursing is massive in scope. The staff is

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educationally, economically, experientially, and ethnically diverse. Levels and types of professional and/or occupational commitment vary widely. Life styles and stages differ substantially. An older nurse, for example, may be three times the age of a co-worker.

Colleagueship is one of the most sensitive indicators of segmentation within a profession (Strauss 1975). Whether defining a colleague as "any co-worker," or as someone with whom one shares a close, sibling-like relationship, the term implies an esprit de corps, a sense of "being in the same boat." Controlled entry into an occupation implies the widespread potential for colleagueship (Strauss 1975). Characterized by open recruitment, that is, attracting and accepting students of highly varied backgrounds, nursing (unlike medicine) lacks that control. Probably the greatest impact on nursing staff relationships stems from the discipline's wide variety of educational institutions, degrees, and types and levels of certification. The existence of and identification with segments of the occupation limits and directs alliances.

Most nurses in the department of psychiatry say that they seldom experience significant colleagueship. They feel that they define and perform their roles differently from their co-workers, and doubt that they share substantial commonalities. There is a low expectation for and realization of mutual support.

LaVerne Strunkus, an RN with nearly thirty years experience in the City and County system, describes its current nursing situation as different from the relative cohesiveness she experienced when nearly all nurses were trained the same way in diploma programs. She uses a

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concrete analogy to illustrate her point:

"We used to be like a cake with all the ingredients baked together into one whole. Now we are like a big bowl of spaghetti; each strand goes its own way, but there is no blending."

Some nurses, unlike LaVerne who misses the cohesiveness and collegueship she formerly experienced, prefer to "go it alone." The question of how much of him or herself each nurse can and/or should invest in relationships with co-workers recurs frequently. Few nurses expressed satisfaction with the status quo. Even those who espouse minimal personal exchange with other nurses sometimes express a desire for more professional and/or occupational closeness.

Intrastaff concern and support, when it is proffered from any level, tends to be crisis oriented. It may result, for example, in response to an assault, a serious patient accusation against a staffmember, or in "having to cover for the head nurse's current target." Despite common acknowledgment of a tendency "to take things too personally" when patients are hostile or actively attempt to split the staff into factions, positive communication among nursing personnel is often limited to evidence of "real need."

The nursing staff tends to unite when dealing with a "serious problem patient or a serious patient problem." At such times discussions are utilized to gather all available data, develop group intervention strategies, and provide support. Cohesion is otherwise apparent only when an issue deals with nursing as a discipline, or is viewed as requiring a unified alliance against another force, for example, medicine.

Line and middle management do little to encourage the staff's

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attentiveness to itself or its interrelationships. Competition on the units, the territoriality of some therapy teams, and open disagreements further discourage staff cohesion. Staff birthdays usually are not celebrated, although departures are. Due to differing approaches on the parts of their immediate supervisors, therapists, including trainees who are on a unit only a few weeks or months, tend to elicit greater recognition upon their arrivals and leave-takings than do members of the nursing staff. An example:

Including the head nurse, CNS, three psychiatrists, and the program director, twenty-four were present at the staff meeting this afternoon. The plans for remodeling the unit were discussed. These involve decreasing census and deciding on color schemes for furniture and a linoleum floor. The rules for ordering medications were once more outlined for the interns who have now been here a month. The program director reported on the most recent inspection; it has ominous tones for nursing and is not encouraging if one feels like one has been working hard. Paul Merritte, a psychiatrist, again brought up the question of when to seclude assaultive patients. The psychologist suggested having a consultant come in to help the staff deal with this issue. This was met by the non-nursing staff with long silences and a defensive air. The discussion continued around the issues of power, hierarchy, and communication on the unit. Staffmembers say that these are all separate issues, but that they repeatedly "get wound into the same debates."

The program director mentioned large staff turnover as a possible factor in the current unsettled feelings and concerns on the unit. The CNS went around the room pointing out who was there a year ago and who was "new." Of those present, ten have been here a year or more, and fourteen (including myself) are new. Today is the first day of work for the newest RN. Despite his being counted among the "new," no one thought to introduce him to the rest of staff.

The least cohesive unit, according to staffmembers' opinions and my observation, is that with the highest rate of staff turnover, and the most cohesive unit, that with the lowest rate. Personnel on the

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latter unit occasionally make an effort to bring the staff together with such events as retreats, during which small groups of nursing personnel and therapists discuss process issues of working together on the unit. Despite occasional parties in the homes of nursing staffers from each unit, there is more interaction pertaining to off-duty activities of staffers on the unit with the least turnover. An example:

One of the evening shift RNs took orders for opera tickets and went to get them during the day. Everyone was excited about getting the tickets for the sessions he or she wanted. Some can attend only a few concerts, but Harry Gilles, the RN, got each what he or she hoped for. Maxine Canfield, the head nurse, arranges the schedule for necessary coverage.

Staffing

City and County's psychiatric nursing positions and scheduling plans appear adequate on paper. The positions, however, are seldom all filled. Replacements are slow due to departmental selection for relatively high educational and experiential standards, a limited number of qualified applicants, and the sluggishness with which hiring requisitions clear in-house and civil service system channels. On the units, ill or otherwise absent personnel are seldom replaced. Typically staffers cannot be "borrowed" from other units since those staffs are equally stretched.

The use of temporary nurses to fill scheduling gaps is planned a month in advance and does not provide for last minute substitutions. The number of shifts filled by unfamiliar, per diem nurses appeared to vary directly with turnover rates and inversely with staff cohesiveness. Two units utilize the bulk of the allotted per diem

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nurse shifts; the third, the most cohesive, more often draws from within its own ranks to provide contiguous care through extra shifts at per diem pay rates, or by procuring familiar per diem nurses.

Much of the expertise that the per diem nurses possess is lost by their temporary status. Many of these RNs, despite their relatively high levels of education and experience, are considered by the regular staff to be inexperienced or inadequately prepared due to unfamiliarity with current patient populations, ward routines, and immediate unit issues and concerns. Because of their sporadic appearances, per diem nurses are also not utilized in the primary care model employed on the units. Although impressive on paper, effectiveness of care and cost may be compromised by supplementing full time staff this way.

Staffing patterns vary widely. Despite frequent patient admissions during evening shift, for example, there tends to be less staff scheduled then. When expected to be busy, weekends and holidays may be heavily staffed with expensive per diem RNs who come theoretically well qualified but limited in of applicability in current unit and patient situations.

Patient census also fluctuates, although there are seldom many, if any, empty beds. This fluctuation pertains more accurately to how quickly patients come and go than to actual numbers at a given time. A unit's staff resources may also be unevenly distributed due to the needs of highly suicidal or assaultive patients for nearly one-to-one attention.

Many staffmembers describe a correlation between short-staffing and a "high" (that is, excessively noisy and active) unit. It is

hypothesized by them that patients "sense" the staff as "hurried and short." Feeling insecure and deprived of attention, the patients "escalate" or become more agitated. Assaults are more likely to occur. When understaffed, unit personnel depend more heavily upon students and inexperienced staffmembers; this likewise threatens an increased assault rate. Several nurses also expressed concern over compromises in the preparation of patients for discharge when they cannot use their passes because there is not enough staff to accompany them off the units.

Turnover

Nursing personnel on all three units describe a sense of limited common history with the other members of the staff. Loss of a co-worker means further decrease in feelings of team membership. Seemingly continuous change reinforces inclinations toward limited relationships.

At times staffmembers look forward to a specific individual's departure. More often, they reluctantly, or with some bitterness over being "abandoned," see leave-takers as "escapees off to better things." Typically, leavings evoke little comment or analysis, although the work situation changes for everyone whenever a staffperson leaves. Individuals are missed, but the nurses seldom openly discuss the impact of turnover upon themselves or the broader system. When experienced and competent staffmembers resign or retire, the remaining staff feels less able to handle and prevent incidents in which someone may be hurt. Although nursing turnover occurs at a lower rate at

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City and County than in many medical settings, the long gaps before personnel are replaced are ominous.

The turnover of personnel and the transitional feel of the units is magnified at City and County by educational rotational systems that funnel large numbers of relatively unsocialized trainees through the units. These include nursing students and, in larger numbers, students of various types of therapy. Many staffpersons attempt to minimize contact with these rotating groups. Longtime staffmembers tend to prefer the "calmer" evening and night shifts, while trainees and newer nursing staffmembers typically work during the day. With a substantial proportion of daytime staffmembers "green," it is not surprising that day shifts tend to be characterized by such phrases as "over-populated," "frantic," "disorganized," and having "different people at every meeting every time."

New staffmembers, when they do arrive, are not socialized to the system so are unknowns not yet trusted in emergencies. Unsosocialized newcomers are accompanied by the threat of increased likelihood of uncontrolled situations. A sense of interdependence and teamwork must be rebuilt through the mutual experience of potentially difficult situations. Since there is little time before some other staffperson comes or leaves the day shift, dyadic relationships are more likely to be established than are those characterizing group membership. The staff, forced to deal with substantial unpredictability in patient behavior, looks for stable behavioral patterns within their own ranks. The nursing staff is, however, often an untested assemblage of individuals, only some of whom are accustomed to working together.

CHAPTER 5

PSYCHIATRIC NURSING AT CITY AND COUNTY

"It is the wretched victims of their poison in life's cup,
Who in increasing numbers fill these vast Asylums up;
And with this human wreckage we are herded all day long.
For all the hours heav'n sends us must we mix with this and throng.
Repulsive work we have to do, and bear obscene abuse,
And undergo a mental strain from which there is no truce;
Our tempers through the live long day are tried full a time;
But if we make the slightest slip 'tis counted as a crime.
Small are our wages, and our food oft times unfit to eat;
While soul-degrading tyranny our mis'ry doth complete."

An Anonymous Asylum Worker
National Asylum Workers' Union Magazine
February 1912.

Times and conditions have greatly changed since an attendant quilled the verse above. Many of the stress-provoking aspects of psychiatric nursing, however, have not changed as much as has the nurse, who today is better prepared to understand and deal with them.

A Shadowed Shift

The following pages describe a single shift in the life of a psychiatric nurse at City and County. Lori Eichelberg is not the "average" nurse, if there is one. In her thirties, slightly built and energetic, she has a master's degree in nursing in addition to teaching credentials. At the time the notes for this chapter were made, Lori had worked as a full time staff nurse on East for about five months.

These data were collected by being with Lori one entire workday. Although similar "shadowing" (as used by Reynolds and Farberow 1981)

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exercises were conducted with other RNs, Lori's day most comprehensively communicates her experience of the nursing role on the psychiatric units at City and County. Self-confident and assertive, and not feeling the need to be defensive about the nursing care she gives, Lori could ignore my presence and go on about her business.

It was dark when I got to the hospital at 6:45 Tuesday morning. In contrast to later arrivals, personnel on the day shift deal with minimal traffic and have a chance at finding a parking space near the main building. The birds in the trees in front of the hospital were chattering. People ran through the area with their briefcases and parcels held over their heads. Droppings underfoot testified that their precautions were well founded.

I met Lori by the elevator, rode up with her to the tenth floor, and accompanied her to East's staff lounge after greeting the night staff at the desk. Lori had a cup of coffee and a pastry with her from a small stand that appears in the lobby each morning. The traffic sounds coming in the windows at the end of the unit grew, soon nearly drowning out voices in the lounge as the day staff gathered.

At 7:15 the night nurse came in with her report. Lori had already listened to most of the shift report from the previous evening on the tape recorder kept on the lounge coffee table. When the night RN, Ellen Landor, came in, Lori stopped the recorder and listened to Ellen's summary of each patient. The report focused on laboratory work and on outstanding, usually negative, behaviors. Descriptions of the patients tended to be impressionistic: "pesky," "obnoxious," "smelly," "baseline" (implying that a patient's condition had improved to "about as good as we can expect this patient to get"), "confused," "that poor sweet little old man," and so on. Interspersed were more or less technical descriptions of physical and/or psychological conditions. There were eighteen patients, "plus one holding" (that is, one patient who was being observed, but who had not been fully admitted). When Ellen and Lori spoke of "sick" patients, they usually referred to physiological symptoms. References to mental illness were for the most part behavioral assessments and descriptions. Lori made notes on a half sheet of paper. Ellen and Lori briefly discussed several questions about plans for patient discharges and placements.

Ellen works per diem. She usually does not know any of

the patients on a unit when she works, unless she remembers them from previous admissions. She has had a hard night. One man, very disruptive, was placed in the seclusion room bed in "two-point restraints" (that is, one arm and one leg were restrained). The seclusion room is not soundproofed; he could still be heard shouting, as he had all night.

Of the five staffmembers scheduled for the shift, two called in sick. That left two RNs and one LPT to staff the unit for the day. The second RN, Tom Kerr, came in half way through night shift's report.

When report finished, Lori walked through the hallway toward the nurses' desk. Almost immediately a usually passive and quiet patient, Ted Smith, approached her and asked to talk "right away." Lori stood with him by the day room divider and they conversed for nearly ten minutes. Lori then came to the nurse's desk with a note that the patient had given her. It accused the city police of slowly microwaving him, described electricity going through his body and wires in the locker in his room, and other delusional material. Ted was unusually distraught. Lori shook her head and told the LPT, Annemarie Baker, "We'd better watch him closely today. He's crazier now than I've ever seen him, crazier than when he came into the hospital."

I followed Lori to the seclusion room where she peered through the door's small window at a large Black man in his sixties who, clad only in a hospital pajama top, sang loudly while banging rhythmically on the bed and jingling the restraints attached to his left arm and leg. After a brief look, Lori said, "Nope, I'm not going in there."

Back at the nurses' station, Lori, as charge nurse for the shift, started making assignments for the other RN, the LPT, and herself. She worked in large part from the chalkboard which, filling almost the entire wall directly opposite the nurse's desk, displays data regarding each patient's legal status, privileges, and assignments to a primary and a secondary nurse, a therapist, and a treatment team. A sizable portion of the chalkboard information had been obliterated in the night during one of the tirades of the man now in seclusion.

At 7:45 Ellen tried to sign off a final item in the medication book. With a chuckle "Oh, shit!" she returned to the chart room for information she had forgotten to bring out to the desk with her. Everyone at the desk laughed at the familiar incident. Ellen was still charting at 8:30, although her shift was over an hour before. Later in the day several items were found to be missing from the night shift records.

Some of them the day staff covered, some they ignored, and a few they acted on. They left a note to remind Ellen, for example, to sign for one medication because it was a controlled substance. Since she works irregularly, however, the chart in which she is to sign may or may not still be on the unit when she returns. Tom explained this to me, adding that he felt his obligation in the matter was filled. The staff was neither concerned nor surprised at the omissions in the records, except that some included PRN (that is, not routinely administered but given "pro re nata," or when required) medications which, when given and not charted, could result in the administration of extra doses when the patient asks for or appears to need them again. Ellen had mentioned during report several PRNs she had given. Lori and Tom worked with that information, trusting that it was "complete enough."

Lori asked two nursing students to feed Aster Jones, "the conversion reaction patient who is paralyzed, most of the time, from the neck down." Tom prepared an injection to be given to the secluded patient who was still very noisy. Lori called the security police for help in administering the medication. While waiting for the guards to arrive, she discovered that she did not have her keys, including those to the medication room and narcotics cupboard. As the police arrived at the unit and the LPT helped them secure their weapons in the gun locker, we all searched around the nurses' desk for the missing keys. Lori borrowed an extra key and let herself into the staff lounge where she located, with relief, the keys in her jacket pocket.

The man in the seclusion room, still naked from the waist down, was sitting on the floor, despite his wrist and ankle being anchored to the bed. Lori explained to the guards, who arrived ready to subdue the already restrained man, that she felt their mere presence would be adequate persuasion. Two large, Black uniformed guards, two RNs, an LPT, a social worker who happened along at the time, and I entered the seclusion room. No staffmembers were left "on the floor" or at the nurses' desk. The man made no attempt to resist the injection, the show of force or the mass of attention temporarily quieting him. The police left with Annemarie to retrieve their guns. Lori checked to see that all of the patients were getting breakfast.

Lori reworked the assignments, making changes to include three student nurses. Each student was given one patient to care for. Two students, relatively inexperienced, got gentle, non-threatening patients; Lori described them as "the kind who need lots of attention and typically pester the staff for it." The senior university student, who was a Licensed Practical Nurse in a psychiatric hospital prior to starting

her RN training, was treated as a member of the regular unit staff, being given a more difficult patient and additional tasks. She is at City and County on a preceptorship. Lori recently became her preceptor when another RN left the hospital. At this point in the student's education, Lori pointed out, the faculty visits the clinical setting only about three times a semester.

After finishing her assignments, Lori transferred the information onto the clipboard used to record summaries at the end of the shift, and to a sheet of paper taped to the top of the desk. This paper was used by both staff and patients to see who was assigned to whom for the shift.

The ward was quieting; the man in the seclusion room was singing, but less loudly. Most of the patients were in the dining room eating breakfast. Lori went in to see Aster, for whom she is primary nurse, and to move her from her wheelchair to the bed. She carefully arranged the patient so as to avoid the same pressure points on which she had slept during the night. Some of the nurses say that this is unnecessary since Aster, despite her widespread daytime paralysis "isn't going to get bedsores because she sometimes turns herself in her sleep."

At 8:30 the head nurse, Charlotte Hastings, came in. Charlotte dropped a note in a mailbox and proceeded to her office at the end of the hall. About twenty minutes later she returned to the nurses' desk to begin phone negotiations with the other units to try to borrow an additional LPT for the day. The staff on two units told her that they were no better off than East was, having either staff who have called in sick or only male or only female staffmembers. (Each unit attempts to schedule both male and female staff each shift.) Several patients intruded into the conversations at the desk, asking for their medications. Assigned to be given at nine o'clock, the "meds" are usually distributed between 8:30 and 9. Another student nurse showed up; Lori again adjusted the assignment sheet and got the tardy student started.

At 8:50 Lori went to the medication room to "pour meds" for the patients on one of the two therapy teams. Tom had already prepared the medications for the other half of the patients on the unit. Only one person at a time can move about comfortably in the medication room. While Lori worked in the tiny space, a student nurse entered and asked for information, Charlotte came in to explain that she could not get any more staff because two of the three other head nurses were out sick and their staffs are not willing to let a co-worker leave when they already felt short-staffed, Tom came in to put away his medication tray after finishing his rounds,

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and I was in there too. Lori continued preparing medications while interacting with all of these people, well aware that her practice differs substantially from the way student nurses are taught to pour meds without distraction. Lori pointed out to me that the supplies included many antibiotics. For many patients the psychiatric unit "is the only place they get any medical care at all."

At nine o'clock the therapists began to arrive. An LPT, Rob Barclay, also arrived unexpectedly from Ten South for two hours. To compensate for the additional staffmember, Lori once again adjusted the assignment sheet, asking the tech, a pleasant man with nearly twenty years of "civil service psych" experience, to "keep on eye on" the patient who had earlier given her the note. His other immediate task was to shower and treat for pediculi a patient who had been admitted during the night. Lori distributed her medications as she gave specific instructions to Tom and Annemarie for patient care while she attended Team Meeting. She then adjourned to the meeting room at the end of the men's hallway. It was the first time Lori sat down since morning report two hours before. There she charted the dispensed drugs as she waited for the therapists to assemble.

At 9:10 the chief physician arrived and stated that from now on the meeting will be held at 9:10, rather than 9:00, because the psychologist needed time to come from another meeting elsewhere in the hospital. The team proceeded to review each patient's condition and status. Lori began by updating those present (including the chief physician, three interns, the psychologist, the disposition worker, and me) with information about each patient, starting with those considered particularly in need of attention at this time. With some input from Lori, the physicians discussed medications and symptoms, attempting to decide which symptoms were attributable to organicity and which to psychosis. The decision was made to interview the patient who had given Lori the note, since he was unusually upset. The team was surprised at this change; they had considered Ted nearly ready for discharge. The intern assigned as Ted's therapist left to ask him if he would allow an interview, and if he would bring the note he had given Lori and then retrieved from her when she had tried to give him his nine o'clock medication. The therapists were perplexed by the sudden reversal in this patient's condition. "But how can an OBS (organic brain syndrome) patient decompensate like that without a medication change?" Lori commented again that the patient's condition was somehow worse, "the worst I've seen him, worse than when he came in." The possibility of a toxic psychosis was discussed. The physicians' discussion focused on the medications administered and their various pros and cons.

They did not debate whether drugs should be used, but rather how much of which ones. The man consented to the interview and it was done during the meeting.

After Team Meeting, Lori worked around the nurses' desk, answering the phone, charting, taking off orders, and responding to questions. Annemarie, the tech, went for coffee, bringing some back for Lori as well as herself. The patient in seclusion was now quiet, although he continued to reject attempts to clothe him, and would accept neither food nor drink from Tom. Lori calculated that he probably had eaten nothing since yesterday morning. Eventually Tom got him to drink a little juice. The staff was not concerned that he had not eaten; "Patients this agitated can't eat anyhow." Dehydration was to be avoided though, as was overhydration "for other reasons." The man had already thrown a used urinal at a member of the night staff.

The unit's carpeting, stained and filthy, was soaked and smelled bad in the men's hallway by the water fountain. The head nurse decided that it was time for something to be done about this. She phoned several people, complaining that "It's awfully hard to get anyone to do anything around here." Eventually a woman in a nice dress and high heels appeared with a large floor scrubber. Soon a janitor joined her with his cart. Since none of the hospital's rug shampooers worked, the decision had been made to clean the area with a floor scrubber. Applying more water to the already soaked and poorly ventilated area, the team scrubbed for about ten minutes, and then left the unit. Only the area of immediate complaint was touched, and this remained wet for several days, but it smelled better.

Lori, meanwhile, spoke with her patient, Ted. At 11 o'clock he still had not had his 9 AM antidepressant medication because he had refused to take it. Lori tried again, gently and quietly, to get him to take the pill. He said he could not swallow. Ted has numerous somatic complaints, none of which the physicians can find reason for. He always speaks with a low, harsh, scratchy voice. He ignored Lori's repeated request and looked up at the tech on loan from the jail unit, "Why's he here?" Lori explained that Rob was borrowed from another unit where he works. Rob pointed out the window from which we could see the south wing, "Over there." Ted nodded. Lori again asked the patient to take his medication. "I can't," he replied. He was neither hostile nor loud, but acted extremely frightened. Lori implored, "Ted, this is the only way we can think of to help you get better." She offered him a choice between the oral medication and an injection. The man looked even more fearful, but persisted in his conviction that he could not

take the pill. Lori drew up the injection, asking him several more times to take the pill instead. He continued to refuse, and offered no resistance as Rob, Lori, and I accompanied him to his room where he sat on the bed and Lori gave him the injection in the arm. Lori thanked him for his cooperation and encouraged him to come out into the day room.

Taking the used syringe back to the medication room, Lori wanted to prepare an injection of thiamine for an alcoholic patient. She found that there were no more syringes of the appropriate gauge. She checked the store room, finding none there either. She sent Annemarie to borrow some from another unit.

Lori then moved the paralyzed patient again. As she did so, she started to say something to me and then stopped. Lori looked so small moving Aster, even using good body mechanics, that I thought she might want me to help her. She shook her head and explained, "It's just so tempting to ask you to do things. I was going to ask you to take (a patient) to the bus station to get her clothes." I replied that since I was not a hospital employee, I probably should not be driving hospital patients around, but that I would go later and pick up the clothes if she had the specifics on where they were. Lori explained that the patient had to get her own things; legally the staff was not allowed to get them without her. She said she would ask the disposition worker (the closest East comes to having a social worker) to arrange something, and she did. She continued with a laugh, "It's just that you're here and it's so tempting to give you things to do like everyone else. I forgot for a minute. There are so many things that could be done."

Except for Team Meeting, Lori has been on her feet all morning. It is now 11:45. Most of the time, she is doing more than one thing at a time. Lori says she is well aware of the dangers inherent in doing things this way, but she does not see how else the necessary patient care and tasks will be accomplished.

We returned to the front desk area. There were five patients in front of the television in one day room. Two were asleep. One was sitting with her head in her hands on her lap. Another stared away from the game show on the set into space. The fifth was lying on the couch, talking to his fingers which he held close to his face. In the other day room was a single patient. He went from corner to corner, standing for a few minutes in each, slowly rubbing himself up and down on the walls and drapes. He then transferred to the opposite corner, doing the same thing there.

Annemarie returned with several syringes and a message from the unhappy donors that "East better get its shit together and order what they need." Over the course of the day, Lori filled out an order form with requests for syringes and other supplies that she found out from the other staffmembers were in short supply. I asked whose task it was to requisition supplies from the central source. Lori said the night nurse usually did it. Tom said the ward clerk sometimes did the ordering because "nights isn't sure it's their job." The ward clerk said she thought she was doing it for the head nurse.

As Lori prepared the order form, a patient stood in front of the desk muttering obscenities to no one we could see. Another brushed too closely by a hostile and volatile young man who immediately spat and screamed at the offender. A fourth patient laid on his bed in the hallway watching the people at the desk and picking his nose.

At 12:30 Lori and I left the unit to attend her weekly supervision session in the office of the Supervisor of Clinical Services, a CNS. Usually these meetings are longer, Lori explained, but today she would stay only ten or fifteen minutes because she was presenting at Nursing Grand Rounds later in the afternoon. Lori carried her hardbound copy of the DSM III (Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association 1980) and a pile of notes to the supervision meeting. She explained to the CNS what she planned to do at Rounds. The supervisor was encouraging, suggested several minor items that Lori agreed should be included, and gave Lori a three-page paper she had written on countertransference during graduate school, apologizing for not having got it to her earlier. Lori did not have time to look at the paper before rounds. On the way back to East she purchased at the snack bar a cup of fruited yoghurt and a bottle of mineral water for lunch. She consumed these on the unit over the next hour while working.

While we were at the meeting with the supervisor, hearings were conducted on the unit by representatives of the court to determine whether specific patients continued to require hospitalization or were capable of caring for themselves (that is, obtain food, shelter, and clothing) elsewhere. These hearings sometimes leave staffmembers in the difficult position of trying to communicate, in front of the patient and to the legal representative, what and how serious they determine the patient's problems to be, while trying to maintain the rapport that established with the patient. If the patient exercises his or her right to be present, and the therapist or other staffmember explicitly describes the patient's condition, the patient-staff relationship may be

jeopardized. On the other hand, if problems are understated, the patient may be released unless he or she elects voluntary admission and agrees to stay in the hospital, an infrequent occurrence. Many patients have nowhere to go and are too disturbed to meet their own basic needs. Some are dangerous to themselves or others. A large number are street people or transients. Some have friends who monitor them, bringing them to the hospital when they pass the point of being able to "make it" outside of the hospital. Sometimes the friends and/or the patient do not agree with the length of time the patient is held on the unit, and work toward discharge. After the supervision meeting, Lori spent ten minutes in a hearing with one of her primary patients, and then fifteen minutes discussing the process with the chief physician and an intern, the latter upset because of the way his patient's hearing had gone.

Coming back to the desk area, Lori glanced at the paper labeled "Suicide Check List" taped to the top of the nurses' desk. She said, "Actually, we don't need this," removed it, and threw it away. Her explanation was that suicide precaution status automatically implies checks on patients at least every thirty minutes. "We do half-hour checks anyhow. Why do we need an extra sheet of paper?"

Ted, fearful and depressed, came to the desk to get Lori to check his room for evidence that the city police were trying to microwave him. Lori went with him and looked around the room. She explained to him that she did not agree that someone was trying to hurt him, but that she understood that he believes that is true. Lori then prepared and distributed one o'clock medications.

While charting the medications, Lori found an order that had been changed since early morning when the medication cards were sorted into piles according to the time of day they were to be given. The student, when "taking off orders" for Lori and Tom, had not pulled the now erroneous card. A similar mistake had been found by Tom, but prior to administering the medication. Since the Kardex (a rack of cards summarizing diagnostic and treatment procedures for each patient) had not been changed either, Lori did not discover that the wrong dosage had been given until recording the medication in the patient's chart. Both Tom and Lori again explained to Sarah Long, the student, the importance of changing the order in each of three places. Unable to reach the prescribing intern by telephone, Lori left a note for him explaining that his patient had been given the old rather than the new dosage.

Lori spent a few minutes with each of her patients. By 1:30 she had not yet finished her lunch. Tom, however, had

succeeded in getting the secluded patient into pajama bottoms. Charlotte, the head nurse came back from lunch and, on her way to her office, made a negative comment about the appearance of the unit and insisted that the suicide check list be reinstated because "It is required."

I asked Lori how typical this day was. She answered: "Similar things happen every day, although I don't always feel so rushed. Really, I do often though. Other than that, it seems pretty usual. I'm nervous today though. I'm not worried about the presentation this afternoon, although I had hoped for some time to go over my notes. What really bothers me is that my dog got hit by a car last night." The latter statement, overheard by Annemarie as she walked by, stimulated concern and sympathy from both of us.

A few minutes before two o'clock Lori went to the staff lounge to collect her DSM III, her notes, a large pad of newsprint, and a felt marker. We left the unit for a meeting room elsewhere on the tenth floor. As Aster's condition had improved, Lori had hoped to bring the patient about whom she was presenting with her to Nursing Grand Rounds. After a recent threat of being discharged, however, the patient was vomiting, incontinent, extensively paralyzed again, and extremely hostile toward the nursing staff. Lori did not mention the rounds to her.

A total of nineteen nurses attended Nursing Grand Rounds. Most of them were head nurses (although East's was not there) or clinical nurse specialists from the units. The clinical supervisor was the only nursing manager present. The other nurses were staff nurses, including two from PEC and one from a city clinic. We started with introductions. Many of the nurses did not know each other, although most worked on the tenth floor.

Lori focused her presentation on the nursing care of patients with conversion reactions. She purposefully tried to avoid a medical treatise on the condition. She began by describing East's nursing staff's reaction to the admission of a patient who was both paralyzed from the neck down and considered responsible for having caused her own condition. Lori related the descriptors initially used by the staff for this patient: "hysterical," "manipulative," "rageful." The attitude had prevailed that "if this patient really wanted to get up and walk, she would get up and walk."

Lori then presented overviews of the patient's history and of somatoform disorders, pointing out that these are not under voluntary control. She also discussed the natural response to someone who always feels neglected and in need of

more attention. The unit staff had resented the strain that this self-described "neurotic" put on them when "real psychotics" were presumed to be sicker, and were often less demanding.

Despite Lori's announced and obvious effort to focus on the nursing care of a patient who had required immediate intervention and more than the usual amount of nursing attention, the majority of nurses present at rounds focused on the medical handling of the patient. Particularly questioned were the medications given and whether hypnosis or a sodium amytal interview had been used to explore "what is really going on with the patient." The consensus was that the intern in charge of the case had "taken the easy way out" by avoiding these approaches.

Lori presented well and confidently. She held her ground with the other nurses and repeatedly refocused the discussion away from medical treatment onto nursing care. She had obviously researched the topic thoroughly. Lori was disappointed, although not surprised, that the audience had insisted on asking questions rather than letting her present as she had planned, and that their questions had been medical, not nursing questions.

We left the conference room at three, in time for shift report to the on-coming nursing staff. Lori had not had time to finish her charting or to organize report. Some patients' blocks on the clip board had already been filled in by Tom or Annemarie. The student nurses had left summaries with Tom for their patients. Lori's own patients' statuses she filled in orally as she went down the list during report. In addition to being given to the second shift, the report was audiotaped for the night staff. Lori held the clip board in front of her, however, so that it somewhat covered the tape recorder. With the outside sounds of heavy afternoon traffic coming in, part of the report was inaudible.

Lori mentioned to me as we left the staff lounge that she was not going to finish her charting this day. "The meds are charted; the rest can be ignored. Usually I stay and do it. Not today." She was on her way to the veterinarian to see how her dog was doing, and then to take her son to the dentist. I asked if there was a legal requirement that each patient be charted on each shift. Lori didn't think so. She thought the administration might send her a note about her failure to finish the expected work, "But...." Lori shrugged and smiled.

I thanked Lori for allowing me to shadow her, asking if my presence had been bothersome to her. "No," she answered,

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"Really not at all. It just seemed odd to have someone around watching me who isn't paranoid and talks coherently."

The Routine That Isn't

Faced with ever-increasing mandates and expectations for paperwork, the nurses at City and County juggle routine tasks with meeting and patient-care schedules. Distinguishing between necessary and superfluous chores is a continuous challenge. Most RNs say they would rather not have to make these distinctions, but all of the expected work cannot be done in the time allotted.

Part of the confusion associated with the current work load is attributed to a large number of recent new policies, the goals and objectives for which sometimes remain unclear or seem conflicting. The staff describes feeling a "crush between the new and the old." Further complexity and sense of being overwhelmed are superimposed when expectations of physicians and therapists apparently differ from those of the department's nursing leadership.

The nurses voiced many complaints about their roles. They say that "there is always more to be done," so satisfaction is limited. They also state that they were taught to work in nurse-patient dyads which have little relevance to the units. Some claim that the nursing role has not adapted to the trend toward shorter patient stays.

New staff nurses on the tenth floor often complain that the routine, especially during day shift, is too vague. It varies each day of the week with the therapists' meeting schedule. In addition to meetings, the nurses deal with admissions and discharges, therapists' orders, direct patient care, maintenance tasks, errands off the unit,

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commitments to group sessions, medication administration and monitoring, administrative requirements, and expectations for prolific documentation.

Many nurses complain that they do "paperwork instead of nursing." Night shift is described as "full time paperwork." Written tasks entail upkeep of assignments; admission, discharge, and transfer paperwork; unit business; flow sheets which log events associated with each patient on each shift; forms to quantify the acuity of patient conditions for comparison with numbers of personnel available; team meeting notes; census check forms; special precaution checklists; time schedules; Kardexes to summarize patient conditions, treatment, precautions, and care; communication books and intrastaff communication procedures; medication cards and records; patient charts which involve orders, progress notes, nursing care plans, and recording of physical data; and various chalkboards recording legal, assignment, precaution, and privilege data. Day and evening shifts estimate that each nurse spends at least three hours on paperwork each shift. Charge nurses spend fifty to sixty percent of their time doing paperwork, and head nurses nearly all of the time they are not in meetings.

Shift variation in nursing routine is significant. During the day the medical staff sets the tone of the unit. Primary care nurses and teams focus minimally on the unit en toto. Tasks and information are dispersed with little uniformity and according to the policy of the nurse in charge. The tone for evening and night shifts is set by the nursing staff. Some of the charge nurses believe in dealing with the unit as a whole, and there is more orientation to a team approach, or

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as some staffmembers put it, "less of everybody doing his own thing." Limited staffing during the second and third shift frequently prohibits primary nursing. Diverse tasks are more likely to be democratically delegated then, and the staff is more likely to consider itself somewhat cohesive.

Role Blurring

The way that Lori Eichelberg performed her work role has little bearing on how others in the same position might fill theirs. Many RNs at City and County express concern about a lack of clear guidelines and boundaries around their roles. Job descriptions are often vague, considered by staffmembers to be of limited relevance to the work at hand, or unfamiliar to unit personnel.

In the work setting, distinctions between RNs and non-RNs, and between RNs with technical training and those with baccalaureate educations in nursing, tend to be subordinate to categories of those who do or do not give medications, and those who are or are not primary nurses. Despite administrative efforts to upgrade unit staffs with increasing numbers of registered nurses, part time personnel, nearly a third of the total, are marginal to the established system. LPTs who give medications are primary nurses; RNs who work part time or per diem are not.

The fact that RN and non-RN roles are frequently blurred to the extent that many LPTs say that they "do everything an RN does," and some RNs do not disagree with that claim, does not imply a communal spirit among the nursing staff. Many nurses express concern over the

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limited cohesiveness with which they characterize nursing in general and intrastaff relationships at City and County in particular.

Nurses come to City and County with a variety of background orientations to their jobs as psychiatric nurses. The units' limited orientation programs do little to standardize the expectations and behaviors of new personnel. Role performance is further diversified by the leadership styles of charge and head nurses. Charge nurses may or may not endorse and support primary care, or delegate tasks and care to specific subordinates. Who the actual nursing leader is on a unit at a given time (head nurse, charge nurse, primary nurse, team leader, team coordinator, or sole RN), and how he or she behaves in the role, varies by shift, individual role interpretation, and the staffing situation. Role performance by staff nurses requires frequent readjustment to accommodate these variations.

CHAPTER 6

DICHOTOMIES IN NURSING: DEPENDENCE AND INDEPENDENCE

"Labor can do nothing without capital, capital nothing without labor, and neither labor nor capital can do anything without the guiding genius of management; and management, however wise its genius may be, can do nothing without the privileges which the community affords."

W. L. MacKenzie King, 1919

Nursing and the Feminine Image

Nursing's image is a reflection of the value that society places on women at a given time. In America, the social esteem attached to occupations of minorities and females is less than that associated with occupations of majority males (U.S. Commission on Civil Rights 1978). Historically associated with women, nursing in the U.S. remains widely perceived as a weak female occupation operating under the jurisdiction of the medical profession.

The traditional image of nurses portrays females of limited initiative and intelligence enmeshed in subservience within medicine's hierarchy of authority. These stereotypes reflect a view of nurses as sexual targets, the practice of nursing in bureaucratic institutions, and lack of public knowledge about activities involved in professional nursing practice (Aroskar 1980). In spite of ongoing efforts to upgrade the quality and image of nursing, the U.S. Commission of Civil Rights' (1978) prestige scores for selected occupations indicate nursing's relative standing to be significantly lower than those of numerous other occupations.

According to a survey of nursing leaders, the major disadvantages of belonging to a predominantly female profession such as nursing are four (Vance 1979): sexual stereotyping, discrimination (in income, status, and education), problems of self-image (such as subservience, low self-esteem and self-confidence, insecurity, passivity, and lack of assertiveness), and isolation from a male perspective. These phenomena have been important obstacles to the development of nursing and its leadership.

The nursing education system that Florence Nightingale established did not replicate the independence modeled by its founder. The system encouraged the subordination of nursing to physicians. Most of Nightingale's followers little resisted female stereotypes and the conventions of traditional health care as an occupationally submissive role was superimposed upon the traditionally submissive female role (Cohen 1981). But times have changed. The model nurse of today is no longer the traditional female figure of yesteryear who, marginally educated and subservient to the health care system, worked for a second income (Vogt et al. 1983). While many struggle against that image, however, others, and many aspects of the social system, perpetuate it.

Women learn during their childhood socialization processes that they are not expected to function as leaders. They also tend not to develop the support systems that facilitate free communication with each other (Duncan and Partridge 1980), although it has been documented that an individual's success within any organization depends upon strong social systems and knowledge of informal relationships (Meisenhelder 1982). A growing literature indicates that nurses are

becoming more aware of their own support needs. In general, however, rather than increasing group cohesiveness, the organization of nursing tends to be divisive (Rawnsley 1978).

Nurses, like most oppressed groups, generally have not expressed obvious concern about their powerlessness, their lack of recognition as responsible members of society, or the social pressure imposed on most of them to conform to traditional "women's" roles. Although awareness of these issues is increasingly widespread, an absence of occupational unity continues to reflect the competitiveness of nurses who depend upon conflict with the male-dominated world as a primary binding force (Meisenhelder 1982).

It has long been questioned whether nursing's traditional roles and functions attract people whose personalities and backgrounds encourage dependence, and whether the socialization process involved in becoming a nurse reinforces dependence. Dozens of psychological and personality studies indicate few replicable differences among nursing students in the various training programs (Cohen 1981). All types of nursing students, however, indicate self-esteem scores that are significantly lower than those of the general college population. Those indicators associated with professionalism (for example, dominance, initiative, and autonomy) are not among the traits which predict successful completion of nursing programs (which are trust, group orientation, submission, deference, nurturance, and endurance) (Cohen 1981). It is the dropouts from nursing schools who most resemble standard college populations in their needs for achievement, deference, order, endurance, and aggression (Cohen 1981).

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Many graduate nurses continue to demonstrate habitual obedience and submission to authority. Nursing school faculties, despite their verbal advocacy of independence and creativity, tend to perpetuate expectations of dependence and submission from their students (Cohen 1981). There tends to be similarly limited tolerance for nontraditional and assertive role performance in nursing practice.

Nursing and Professionalism

Professions are characterized by autonomy, competence, expert and technical knowledge, and control over education and practice (Cohen 1981). Such traits are frequently considered masculine as well as professional. Nursing as a discipline remains conflicted in its attempts to integrate caring and nurturance, traditionally associated with femininity, with its stereotypically masculine professional and technical aspects. The confusion between professionalism and femininity is perpetuated by a scarcity of role models who successfully portray autonomous and professional interpretations of nursing roles, and by the lack of a clear-cut theoretical base with which to define nursing roles, functions, and priorities (Cohen 1981).

It was Nightingale's intention for nursing to appeal to "'ladies' of the middle and upper classes and others with intelligence and maturity" (Sward 1980). Students had to demonstrate evidence of "culture" upon entrance into training. Nursing has attempted to preserve its standards for character and to enhance those for education. Despite the focus on standards, however, nursing has always had a relatively open recruitment. As a discipline designed to

meet specific societal needs, nursing expanded its recruitment as needs were identified, until nearly anyone can enter some level of the field (Strauss 1975). Typically nurses are women from the middle and lower-middle socioeconomic strata. Relative to medical students, nursing students are more likely to have an unemployed or blue collar father, and less likely to have a professional or businessman father (American Council on Education 1977).

The preparation of RNs has evolved from an orientation to tasks and procedures in now-declining hospital programs, to two educational levels characterized by a bio-psycho-social basis and a problem-solving approach to patient care (Germain 1979). Nursing remains, nonetheless, only partially in control of its education and practice. Dependence within the medical hierarchy, in combination with the practitioner diversity resulting from multiple levels of training and open recruitment, leaves nursing struggling for the autonomy, status, and recognition of professional standing.

Contemporary leaders are attempting to change the traditional, invisible nurse's non-feminist, non-assertive stereotype and to socialize nursing recruits into a nursing profession. The settings in which nurses practice, however, often limit opportunities for and acknowledgment of professional performance. A generalized failure to clearly distinguish between levels of nursing education and performance and to prepare nurses as effective managers reinforces this.

Nursing Staff and Nursing Management

Nursing staffmembers at City and County's Department of Psychiatry

tend to classify themselves and others who work in the department into categories nearly as concrete and exclusive as the dichotomy between staffpersons and patients. More RNs indicated concern about their relationships with their nursing "bosses" than they did about any other aspect of their jobs. To the nurses, there is a "We-Them" distinction between themselves and nursing management and administration. Within this division, head nurses and clinical nurse specialists, failing to fit neatly into either category, are anomalous. They are classified according to individual relationships and whether incumbents of those statuses are perceived as "peoplepushers," that is, oriented primarily to the unit and/or patient care, or as "paperpushers" focused on administrative tasks. Even those nurses who describe relatively positive relationships with nursing administrators often describe administrative roles as aligned with the department or with its medical controllers, rather than with the "front line patient care" that they associate with their own jobs.

Many nurses and LPTs communicate limited trust and respect for nurse managers. One example used to justify this negativity is the conviction that some nurses above the staff level tend to "overcompensate for being nurses by acting intellectual around the doctors and hospital administration, when it is experience, not academics, that counts." Others feel betrayed by the observation that information given to nursing administrators may be shared "with medicine" when it is expected to be held in confidence. A third frequently voiced concern is the widespread suspicion that continual short-staffing is ultimately the result of administrative "hold-ups of

staffing requisitions to look good in the department" by limiting budgeting expenditures. Some staffmembers describe their administrative superiors as uncaring toward them and/or forgetful of "what it's like to 'live' here on the units."

As reasons for feeling unsupported, nurses usually gave examples of administrative "interference" with nursing practice. An example:

A masters-prepared staffnurse who was acting as charge ran "head-on" into nursing administration when she arranged for a per diem nurse to accompany a patient to a beauty shop on a Saturday afternoon. The charge nurse's decision was influenced by her desire to leave full-time staffmembers on the unit because of their familiarity with the patients. The temporary nurse was "the least familiar with the routine and the patients, and, therefore, of the least immediate value to the functioning of the unit." The ward was generally quiet and "well-covered by personnel who knew the patients."

For the patient, the nurse explained, "Getting her hair done is inexpensive psychotherapy. She's been in the hospital for weeks. She's Black, and to get her hair done the way she likes it takes professional work. And getting her hair done made her feel better about herself than probably any amount of meds (medication) could." The patient had several court appearances coming up and wanted to look nice for them. Someone brought in some attractive clothes that fit her well, and "It is only natural that she wanted to get her hair done too."

The charge nurse received the administrative argument that "This is not an effective use of RN time. We can't afford such luxuries. This is a public institution." From the administrator's perspective, the nurse exercised poor clinical judgment by allowing the patient to go to the beauty parlor accompanied by the per diem RN, although the nurse volunteered to go and the patient could not go alone. The "second-guessed" charge nurse was seriously disappointed by the overt administrative lack of faith in her clinical decision-making.

Such experiences lead staffmembers to consider administrators "blind to reality and warped by the books," that is, grounding decisions on written procedures, regulations, or precedence, rather

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than on immediate and "real" circumstances. Nurses in unit level leadership positions complain of frequent interference in or contradiction of their clinical decisions by nursing administrators. Some supervisory statuses and roles, from staff viewpoints, seem unclear, inconsistent, and at times irrelevant. It is common for managerial decisions to be viewed as compromising good nursing practice. Another example:

East's nursing staff is fuming because, after a patient hit a staffperson with a crutch, the supervisor ordered "all such instruments removed from the all patients on the units." Now East has an elderly patient who would be essentially immobilized without his cane. The evening charge nurse, shaking her head, defended his right to have a cane: "For Pete's sake, if you even take their means of walking around away...." After she "locked horns" with the supervisor, there were no further comments on the presence of the cane. This was interpreted as a hopeful sign that the supervisor "might be mellowing. You just can't nurse by the book all the time! When you have to fight other nurses (the management) to do a good job, then we really have a problem! They say to do primary nursing, but those who really want to simply have to do something else. There is too much interference."

Another example involved a member of the nursing staff who developed a good rapport with a mildly retarded man. Because of his history of violence, and because he was sent to City and County from prison, the man was transferred to the maximum security unit to provide a bed on East for a non-custody patient.

Rose Metlach was assigned to the patient as his associate nurse. (The primary nursing model used on the units provides each assigned patient with a primary and a secondary nurse in charge of his or her nursing care.) She was unaware of the decision and plan to transfer him until she was asked to "have him get his things together." She felt especially bad about the sudden move because she had just had the patient switch rooms with another man who was not getting along well with his roommate. I heard Rose thank the patient for cooperating with that move. She later worried that the second, unexplained move would seem punitive to the patient "when he's been fine

here lately, no real trouble at all." She felt even more frustrated when a deputy came with hand and leg cuffs to take him to South.

The common sentiment among nursing personnel that administrators are closed to hearing staff problems and unwilling or unable to risk change was summarized by an RN who stated:

"Bosses don't deal with reality. We do. Unless they are going to come in here and see what the reality is today, they should not be second-guessing our decisions. They are either out to protect themselves or they just don't trust us. I guess both."

Leadership

Unit level nursing personnel tend to avoid responsibility for, and are highly critical of, the nursing organization within which they work. While resentful of "interference" from supervisory personnel, nurses also frequently complain of a lack of direct leadership. Existing leadership is described as manipulative, passive, and "none." Commonly cited reasons for this negativity included examples of use by nurses in leadership positions of informal relationships which at times complicate or contradict the formal chain of command, and their reluctance to evoke disciplinary action when it is needed.

Some nurses say that they have never observed in practice the types of leadership idealized in their training. Several RNs with background educations and experience in business or nursing management independently expressed concern that nurses tend to be prepared for management positions by "OJT" (on-the-job-training). One pointed out that

"... it lets them (the nursing managers) ignore the realities of accountability and cost-effectiveness. And it keeps people

in management with responsibility but very little power."

She might have added that the staff remains similarly powerless.

Although the nurses have analyzed and formed definite opinions about the way in which nursing at City and County is managed, none of the staff nurses with management training is willing to assume a greater leadership role than he or she now has. Their explanations follow:

"The hardest part of every nursing job I've ever had has been dealing with the administration. There are more politics here than anywhere I've ever been. All that administrative in-fighting! Why try to be a manager when you have to be a politician? I don't like politics."

"I am supported only when they want something, like information about how things are on the unit. Why should I support them?"

"The leadership here needs to be looked at again. Our unit has a nursing philosophy that includes a phrase about nurses taking responsibility for their own growth and development. Unfortunately, it has no administrative backup. Patients should be given credit for their creativity and those things about them that are positive. Nursing needs to give itself permission to see those things. Staffmembers' self-health and growth gets lost. There is no administrative focus in that area. So nurses have trouble being positive about patients too. The working philosophy of the unit is that punishment is therapeutic."

"Why can't nurses just be nurses? The 'bureaucrazy' around here really grinds you down. Why would anybody want to be a part of it?"

"Administrators and supervisors should be managers. Managers should be supportive and problem-solving. Sometimes ours don't support us at all. They pick non-problems to solve. They don't allow us to do what nurses can do."

While those in charge describe experiencing "a lot of pressure from the top because of the current reviews" or other causes, the staff generally feels unsupported and unappreciated. A substantial part of

the dissatisfaction expressed toward the management stems from what staffmembers perceive as an inadequate amount of positive feedback. "I'm putting out, but there is not much return, no reward" is a frequently heard lament. Experiencing little positive feedback in direct patient care and from co-workers, nursing personnel seek support elsewhere. The CNSs and nursing management are most often targeted with this responsibility. Occupants of these positions, meanwhile, often focus on "running interference between the units and everybody else," and not directly on the units and unit personnel.

Members of each hierarchical stratum describe "putting out," but working with deficit responses. Each claims to lack the energy to "put out" more than is necessary to the next level. Simple systemic input and output processes illustrate the experiences they relate. One CNS pointed out that "benign neglect" of the staff is "not intentional."

She continues:

"It just happens. Everyone is resting up from the last crisis and for the next. Everyone knows everybody needs feedback, but you have to protect what you have left of yourself. There is no more to give sometimes."

Staffmembers say that they want open, direct, involved, and understanding leadership. While complaining of inadequate management, administrative inflexibility, avoidance of outside input, and "too much interference," they look for increased trust and more direct and visible involvement with unit staff and patient care.

With the staff accustomed to crisis-oriented attention, actual administrative presence on the units more often than not symbolizes trouble. The unit routine and atmosphere changes to adapt to this

event. Communication is likely to be strained and perspectives not openly shared. An example: An RN, having been struck on the head by the same patient twice within a few days, was upset in the staff lounge. The presence of the clinical supervisor on the unit was viewed by the two LPTs left at the desk as a sign of the seriousness of this incident. Overheard discussing "the assault," the LPTs were told by the supervisor not to discuss the incident "behind the nurses' desk." Although perhaps intended to avoid discussion where it could be overheard by patients, the LPTs, required to stay on the unit and to cover the desk, interpreted the comment as "an order not to talk about what happened." They complied, feeling deprived of the opportunity to express their concerns and to provide support for each other. Several days later, one of the techs told me of her conclusion that administrators respond preferentially in crisis situations.

"No one showed up to see how Annemarie (Baker) was when she got almost strangled. Or Tim (Morse) when some guy beat the shit out of him. Nobody transferred the patients out who did that. They aren't important; they are only techs. But let the charge nurse get hit, two docs and the supervisor are here holding her hand, and the guy who hit her goes to South. They don't want her to quit. They didn't even want us to talk about it!"

Ambiguity and Autonomy

Contemporary nursing leaders and educators advocate autonomous and innovative nursing positions and roles. In traditional health care settings, however, these may be misunderstood, confusing, and essentially rejected. Unconventional approaches to nursing remain especially incongruous within hospital structures that are otherwise traditional and rigid.

When head nurses fill their roles in varying ways, these differences are likely to be attributed to their personalities and/or experiences. Nearly any amount of variability is interpreted as within the boundary of the familiar, hierarchical status of head nurse. Although typically limited in power, head nurses have extensive, relatively standardized, and well known responsibilities for and control over their staffs, patients, and units.

In contrast to the customary head nurse role, City and County's psychiatry department differs from the traditional model by the inclusion of nursing administrators within the departmental hierarchy and by the presence of clinical nurse specialists and program directors. (Two of three of the latter are trained as CNSs, but only one identifies herself as a psychiatric nurse.) The three CNSs (one being a program director as well) are Caucasian women in their thirties with masters degrees in psychiatric nursing.

As parts of a social organization designed to meet specific needs and problems, and composed of groups of people governed by established implicit and/or explicit rules and expectations, the CNS and program director positions are incongruous. They fit into neither of the hospital's two distinct hierarchical systems, the administrative bureaucracy and the medical profession (Germain 1979). On the other hand, program directors and CNSs tend to be treated by administrative and unit staff as equally or more powerful than head nurses.

Nurses, traditionally excluded from both of these hierarchies, struggle with the dissonance experienced by the development and existence of roles which defy the narrow confines of traditional

nursing. Most members of the nursing staff, including head nurses and clinical nurse specialists, indicate difficulty with the productive co-existence of these roles on the units. The staff, meanwhile, observes variability in the interpretation and performance of these roles. Examples include the assumption of teaching, advocacy, consultation, therapy, supervisory, or ward organizational duties, and the extent of staff involvement and independence.

At City and County, neither CNSs nor program directors have clearly defined responsibilities for other persons, whether staff or patients. Many staffmembers, however, project their need for mediation between themselves and the administration onto the CNS role, only to be disappointed if the CNS does not recognize or accept this function. When contrasted with the traditional structure, the disparity felt by staffmembers over these roles, statuses, and relationships is unsettling.

As an occupation, nursing characteristically provides limited opportunity for upward mobility (Lewin and Olesen 1980). At least eighty percent of the changes made by RNs in jobs and employers are lateral moves rather than position advancements (Donovan 1980). Entrenched in a medically dominated health care system, "moving up" in nursing to many people is analogous with moving out of the discipline. Some individuals who "move up" communicate a broadened nursing perspective; others, substituting different conceptual frameworks, retain little or no identification with traditional nursing. In either case, the typically clear "We-Them" dichotomy is blurred. Unit personnel performing traditional roles frequently find the variability

and marginality of nontraditional roles confusing.

The consensus of nurses on City and County's psychiatric units was that nursing supervisors should be active, supportive, listening role models. One nurse stated summarily that

"They need to offer the staff the same opportunities that the patients get for healthy interactions. The way the system is, if you are full time, you never have the space to take care of yourself. And no one helps you do it. I know there are realistic alternatives. There always are when you want them badly enough."

Feeling that they lack other alternatives, nurses project responsibility for the idealized role onto supervisors, administrators, CNSs, and head nurses. The individuals in those positions vary in their acceptance of the imposed role expectations. Consequently, a substantial number of nurses in traditional staff roles limit their support of those individuals from whom they feel occupationally estranged.

Head nurses

The head nurse position, although reflecting the traditional model, in some ways is hardly less ambiguous than the nontraditional statuses previously described. Encumbered with heavy responsibilities, City and County's psychiatry department head nurses answer to the senior attending physician regarding patient treatment and care, to nursing middle management and administration about staff issues and clinical performance, and to their unit's program director concerning patient program issues.

North's, East's, and West's head nurses are female, BSN-prepared,

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and unmarried. One is in her mid-twenties; the others around forty. They reflect different ethnic origins, but similar economic and educational backgrounds. Each has at least six years of nursing experience. Each has been a head nurse at City and County at least two and fewer than four years. Two are awaiting permanent appointments dependent upon the outcome of competitive civil service examinations given to select for head nurse positions.

The head nurses describe their roles as competitive with those of the CNS and program director (less so with the latter); as prohibitive of "being out with the patients;" as incompatible with family life; as having too few clear "role distinctions" (that is, rights and responsibilities associated with only that status and behaviors associated with only that role); and as complicated by the increasing number of staffmembers who have more education than they have, by the system's increasing and rapidly changing expectations of nursing practice, and by the imposition of more responsibilities than power.

The head nurses vary widely in their interpretations of appropriate leadership and their relationships with unit staff. It is unclear whether the philosophy each professes regarding the control and organization of her unit reflects an actual management plan, or is a description of the situation as it occurs or is idealized.

One head nurse describes her relatively authoritative reign over her unit as "traditional." Staffmembers with whom she works describe (often in psychiatric terms) her leadership as "reassuring;" "insistent that order be maintained;" "sane and rational;" "fairly active;" "listening;" "usually supportive, with an inflexible streak;" and

sometimes unwilling to share as much detail about her expectations as some staffmembers would like. It is not uncommon to see this individual caring for and/or interacting with patients. This was the only head nurse observed unself-consciously modeling practical nursing skills.

The other two head nurses perform their roles somewhat differently. One describes her approach as analogous to the way her parents ran their family, that is, "like a business." Although staffmembers complain that their requests for information or assistance may be met with increased intrusiveness and criticism, this nurse's approach is appreciated for the "power" with which she "can handle non-nurses when she wants to." Her aggressive interactive style is at times intimidating. The defensive and sometimes angry staff with which she works characterizes her approach as "critical" and her as "a sharp nurse but a poor manager." This nurse's style is described as "punitive," "verbally abusive," "threatening," and unfair to less assertive personnel. The unit's interactive atmosphere varies markedly with the presence or absence of the head nurse. The following incident illustrates her approach.

I returned to the unit during the patient's lunchtime. A fire drill had been called and the staff was going through its routine, gathering all of the patients in the day room and checking the census. The fire alarm is sounded via a system of bells. These bells are supposed to occur in sequences that are translatable into messages about the location of the problem, whether it is a drill or a real fire, and so on. The bells and the silences are indistinct, however, and I could not always tell where the breaks were in the code. Although the staff thought that the code read that it was a drill, when an RN called the assigned number to find out whether the alarm was over, she was told that it was a real fire and that the appropriate precautions were to continue until further notice.

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A few minutes later the head nurse, who had been at lunch, returned to the unit. She asked what everyone was doing in the dayroom. A staffmember explained, and then, calling the verification number again, was told that it had been a drill all along. The patients were ushered back to their now cold spaghetti. The head nurse made it clear that she was "not impressed" with a staff who could not tell when a fire drill was over. She remained incisively critical for the rest of the shift.

The third head nurse describes her managerial approach as "shared leadership." Disliking the disciplinary aspects of her position, she tends to avoid direct confrontation and feels that being a head nurse makes her "the object of a lot of displaced rage." The following interaction typifies this nurse's non-assertive style.

Believing that he has been poisoned by lunch and his medication, a patient has been hanging around the unit door begging people to take him to the emergency room. The nurse in charge asked an LPT to make a "High Risk of AWOL" sign to alert persons using the door that he might try to leave the unit. The head nurse, upon seeing the sign, asked why this was necessary, implying that she did not think it was. The RN, after explaining her rationale, asked, "Want me to take it down?" The head nurse responded, "Well, not if you think it's necessary. What do you think?" The sign stayed.

Reflecting their interactive and management styles, the head nurses vary noticeably in the extent to which they are visibly involved on the units. Direct and assertive interaction with patients and staffmembers (that is, in staff terms, "with the unit") was observed and described by the staff as correlating with personal visibility, attendance at team meetings, personal supervision of unit personnel (Some head nurses and CNSs have supervisory sessions with primary and associate nurses from other units.), sensitivity to current unit issues, "balanced and appropriate feedback" to staffmembers, and perceived supportiveness. Distance from "the unit" was associated with time spent off the unit

(for example, "retreats" to administrators' offices), preoccupation with administrative tasks, a crisis orientation when dealing with the staff, limited perceived support, lack of sensitivity to current staff concerns, and distance of the head nurse's office from the nurses' desk.

Educational Opportunities

Two other topics of major concern among the staff are included here because of their association with the nursing hierarchy and with the internalized dependence-independence struggle. These topics are administratively sponsored or condoned opportunities for increased education and orientation processes for personnel incoming to the units.

The psychiatric nurses at City and County generally highly value the opportunity for more increased knowledge and tend to view it as a potential solution to occupational and personal problems. The nursing staff expects a teaching hospital to support ongoing education programs and attendance at routine inservice sessions is usually as good as staffing allows. Many staffnurses in the psychiatry department maintain, however, that the organization does not adequately or beneficially support work-related education.

The nursing administration professes to strive for improved clinical skills and theoretical expertise, and advocates participation in inservice and other educational resources. Policies allow each nurse to be compensated for several days of education time each year. Nonetheless, the unit staff says, the reality is often double messages.

Unlike many other occupational groups, all nursing personnel cannot attend any session at one time. When an inservice workshop is designed with mandatory staff attendance in mind, the administration sees to it that scheduling allows this. Other sessions are less supported. Middle and line management do not deny the need for continuing education, and at times verbally encourage utilization of specific local educational events, but the responsibility for finding out about and making arrangements for them is left to staffmembers, who may or may not have access to the necessary time and informational resources. Information is frequently obtained too late to arrange unit schedules accordingly, or, due to short staffing, plans made in advance are changed at the last minute.

Despite authorization of a specified amount of annual educational leave, staffpersons may experience difficulty in getting time off or in getting compensation time for sessions even directly related to their work. One nurse commented, "It is easier to volunteer my day off than it is to fight for comp time. Then I wonder if it is worth it." Permission to go during work time may entail frantic efforts to make up the work, discomfort over stressing co-workers with additional work, or punitive attitudes from co-workers or head nurses.

On the units, routine inservice sessions vary from systematic and informative classes to unstructured "gripe sessions." Many organized educational sessions are more medical than nursing in orientation. On one unit inservice training is the responsibility of the CNS. On another it typically passes between head nurse and CNS. Each differs in interpretation and assumption of teaching roles. Typifying the

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pass-the-buck approach prevalent where role expectations are not shared, one head nurse stated,

"You can't have a good psych service without the nurses. They need more acknowledgment of their contribution and there should be a better inservice education system in the department. We need a CNS who likes to teach."

Training can have significant impact on the staff. For example, administration-sponsored training sessions are given occasionally for new staffmembers. These focus on handling potential assault incidents. In response to several assaults involving therapists, these well-organized all day workshops were also made available, at their request, to therapy trainees. The sessions focus on avoidance of physical confrontation, and management of situations in which communicative and evasive procedures are not effective.

No nursing program prepares its students for the real possibility of physical confrontation. Even the techniques practiced at the workshops are ineffective when dealing with patients armed with lethal weapons or trained in martial arts. For more typical unit involvement, however, the procedures provide staffmembers with defensive power while minimizing risk of injury to all involved. Following such sessions, several nurses commented on feeling more confident. This "psychological boost" worked in more than one way. Individuals felt better prepared to deal with the unpredictability of their units. Also important, however, was their observation that "It just feels better to know that other people here know the same things." Uniform training encourages staff cohesiveness. Some veteran staffmembers described former monthly

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"... practice sessions, but the people who ran them left. Nobody bothers to put them together anymore. That was back when we were used to working together more."

The nurses also express interest in other types of training. That most often mentioned pertained to the cultures and subcultures from which their patients come. Several staffmembers recounted past transcultural nursing courses and inservice sessions from which they felt they benefited significantly. They expressed a desire to have such information updated and expanded. Other aspects of training in which particular need was described included problem solving, decision making, and encouraging patients' coping skills.

Therapy trainees in the department attend series of weekly sessions designed to provide an overview of the community mental health system and the place of in-patient psychiatry within that system. The administrator in charge of training and the Director of Psychiatric Nursing say they welcome nursing participation in the course. Most nurses, however, are not aware of this potential resource. Those who express interest in the classes must be highly motivated and persistent to actually attend. Again short staffing was the reason usually given for denial of permission for nursing personnel attendance. While therapy trainees sometimes balked at having to attend "more classes," nurses were likely to be denied the opportunity. If allowed to attend the series, they often missed some sessions. Partial participation can be disruptive, yet full participation is nearly impossible when unit situations threaten last minute changes of plans and management is preoccupied with unit staffing. In the present system, continuing nursing education is a luxury.

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Orientation to the Unit

In addition to continuing education, the area most often cited by nursing staff and middle management as needing more attention and support is that of orientation of new personnel to the units. As is the case with education, responsibility for this component of unit organization is in large part shunted from nursing staff to management to administration.

Staff replacement patterns on the psychiatry units prohibit overlap of departing and incoming personnel. To orient newcomers to their work places and jobs, nursing administration designed an elaborate three week orientation schedule. Impressive on paper but rendered non-functional by limited staffing resources, this idealistic program has not been replaced by a standardized simpler and more realistic plan.

Nurses typically begin working at City and County with the expectation that they will learn how the unit and the system work during a structured orientation period. More often than not, they are greeted instead with a busy unit to which they are socialized by immersion. Lacking a systematic and guided period of adaptation, nurses utilize information and knowledge gained from previous experience. This information, however, may have originated in different types of roles as well as settings. The hiring process, although attentive to educational qualifications and past nursing experience, apparently assumes transferability of information. It also accepts paraprofessional work experience (for example, as an LPT) as a substitute for RN experience.

The new employee soon finds that asking questions about "routine" unit procedures elicits a variety of answers. Even watching other staffmembers is of limited help. The weakly structured unit organizations in large part reflect a pot pourri of routines, procedures, and approaches adapted by other (previously minimally oriented) individuals. On all units, including that considered by nearly everyone to be "the most organized," nurses complain of blurred and vague role expectations. Most describe this aspect of work at City and County as stress-provoking and frustrating: "To survive around here does not necessarily take competence, but it does take flexibility." One nursing administrator, acknowledging this problem, says that she tries to recruit staff who can "cope with extremes of rigidity and ambiguity."

Head nurses, CNSs, charge nurses, and staff nurses express differing opinions about who is responsible at the unit level for the orientation of new nursing personnel. With the exception of the occasional individual who assumes the task for an incoming staffmember, occupants of each status point to those of another as responsible. Some nurses claim to have been too poorly oriented to their unit themselves to pass on their impressions of unit rules and procedures to someone else. When charge or and head nurses attempt to clarify standard operating procedures (SOPs) and/or job descriptions, however, they claim generally limited success due to the immensity of the task relative to the time found to do it, incompatible departmental and hospital policies, and inexperience with such endeavors.

Coping

The nursing staff copes in a variety of ways with its frustrations with the nursing organization. Some RNs say that they cultivate supportive relationships with their immediate superiors; more compensate by soliciting the support of persons away from the work setting. Fewer describe consciously reinforcing positive relationships with co-workers, although some depend upon the support of or help of specific others at work. Some individuals work with and depend upon their labor union for support.

Nurses also describe other ways of managing their behavior with the hope that it will work to their advantage. Some attempt to manipulate others' personality or behavior traits to meet their own goals, usually through the use of assertion, argument, or intimidation in dyadic interactions. Sometimes nurses align themselves with administrators and/or therapists rather than with the nursing staff.

Many dichotomize co-workers and others into trusted and not trusted, proven and unproven, supportive and nonsupportive, or other positive and negative categories. At times such a classification represents the shift or unit with which a nurse identifies against all other shifts or units. Negativity may be expressed toward others on the staff in the form of scapegoating, blame for failure to adapt to change, or resentment against staffmembers viewed as less hard working. Some resent hierarchical superiors for perceived socioeconomic differences.

Nurses at times neglect themselves and other staffmembers, or alternate neglect with care and reassurance that they are doing a good

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job and that what they do is important. Caring of others on the staff, if visibly expressed at all, is typically shown symbolically through supportive actions.

Staffmembers also manipulate communication by by-passing parts of formally established channels (although they complain if superiors do this); expressing different opinions in the presence of nurses and non-nurses or according to rank in the nursing hierarchy; or limiting discussions with superficiality, humor, denial, or time constraints. Many utilize nearly any opportunity to discuss the recurrent themes of medical versus nursing territoriality, control versus autonomy, or communication; other unresolved ideological issues; or matters underlying conflicts on the units. Others consciously avoid such topics. Some nurses try to increase open communication and energetically contribute at rounds, team and other meetings, consultation group, shift report, and other opportunities for sharing with co-workers. As many or more minimize their involvement.

Despite the use of varied coping mechanisms in dealing with hierarchical relationships, the most prominent and widespread strategy is the monitoring of involvement and investment in the work situation. Many nurses make the decision not to seek or assume leadership or other positions of increased responsibility. Interest, attentiveness, and input at meetings may be dispensed sparingly. Fatigue, families, schedules, personal circumstances, and other interests are cited as justifications for limiting involvement in existing or potential roles.

Passivity may be directed downward as well as upward in the hierarchy. Common examples include the performance of concrete tasks

and resistance to other responsibilities for patients, and the maintenance of a generally superficial involvement with patients. Other nurses, in contrast, focus on interaction with patients, but remain minimally involved with administrators, other staffmembers, or the unit as a whole. Many nurses view the foci of their nursing roles as either attentiveness to their patients or getting along in the hierarchy. Few seriously consider close involvement with their co-workers as a viable objective.

Nurses resent invisibility; recognition is what they have worked toward for over a century. At the same time, they sometimes behave in ways which perpetuate stereotypes of passivity and dependence. In an atmosphere in which females may be stigmatized as non-persons (Berreman 1981), nursing is defensive. The discipline and its membership are still overcoming their own attitudes of isolation and inadequacy. Perhaps the lack of mutual support within the field is in part due to nurses being too much in need of support to give much (Mullins and Barstow 1979). It has been suggested that more attention should be given to nurses helping other nurses (Meisenhelder 1982). The data reported throughout these chapters testify to the need to develop that theme.

CHAPTER 7

NURSING AND PSYCHIATRY: IDEOLOGY AND PRACTICE

"All men are like existential spiders: We spin our symbol-systems and languages and cultural hypotheses out of our own substance -- and then blindly and hopefully walk on the webs over the void."

Weston LeBarre

"America! America! God mend thine every flaw,
Confirm thy soul in self control,
Thy liberty is law!"

Katherine Lee Bates
"O Beautiful for Spacious Skies"

Contemporary models for conceptualizing mental illness vary widely in their definitional and labeling processes, etiologies, treatment, prognoses, goals, and conceptions of the rights and duties of society, practitioners, families, and individuals (Siegler and Osmond 1974). Psychiatric nursing involves a conglomeration of psychiatric and nursing ideologies. Lacking a unified theory on which practice may be based, nurses develop and present a broad spectrum of approaches to their roles.

Theory in Nursing

Nursing seeks professionalization. In addition to that quest, the discipline struggles for recognition as a legitimate science as well as an art. Since the writings of Florence Nightingale, it has been apparent that nursing requires knowledge distinct from medicine's (Chinn 1983). Allopathic medicine and nursing espouse different

ideologies, values, and perspectives. Nursing emphasizes care and rehabilitation; medicine treats symptoms of diseases.

A serious obstacle to the development of nursing is a lack of consensus among nurses that a science of nursing exists or has value for practice (Menke 1983). The links between theory, practice, and research in nursing have not been strong. Historically, each nursing researcher followed his or her own interests and scientific orientation in studying phenomena. There is more focus now, however, on developing cumulative knowledge (Menke 1983), much of which is applicable in practice. Professional nursing knowledge includes basic social, natural, and behavioral sciences; tools, skills, and attitudes that comprise the clinical act of nursing (for example, communication, assessment, and ethical reflectiveness); and theories for and of nursing (Wilson and Kneisl 1983).

The development of theory and of a theory-based practice (Maloney 1984) are widely advocated as the means to scientific development within nursing. Theories are sets of interrelated concepts that present systematic views of phenomena for explanatory and predictive purposes (Kerlinger 1973). Nursing theories attempt to describe or explain phenomena within nursing (Stevens 1979).

In any field, theory distinguishes professional from technical practice. In nursing, theories, based on research and combined with the process of practice, organize knowledge and provide a scientific way of knowing what to do for and/or with patients (American Nurses Association 1982). Nursing, however, is foremost a practical discipline focused on complex human interactions for which there are

no quick and easy explanatory formulae. The nursing process requires flexibility. Despite awareness of various theories on which to base practice, patient care typically necessitates an eclectic approach (Maloney 1984). Practitioners need and utilize theories that are appropriate to specific situations (Stanton 1980). Nursing behaviors also vary according to the ideologies implemented in particular work settings.

Nurses do not act with common perspectives, sets of assumptions, and/or cognitive orientations to nursing knowledge (Hardy 1983). A discipline still in the preparadigmatic stage of scientific development, nursing lacks a metaparadigm. Its theoretical pluralism is held by some theorists to be appropriate to the discipline's early stage of scientific and intellectual development (see, for example, Wilson and Kneisl 1983). Others advocate a more unified theoretical approach, although the idea that there needs to be a single grand theory or unified model of nursing is unrealistic; no discipline has one. Such idealism presents barriers to theory development.

The goal of developing a nursing theory is to be able to use it for prescription and change. Such theories give boundaries to a field, provide a source from which propositions evolve, establish a basis for formulation of principles and laws, and are pivotal to the development of a relevant body of knowledge (Meleis 1983). Contemporary debates over theories in nursing tend to be basic: what a theory of nursing should be, whether any theories unique to nursing exist, and how nursing theory might be evaluated.

Often found in nursing are broad holistic and humanistic conceptual

schemes (Wilson and Kneisl 1983). These focus on such concepts as mankind, society, health, caring, and looking at the patient in relation to the environment (Nursing Theories Conference Group 1980). Dependency and adaptation within the context of nursing are other common themes (Stanton 1980). Such concepts are more often incorporated into conceptual frameworks than into actual theories, although a number of nursing theories with those themes have been proposed. Some of these theories are useful in the care of the ill, others for well and ill.

Psychiatric Nursing Practice

Another primary issue among nursing leaders today is the reformulation of roles of nurses (Roy 1983). Nursing process is proposed to be deliberate, intellectual, activity-oriented (that is, toward change), orderly, and systematic. The method by which this is accomplished involves sequential phases of assessment, nursing diagnosis, planning, implementation, and evaluation, with reassessments after each of these phases (Roy 1983). Nursing actions generally focus on assuming responsibility for a patient until he or she is ready to do so him or herself, changing or manipulating the environment to facilitate health, and helping persons toward some goal (Stanton 1980). The focus and consequences of specific nursing practices differ with the theoretical frameworks within which they are developed.

Nursing behaviors that are associated specifically with the nursing care model promoted on City and County's psychiatric units include acting for patients who are critically ill or unable to participate

in decision making; guiding patients who require supervision to make choices or take action; supporting patients as an advocate; providing an environment that encourages personal development, communicates respect, and uses patients' actualized potential; and teaching by providing information and guiding patients so they can obtain knowledge or skills essential to specific series of acts (Wilson and Kneisl 1983).

Nursing Theory in the Psychiatry Department

Those responsible for psychiatric nursing at City and County advocate the use of Dorothea Orem's Self Care Theory for nursing practice. Orem's theory focuses on the individual and his or her need for action in the direction of self care. This approach is based on that of Virginia Henderson who earlier isolated the practice of doing for patients what they cannot do for themselves (Nursing Theories Conference Group 1980).

The self care theory is designed to meet basic, universal human needs that are acquired in the event of illness, injury, or disease (Nursing Theories Conference Group 1980). This, like other nursing theories, views nursing first as an interpersonal process. Nursing contributes, through interpersonal exchange, continuous, direct, necessary assistance to individuals who cannot adequately care for themselves. These interactions between nurse and client or patient are conceptualized as a nursing system (Beard et al. 1984).

Three assumptions are associated with Orem's approach to nursing care (Beard et al. 1984). One is wholeness; the person is viewed as

an integrated whole who functions biologically, symbolically, and socially. Secondly, the environment and person form an integrated system with human functioning, which is alterable with environmental manipulation, integrated at each stage of the life cycle. Finally, a person's functioning, linked with his or her environment, forms an integrated functional whole, or system. The needs of the individual are responses to the stresses of the environment.

Modified to make it more readily usable, Orem's theoretical model focuses on five self care requisites: (1) air, food, and fluid, (2) elimination, (3) body temperature and personal hygiene, (4) rest and activity, and (5) solitude and social interaction (Wilson and Kneisl 1983).

Self Care Nursing at City and County

Many nurses on the psychiatric units at City and County find the self care approach unfamiliar. Some feel that the information used to introduce the model is unnecessarily complex and threatening to those orientations to nursing with which they are comfortable. For some nurses, the concept of self care in an acute care setting is contradictory, or too theoretical to be realistically applicable.

Reflecting confusion and resistance among nursing personnel, some patients equate "self care" with apathy on the part of the nursing staff. The appropriateness of a nursing model which emphasizes individual responsibility has also been questioned in situations in which cultural expectations involve passivity on the part of patients. Self care practices and values are associated with cultures such as

that predominant in the U.S.A., which values individualization (Leininger 1984). In some instances this conflicts with the cultural sensitivity professed on the units at City and County. An example:

The therapy team discussed an elderly Filipino man who "has been escalating the unit all weekend" because he is in the hallway screaming, demanding, and "glutting" the staff's attention. The nursing staff felt he is too frail and too suicidal to leave alone in seclusion, so he has been maintained in the hallway. The man expresses great agony and is being treated for a self-inflicted stab wound in his abdomen.

Apparently severely ill for a long time, this patient was kept at home by family members who are reputed to have tried, in accord with their cultural expectations, to satisfy his continuous demands and desires. The unit's occupational therapist argued that the patient should be moved into a side room for the sake of both patients and staff. The nurses maintained their position against this, but expressed feeling double-bound by the model of practice expected by the nursing administration and patients who expect, and in other settings would get, total care. Encouraging this man to be in any way independent only infuriates him further. He and his family have no goals of self care for him, and have behaved accordingly for years.

Primary Nursing

In addition to Orem's self care model, nurses working on City and County's psychiatric units are encouraged to use a "modified version of primary nursing" in their practice. Primary nursing, a current trend in in-patient psychiatric settings, implies an individual nurse's responsibility for the total management of care for a small group of patients (Shannon et al. 1984). This involves the development and maintenance of a plan of care, and collaboration with other nursing and interdisciplinary team members to coordinate the implementation of the therapeutic plan (Shannon et al. 1984). Primary nursing is said to encourage relationships between nurses and patients, and continuity

of care. In contrast to team nursing, which is characterized by a mutual sharing of work, primary nursing requires the division of nursing time and attention between primary patients and other unit activities.

Primary care is viewed by the psychiatric nurses at City and County in a variety of ways. Some say that the approach tends to limit their familiarity and knowledge to those few patients assigned specifically to them. Many are uncomfortable with this approach because they think they should be aware of all patients on the unit in order to understand interactions there, to be knowledgeable of care and treatment plans for other patients as well as their "own," to be aware of potentially dangerous patients, and to be able to act informed when therapists expect all nursing personnel to be knowledgeable about all patients on the unit. Nurses also complain that primary nursing limits decisions and decision making to their own patients. They are hesitant to answer other patients' requests and questions for fear that they will confuse or contradict other nurses' decisions of which they are unaware.

Although relatively recently instituted, primary nursing is increasingly demanded by those in authority in the department. Some nurses feel that the approach is precluded by limited staffing. In reality, staffmembers, although primary caretakers for only a few patients, must be knowledgeable about all patients on the unit in order to work during evenings, nights, or weekends when there is an inadequate number of regular staff to practice primary nursing as it is outlined at other times during the week.

The approach is further compromised because part time RNs are not

primary nurses. Although most per diem nurses are technically prepared for the role, the lack of continuity resulting from their sporadic presences on the units prohibits full utilization of these skills. On the other hand, LPTs on day and evening shifts who meet the hospital's qualifications for administering medication, although less prepared for the role, function as primary or secondary (associate) nurses.

Most of the psychiatric nurses at City and County were trained in the team approach, not primary nursing. Some are resistant to the change in orientation, especially since limited practical effort has been made by nursing management and administration to introduce and institute the newer approach on the units. Lacking a consistent orientation program, primary nursing, like the self care model, is interpreted in diverse ways.

Ideology and Explanatory Models

The models proposed for practice are not the only influences upon nursing behaviors on the units. Composites of personal and professional ideological systems form explanatory models (Kleinman 1978). These are defined as conceptions that reflect social and cultural determinants and influence the definition and meaning of illness, health seeking behavior, sick role and sick role behavior, and the evaluation of care. Explanatory models tend to reflect retrospective views of common events and those elements perceived as causal for sickness (Chrisman 1977).

Persons engaged in clinical practice, as well as members of the lay population, hold explanatory models. They are the chief mechanism

by which cultural and social contexts affect patient-practitioner and other health care relationships (Kleinman 1980). The models also affect interactions between practitioners, in this case various members of the nursing staff and/or the nursing staff and therapists.

Associated with expectations about caring, norms, attitudes, and support systems, explanatory models direct reasoning along certain lines. Relevant to specific settings and situations, they determine what is considered pertinent clinical evidence, and how that is organized and interpreted to rationalize specific approaches to care and treatment (Kleinman 1980).

Explanatory Models of Nurses

Numerous theoretical approaches to psychiatric problems are presented during psychiatric nurses' training (Topalis and Aquilera 1978). Each nurse brings to the nursing situation a composite of popular (lay) and public (professional and/or scientific) ideas and beliefs about people, mental illness, and mental health. Examination of differences in these explanatory models is an important but neglected aspect of the analysis of clinical communication.

In addition to a variety of conceptions about health and illness, the hospital-employed psychiatric nurse must integrate nursing, with its health-oriented ideology (Lovell 1980) and an increased public expectation of humanistic services (Leininger 1973), with psychiatry, which represents disease-oriented allopathic medicine (McQueen 1978). Although the medical model predominates in the institutional setting, it is often supplemented in psychiatric practice with other treatment

modalities. Ideological models currently in use in the U.S.A. focus on, in addition to biomedicine, psychoanalysis, morality, rehabilitation, madness as a positive experience, victimization with labeling, communication and interaction, and social deviancy (Siegler and Osmond 1974).

Within a psychiatric setting, Topalis and Aquilera (1978: 116) point out, "the degree of congruence or consistency in feelings, thoughts and behavior exhibited by the nurses affects their therapeutic potential." Despite training to use the nursing process as a conceptual framework for psychiatric nursing, little is known about the adaptive process by which nurses integrate these varied schemes in actual practice. The fact that there is little ideological consensus among nurses is not new. Strauss et al. (1981) refer to nurses as "ideologically uncommitted." This implies neither consensus nor strong commitment by individual nurses to specific models. It is commonly assumed, nonetheless, that RNs utilize in their practice medical and/or nursing ideological frameworks. However, studies of the actual explanatory models and ideologies held by psychiatric nurses are unavailable.

Each nurse working on the psychiatric units at City and County was asked to give his or her opinion about why some people are mentally ill and others are not, the process of caring, the role of nurses and the in-patient psychiatric setting, the outcome and prognosis of psychiatric conditions, the therapeutic models used, the way in which an individual's ideologies affect relationships with other health care providers, and the adaptation of ideology(ies) to the work role and

its(their) integration in the therapeutic setting.

Nurses' training frequently focuses more on medical than on nursing theories. Consequently, nurses who work in psychiatric settings frequently conceptualize their roles in psychiatric rather than in nursing terms. This proved to be the case with the psychiatric nurses at City and County. Very few used nursing theories in any part of the explanations given to the topics listed above, including caring which is held by many to be the essence of nursing (for example, Leininger 1984). Among the explanations offered, however, there was also conspicuously little agreement. Some nurses described considerable conflict between their perspectives and those of other personnel, and at times, in their attempts to rationalize psychiatric phenomena for themselves.

Etiology: Psychiatric Disorders

It is not known what causes some people to behave markedly differently from mainstream societal expectations. In the U.S.A. there are, however, consistent (although still disputed), inverse relationships between socioeconomic strata and rates of disorders (Dohrenwend and Dohrenwend 1969). People in lower socioeconomic strata have a greater chance of being hospitalized for psychiatric conditions than people representing other levels of society. Several theories attempt to explain this disproportion. Commonly cited variables include, for example, stress associated with poverty, migration, endemic disease, city size, community organization, and various life events. In short, the life circumstances of the poor, the unemployed,

and the undereducated are viewed as contributing factors in the development of psychiatric disturbances (for example, Vaillant 1980). Other theories attribute incidence variance to social selection (such as varying tolerances for behaviors, voluntary segregation, differential social labeling and treatment of problems) and a downward drift of impaired individuals into lower socioeconomic strata.

Debates continue within many disciplines concerning the root of mental illness in nature (that is, as a biological or organic phenomenon) or nurture (as a functional disorder with environmental causes), and to what extent the mind is reducible to a neurophysiological basis. Reflecting a biological stance, genetic influences have also been suggested as affecting the incidence of mental illnesses. Since the biological and social aspects of life cannot be completely segregated, it is widely held that most human conditions and types of human behaviors lumped under the rubric of "mental illness" or "mental disease" are probably influenced by both environmental and physiological phenomena.

The major psychotic patterns of schizophrenia and depression vary in form and frequency, but occur in all societies (Kennedy 1974). International research programs suggest (but do not clearly indicate) that the schizophrenias, the most studied category of disorders and that considered most likely to occur universally, have the same incidence and prevalence all over the world (German 1984). These syndromes appear to depend upon influences from both genetic and environmental variables operating on several organic and functional systems throughout many years of development (German 1984). No single

factor, or known combination of a small number of variables, has a strong association with illness course and outcome (Sartorius et al. 1977). Even the best predictors account for, at most, less than thirty percent of the variance in patient outcomes (German 1984).

Etiology: Nurses' Perspectives

Although the questions posed dealt with both mental health and mental illness, the responding nurses inevitably proposed explanations for the latter. This implies that mental health may not actually be conceptualized as a positive state but rather as an absence of mental illness.

None of the nurses' etiological explanations differed substantially from the medical and non-medical models used by allopathic psychiatry (for example, Siegler and Osmond 1974). Most of City and County's psychiatric nurses describe the causes of mental illnesses as a complex blend of environmental and organic factors. The majority of these viewed environment as more significant than genetics or physiology, but nearly all described a combination of factors from both areas as leading to the severe and chronic psychological problems commonly observed in their patients.

A few nurses steadfastly believe that only organic or only environmental factors are involved. Those ascribing to organic models of etiology typically included both genetic and chemical factors.

Those nurses proffering environmental rationales for mental illness focused on difficulties in family systems, especially early traumatic events, the teaching and learning of inadequate coping skills,

communication and support, and lack of education (specifically information about individual rights and opportunities); low self-esteem manifested in feelings of worthlessness, competitiveness, stigmatization, hopelessness associated with low status; and social pressures such as poverty and unemployment.

Labels and Prognoses

In every society, culture strongly affects the perception, experience, and presentation of each role and status. Symptoms of illness represent social roles molded by specific cultural and behavioral contexts (Townsend 1978). The American advocacy of tolerance and individualism is well known. There is, nonetheless, a strong expectation that people behave in ways considered appropriate. There is also a tendency to label those behaviors deemed unacceptable, unfamiliar, or "strange" as psychopathological (Ackerknecht 1943). When an individual becomes socially labeled as deviant, therefore, stereotypes of insanity are applied (Scheff 1966). "Crazy" denotes psychiatric symptomatology as well as sociocultural situations which are "nonsensical, perverse, and contradictory" (Estroff 1981: 39). The degree to which psychiatric morbidity is recognized depends much on the zeal with which it is sought and identified (Clare 1979). The prevalence of a disorder is not synonymous with demand for its treatment.

Unlike those parts of medicine associated with physical signs and symptoms, psychiatry deals with perceived dissonances in behavior and social competence. The recognition of severe psychoses is relatively

easy and reliable. For "strange" behavior that is less extreme or not known to be chronic, the recognition process is complex and involves social negotiation. With no readily observable organic phenomena to diagnose as disease, observed behaviors must be given a negative moral evaluation to be tagged as psychopathology. It becomes the person and not simply his or her behavior that is labeled. The rigidity and lack of validity of the diagnostic process was displayed in Rosenhan's (1973) study of the admission of eight pseudopatients into mental hospitals on the basis of a single simulated symptom, and their retention in the hospitals after ceasing to display that symptom. Rosenhan's demonstration that the sane are not detectably so reinforces the common accusations that in psychiatry "abnormality" is sought and "normality" must be proven.

Mental status evaluations tend to be highly formalized and involve assessment based on parameters such as appearance, mood, affect, orientation, memory, and judgment (Rittenberg and Simons 1985). Tolerance varies for behaviors which deviate from the norm (Murphy 1969). Judgments are based on experience, which is interpreted by each assessing individual in terms of his or her own background.

Of two hundred diagnoses recorded at City and County at six-week intervals on the three psychiatric units studied, 41% were schizo-related, 31% were affective disorders (usually depressions), 8% were associated with drugs and/or alcohol, 6% were associated with organic problems, and 14% were vaguely described as acute psychoses which were atypical or undifferentiated. Fifty-two percent of the patients admitted to City and County's psychiatric units also have

histories of violence associated with their admissions. That statistic did not include the jail unit.

Psychiatric labeling usually results in distinct changes in moral and jural status. According to the traditional sick role (Parsons 1951), the so-labeled individual is exempted from normal responsibilities, at least to the extent necessary to get well; is not held directly responsible for his or her conduct, therefore, cannot be expected to recover by an act of will; must wish to recover; and is obligated to seek and cooperate with a competent treatment agent, usually a physician.

With an increase in chronic illnesses due to the predominance of illnesses which are neither curable nor lethal, American medicine is increasingly an illness maintenance system (Alexander 1982). A new sick role has developed in which chronically ill individuals are exempt from other responsibilities only until their problems are judged to be controlled or are discredited. They are more often held responsible for their problems and are expected to be motivated to abandon the sick role whether or not this is feasible (Alexander 1982). Whether a case of "blaming the victim" or the application of social cost-effectiveness, health is increasingly viewed as more a duty than a right (Brown 1980). With the medicalization of psychological and social problems, troubled individuals are socialized into a sick role which is changing. The dependency of the ill, however, is not.

Labels of psychopathology imply helplessness, dependence, and rejection. They undermine the principles of personal responsibility (Szasz 1974). Langer (1983) points out the labeling bias: "a patient

by any other name" will elicit different, less limited expectations even from therapists.

The stigmas attached to health conditions influence personal and group adaptive strategies (Ablon 1981). The psychiatric sick role typically involves a decrease in rights and responsibilities, and often leads to isolation from the community. Through social response to the labeled condition, patient roles tend to be reinforced and adjustment shaped accordingly.

Chronicity of mental illness develops at different frequencies in different circumstances. Research suggests that psychotics in non-industrialized societies tend to have less severe courses of illness, fewer recurring episodes, and greater chance of full remission than psychotics in industrialized societies (German 1984). These claims are based on patient outcome studies (for example, Murphy and Raman 1971, Sartorius et al. 1977, Waxler 1977, 1979).

Patients meet social expectations for acuity and/or chronicity. In traditional societies, prolonged lack of productive participation in the community can threaten the loss of primary resources and family ties. In industrialized societies, on the other hand, chronicity may become the source of food, shelter, and attention (Waxler 1977). Attempts to return to conventional (that is, non-patient) roles may be subtly discouraged (Scheff 1966).

The psychiatric patients at City and County are seen as acutely ill and in desperate need of many kinds of support. They are typically described as impaired intrapsychically, interpersonally, socially, and often physically. Many are viewed as experiencing acute episodes

of a chronic condition.

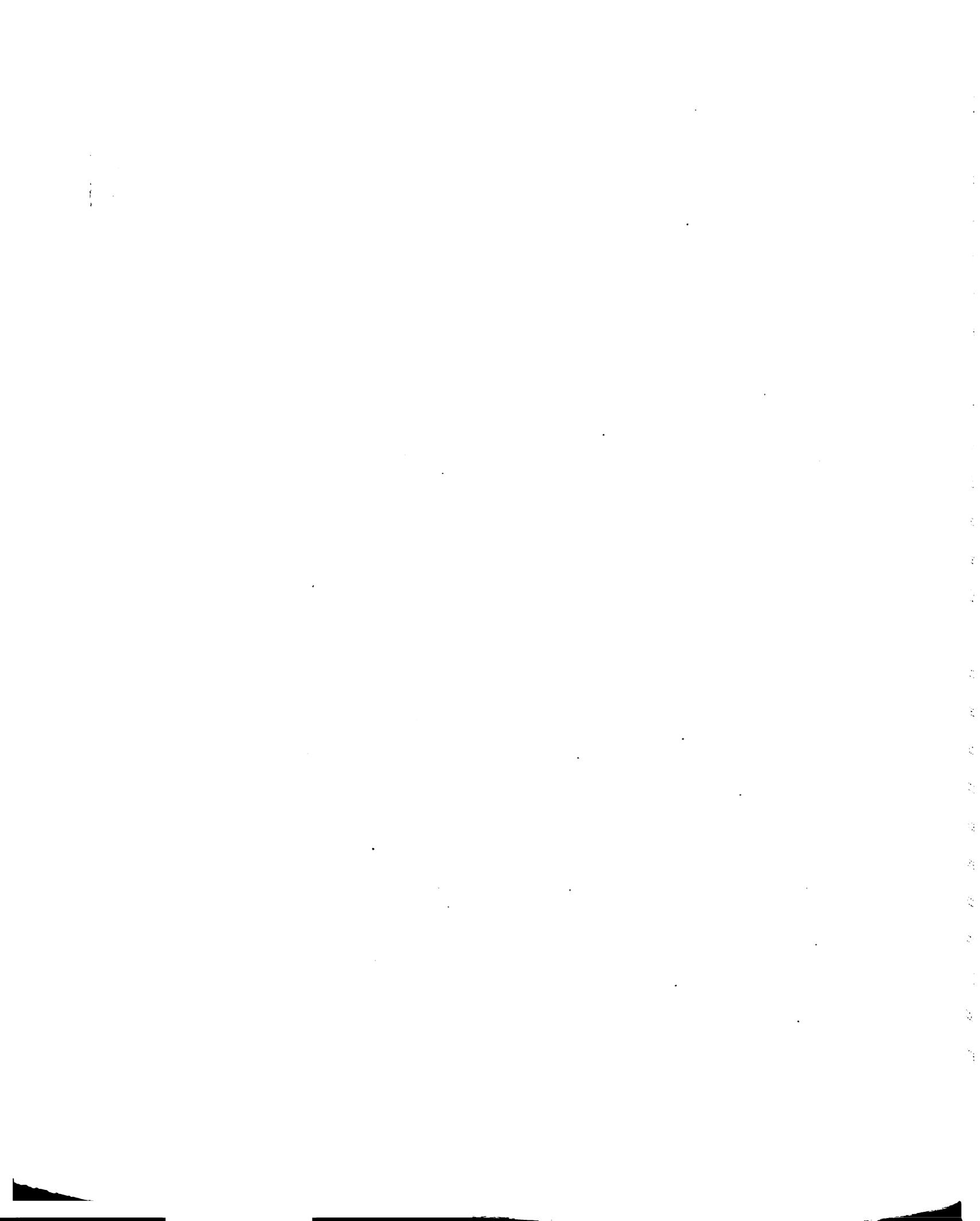
The psychiatric nurses at City and County were closer to agreement about prognosis than they are about most ideological issues, although there was not consensus. Most express little hope for the patients they care for, although few felt that there is either "no hope" or "always hope" for any patient. The following excerpts illustrate the nurses' general conservatism in expectations for patient outcome.

An RN stated that "there is a limit to how much one can care and do, especially for sociopathic patients." Another nurse said that she finds the patients "frustrating because they don't really get better." She qualifies this with, "Each time they meet you, they learn something from you. You make a tiny impact on their lives. That's all we do. That's all we can do."

While visiting a day treatment facility, after an interview with a patient who was gradually separating from the out-patient program there, an RN commented: "That's an incredible success story after working in an acute hospital. Coming from City and County, it's hard to be so optimistic as you all are here. To think that patients might actually get well enough to not need care anymore!"

A twenty-year veteran of the system stated: "There is no hope for these patients because there is no money and they have to go back to the same place they came from. That accomplishes nothing. The community mental health system does not deal with the neighborhoods. They think they understand, but they never really do. They never really know what it is like out there."

A clinical nurse specialist: "For some people nothing can be done; they will be crazy no matter what you do. For most, supportive services help; they need a friend or a program. Some people get better. I know that. But most of the people we work with here don't get better. They may function at a higher level, but so many have been here before. And most will be back, if not here, somewhere else. If they keep cutting funds, the people will get worse. We'll have our jobs forever. It's crazy when you think of it-- that our bread and butter is with the people of the world who are nuts. And their staying that way keeps us employed."



The Role of Psychiatry in General Hospitals

Psychiatry is that branch of biomedicine that deals with the study, treatment, and prevention of mental illnesses. In diverse ways, the discipline deals with the basic tensions between persons and the societies in which they live. In industrialized societies, most deviancies from the norm are classified as illness (Fox 1977). Deviance, in other words, has been medicalized.

Psychiatry stands in a peculiar position between individuals with problems of living and those with brain diseases (Torrey 1972, Szasz 1974). Medicalization individuates human difficulties. Individualizing patient problems aligns well with the individualistic ethic of American society, but it also allows for social control in the name of health (Conrad 1980). Implicit in the sick role is the function of medicine as an agent of social control.

Allopathic medicine is increasingly focused upon technological intervention. The knowledge generated by medical science and the techniques of medical technology maintain physicians' claims to authority over the practice of medicine (Brown 1980). Medicalization professionalizes human and social problems and delegates medical experts to handle them. As the methods of treating deviant behaviors generally support the status quo of society, the sick person is treated with the goal of altering the conditions that prevent his or her conventionality (Conrad 1980).

For most members of industrialized societies, physicians legitimate sick roles and act as the healers who attempt to return the sick to conventional roles (Conrad 1980). Medical authority, therefore,

controls sick role entry and exit. Wing (1981) suggests that psychiatry, as a professional licenser of the sick role, may have more of a legal than a medical role. Public psychiatry functions as a social control mechanism in the interface of society, the law, and medicine by validating complaints about individuals' behavior with the stamp of professionalism. At times, labeled individuals are mandated into the treatment system. Others come voluntarily.

In the past three decades new ideas in social psychiatry have increased emphases on providing services to all social groupings (Wing 1978). A primary objective of the new ideology involves providing treatment and care which is appropriate to the people receiving it. A basic premise of the community mental health movement held that many acutely ill patients could be treated near their own homes and admissions to the traditional, remote, and socially isolating state institutions avoided (Wing 1978). General hospitals, with and without psychiatric units, have become the new locus of in-patient care (Lerman 1984).

Due to restrictions in beds, staff, time, and money, and due to the intrusiveness, limited therapeutic effectiveness, and iatrogenic potential of most physical treatments for mental disorders (for example, Gostin 1980, Bridges 1980), psychopharmacology is the most common resort in American psychiatry. The view is generally held that drugs are useful in restoring a patient's perceptual control so that therapeutic relationships can be established and other psychological and social methods of treatment utilized (May 1976).

In conjunction with medication, City and County's in-patient

setting attempts to offer a modified therapeutic community. In therapeutic communities, assumption of the patient role is viewed as a form of preparation for role-taking after discharge (Hall 1975). Such milieux reflect society by promoting upward mobility, while providing a presumably safe environment (Hall 1975).

Trends in mental health reveal fewer people in institutional residence at any given time, and briefer stays. With shortened stays, however, admission rates increased to the point that the number of admissions exceeds the number of residents (Lerman 1984). Despite "deinstitutionalization," the total number of persons actually experiencing institutionalization for mental illnesses in a given year has not decreased, even when controlling for population increases (Lerman 1984). Since 1955 the in-patient care episodes from all specialized psychiatric facilities surveyed by the National Institutes of Mental Health (NIMH) have increased about 6.5% (President's Commission 1978). By 1977, American general hospitals annually discharged 1,625,000 patients with primary diagnoses of "mental disorder" after average stays of 10.8 days (Lerman 1984). As a result of this ever more rapid turnover, general hospitals continue to serve more and more psychiatric patients (Castel et al. 1982).

American society has developed a health system that is both expensive and only partially effective in serving the health needs of the population (Brown 1980). In psychiatry, reflecting the popular position which advocates patient care in the "least restrictive environment" (Bachrach 1980), it is common for acutely and chronically ill people to be repeatedly admitted and discharged by hospitals.

Many mental health workers acknowledge the limited success their efforts produce. They continue to experience, meanwhile, the squeeze between society's demands that they continue to provide their services, and inadequate resources with which to provide them (Kovel 1980).

Nursing Care and Caring Nurses

Many RNs say that their primary concern is the protection of patients so that natural healing can occur. The hospital is sometimes described as essentially a time and space away from the environments in which patients become ill. What happens to patients on the unit is viewed by a few nurses as less important than the fact that patients are removed from the precipitating stresses in their lives. Other nurses, in contrast, see the relationships formed and the care (but not necessarily the treatment) given in the hospital as central to an improved psychiatric status. Some psychiatric nurses at City and County state that the staff is essential in changing patients' conditions; others feel it is irrelevant.

"Care" and "caring" are terms that have been used in the nursing literature for more than a century. For many years the uncritical acceptance of caring as part of nursing avoided examination of actual caring motivations and behaviors in nursing practice (Gustafson 1984). Only recently have these terms been systematically examined as applied philosophic and scientific concepts (Ray 1984). This new interest in caring reflects growing societal concern about an overemphasis on technology in health care.

Care is "the essence of nursing" (Leininger 1984: 4), and the

discipline's unique boundary feature. Curing is additive to caring; although there "can be no curing without caring ... there may be caring without curing" (Leininger 1984: 6, 54-55). Caring involves direct or indirect

"... nurturant and skillful activities, processes, and decisions related to assisting people in such a manner that reflects behavioral attributes which are empathetic, supportive, compassionate, protective, succorant, educational, and others dependent upon the needs, problems, values, and goals of the individual or groups being assisted" (Leininger 1984: 4).

Caring is described in psychological, practical, interactive, and philosophical terms. It implies affective feeling or empathy, knowing or meeting needs, economic considerations, and skills (Ray 1984). Interactionally, caring may imply a physical "doing for" or touching; socially, "doing with" or communication. Caring also deals with moral concerns and spiritual needs, attitudes, concern, and equity (Ray 1984).

Caring at City and County

Each nurse working in psychiatry at City and County was asked the following question: "Given that caring is the essence of nursing, how do you define caring for your practice with this patient population?" No two responses were alike, although the nurses' answers fell into one of three general categories: behaviors based on nurses' perceptions of and relationships with patients, goals for patients, and orienting nursing roles toward reality. The responses were so varied, however, that these categories are quite arbitrary.

Several nurses described dealing with the whole patient, who is

typically thought of as experiencing an emotional crisis. Caring involved determining individual needs, and meeting those needs as fully as possible. The nurses made it clear that caring behaviors change with the practitioner, the patient, and the circumstances. On night shifts, for example, care focuses on helping patients rest. The need for care was also described as inversely proportionate to a patient's capacity for self-care.

Some nurses describe caring in terms of concern or fondness for a patient. They try, for example, to follow up on them after they are discharged, asking about adjustments in the community, watching for news of them in the newspapers or on television, and monitoring readmissions on the units. Nurses who encounter former patients outside of the hospital often bring back news of them to the unit and those staffmembers who worked directly with them. Not all patients are followed with the same intensity. And these nurses do not claim to care for all of the patients with whom they work.

Many nurses presented the need for realistic goals for patients as the major aspect of care. According to these RNs, foremost in this process is avoidance of imposing the staffmember's own values upon the patient. Generally, however, it is considered necessary to expect more of the patient than he or she does of him/herself. On the other hand, some nurses say that they find it difficult to establish goals for patients without basing them on the nurse's value system.

Also crucial to caring in this setting, according to some nurses, is the restructuring of their own goals. They say that they "cannot expect to cure," for example, but aim instead to relieve pain and

discomfort. In spite of the departmental thrust for self care, the nurses say that the real goal is interdependence, not independence. They also learn not to be disappointed by, if not to expect, rehospitalization of the patients with whom they deal.

Regarding the nursing role, the caretaker's willingness and motivation to care are considered extremely important. This, it was pointed out, involves not only individual patient care, but evaluation of and intervention in the needs of the unit as a whole. Many nurses said that for them caring behaviors deal most directly with negotiating the legal and bureaucratic systems as patient protectors and advocates.

Much discussion of care involved comparison of reality with the ideal, and the compromise of care. Nurses expressed several areas of recurrent concern about the care that patients get at City and County. A primary issue was the physical and technical safety of all involved when the units are short-staffed. Another major consideration was the "dumping syndrome" by which inappropriate and often vulnerable patients are admitted to the units. (Lerman (1984) discusses the precedence for hospitalization of these diverse populations.) A widespread criticism of the entire system involved the lack of adequate placement facilities that encourages this practice.

Medications pose another area of concern for care. The majority of City and County's psychiatric nurses questioned the effectiveness of drugs as treatment. Many worry about the side effects that they see in current patients. Also noted were the signs of earlier treatment modes observed in patients who have been in the system for a long time. The risk and reality of medication errors is viewed as related to both

the staffing situation and "over-dependence" upon medication for treatment. The procedures used in actual preparation and distribution of medications, inadequate and/or inconsistent charting, the "need to do several things at a time," and experimentation by trainee therapists were cited as specific concerns.

Other areas of distress over the care given psychiatric patients at City and County involved inattention to the complex situations from which patients come. Due to the discontinuity perceived between the in-patient setting and the community, the acuity of patients' conditions, and the isolation of the in-patient psychiatric setting, outside situations are hard to assess and, despite observation of desperate circumstances, the staff questions what, if any, attempt at intervention is realistically and humanistically appropriate.

Aware of and concerned about patients' background situations, the nurses contend that a caring system should and would extend its involvement to factors external to the patient him or herself. With direct contact between out-patient mental health resources and City and County for the most part limited to therapists, most nurses who have not worked in the community express little faith in the potential for help for patients outside of the hospital. The staff generally suspects that the interventions made while the patient is hospitalized are not followed up after discharge and may be contradicted in the community. The difficulty of individualizing patient care in a system which is considered both vague and cumbersome was also repeatedly brought up. Caring was clearly associated with patient-specific attention which goes beyond immediate physical requirements. Many

nurses, however, say there is no way that they can provide the comprehensive care needed.

The nurses reflect various models of care and treatment in their work. The psychiatric nurses at City and County typically view the theoretical frameworks with which they work as basically psychological, communicative, or biomedical. Despite the psychiatric nature of the labels, many of the behaviors associated with them are nursing actions. Most nurses described their ideal caring and nursing practices as falling into one of four major categories. These are referred to here as behavioral, interpersonal, psychodynamic, and nurses' self care. Although some nurses describe idealizing and utilizing a variety of approaches to nursing care, the descriptions here represent the ways considered most significant.

Behavior-Oriented Nursing Care

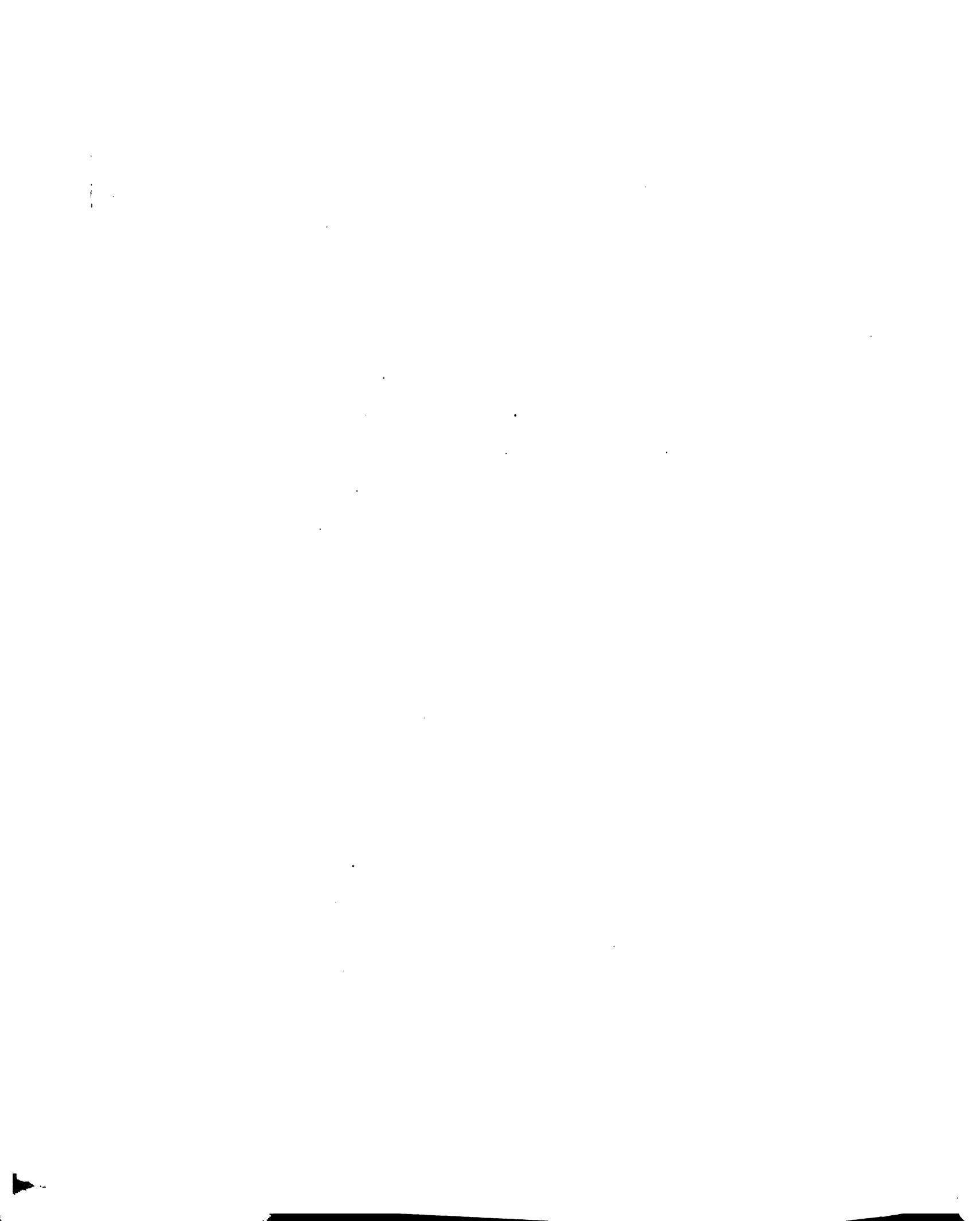
Predominating among but not limited to nurses prepared in diploma and associate degree programs are RNs who use a task orientation toward their jobs and a behavioral modification approach with the patients. Nurses who describe their nursing as oriented toward behavior emphasize the provision of a milieu in which patients can stabilize themselves physically and emotionally. Integral to this is structure, advice, and the avoidance of institutionalization. Some of these nurses see as a goal significant improvements within the unit environment.

The physical needs of patients are strongly emphasized by the proponents of behavioral approaches to care. Guiding and ensuring nutrition, rest and sleep, recreational and occupational activities,

medications, cleanliness, concrete activities of daily living, communication, socialization, and the acquisition of physical necessities (such as clothes, food, cigarettes, and small change) are considered the main criteria for meeting the needs of patients. Some nurses summarize this approach as "basic nurturing that the patient can't do for himself," and "pointing out what might be comfortable for him."

Protection was a frequently mentioned aspect of care. This is viewed as necessary because of medications, other patients, patients who act against themselves, and "the system." Protecting patients from the system involved mediating between them and the hospital, medical, and nursing administrations; minimizing chances of misdiagnosis, inappropriate labels, decisions made on the basis of history alone, inadequate placements and treatments, and unnecessary seclusions; and intervening between patients and insensitive therapists and staff. Patients must also be protected against loss of possessions as they are moved from facility to facility, as many of them are. The protection of visitors and other staff, in addition to patients, is seen as part of nursing care.

Pamphlets enumerating patients' legal rights are distributed in one of several languages to each patient shortly after admission. The nursing staff discusses individual rights as fully as possible, often several times with every patient. Individuals are frequently later reminded of specific rights, especially if conflict is perceived between the patient and his or her therapist, significant others, or the legal system, or when nurses disagree with the treatment process



observed. This process was pointed out as an example of protective care.

A structured environment is considered by most nurses to be essential to providing a place in which patients can "stabilize." This setting is usually characterized by supportive control, which involves establishing limits or boundaries between acceptable and unacceptable behavior, discipline, and/or the increase or decrease of stimuli. Nurses say that observation; isolation, seclusion, and shows of force when necessary; reassurance; and interactive techniques are used toward this end. The nursing staff is cognizant of the risk of institutionalization in an environment in which individual decision making is limited. This leads to on-going debates about how much freedom or constraint should be allowed. This topic is dealt with more fully in another section.

Nurses are often called upon to answer questions for patients. Advice-giving is seen as a significant nursing function. This activity usually includes information about medications (especially pertaining to follow-up and compliance), the course of and possible responses to mental illness and/or disease, and options for behavior and coping. Self care, decision-making, and accepting responsibility for oneself are overtly advocated. Nurses also function as sources of information regarding local resources and facilities.

Interpersonal Nursing Care

Nurses at City and County who espouse an interpersonal approach to their nursing practice state that they focus on communicating empathy,

understanding what troubles patients, and sharing themselves with specific individuals. The communication of empathy, they say, emphasizes dignity, respect, acceptance, trust, interest, concern, and the individuality of the patient. Understanding problems that patients experience at the present time implies learning "what is going on for patients," "what it is to be crazy," "what the patient needs," and/or discovering "each person's island of sanity" with which a link to more rational behaviors might be built.

The nurses describe "sharing the self with patients" as being accessible, knowing themselves, responding emotionally to patients, and, for some nurses, treating patients as they would want members of their own families to be treated.

Particularly emphasized in this approach is the value of time. Spending time with patients is presented as "listening," "being there, being with," and "talking with" patients. Talking with patients typically focuses on giving advice and/or exploring past behavior patterns.

The nursing behaviors associated with this approach focus on receptivity, recognition of individuality, genuineness, warmth, affection, and body language. The need to deal with countertransference is spoken of often by nurses who focus on interpersonal aspects of care.

Psychodynamic Nursing Care

The few nurses who describe their primary approach as psychodynamic or intrapsychic emphasize the self esteem of patients. Honesty, they

say, when it does not imply negativity, is a major factor in the caring process. Some add that honesty also involves acknowledging to yourself when you cannot help.

The nurses describe "giving a lot of positive strokes" for socially acceptable behavior traits, creativity, and self control observed in patients. An effort is made to avoid helplessness, dependence, and blaming patients for their conditions. Reality orientation and support are the two aspects of care most often cited. A few nurses describe trying to "let patients experience what is going on for them" or helping to increase patients' insight into their situations. Those nurses who use a "talk therapy" approach to care limit this to selected patients. For these, however, they think the approach can be very important.

Nurses' Self Care

Several nurses characterized nursing care as focused on the care of nurses. These individuals (who typically have baccalaureate or masters degrees) felt strongly that nurses' responsibilities for their own care underlie any type of nursing of patients. Self care in this respect was described as awareness of and active involvement in one's own growth and development, increasing knowledge of human behavior and of communication skills, taking care of each other on the staff, and knowing and respecting caretaking limitations. The latter attitude includes, according to the nurses who define care in this manner, monitoring work schedules to remain energetic and avoid long-term fatigue and burnout, encouraging adequate staffing coverage, knowing

when to be taken care of (rather than always trying to take care of others), knowing how to be taken care of and assuring the resources allowing this, and avoiding "taking the job home with you."

The nurses pointed out the difficulty of focusing on themselves as nurses. The social norm, they say, is for nurses to give; it is considered "selfish" for them to take as well. In reality, however, nurses must balance giving with taking. Conflict between societal expectations and individual needs exists at all levels of the system, they say. "Nurses must give themselves permission to take care of themselves" and also to "nurse as you feel is best," in contrast to bending to

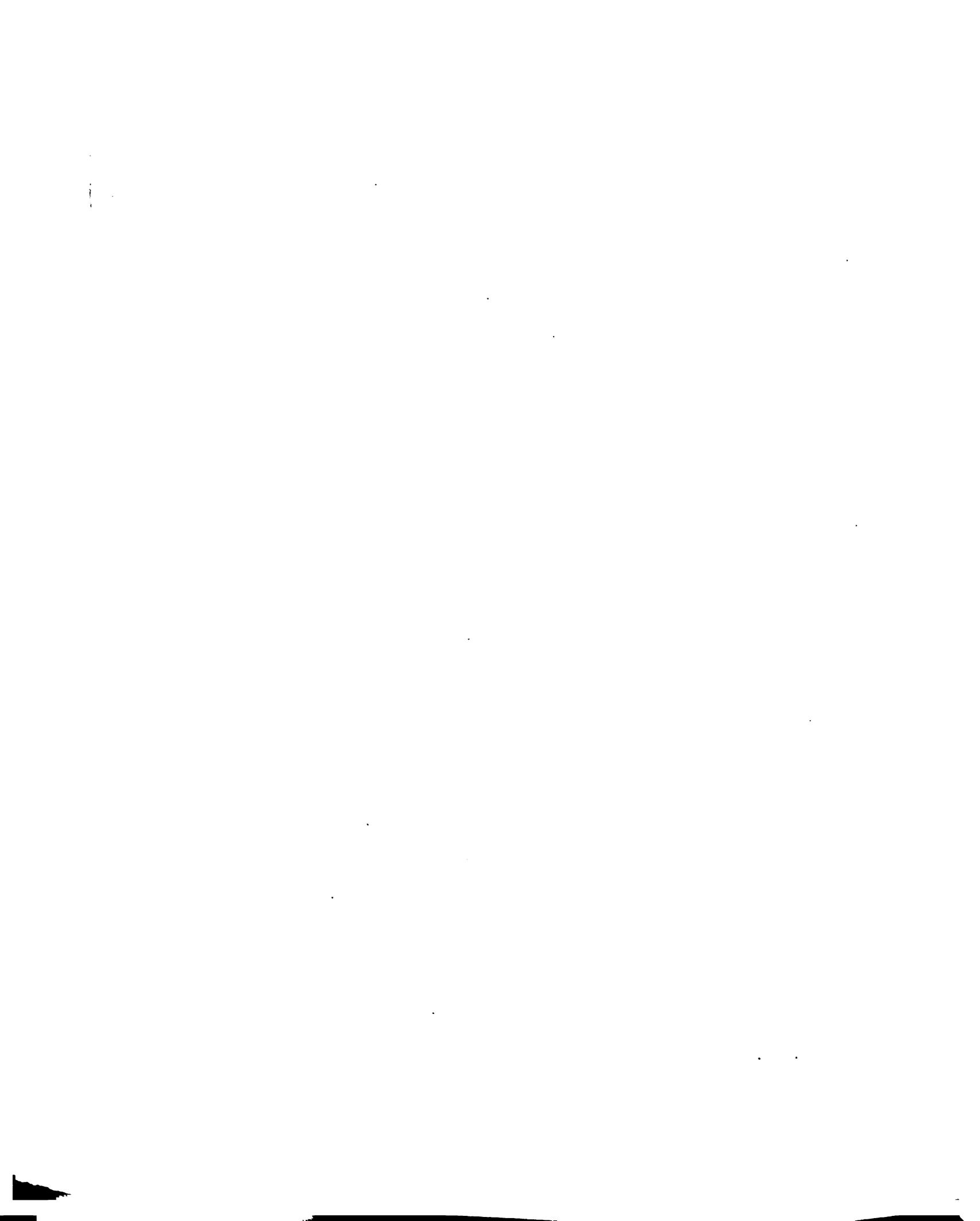
"... how the system tells you to do it. If you do that, you will be a lousy nurse and burn out too. Nobody is ahead then."

The consensus among the staff is that "you have to take care of yourself around here; no one will do it for you."

The Issue of Control

The issue of control recurred on all three psychiatric units throughout the research period. Ideas about control over patients versus their autonomy were found to be of major importance. These tended to be separate from other nursing or psychiatric ideologies, and cut across the ranks of nursing and into the other disciplines. Practices were notably influenced by individual perspectives on and experiences with amount of control. Intrastaff relationships were also strongly influenced by these differences in opinion.

In the U.S.A., where rights to individual freedoms are emphasized



and social control is in large part minimized, responsibility for self control is assumed. The psychiatric patients at City and County often are there because of socially-perceived lack of control over themselves. Evidence of increased self control is highly valued on the units. Selected patients are granted passes to leave their units for trial periods, or given special privileges by staffpersons. Privileges might include, for example, unaccompanied use of the kitchen or music room, use of potentially dangerous instruments such as scissors or pencils, or time alone to work on a specific project. More often, however, the self control of patients is demonstrated by requests for abdication of self control. In these ambiguous circumstances, patients show self control by asking for medication or "time out" in their rooms or in the seclusion room when they feel they need it (that is, when they think or feel they may lose control of themselves). In either case, the opportunity to demonstrate such control varies inversely with the amount of control exerted by the staff over patients. What this ratio should be is debated continuously by the staff.

The nursing staff on the tenth floor frequently discussed the contradictions inherent in their positions. The goals of each unit include both increased self control of patients, which implies allowing patients some freedom to make decisions, and maintenance of a quiet, peaceful unit, which implies the creation and enforcement of rules. The psychiatry department advocated staff-imposed limit setting as an avenue to acceptable behavior and social acceptance for patients. Objective, systematic ways to modify behavior were sought and encouraged. At the same time, nursing's self care model and various

individuals on the nursing and therapy staffs advocated relative independence. Inherent in this control-autonomy dichotomy are significant differences in values and norms.

Historically the most important characteristic of psychiatric attendants' roles was the exemplary replacement of excitement and disorder with industry, order, cleanliness, obedience, discipline, and routine (Carpenter 1980). As uncleanness is matter out of place (Douglas 1979), disorder on the psychiatric ward is behavior out of place; it is corrected through order.

Although control is often equated with power, they are not the same. Power implies the ability to affect tangible outcomes. Control, a psychological process of mastering, is less concerned with external conditions (Langer 1983). This difference is significant given nursing's limited power. Control allows an illusion of power, as does the role of caretaker. The staff is continually conflicted over the amount of monitoring of patients that is necessary. Restraint deprives patients of individual rights that are valued and expected in contemporary society. Non-restraint systems, however, strip traditional caretakers of their customary roles and tools.

Within an ethos of control on the psychiatric units, the RNs officially advocate that patients take care of themselves as much as possible, while doubting that many actually can care for themselves to a significant extent, and, for some, believing that it is their role as caretakers to do at least part of what patients might be able to do for themselves. Some nurses describe an underlying contradiction akin to Foucault's (1961) argument that the "reason" with which madness is

confronted in asylums is little different from the madness itself.

The variation among staff attitudes toward control functioned as a basic divisive force among staffmembers. While some nurses insisted that the need for increased control reflects exaggerated staff fears and creates conditions in which control then becomes necessary, others felt insecure and threatened without it. Which nurses emphasized control and which emphasized autonomy could not be predicted by educational background, but was associated with the types of experiences they have had in nursing. When staffmembers have been involved in episodes of violence, some claimed, they become less tolerant of uncontrolled behavior. One nurse, for example, since narrowly escaping being knifed by a patient, will no longer allow patients to "yell, scream, pound, or otherwise act out" on the unit. This individual states that "such tantrums don't help or heal."

Many staffmembers associate a highly controlled milieu with learning and positive change. However, whether caring is focused on treatment or containment was typically only part of the issue of immediate concern. The other aspect was whether the actual unit situation could afford to be any less controlling than it was or individuals thought it should be. Several RNs found the philosophies of the units on which they worked threatening because they were perceived as increasingly permissive, while the acuity and severity of patients' conditions required, by the nurses' assessments, more rather than less structure.

Incidents involving patients and loss of control of the unit pose real threats. Increased control by staffmembers protects the staff

from both administration and patients. In the event of an incident in which someone is injured, the staff is held responsible for the lack of control which allowed the situation to occur. Many members of the nursing staff feel that additional policies enforcing control on the units are necessary for consistent performance of staff roles and for protection from lack of administrative support when a violent episode occurs.

The safety of people on the units, the limited staff coverage, and the limitation of one seclusion room per unit are recurrent topics discussed by nursing and non-nursing personnel. Fear of loss of control of the unit and/or of oneself was countered with that of confusing therapeutic limit setting with callousness. These issues were most heatedly debated on those units generally characterized as disorganized. For some, the powerlessness felt in the work setting resulted in a quest for additional measures of control over patients. Lack of power over the hierarchical system, the work setting (including the numerous trainees with whom they work and to whom they are expected to show some deference), and the unpredictability of patient behaviors seem to lead some nursing staffmembers to project a general need for control onto the most easily definable and censurable variable within that setting, the patients. When feelings of threat, unpreparedness, and lack of control were decreased, there was less expression of need for greater control over patients. Many staffmembers, for example, expressed relief following the assault-prevention workshops in which they learned and practiced non-offensive measures of control.

As an issue on the units, control was broken into various aspects,

each leading to more ambiguity and questions. These involved such problems as how and by whom control should be enforced (for example, whether the therapy team and/or primary nurse should be responsible for patient control and what is to happen when these individuals are not available); whether rules should be specific to each patient or generic "house rules" specifying access to unit resources; and what the rules should cover (for example, interactive behavior, smoking, television, the presence of children on the unit, mail, food, kitchen privileges, and visitors). Also questioned was when intervention is appropriate, and when and to what extent control should be imposed. None of these issues were resolved, except on the reputedly "most organized" unit where they also tended to be less often asked because decisions by the head nurse provided a structure which to some extent precluded them.

Nurses who advocated increased patient autonomy associated control over patients with infantilizing, disrespect, paternalism, acting "as if patients have no intellect," lack of individualization, fear, pejorative attitudes, ambiguity (for example, double locked doors and a philosophy of self-care, or inconsistent search policies for visitors to the locked units), too much trust of long term patients and too little trust of new ones, and over-identification with patients. More typically the concept of control on psychiatric units was associated by the staff with setting limits, punishment, compensation (with small change, cigarettes, clothes, small gifts, or medication), and the physical symbol of control, keys.

Each staffmember possesses several keys related to his or her job. These are for unit doors, restraints, cupboards and lockers, and

various other controlled parts of the units. The visibility with which these keys are displayed varies.

Keys are a prominent symbol of these roles of social control. When a unit is quiet and patients not too difficult to handle, the keys seem less apparent. But when things get "hairy," the keys seem to be everywhere, more tightly grasped, more often in hands than in pockets. Some staffmembers carry keys in excess to those associated with the job. One head nurse has at least fifteen keys on her hand-carried ring, although only three or four of them are for locks on the unit.

Staffmembers sometimes wear clothing without pockets, so the keys must be carried or attached at the belt. This makes them even more noticeable. Some people choose retractable key keepers which they hook to their belts in lieu of using pockets. These are conspicuous and reinforce an image described by a patient as "the psychiatric mechanic look which is not to be confused with the mentally rattled but quiet and unrattling psychiatric patient look."

At times how keys are handled correlates with attitudes about nursing roles: more keys, carried keys, and jangled keys might be associated with a need for control and/or power. Verbal references to keys verify their significance. One staffmember, for example, mentioned that he "got (his) keys" at the state hospital, another that he "would never give up his keys" for an administrative job. Keys signify a capacity to exert control that stays with an individual as long as he or she remains employed in the field. There is a clear distinction between key-holders and non-key-holders, whether patients or otherwise. With keys comes societal permission to control.

Nonconsensus

The fact that there is little ideological agreement among the psychiatric nurses at City and County underscores the extreme variability that typifies the staff. Personal and public explanatory models, conceptual orientations to nursing and psychiatry, and reactions to experiences in the field have led to the formulation of different and at times conflicting convictions about their

relationships with those others who are labelled as patients.

The explanatory models and ideologies which nurses describe as the bases for their practices are not always apparent; many nurses point out that theirs are more ideal than real. Their practices have been adapted to fit what they perceive to be the reality of working on the psychiatric unit. Many of these practitioners have adapted their roles to be more reactive than proactive when dealing with patients and others. None of the nurses claims to use a crisis intervention approach (Aguilera and Messick 1974) to nursing, despite the appropriateness of that extension of brief therapy for City and County's patient population. In reality, nonetheless, they often tend to be participant observers who intervene in only the most immediate of crisis situations.

The following excerpt hints at the social and interactive challenge of the units. It is scenarios such as this that result in each nurse's development of an approach that will allow him or her to cope with the setting and the status and role he or she as a nurse has within it.

The breezy, clear weather inspired a mid-morning trip to the patio. The charge nurse and the occupational therapist accompanied eight patients there. One patient pushed the projector cart (equipped with plugs and cords) on which sat two large cans of apple juice, plastic cups which blew all over the courtyard before they were gathered and used, a can opener that was entrusted with ceremony to a patient, a volleyball which repeatedly rolled off the cart, and a box of graham crackers. One patient pushed another in a wheelchair. A third was assigned to give the partially paralyzed man drinks and crackers. The tasks were distributed to the "pesky" patients.

Once on the patio, a patient took the volleyball and shot it into the wastebasket at the far end of the patio. He then stood over and stared at it for twenty minutes. Another patient went around the patio trying to lift the eighteen-inch concrete squares that form its flooring. A third rolled first one and then the other huge standard which held the volleyball

net aloft. Automatically everyone moved out of his way in case one came crashing down. He did not look like he would do it on purpose, but the stands are tall and heavy, he was not about to give up his game, and the staff was not inclined to push it after their first two requests that he leave the bases alone. The fourth patient consumed most of the food while the fifth stood staring at an azalea bush for the duration of his time outside. The sixth repeatedly attempted to plug the cart's electrical cord into the apple juice can. Patient number seven poured his juice, crumbled a cracker and a cigarette butt into it, and drank it. He then prepared a second cup in like manner and poured it on the wheelchair-bound patient who immediately burst into tears.

Other than dealing with the offended, wet, and sticky eighth patient, neither staffmember attempted to engage the patients in activities other than those they created for themselves. The patients were all "more or less behaving," and this was also the staff's first break from the ward all morning.

The following chapter continues exploration of the explanatory and theoretical models held by the psychiatric nurses at City and County, and compares those of the nurses with those of the psychiatric technicians and therapists.

CHAPTER 8

CONCEPTIONS AND ATTITUDES: DIFFERENCES OF OPINION

"Opinion is ultimately determined by the feelings, and not by the intellect."

Herbert Spencer, Social Statics, 1851

"... ÄÜf my convictions have any validity, opinion ultimately governs the world."

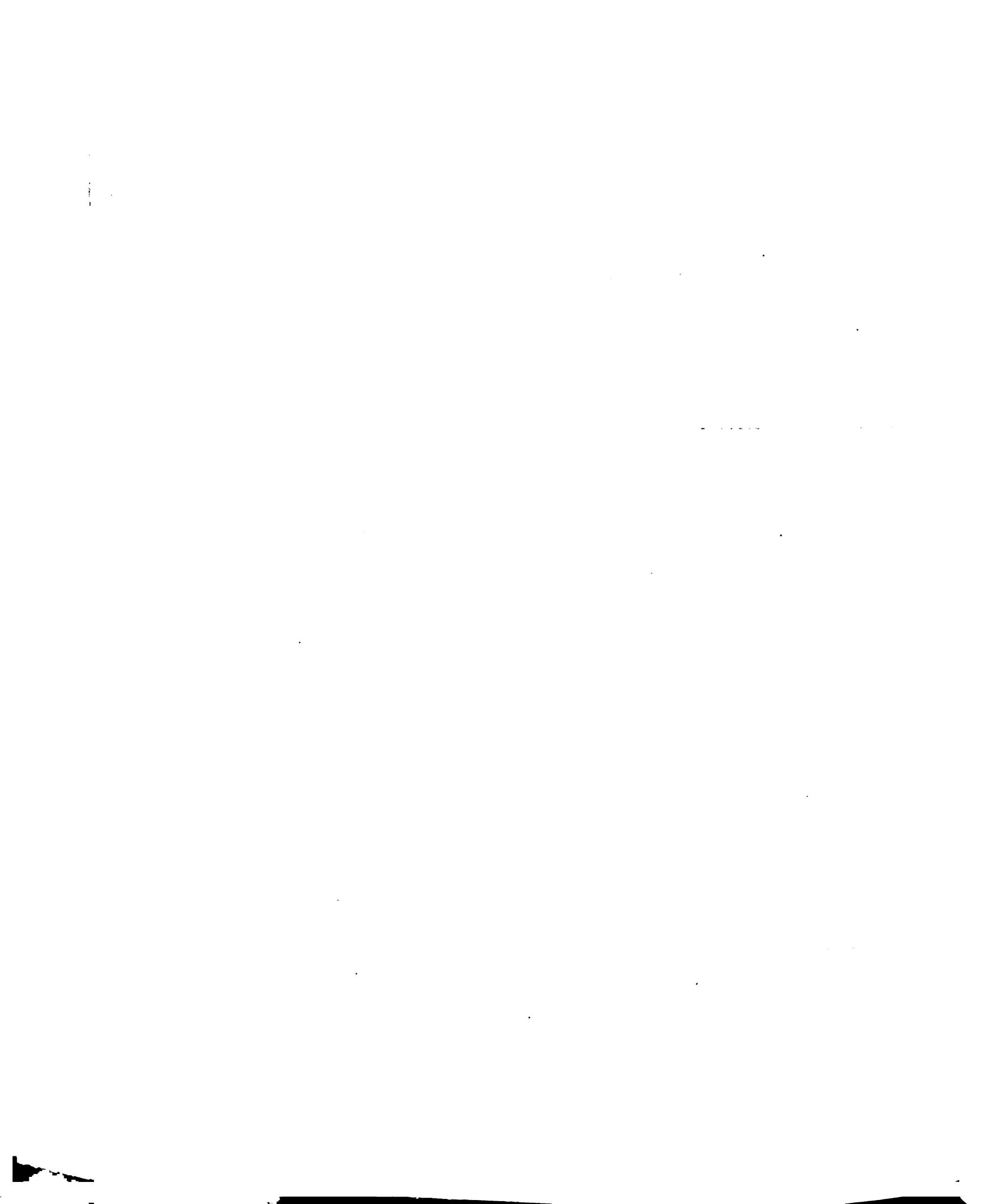
Woodrow Wilson, Address to the Associated Press, 1915

Attitudinal Questionnaires

Self-administered questionnaires (Appendix C) were completed by 36 RNs, 26 LPTs, and 31 therapists who worked on the psychiatric units at City and County. The therapist group included psychiatrists, psychologists, social workers, students, and others with clinical therapy roles. All respondents volunteered to complete the 110 question, agree-disagree scaled survey form, and did so anonymously.

The questionnaire was used to detect attitudinal differences between the groups of RNs, LPTs, and therapists regarding popular and professional conceptions about patient behavior and/or characteristics; the etiology, prevention, diagnosis, treatment, and prognosis of psychiatric problems; clinical roles; and societal concerns about mental illness, mental health, and psychiatry. Numerous statistically significant differences were found between and among the groups.

William G. Kavanagh, PhD, LTC, Medical Service Corps, US Army, is acknowledged and thanked for his assistance with the statistical analyses of the attitudinal questionnaires.

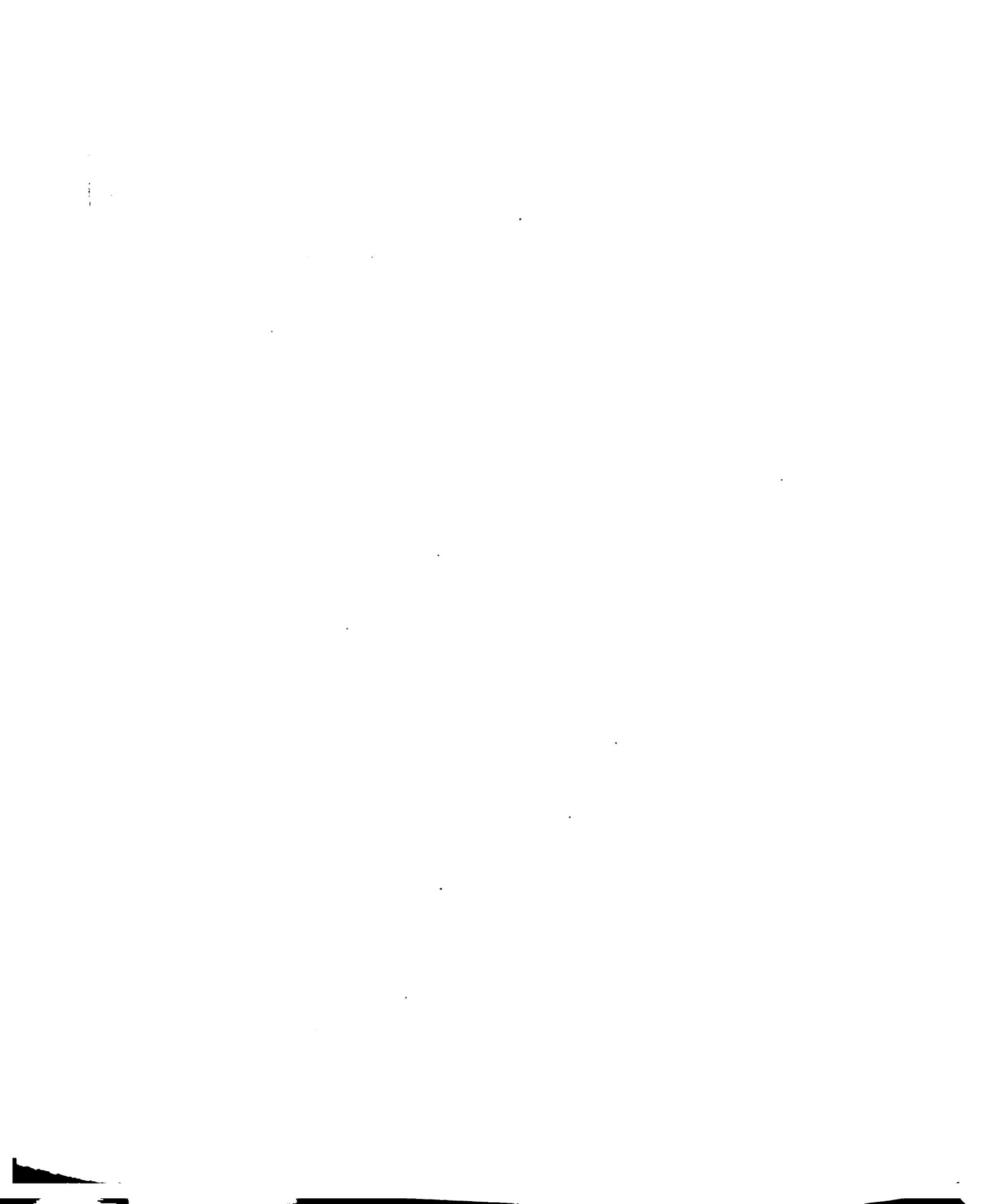


Statistical Analysis

A one-way analysis of variance (ANOVA) was used to determine the variation within and among groups and to determine the degree to which the information may be generalized, that is, considered to represent real differences not due to chance fluctuation (Hodges et al. 1975). This technique tests the null hypothesis that the compared groups actually do not differ and they are all samples of the same population.

ANOVA is based on the assumptions that the samples are independent of one another, that the variances of the samples are homogeneous, and that the population underlying the samples are normally distributed (Ericksen 1970). This population has a mean, a standard deviation, and a variance derived from the characteristics on which the groups are being compared, that is, the questionnaire responses. An analysis of variance involves using the variance of the population as estimated from the within and between group variances of all the samples. The overall concept creates estimates of the population variance that serve as the basis for deciding whether or not the groups in the study differ significantly in central tendency.

The F test was used to assess for significant differences in the estimates of variability (Hodges et al. 1975). Unlike the chi-square or the t test, the F test involves different degrees of freedom for each of the variables being compared (Ericksen 1970). There may be little difference among the group means relative to the unexplained variability within the groups, or there may be large differences among the group means relative to the within-group variability. If the group means are far apart relative to the spread of scores within groups,



the ratio will be large. Otherwise it will remain small (Ericksen 1970).

The test statistic follows Fisher's F probability distribution and is determined by use of a table for 5% points for the distribution of F. After the rejection region is determined, the null hypothesis may be rejected and the alternative hypothesis that the population means are unequal may be accepted. This means that there is at least one significant difference among the groups compared; that is, the samples are not from the same population. Once this is established, the t test can be utilized to evaluate the significance of differences between the group means (Hodges et al. 1975).

Analysis of responses to 26 of the 110 statements generated significant differences between or among the three groups (Appendix H, Table 1). Each of these was then subjected to a two-tailed Student's t test for unpaired samples with degrees of freedom corrected for inequality of variance (according to Remington and Schork 1970: 177). The second test was administered to determine between which specific groups the differences indicated by the ANOVA laid, that is, between RNs and LPTs, RNs and therapists, or LPTs and therapists.

Application of Student's t test demonstrated statistically significant differences between group means in responses to twenty-one questions (Appendix H, Tables 2 to 4). The t test, when applied to the responses of five other statements, indicated that the differences between the means of the specific groups were not significant at a 95% confidence level when the degrees of freedom were corrected for inequality of variances, despite demonstration by ANOVA of significant

differences between the groups. The second test, therefore, both delineated where the differences are (that is, between specific groups) and checked the reliability of the differences originally detected.

Attitudinal Differences Between RNs and LPTs

Differences proved to be statistically significant between the responses to two statements by RNs and LPTs. (The differences were not significant between RNs and therapists and between LPTs and therapists for these statements.)

Statement Number 61 reads: "Nervous breakdowns usually result from working too hard." Forty-four percent of the LPTs disagreed with this; 32% agreed. Nearly one-fourth of that group remained neutral on this question. The responses of the RNs and the therapists were similar, although only those of the former group differed significantly from the LPTs'. Fourteen percent of the RNs and 16% of the therapists agreed that "nervous breakdowns" usually result from over work, while 78% and 74% of RNs and therapists, respectively, disagreed. The most notable difference between the RNs' and therapists' responses to this statement was that 28% of the nurses, but only 10% of the therapists, disagreed completely with it.

The other questionnaire statement that generated a statistically significant difference in responses only between RNs and LPTs was Number 110: "The distinction between being 'mentally ill' and being 'normal' is not always clear." Eighty-nine percent of the RNs agreed with this statement, in contrast to 60% of the LPTs and 81% of the therapists (the latter group's responses not differing significantly).

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Less than 6% of the RNs, but 28% of the LPTs and 19% of the therapists disagreed with the statement.

Attitudinal Differences Between RNs and Therapists

Two questionnaire statements indicated statistically significant differences in opinions of the RNs and of the therapists (but not between the RNs and LPTs or LPTs and therapists).

Questionnaire statement Number 84 read "A woman would be foolish to marry a man who has had a severe mental illness, even though he seems fully recovered." The responses of the RNs and LPTs to this statement were markedly similar, although, when subjected to statistical analysis, only the opinions of the nurses differed significantly from those of the therapists. It is possible that gender influenced the responses to this question. Approximately three-fourths of the RNs and half of the LPTs were females, in contrast to less than one-third of the therapists.

Fifty percent of the RNs and 52% of the LPTs disagreed with the statement. The technicians indicated stronger disagreement than did the nurses, that is, 28% of the LPTs, but only 8% of the RNs, completely disagreed. On the other hand, seventy-four percent of the therapists disagreed, 23% of them completely. While 13% of the therapists weakly agreed with the statement, 36% of the RNs weakly or moderately agreed, and 32% of the LPTs weakly, moderately, or completely agreed.

The second statement which elicited statistically significant

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differences between the responses of RNs and therapists was Number 85. This stated that "If the children of mentally ill parents were raised by 'normal' parents, they would probably not become mentally ill." Only three percent of the therapists (and 8% of the LPTs) agreed with this etiologically-based proposition, while 20% of the RNs agreed. Eighty-one percent of the therapists disagreed, 23% of these completely. In contrast, 64% of the RNs disagreed (8% completely). Although 32% of the LPTs completely disagreed with the statement, 40% of that group indicated neutrality. It is noteworthy that no one in any of the groups completely agreed with the statement's environmental implications of causation and prevention of mental illness, despite the inclusion of "probably" in its wording.

Attitudinal Differences Between RNs and Therapists and Between LPTs and Therapists

Three questionnaire statements elicited statistically significant response differences between RNs and therapists and between LPTs and therapists (but not between RNs and LPTs).

Statement Number 55 read: "Books of 'peace of mind' prevent many people from developing mental disturbances." Ninety-four percent of the therapists disagreed with this, in contrast to 57% of the RNs and 62% of the LPTs. Three percent of the therapists agreed (weakly), whereas 17% of the RNs and 19% of LPTs agreed (the latter more strongly). Interestingly, more than one-fourth of the RNs found this a neutral statement, compared with 19% of the LPTs and only 3% of the therapists.



To statement Number 67, which reads "People who are mentally ill let their emotions control them; other people can think things out," 84% of the therapists disagreed. Fifty-eight percent of the RNs and 52% of the LPTs also disagreed, but most less strongly so. Thirty-six percent of the RNs and 40% of the LPTs agreed, half of the latter completely, in contrast to weak agreement by 13% of the therapists.

Number 97, "People who are unable to work because of mental illness should receive money for living expenses," indicated strong correspondence between responses of RNs and LPTs, and differences between each of those groups and the therapists. Ninety-four percent of the therapists agreed with the statement, the vast majority moderately or strongly so. Seventy-two percent and 76% of the RNs and LPTs, respectively, agreed, but generally more weakly. Only one of 31 therapists disagreed, in contrast to 11% (4) of the RNs and 16% (4) of the LPTs. Seventeen percent of the RNs remained neutral on this question.

Attitudinal Differences Between LPTs and Therapists

Perhaps an expectable reflection of educational differences between LPTs and therapists, the largest number of statistically significant differences were found in comparisons of the opinions of these two groups. In addition to the already discussed statements which indicated significant differences between therapists and both LPTs and RNs, responses to seven other statements generated such differences only between the LPTs and therapists. (Another six detected differences between the LPTs and therapists and the LPTs and RNs.



These will be discussed in another section.)

Statement Number 20, "A change of climate seldom helps an emotional disorder," elicited disagreement from 13% of the therapists and 42% of the LPTs. This implies that, according to these respondents, a change of climate might help in dealing with emotional disturbances. The RNs were intermediate between the LPTs and therapists with 25% disagreement. Seventy-one percent of the therapists agreed that climatic change seldom helps, as did 38% of the LPTs.

Analysis of the statement "A person can avoid worry by keeping busy," Number 42, also resulted in a significant differences between the LPT and therapist groups. The RNs' responses more closely resembled those of the therapists than those of the LPTs. One-half of the LPTs agreed that keeping busy allows one to avoid worry. Thirty-two percent of the therapists (and 31% of the RNs) also agreed to this proposition, although less strongly so. Whereas 46% of the LPTs disagreed, implying that keeping busy need not be associated with freedom from worry, 65% of the therapists more strongly felt that way. Fifty-eight percent of the RNs disagreed, most moderately or completely.

The distribution of responses to Number 45, "Good emotional habits can be taught to children in school as easily as spelling can," reflected the most highly significant difference between two groups of all of the statements. Fifty-eight percent of the LPT personnel agreed that good emotional habits are teachable (and presumably learnable) as academic subjects are. Only 16% of the therapists agreed with this statement, as did 36% of the RNs. Reversing the proportion, 27% of

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the LPTs and 77% of the therapists disagreed, implying by their responses, therefore, that emotional habits cannot be developed in the forum traditional to formal education.

Statements Number 54 also warranted statistical significance in the differences between responses of the LPTs and the therapists. Although 81% of the LPTs agreed that "If people could learn to avoid stress and relax, they would be less likely to develop mental illnesses," only 45% of the therapists considered that true. The RNs were again intermediate with 66% agreement. Only 11% of the LPTs disagreed (none strongly) that learning to avoid stress could decrease the incidence of mental illness, in contrast to 39% of the therapists and 29% of the RNs.

The role of physical rest in psychiatric treatment also precipitated significantly varied responses. Number 59 states simply that "Physical rest is part of psychiatric treatment." Ten percent of the therapists disagreed with this, while 71% agreed. Only 4% of the LPTs considered rest independent of treatment, and 92% of that group found rest to be part of psychiatric treatment. The strength of the LPTs' conviction was demonstrated through complete agreement with the statement by half of them. The RNs, regarding rest and therapy, indicated agreement (83%) that was midway between that of the LPTs and that of the therapists, but greater disagreement than either of the other groups (14%).

Statement Number 62, "Mental illness is an illness like any other," again demonstrates RN mediation between the LPT and therapist groups. Thirty-nine percent of the therapists agreed that mental illness is

analogous to other conditions. Of the LPTs, on the other hand, 73% agree (most completely or moderately), implying a stronger association for them between psychiatric and physical conditions than for the therapists. More than half (52%) of the therapists disagreed with the simile, in contrast with only 19% of the technicians. Of the RNs, 33% disagreed and 58% agreed.

The seventh statement which elicited statistically significant differences between the LPTs and the therapists (but not between the RNs and either of the other groups) was Number 107, "One of the main causes of mental illness is a lack of moral strength or will power." To this only 7% of the therapists agreed, all weakly so. Ninety-four percent of the therapists disagreed, nearly two thirds of them completely, that lack of moral strength or will power is an important causative factor in mental illness. Twenty percent of the LPTs remained neutral of this statement, while none of the therapists did. Sixty-four percent of the LPTs disagreed and 16% agreed with the statement. The nurses again indicated intermediate responses in all three response categories, agreement, neutrality, and disagreement.

Attitudinal Differences Between RNs and LPTs and Between LPTs and Therapists

The final group of statements that generated statistically significant divergences as detected by Student's t test involved opinion differences between the RNs and the LPTs and between the LPTs and the therapists, but not between the RNs and the therapists. Seven statements provided results of this type.

Statement Number 13, dealing with nursing roles, reads that "The main job of the psychiatric nurse is to recommend activities and other ways for the mental patient to occupy his mind." This is an especially important statement since the RNs and LPTs are parts of the same nursing staff and frequently have minimal role differentiations. In general, the RNs' and therapists' responses were more similar than those of the LPTs and either other group. Only 7% of the therapist and 11% of the RN groups agreed that nurses should focus on ways to keep patients' minds busy. Thirty-six percent of the LPTs, in contrast, agreed with the statement, most of them strongly. Whereas 52% of the LPTs disagreed, half of them completely, ninety percent of the therapists felt that the main nursing role involved other activities. Seventy-eight percent of the RNs disagreed, most of them strongly. Since the LPTs disagree with the RNs and the therapists on the main functions of psychiatric nurses, one is left wondering what other aspects of the role involve different expectations, and what these might be.

Statement Number 27, "Mental health is largely a matter of trying hard to control the emotions," also elicited statistically significant differences among all combinations of the sample groups, except the RNs and therapists who had noticeably similar responses. Only 3% of therapists (1 of 31) agreed, and then weakly. Four of the 36 nurses agreed (11%). Contrasted with these were 27% of the LPTs, although agreement by that group was not especially strong. The majority of each group disagreed that mental health for the most part is dependent upon emotional control. Sixty-two percent of the LPTs, 89% of the

RNs, and 94% of the therapists disagreed with the statement. This disagreement was especially strong by the nurses, with over half of the sample expressing complete opposition. A smaller proportion (54%) of the LPTs likewise disagreed.

Another statement that generated statistically significant differences between the RNs and the LPTs and between the LPTs and the therapists was Number 34, "The good psychiatrist is like a father to his patients." The sexually biased phraseology of this statement may have affected responses to it, or respondents may have assumed it to be equally applicable to female psychiatrists (to imply, for example, that the good psychiatrist is also like a mother to her patients, which connotes quite different behavior).

Nearly a quarter of the LPTs responded to statement 34 with neutrality. Also noteworthy is that 16% of the therapists neither agreed nor disagreed. Seventy-eight percent of the therapists rejected the statement, the vast majority of them strongly. Only two (7%) agreed with the paternal stereotype of therapist-patient relationships, and then only weakly. A few more of the RNs agreed (4 or 11%), but still not strongly. Slightly less than a quarter of the psychiatric technicians (6 or 23%) agreed with the statement. The strength of their agreement was spread across the weak, moderate, and strong categories.

"The eyes of the insane are different from others'," statement Number 46, implying that insanity might be detectable by observation of one's eyes, is a statement with implications for nursing and medical diagnosis and assessment. Again the responses of the RNs and the

therapists were markedly similar. Only 8% of the former and 10% of the latter agreed, with 86% and 87% disagreement, respectively. Of the LPTs, 54% disagreed. Among each sample disagreement tended to be strong if not complete. Thirty-one percent of the LPTs agreed that the insane and others differ in appearance.

Also pertaining to characteristics of patients, half of the RNs who completed the questionnaires disagreed with statement Number 52: "People who are likely to develop a mental disturbance are likely to pay little attention to their personal appearances." A similar proportion, 52%, of the therapists also disagreed, although fewer of these did so completely. Only 27% of the LPTs were of the opinion that individuals who are prone to mental disturbance are unlikely to neglect their personal appearances. It may be noteworthy that that group represents the nursing personnel most likely to be given the task of bathing and delousing the dirtiest and most unkempt patients upon their admissions to the units. The RNs expressed the least agreement with the statement, with 36% implying that appearance is not particularly apt to be neglected by disturbed persons. Forty-five percent of the therapists also agreed, but in all except one case their agreement was weaker. Over half (54%) of the LPTs concurred with the statement, with 8 (31%) of those indicating moderate or strong agreement. Sizable numbers of RNs (14%) and LPTs (19%) neither agreed nor disagreed with the assertion that mental illness and personal physical neglect may be associated.

Statement Number 58 also generated statistically significant differences between each combination of groups except RNs and

therapists. "The adult who needs a great deal of affection is likely to have had little affection in childhood" resulted in agreement from more than three-fourths (77%) of the LPTs, half of the nurses (50%), and less than half of the therapists (45%). Five of the 31 therapists, 16%, remained neutral on the question of a relationship between childhood and adult needs for affection. Only 15% of the LPTs disagreed that such an association was likely, in contrast to 42% of the RNs and 39% of the therapists.

Statement Number 104, "Although some mental patients seem all right, it is dangerous to forget for a moment that they are mentally ill," is the seventh statement that indicated statistically different results between the LPTs and each of the other groups. Although 32% of the LPTs disagreed with the statement, 52% accepted it. Seventy-three percent of the RNs and therapists rejected the necessity of constant wariness, twice the percentage of parallel LPT responses. Acceptance of the statement by the RNs was less than one-third that of the psychiatric technicians.

F But Not t: How Significant Is Significant?

Five of the 110 questionnaire statements yielded results which indicated statistical significance on the basis of analysis of variance, but not under application of Student's t test for variability of means (as controlled for the unequal variances indicated by the first calculation). ANOVA indicated that the variances within or between the groups were ample enough to indicate significance. When the between group means were examined, however, no statistically

significant differences were found. When the relative strengths of responses are considered, therefore, differences among means of the samples sometimes prove to be greater than those between the RN and LPT, RN and therapist, and LPT and therapist samples.

One statement resulting in these rather ambiguous sequelae was Number 2, "People who keep themselves occupied with pleasant thoughts seldom become mentally ill." Substantial differences are noticeable when comparing the analysis of the RNs' and therapists' responses with those of the LPTs'. Whereas 86% of the RNs and 87% of the therapists disagreed with the statement, only 54% of the LPTs did so. Nineteen percent of the latter group neither agreed nor disagreed, while 27% agreed. Only 11% of the RNs and 13% of the therapists accepted the idea of pleasant thoughts as instrumental in forestalling mental illness.

Statement Number 7, "Women have more emotional problems than men do," was the only one of the four statements pertaining to gender-related differences (Numbers 7, 19, 30, and 39) which indicated marked contrasts in responses. As previously discussed, however, the within group differences proved to be stronger than those between the samples.

The nurses most strongly disagreed with the proposal that women are more emotionally troubled than are men. Only one nurse agreed with it, although 4 (11%) indicated neither concurrence with nor rejection of the statement. The strength of disagreement may reflect the predominance of females among the RNs, although only 42% of the RN sample completely rejected the proposition. Taking a stance midway

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between the RNs and the LPTs, 73% of the therapists indicated disagreement with the statement, in contrast with the 10% who agreed with it. A greater percentage (17%) of the therapists responded with neutrality. Nearly as many (15%) neutral replies were recorded by the LPTs, but more of that group (23%) agreed with the statement. Only 62% of the technicians rejected the statement that men have fewer emotional problems than women have.

Statement Number 60, "Most of the people who seek psychiatric help need the treatment," elicited strong agreement from all three groups with 85% concurrence by the LPTs, 92% by the RNs, and 94% by the therapists. The differences among these groups lay in the strengths of their agreement. None of the nurses, and only 8% and 7% of the LPTs and therapists, respectively (that is, two members of each of those groups) disagreed with the statement. However, that agreement was markedly stronger among those two LPTs than the two therapists.

"Even though patients in mental hospitals behave in bizarre ways, it is wrong to make fun of them," statement Number 72, met with agreement from at least 90% of each of the samples. Of these, the strongest (96%) agreement came from the LPTs, 88% of whom agreed completely. Ninety-five percent of the RNs also ascribed to that view, although only 69% did so completely. Two RNs indicated impartiality toward the question of appropriateness of making fun of hospitalized psychiatric patients, a stance no members of the other groups took. Although only 55% of the therapists were in total conformity with statement Number 72, a total of 90% concurred. Three therapists (10%) recorded weak disagreement with the dictum.

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The final statement which generated statistical significance when examined with the F test but not with the t test was Number 77, "Patients in mental hospitals are in many ways like children." Having profound implications for staff-patient interactions, this statement elicited the agreement of 64% of the LPTs, 44% of the nurses, and 48% of the therapists. This concurrence varied qualitatively as well as quantitatively. While LPTs who agreed did so with nearly equal numbers in the weak, moderate, and strong categories, the agreement of the nurses and therapists was predominately weak (about three-quarters of those accepting the statement) or moderate (about one-quarter).

Disagreement that mental patients are childlike indicated similar variability. Twenty-four percent of the LPTs disagreed, half of them completely. Forty-two percent of the RNs and 49% of the therapists disagreed, but less strongly so. Twelve percent of the LPTs and 14% of the RNs noted neither agreement nor disagreement on the topic, despite its importance in shaping caretakers' responses to patients' conditions and behaviors.

Opinions About Behaviors and Characteristics of Patients

Five of the questionnaire statements which generated statistically significant differences in responses dealt with characteristics of patients and their behaviors. A substantial amount of information about staffmembers' attitudes might be gleaned from these. They are statements 46, 52, 67, 77, and 104.

It has long been debated whether one could detect mental illness by appearance. The LPTs responding to the questionnaire indicated a

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tendency to see those prone to mental illness as neglectful of their physical appearances, while the majority (or more) of the RNs and therapists did not note an association between psychiatric state and appearance. Although most members of all three groups disagreed that the eyes of the insane differed from those not designated as such, the RNs and therapists were much more likely than the LPTs to indicate that conditions of insanity were not detectable by looking into an individual's eyes.

Also alluding to differences between the mentally ill and others are the statements that correlate patienthood with childhood, mental illness with lack of control over one's emotions, and constant caution around patients with safety. Regarding any similarity between patients and children, the nurse and therapist groups were evenly or nearly evenly split. That is, they indicated equal amounts and strengths of agreement and disagreement. Only the LPTs differed markedly, and that was toward viewing patients as even more childlike than did members of the other groups. Despite the efforts of modern mental health ideology to minimize the formerly popular conception that the mentally ill are like (and therefore to be treated like) children, it is apparent that that attitude persists.

That people who are mentally ill allow their emotions to control them and others do not met with varied but general disagreement. The strongest opposition to this concept came from the therapists. On this issue the responses of the RNs and LPTs show similar trends, with the results from both groups suggesting that they do not view emotionality on a continuum with rationality and/or that the individual is not

responsible for his or her condition by way of having given in to emotions.

The LPTs were of much stronger conviction than the other samples that when around mental patients it is never safe to forget that they have been so designated. Although members of all three sample groups at times noted during conversations a tendency to be wary of anyone not familiar to them, only LPTs expressed the belief that trust in patients, although "insidious" and "natural," was dangerous. Several assault incidents that occurred during the research period were attributed by their victims to a failure to maintain their guard. The LPTs' perspective may be influenced by the closeness with which they deal with patients as much or more than it is by educational and/or ideological differences between that group and the others.

The above conclusions are based on analyses of questionnaire responses which were found to include significant differences among or between the sample groups. The other statements composing the questionnaire also provide valuable insights into the belief and attitudinal systems used by the RNs, LPTs, and therapists in filling their roles. The fact that no statistically significant differences were detected among these groups validates the strength of the conception or opinion expressed in the statement. These have important implications in role performance and health care provision on the units.

Five statements, in addition to those discussed above, pertain to the appearance of patients. These are Numbers 1, 37, 66, 71, and 101. In their replies to statement Number 101, 60% of each sample grouping

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opined (usually weakly) that psychiatric in-patients generally do not care how they look. To statement Number 1, 55% of the respondents indicated (also weakly) that the mentally ill pay little attention to their personal appearances. Statement Number 37 elicited from 75% of the three groups the opinion that one cannot tell a person who is mentally ill from his or her appearance. Sixty-three percent noted that there nothing special about the mentally ill that easily distinguishes them from others (Number 71). Reactions to Number 66 were also consistent with the trend toward rejection of appearance as correlated with patienthood when 83% of the three groups denied that "It is easy to recognize someone who once had a serious mental illness." Dispelling another old myth, 93% of the multidisciplinary sample strongly expressed the opinion that the insane laugh no more than others do (Number 14).

Six statements deal directly with the participation of psychiatric patients in society. Sixty-nine percent of the staff acknowledges the capacity of most psychiatric in-patients to communicate with others (Number 26). An average of 87% of the three groups believe that many patients, even when very disturbed, would be able to perform skilled labor (Number 87). Only 51%, however, consider that population to be willing to work (Number 73). (An exceptionally high proportion of respondents indicated neutrality on the latter question: 40% of the LPTs and 22% of each of the other groups.)

Statement Number 44 caused 53% of the three samples to deny that "Emotionally upset or unstable persons are often found in important positions." The overwhelming majority of responses noted that people

who repeatedly seek medical attention with multiple complaints may not realize that "there is really nothing wrong with them" (Number 48).

Three statements, Numbers 63, 68, and 95, dealt with the issue of dangerousness of psychiatric patients. About sixty percent of the total sample felt that "Most patients in mental hospitals are not dangerous" and/or are no more dangerous than the average citizen." Four-fifths of the respondents rejected the notion that every psychiatric unit should have tight security and guards.

Two further questions, Numbers 79 and 99, pertained to further differences between mentally ill persons and others. The variability did not result in statistical significance, but noticeably more LPTs (48%) felt that psychiatric patients are completely different from other patients (for example, those with physical diseases). Seventy percent of the other two groups, in contrast, alluded to greater similarity between patients with physical and psychiatric diagnoses.

The vast majority of nursing personnel indicated that the severely mentally ill retain their humanity despite their marginality to typical social processes. All of the therapists expressed that conviction. The issue is not one without evidence of doubt, however. At least 15% of each group noted less than complete agreement, and one RN and one LPT denied that the severely mentally ill are "really human."

Opinions About Etiology

Of the questionnaire statements yielding statistically significant results, those which deal most directly with the question of biological versus environmental roots of mental disorders are Numbers 62, 85,

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and 94. The degree to which psychiatric illnesses are viewed as like other illnesses varied widely. The majority of nurses and LPTs agreed that all illnesses are basically similar; the majority of therapists expressed the opinion that mental illnesses differ from other illnesses, although many (probably most) of the therapists profess biological foundations for their treatment practices. The general opinion was that children of mentally ill parents were not likely to become mentally ill if raised by "normal" surrogates. Furthermore, responses to Number 94, which is the converse of Number 85, elicited a general sentiment that the children of "normal" parents, if raised by mentally ill parents, would probably not become mentally ill. The consistency of these results may be viewed as reflecting the biomedical underpinnings of attitudes toward psychiatric illness and treatment.

Four statements (Numbers 2, 27, 67, and 107) pertain both to the etiology of mental illness and to the degree to which a mentally ill individual might be held at least in part responsible for his or her condition. Despite enough variability to generate statistically significant differences among the groups on each statement, the opinions generally expressed held that the mentally ill do not allow themselves to be controlled by their emotions while others "think things out," that mental health is not primarily a matter of trying to control the emotions, that focusing on pleasant thoughts does not stave off psychiatric problems, and that lack of will power or moral strength does not cause mental disorders.

Regarding who does become mentally ill and why (Numbers 7, 54, and 61), it was generally agreed that women do not have more emotional

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problems than men have, that "nervous breakdowns" are not usually the result of working too hard, and that learning to relax and avoid stress can help prevent mental illness.

The questionnaire responses discussed above in this section are among those indicating outstanding differences between the sample groups, despite general tendencies as reported here. The following statements also deal with attitudes toward causation and development of mental illnesses, but, since strong differences were not detectable, these demonstrate greater agreement among the total staff.

Two statements, Numbers 38 and 70, pertain to stress as a factor in the development of psychological problems. The total sample expressed a strong tendency to agree that mental illness is usually associated with life stresses. There was markedly less agreement with the proposition of mental illness as a refuge from the problems of everyday life. The majority of RNs and therapists disagreed with the latter notion, but most LPTs did not. The within group variability was high in each sample.

Questionnaire statements 4, 24, 30, 35, 39, and 41 concern the correspondence of mental illness incidence with age and sex variables. The total sample strongly expressed the opinion that children may become as severely mentally ill as adults do. The trend was toward agreement with the statement that early adulthood is a more dangerous stage of life regarding the development of psychiatric problems than later years of life are, but many members of each group also felt otherwise. The entire group resolutely indicated, moreover, that older people have as many or more emotional problems than individuals

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who are younger.

In addition to statement Number 7, which was discussed previously due to the statistical significance of its responses, statements Number 19, 30, and 39 dealt with differences in tendencies of men and women to develop mental disorders. Three-fourths of the total sample disagreed that women are more likely than men to become mentally ill, which coincides with the previously mentioned conclusion that men have as many or more emotional problems. There was also general agreement that women are as emotionally healthy as are men, and that it is not easier for members of either sex to "get over emotional problems."

Statement Number 41, "People who are uncomfortable with their sexuality are more likely to develop mental disorders than other people," got mixed reviews. Slightly over half of the LPTs indicated moderate agreement, but no other group or category achieved a numerical majority. More than a fifth of the nurses and therapists indicated neutrality on this question.

Attitudes toward associations between childhood experiences and adult psychiatric states, a long tradition in many psychological and psychiatric theories, were examined by statements numbered 29, 40, 58, 80, and 89. About 68% of the total sample concurred that most mental disturbances of adults are traceable to emotional experiences in childhood. A smaller majority indicated that psychiatric patients are not especially likely to have come from homes in which parents took little interest in their children. On the other hand, a small majority of each group noted that mentally ill persons have not received enough guidance from their significant others.

More than half of the nurses and therapists concurred that for many people mental illness is not attributable to separation or divorce of their parents during childhood. The LPTs showed a tendency toward belief that these phenomena were connected, but reached no majority. A relatively high percentage of each grouping neither agreed nor disagreed with the statement.

These statements are related to that discussed elsewhere that adults who require a great deal of affection tend to have been deprived of it as children (Number 58), the responses to which provided statistically significant differences among the groups with the LPTs in strong agreement with the statement, and the RNs and therapists essentially undecided.

Many attempts have been made to link mental illness with physical causes. Statements 8, 18, 25, 36, 43, 56, 57, and 98 refer to the possibility or probability of this association. Despite tendencies already noted that suggest a predominately biological conceptual framework, three-quarters of all respondents did not agree that mental illness is usually precipitated by physical causes. A slightly smaller ratio indicated on another statement that "nervous breakdowns" often have physical origins. However, the premise that mental illness is usually caused by some physiological condition met with little agreement. A slim majority of therapists rejected that, and neither other group indicated a solid tendency toward either agreement or disagreement. A fourth of the nurses and more than a third of the LPTs resorted to neutral responses to the question.

The total sample showed moderately strong inclinations toward

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associating physical exhaustion with psychological problems, diet as a contributing factor in mental disturbances, and skull x-rays as irrelevant in predicting mental illness. The same strength of disagreement was leveled against the statement that "Almost any disease that attacks the nervous system is likely to bring on insanity" (Number 36).

Opinions related to psychosocial theories of psychiatric etiology were elicited by statements Number 51, 75, 76, and 102. The proposal that "People would not become mentally ill if they felt better about themselves" met with little conclusive agreement or disagreement. At least 75% of the total sample disagreed that people who are successful in their work seldom become mentally ill. Also strongly rejected, however, was the proposal that professionals more often become mentally ill than do the unemployed. No group reacted to the statement that "Most suicides occur because of feelings of rejection" with even 50% concurrence or negativity. All three were split on that question, and more than 25% of the therapists noted neutrality.

A final statement, Number 105, deals with ancient ideas about mental illness as punishment for misbehavior. The overwhelming majority of each sample dispelled this archaic belief, although three LPTs and two RNs remained neutral, and two therapists registered weak agreement with that conception.

Opinions About Preventing Mental Illness

In addition to a generalized conviction that people who busy themselves with pleasant thoughts are as likely as others to become

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mentally ill (Number 2), and that relaxation and the avoidance of stress may help prevent mental illness (Number 54), the total sample expresses a tendency toward the opinion that mental health is not merely a matter of controlling the emotions (Number 27). Each of these conclusions was noted in prior sections due to the statistical significance generated by variability within the total sample. Also discussed, but less easily characterized, were the results of statement Number 45, "Good emotional habits can be taught to children in school as easily as spelling can." Although the nurses and therapists chose generally to reject the idea of academically teachable and learnable emotional adaptation, a sizable majority of the psychiatric technicians accepted it.

The following portion of this section reports data from questionnaire statements which concern the prevention of psychiatric illnesses, but which indicate no significant differences among the groups surveyed.

A strong majority of the combined sample indicated that neither the avoidance of morbid thoughts (Number 21) nor concentration on happy memories (Number 28) is the key to mental health. All three groups associated mental illness with life stresses (Number 38), the nurses slightly more vigorously than the other groups.

The role of parenting in the prevention of psychological problems is dealt with in statements Number 5, 12, 29, 65, 74, and 80. Each sample was nearly evenly divided between disagreement and agreement over whether the expression of more concern by parents would reduce the incidence of mental illness. On the other hand, slightly over half of

each group disagreed that mental patients come from homes where the parents took little interest in their children. A slim majority of each group determined that "People cannot maintain good mental health without the support of strong persons in their environment." However, there was slight disagreement that mentally ill individuals have not received adequate guidance from the important people in their lives. A stronger majority indicated that the time spent by small children with their mentally ill parents should not be limited. A vast majority of respondents felt that children are as affected by disappointments as are adults.

Opinions About Psychiatric Diagnosis

Eighty-five percent of responding therapists and nurses agreed (usually strongly) with the statement that "The distinction between being 'mentally ill' and being 'normal' is not always clear" (Number 110). In contrast with these, only 60% of the LPTs concurred that ambiguity is involved in the diagnostic process. Validating the lack of clarity felt by many staffmembers is the wide variability among the responses to Number 62: "Mental illness is an illness like any other." To this, 52% of the therapists disagreed, while 58% of the nurses and 73% of the LPTs agreed. It follows that mental illnesses, if indeed they are analogous to other illnesses, should be similarly diagnosable. Perhaps the therapists' responses reflect the difficulties they meet in applying that approach.

Although significant differences exist among the three groups' responses, the vast majority of each consider most of the people who

seek psychiatric help to be in need of the treatment. It must be remembered that the staff on City and County's psychiatric units typically come into contact with patients only after they have been through one or more screening facilities and designated as requiring hospitalization. Given that attitude, which at 94% was most pronounced among the therapists, it is not surprising that assessment and diagnostic processes tend often to be biased toward a search for pathology.

Among the statements not yielding statistically significant results, responses to Number 103 lacked any majority conclusiveness. To the statement "Many people who have never been patients in a mental hospital are more mentally ill than many hospitalized mental patients" nearly a fifth of each group reacted with neutrality. The remainder were divided between agreement and disagreement.

At least three-fourths of the total sample disagreed that appearance alone identifies mentally ill persons (Numbers 37 and 66). More than 60% deny that "There is something about mental patients that makes it easy to tell them from other people" (Number 71). The vagueness and subtlety of diagnosis seems to underlie all of these generalized opinions.

Opinions About Nursing Roles

Five questionnaire statements referred directly to psychiatric nursing roles. Of these, one, Number 13, produced statistically significant differences among the groups queried. That statement proposes that "The main job of the psychiatric nurses is to recommend

activities and other ways for the mental patient to occupy his mind." As discussed previously, the majority of each group disagreed with this, but the strength of rejection varied from 52% of the LPTs, through 78% of the RNs, to 90% of the therapists. Although 11% of the nurses agreed with the statement, they did so weakly by indicating only that they agreed more than disagreed (response number 5). Of the 36% of LPTs who agreed with the statement, however, 16% agreed completely.

Responses to Number 50, "The main job of the psychiatric nurse is to explain to the patient the origin of his troubles" was rejected by 62% of the LPTs, 84% of the therapists, and 100% of the nurses. Of the latter grouping, 42% presented complete disagreement, 39% moderate disagreement, and the remainder weak denial of such a role.

That "Psychiatric nurses try to show the mental patient where his/her ideas are incorrect" was assessed with considerable variability. The most definite response was disagreement by 58% of the RNs; however, one-third of that sample accepted the proposition. The therapists provided a response pattern that was nearly the inverse of the nurses' with 53% agreement and 27% disagreement. The LPTs were more evenly divided with no majority view.

Eighty-five percent of the combined sample opined that psychiatric nurses do not try to teach mental patients to hold in their strong emotions (Number 10). The LPTs were the most resolute about this with 92% of them so deciding. Eighty-six percent of the RNs and 77% of the therapists also negated that role for nursing.

Statement Number 56 is "Mental illness is really a disease and psychiatric nurses should treat it as such." Although 58% of the

nurses agreed with this, 31% of them completely, neither other group presented a majority opinion for or against the statement. The LPTs, nearly evenly split, leaned slightly toward agreement. The therapists were numerically in greater agreement (48%), but tended to express this as weak or moderate concurrence.

The results of statements relevant to the nursing role provide more insights into what the role is not than what it is. Nurses are generally not viewed as focused on explaining patients' problems to them, correcting patients' ideas, teaching patients to restrain their emotions, or providing mind-occupying activities. Nor is it definite that nurses should deal with mental illnesses as disease states, although the trend appears to lean in that direction.

The wording of some statements may lead nursing personnel to indicate what they do or think they should do, whereas therapists' responses are more likely to reflect their observations or assumptions about nursing behaviors. In any event, the groups vary considerably in their analysis of nursing roles as represented by these few items. The underlying limitation of the survey approach used to elicit this data is that it does not extract what it is the respondents view to be nursing's role.

Opinions About Psychiatric Treatment

There are many approaches to psychiatric treatment. Aspects of several of these are dealt with through the questionnaire statements. Responses to six statements of those generated statistically significant results. Since they have been discussed previously, the



data will be briefly summarized here.

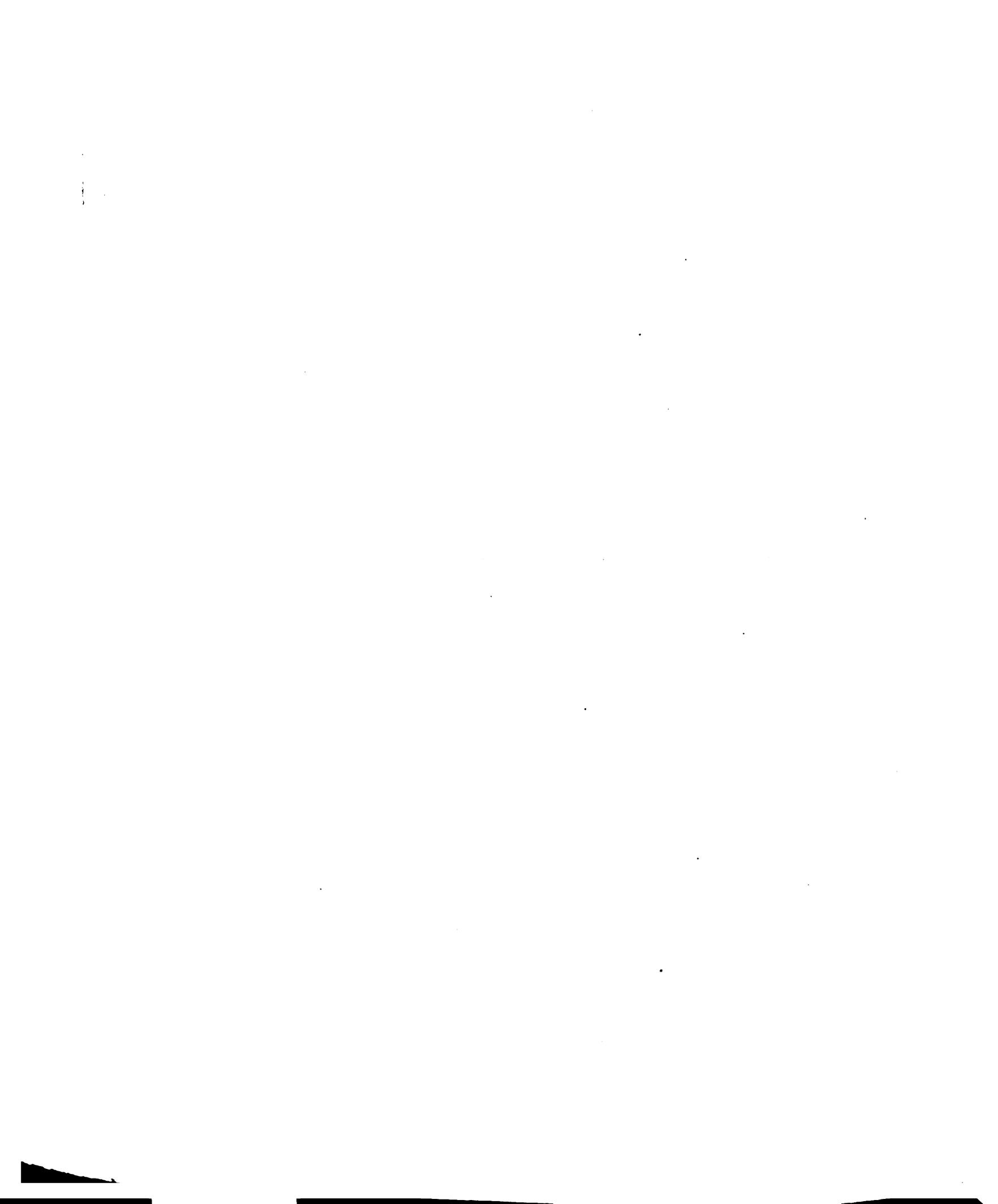
More than three-fourths of the total sample agreed that physical rest is a part of psychiatric treatment (Number 59), although the strength of this opinion diminished 10% between therapists and RNs and again between RNs and LPTs. Increasing with levels of education was the conviction that changes of climate were not likely to help in emotional disorders (Number 20).

Half of the LPTs agreed that worry can be avoided with activity, but nearly as many disagreed. Sixty-one percent of the other groups also rejected busyness as a solution.

Pronounced differences were detected between the LPTs and the others. Whereas 52% of the technicians strongly agreed that "Although some mental patients seem all right, it is dangerous to forget for a moment that they are mentally ill" (Number 104), 73% of the nurses and therapists disagreed. Interestingly, the strength of the 36% of LPTs who also disagreed was greater than that of the numerically larger others who also rejected the position.

The issue of dependence of patients is inherent in Numbers 34 and 97: "The good psychiatrist is like a father to his patients" and "People who are unable to work because of mental illness should receive money for living expenses." With the former statement 72% of the respondents disagreed, the nurses most strongly and the LPTs least. The latter elicited agreement from all three groups, but by far the strongest from the therapists.

The following data continue to contribute to the profile of attitudes and conception which predominate among the combined nursing

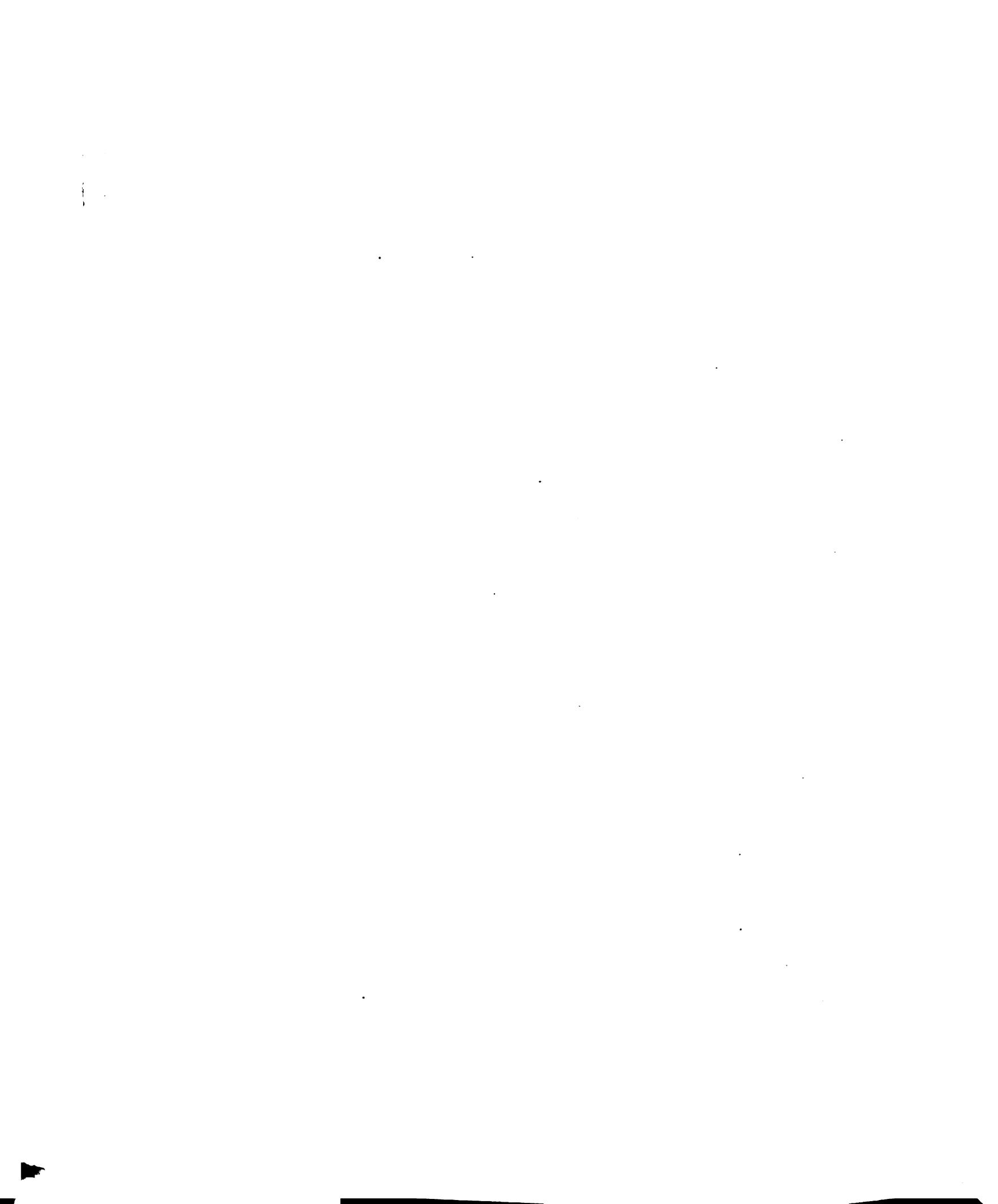


and therapy staff at City and County. The generalizability of these is based on the lack of substantial differences between the groups as represented by their responses.

Eleven statements deal directly with conditions of hospitalization (Numbers 22, 78, 81, 83, 90, 92, 93, 95, 106, 108, and 109). Fifty-six percent of all three groups agreed that mental hospitals should be organized in a way that makes patients feel as much as possible like they are living at home. Sixty-eight percent felt that patients in mental hospitals should have more privacy than is now typically available. It was generally denied that locked doors, security, and guards are requisites of psychiatric units. Punishment for abusive behavior by patients was also rejected, most strongly by the therapists. A moderate majority indicated that mentally ill people should be segregated from physically ill people.

With a wide margin, the respondents strongly rejected the proposal that little can be done for patients in a mental hospital except to see that they are comfortable and well fed. One hundred percent of the therapists, 95% of the RNs, and 88% of the technicians disagreed with that statement. Similarly rejected was the statement that "There is not much that can be done for a person who develops a severe mental disorder" (Number 22). Whether or not patients would remain voluntarily in the hospital until they were well (Number 109) met with more varied responses. The LPTs were evenly divided between agreement and disagreement. Sixty-four percent of the nurses felt the patients would remain, but 58% of the therapists thought they would not.

Despite the conviction that mentally ill and hospitalized patients



can be helped, a very slim majority of the total sample disagreed with statement Number 83: "If our hospitals had enough well-trained doctors, nurses, and techs, many of the patients would get well enough to stay out of the hospital." Eighty-four percent agreed, however, that more tax money should be spent on care and treatment for the severely mentally ill.

Four-fifths of the combined sample felt that vacations or changes of scene are usually not helpful in dealing with psychiatric illnesses. It was strongly agreed, on the other hand, that helping with social and financial problems often had the potential to improve patients' conditions.

It was also agreed that respect is due those who try hard to better themselves (Number 82), that will power alone does not cure mental disorders (Number 6), that unpleasant thoughts do not go away with self-effort (Number 49), and that keeping busy to mask or deny a problem is not the approach of choice (Number 69). Stimulating total agreement from every responding RN and therapist, and from 92% of the LPTs, was statement Number 47: "When a person is recovering from a mental illness, it is helpful to discuss his/her treatment with him/her."

Opinions About Psychiatric Prognoses

The responses to only one statement of those pertaining to prognosis yielded statistically significant differences. That was Number 84, "A woman would be foolish to marry a man who has had a severe mental illness, even though he seems fully recovered."

Approximately half of the LPTs and RNs disagreed with the statement, in contrast with qualitatively and quantitatively stronger rejection by 74% of the therapists.

Responses to eleven statements provided generalizable results without statistically significant differences among the combined staffs. These contribute considerable information regarding the outcomes that the patients are projected to have.

Eighty-nine percent of the total sample agreed that mental illness is not hopeless (Number 16). The same proportion of respondents rejected the notion that little can be done for severely mentally ill individuals (Number 22). The strength of both of these convictions increased with level of education.

The total samples of nurses and of therapists and 88% of the LPTs indicated that emotional problems are greatly damaging (Number 9). Sixty-two percent of the LPTs and therapists and 75% of the RNs noted mental disorders as among the most damaging conditions that humans experience (Number 23).

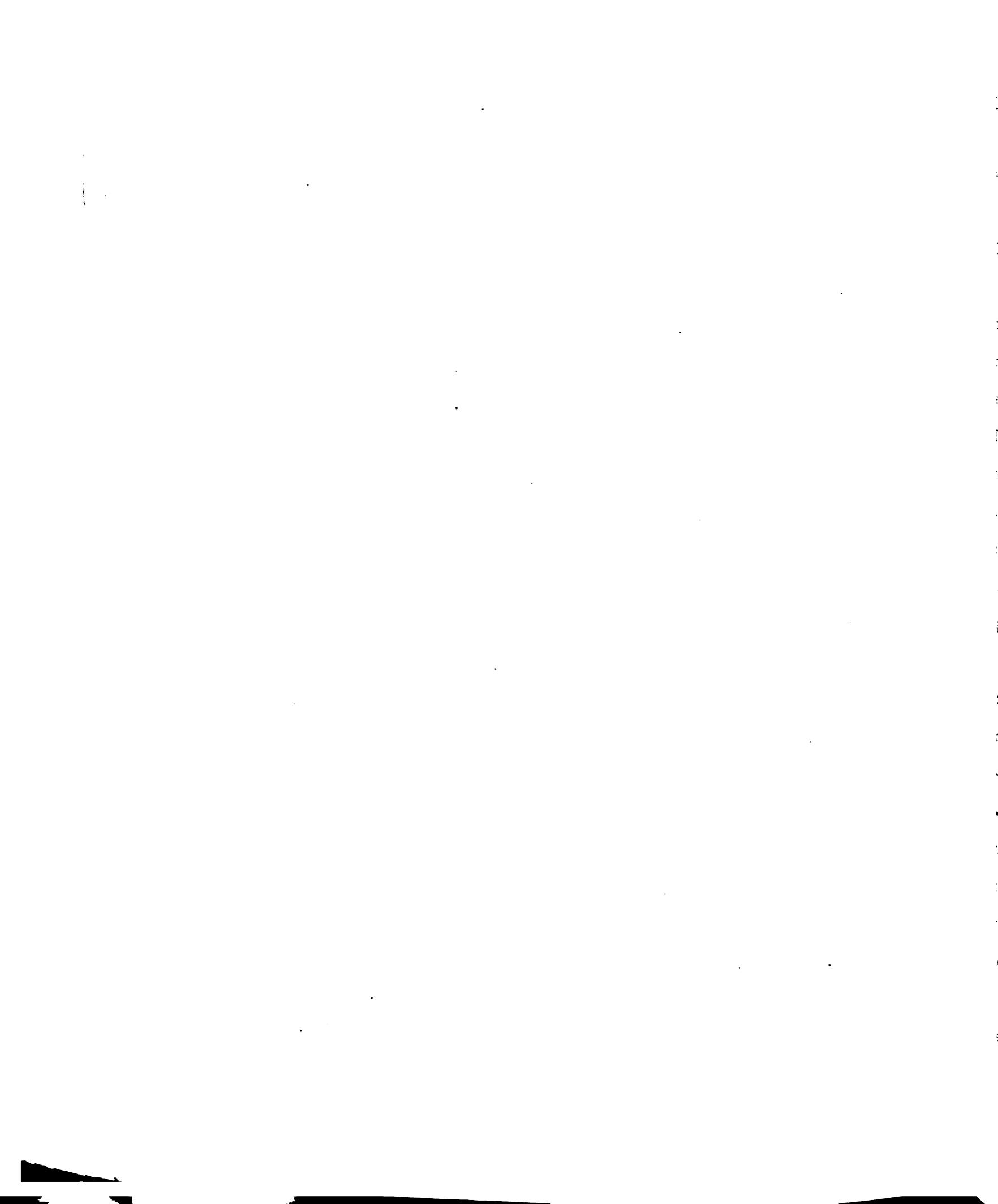
By a slim margin, the majority of LPTs and RNs agreed that "Most of the time there is no way to predict whether or not a patient's mental disorder is curable" (Number 53). Fifty-eight percent of the therapists disagreed with that, although none completely. The numbers are not highly concentrated in any category on this question, but it is apparent that the therapists place greater trust in the diagnostic and prognostic processes than do most nursing personnel.

Three-fourths of the combined sample disagreed that spouses should be permitted by law to divorce as soon as one is treated and/or

confined for a severe mental illness (Number 96). Slightly over seventy percent of the total sample expressed the opinion that it is no easier for women than men to resolve emotional problems (Number 19).

Despite the general hopefulness for recovery from mental illness noted in some questionnaire responses (but often not during personal contacts), statements related directly to long-term prognosis alluded to more pervasive pessimism. Number 33, "Mental patients usually make a good adjustment in society when they are released," met with rejection by 64% of the three groups of respondents. Unusually high proportions (22% of RNs and 36% of therapists) indicated neutrality, that is, neither agreement nor disagreement. Few RNs or therapists agreed with the statement, in contrast with 31% of the LPTs. Perhaps also alluding to the doubts haunting many who are involved with the care and treatment system are the responses to Number 3, "Few people who enter mental hospitals ever remain permanently discharged." Fifty-four percent of the LPTs agreed with this, but greater percentages of RNs and therapists rejected the statement (58% and 68%, respectively).

Eighty percent of the combined respondents, the LPTs slightly less strongly than the other groups, disagreed with the statement that "People who have been patients in a mental hospital will never be their old selves again" (Number 86). A similar proportion indicated that ex-patients should not be restrained from marriage and having children (Number 64). However, the majority of none of the groups felt that former patients could be trusted as baby sitters (Number 100). Over a fourth of the combined sample resorted to neutrality on that question.



Opinions About Society and Mental Illness

Each of the three statistically significant statements that pertain to societal views of mental illness has been discussed previously, so they will be only summarized here.

There is considerable difference between the responses of RNs and LPTs to statement Number 110 on the clarity of differences between "mentally ill" and "normal" persons. Although all three groups generally agreed that the categories are not always clear, 30% more nurses and 20% more therapists expressed this than did LPTs.

The differences were less pronounced but still significant in terms of whether people who are unable to work due to mental illness should receive money for living expenses (Number 97). Seventy-four percent of the nursing personnel and 94% of the therapy staff concurred with this proposal.

Approximately half of the LPTs and RNs disagreed that "A woman would be foolish to marry a man who has had a severe mental illness, even though he seems fully recovered" (Number 84). In contrast to the nursing staff's hesitancy on the question, was disagreement by nearly three-fourths of the therapists.

Twelve additional statements dealt with issues of societal responses to mental illness and mentally ill individuals. The responses to these did not generate statistically significant differences, implying, therefore, generalizability among the sample of combined nursing and therapy staffs.

As mentioned in a prior section, 87% of the total sample consider many severely disturbed mental patients capable of skilled labor

(Number 87). Eighty-five percent deny that hospitalized psychiatric patients should lose their voting rights (Number 88). Three-fourths of the respondents disagree with the notion of readily obtainable divorce when a spouse is hospitalized and/or treated for a severe mental illness (Number 96). Four-fifths of the combined sample indicated trust in the ability of ex-patients to become "their old selves again" (Number 86).

Less optimism was displayed in responses to the statement regarding good adjustment in society by released mental patients (Number 33). However, only 6% of the nurses and 12% of the LPTs weakly consider the individual who becomes a hospital patients a "failure in life" (Number 91). Eighty-two percent of the nursing personnel and 100% of the therapists rejected that association.

How distinctive persons who were once psychiatric patients are in the community is dealt with by statements Number 66, 71, and 103. There was general agreement that it is not easy to recognize someone who once had a serious mental illness and that there is nothing special about mental patients that distinguishes them from other people. There were no majority opinions in response to the statement that some people never hospitalized for mental illness are more severely ill than those who have been.

Three statements, Numbers 17, 31, and 78, refer to the magnitude of mental health problems and official responses to them in the USA. The overwhelming majority of the combined sample expressed the opinion that more tax money should be spent on psychiatric care and treatment. All of the RNs and therapists and 88% of the LPTs disagreed that mental

health problems have been exaggerated. Eighty-seven percent of the total group judged mental health to be one of the most important national problems.

Conclusions

Despite the fact that the RNs, LPTs, and therapists work together on the same hospital units with the same patients and under the same administration, their opinions about mental health, mental illness, and mental patients vary markedly. The questionnaire used here taps only some of the potential reservoirs of differences in attitudes and opinions which underlie role performances on the units. In most cases, the survey serves only to determine that differences exist, not what the preferred alternatives might be. Nonetheless, the large number of readily detected differences helps explain observable behavioral discrepancies.

The most pronounced differences were found between the LPTs and the other two staff groups. This has important implications for several reasons. The LPTs work jointly with the RNs to provide nursing care for a shared patient population. There are few clearly defined role differences between the RNs and the LPTs, and to many therapists "a nurse is a nurse is a nurse." Often, when asked, nursing personnel were unable to identify therapists by discipline. The inverse was also true: few therapists (especially students new to the system) reliably differentiated RNs from LPTs among nursing staff personnel.

Several themes prominent in the data obtained by participant observation were reinforced by responses to the attitudinal

questionnaires. One is a lack of uniformity among expectations associated with nursing roles. Considerable variability was found in the within group responses of RNs and LPTs. In the subset of statements which dealt with nursing roles, the therapists' responses fell between those of the RNs and the LPTs in three of five cases. Responses to over half of the 110 statements indicated, however, that the opinions of the RNs were between those of the therapists and the LPTs. The role of the nurse as patient advocate has long been acknowledged. Perhaps more attention should be given to that of buffer between professionals and paraprofessionals, in this case, therapists and LPTs.

A second recurrent theme is that of trust versus fear of psychiatric patients. Although responses to those questions dealing directly with need for physical control over patients met with generally liberal responses, the unusual strength of agreement and disagreement with these statements expresses the force and depth of feelings about these positions. Some staffmembers advocate increased and others decreased control and monitoring. All have reasons for their opinions on the issue. And all are probably affected in their role performances by their opinions.

A third theme involves doubt and confusion about the present system and its effectiveness. All three surveyed groups are generally convinced that the patients they see need help. That attitude at least in part reflects the highly selected group of patients with whom they deal. The therapists indicate much stronger trust in the diagnostic, treatment, and prognostic processes than do the RNs and LPTs. Yet

little hope is expressed by any group for good post-hospital adjustment and/or permanent discharge. Although only a fifth of the total sample expects patients to never fully recover "their old selves," most nursing personnel feel there is no way to predict who will recover and who will not. The majority of respondents doubt, furthermore, that greater numbers of well-trained personnel would significantly reduce numbers of hospitalizations.

A fourth theme involves ambiguity and ambivalence in relationships between individuals who have been labelled mentally ill and those who have accepted the roles of caring for those so labelled. A difference between mental illness and "normality," for example, is least clear to the RNs. The other portion of the nursing staff, the LPTs, however, indicated the greatest assurance that such a distinction is real and discernible.

A few statements generated overall agreement from all respondents. Notable among these was that indicating that patients should be consulted regarding their treatment. Others reflected a strong conviction that mental illness is a serious national problem deserving of greater public attention and intervention.

CHAPTER 9

PATIENTS AND STAFF INTERACTING:

THE PATIENTS' STAFF AND THE STAFFS' PATIENCE

"It is not well to sneer at political economy in its relations to the insane poor. Whether we think it right or not, the question of cost has determined and will continue to determine their fate for weal or woe."

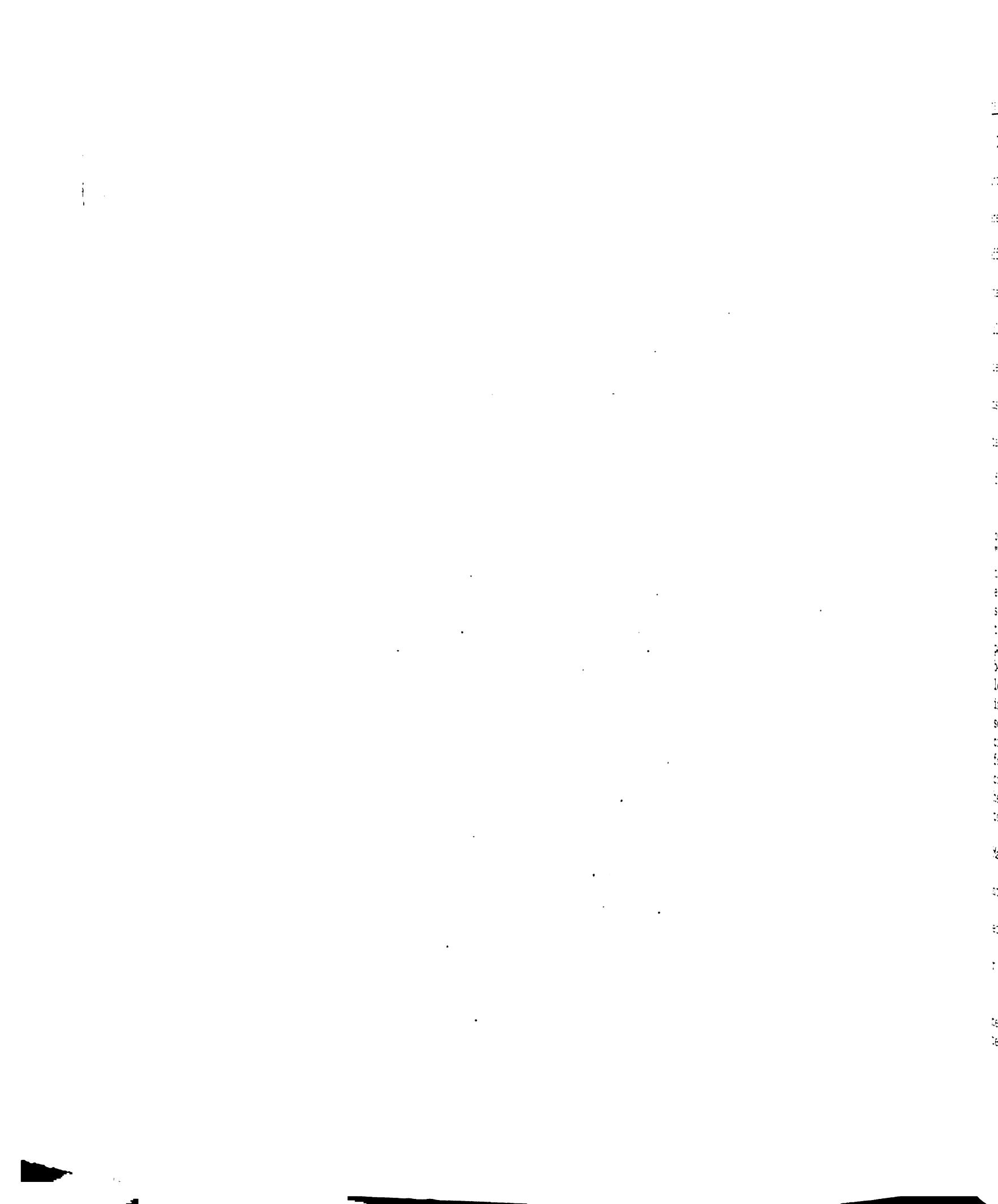
George Cook,
The American Journal of Insanity, 1866

"Where do we come from? What are we? Where are we going?"
Gauguin, 1897

"Is there no place on earth for me?"
Susan Sheehan, 1982

"The patients near the nurses' desk are pacing, laughing at no visible stimuli, posturing, and speaking to images only they perceive. They are a motley crew dressed in hospital gowns, donated clothes, a jail suit, all without belts. One just threw up in the tobacco box. Yup, all is well on East."
Curt Kinsdorf, RN on Ten East

At City and County, due to the area it serves and its existence as a city and county institution, many of the psychiatric patients are homeless and/or medically indigent. All are adults and most are male. A high percentage represent ethnic minority groups. For at least one-third of its psychiatric patients, City and County provides a "revolving door" (Castel et al. 1982: 108) with serial admissions and discharges, sometimes a dozen or more times in a year. This profile, although brief, illustrates several prominent characteristics of contemporary public psychiatric treatment and care.



Behavior on the Units

It is difficult to describe psychiatric units like City and County's without seeming to exploit the bizarre and dramatic. When there are eighteen or twenty patients in a small, enclosed, inefficiently-arranged, U-shaped space, their presence, along with the perhaps six to ten staff and therapists on the unit during the day, can result in an intense atmosphere and interactive cacophony. Some of the patients, severely depressed, isolate themselves in their beds and rooms most of the time. Others are out and about, often agitated and agitating, creating a roller coaster of interactive highs and lows. The following provides a brief illustration.

When I returned to Ten East, the elderly Black woman was out of the seclusion room and yelling in her bed by the desk, "I want to get out of here!" The ward clerk turned to me with her usual smile and said, "So do I!" A patient was trying to explain to one of the RNs his theory that caffeinated soft-drinks are morphine based, his voice getting louder as the nurse expressed even non-confrontive skepticism. Another patient demanded her (nonexistent) cigarettes and tried to bolt through the door when the psychologist and some interns left. Becoming upset to the point where she hit two of the interns and was forcibly restrained, the patient repeatedly screamed that all of this was a conspiracy. "Now they have my cigarettes," she screamed, "Now they want to lock me up forever! Get off my throat!" The elderly woman by the desk continued to shout about once a minute, as if some timer in her mind activated the same tape over and over again: "I want to get out of here!"

Many behaviors seem bizarre, extreme, and irrational. The impact of interaction is intensified by frequency, diversity, and unpredictability. Conscious attention to specific behaviors, on the other hand, tends to dull with exposure.

The Saturday morning cartoons are on in the day room. A new patient is sitting on the coffee table in front of the television, repeatedly spitting into his hands and wiping

them on his beard. Since he would not go into the dining room to eat breakfast, his tray was brought to the day room. Unable to sit still and eat, he has climbed onto and over each piece of furniture in the day room, except for the television set in the corner. He ate part of his breakfast this way, but he could not focus on it long enough to finish.

One patient stands for hours in the bathroom with the lights off, but comes out with a smile for meals. She says she is married to Elvis Presley and Bruce Lee, and also claims to be Maria-Elena (a Filipina character portrayed as both the Virgin Mary and the consort of Christ). The staff refers to her as "multiculturally grandiose."

West happens to have several pacers right now. These patients travel miles every day just pacing through the unit. There are now five men pacing, one periodically yelling in Japanese. Although the space is small and crowded, the pacers somehow space themselves. No two converge on the same part of the unit at the same time.

The patient who set himself on fire is back. He has already set two more fires in PEC and two on the jail unit. He manages all this with one arm, and that usually restrained. He also has been subjected to "full strip searches" prior to these incidents. In at least one case, another patient rolled a cigarette in to him under the door.

One of East's patients tries to choke himself. Apparently he has been doing this for years. An amazed trainee proposed that "He needs to get a grip on himself." The staff has been trying to decide whether they should encourage this patient to stay out in the day room "where everyone can ignore his choking and not play into it," or to encourage him to limit his choking behavior to his bedroom "but he might really hurt himself, and we want him to socialize. Besides, it freaks his roommate out." Finally it was decided that the choking behavior would be ignored and non-choking behavior rewarded. The patient now spends his time in the day room. He walks around with his wrists tensed and his hands dangling. This afternoon I watched him walk to the day room window. He slowly turned around to face the room and the nurses' desk, raising his hands to his throat. No one seemed to pay any attention to him, although he was obviously putting considerable pressure into his grip.

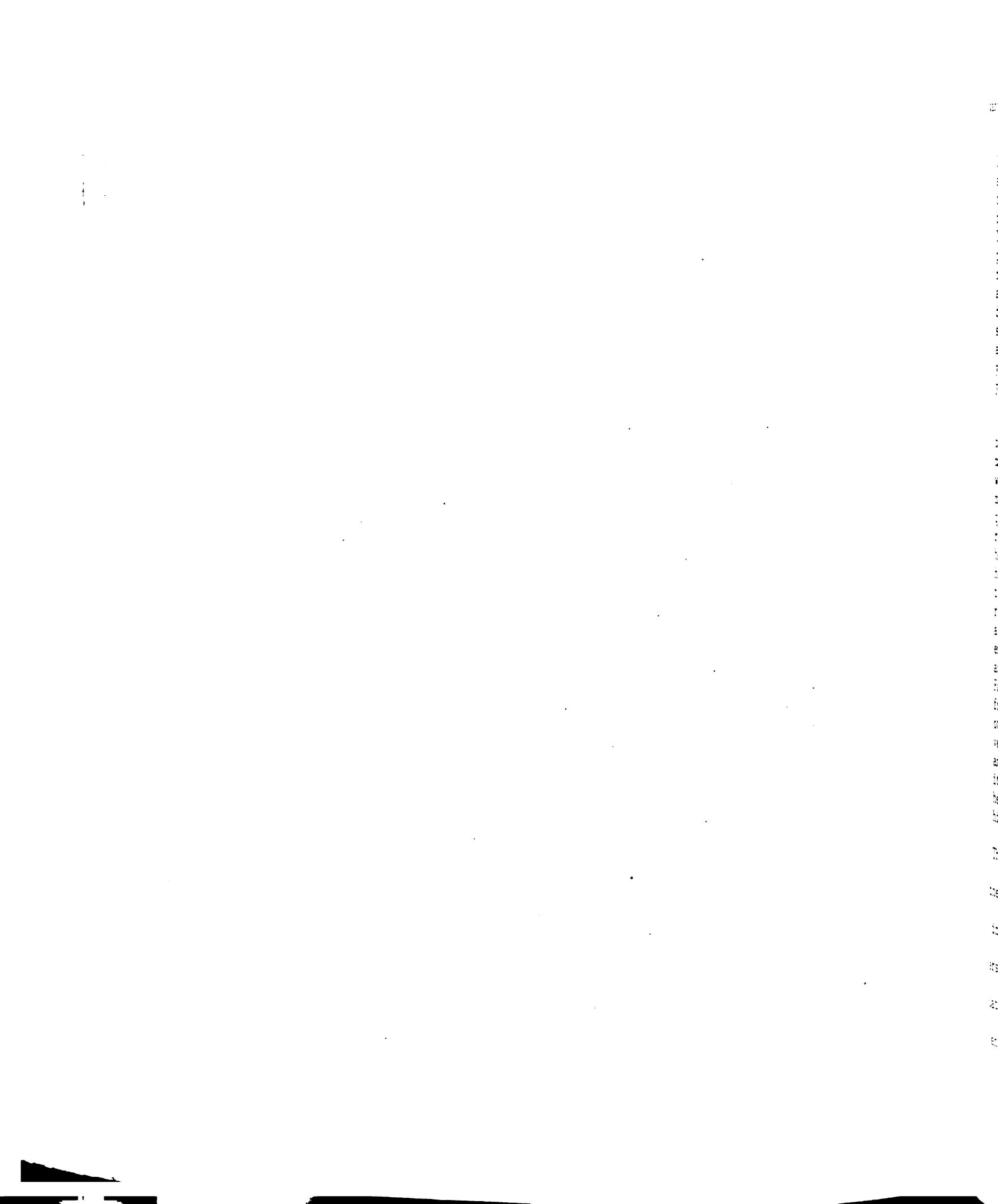
Pedro spent several hours this evening cleaning the ward. He systematically cleaned out every wastebasket, then emptied them all over again. Pedro was first institutionalized at the age of four. Of all the patients here, he is probably the most institutionalized in the

traditional sense. When about to be put into the seclusion room he goes through a clothing removal and folding ritual usually observed only among over-institutionalized people who have learned to conform to the precise expectations of some austere authority. Now in his early twenties, Pedro continues to cycle through psychiatric hospitals, prison, and the barrio. When he is most disturbed he speaks only pressured, incoherent Spanish. He also goes through phases of mutism and coherent bilingualism. He encourages the staff to put him into seclusion, behaving in ways that ensure that response. Once there, he tells the staff to hit him, to use straps, and to lock him up more tightly. Here they don't, but no one knows whether his urging reflects his fantasies or his history.

Pedro ended up in seclusion again today after having three teeth, broken and rotted to the gum, removed in the oral surgery clinic. Rose Metlach, an LPT, took him to the clinic at the appointed time, but they had to wait. By the time he got into the dentist's chair, Pedro decided that he didn't want the teeth out. He and Rose came back to the unit where they discussed the problem with Pedro's therapist. The intern called the clinic and arranged to have him seen right away. Rose took Pedro back downstairs and the teeth were extracted. Upon return to the unit, he removed several bloody compresses from his mouth and threw them at the ward clerk, thereby buying his ticket into the peace and quiet of the seclusion room for another afternoon.

The community meeting this morning was led by Marsha Siu, the program director. Two new patients were admitted during the night. One is in seclusion and could be heard, despite the distance, throughout the meeting. The other one sat next to Marsha. He is a White man in his fifties, very grubby in appearance with a stubbly beard, wild hair, and filthy and shabby clothing. He frequently interrupts and is very confused, talking about a "German universe" and various irrelevant ideas. Every few minutes he tries to shake hands with those around him. This man, in the middle of one of Marsha's translations for the Chinese patients, blew his nose into his hands, wiped his hands thoroughly together, and then wiped his face with his hands. Marsha made no attempt to hide her concern for this behavior and would not shake hands with him the next time he attempted to do so. He was handed a box of tissues by a staffmember. He took a wad of these and stuffed them into his pocket. Then he took a few more, wiped his tongue with them, and stuffed them back into the tissue box. The meeting progressed in spite of this and other patients' inappropriate behaviors.

At times bizarreness seems to extend beyond the patients. An



example:

The day room looked like something out of the movies. One man was chanting at the top of his lungs in Cantonese, another praying in English as loudly as he could, frequently bowing to the floor. The praying patient periodically stands in the day room, exposes his penis, and prepares to urinate. Tim Morse, an LPT, ushers him to the bathroom, after which the patient goes in his bedroom and masturbates. The cycle is repeated when he returns to the day room to pray and repent, and eventually has to urinate again. When this patient was discussed in the therapists' team meeting, the ceiling sprinkler over us dripped a puddle of water onto the table around which we sat. The team leader leapt to his feet and yelled, "God! He's even in the ceiling pissing! Joe, are you up there?"

Elderly parents came to visit their disturbed son. They brought bags of fruit and potato chips with them. The young man immediately started eating, washing chips and bananas down with great gulps of orange juice from a large carton. The mother settled into a corner of the couch and started asking questions of her son about his court appearance, potential for release, and so on. Finding that the hearing had not gone in his favor and he would have to stand trial for an attempted homicide, she encouraged him not to believe what he had been told. Liberally interspersed in this conversation were religious admonitions. The father, meanwhile, was more attentive than the others to the unit itself. While Mother enumerated and acknowledged each additional orange and apple, as if personally introducing the pieces of fruit to "my boy," Father repeatedly moved his chair, trying to find some place from which he could see his son and still keep an eye on the others in the area around him. Throughout the visit he verbalized only when directly addressed by one of the others, and then with brief reassurance that "the Lord" would see to it that everything would be all right. The rest of the time he spent apparently helping "the Lord" see to it that he and his family were safe in this "unsafe place."

These vignettes are the briefest of introductions to the behaviors on the units. Each patient, staff member, and visitor has his or her own interactive approach to others and to the unit itself. The diversity here is well beyond that encountered in other social situations. When asked what is most stressful about working with these patients, the nurses say it is their intrusiveness and demands

for attention, their unpredictability, and their preoccupation with internal activities (for example, hallucinations). The irrationality of patient behavior and the distress that many patients express are additional stressful aspects of the environment.

Assault of the Senses

Many patients appear unkempt and uncared for. Some have the potential for attractiveness with more grooming, but few, during hospitalization, have the necessary abilities and/or motivation for that.

One of West's patients has been walking around all morning with both legs in one leg of her coulottes. She does not seem concerned about the loose leg flapping about as she walks. The staff finally gave up and ignored her appearance.

The new man on East is very attached to his filthy red jumpsuit from jail. He says he feels safe in it. The staff has been encouraging him to wear regular clothes, but he does not want to. Considering his history of violence, no one is inclined to push him.

The tall, bent man's top teeth are missing in the center. From grinding them at night, those teeth that are left slant on both sides nearly to the gum.

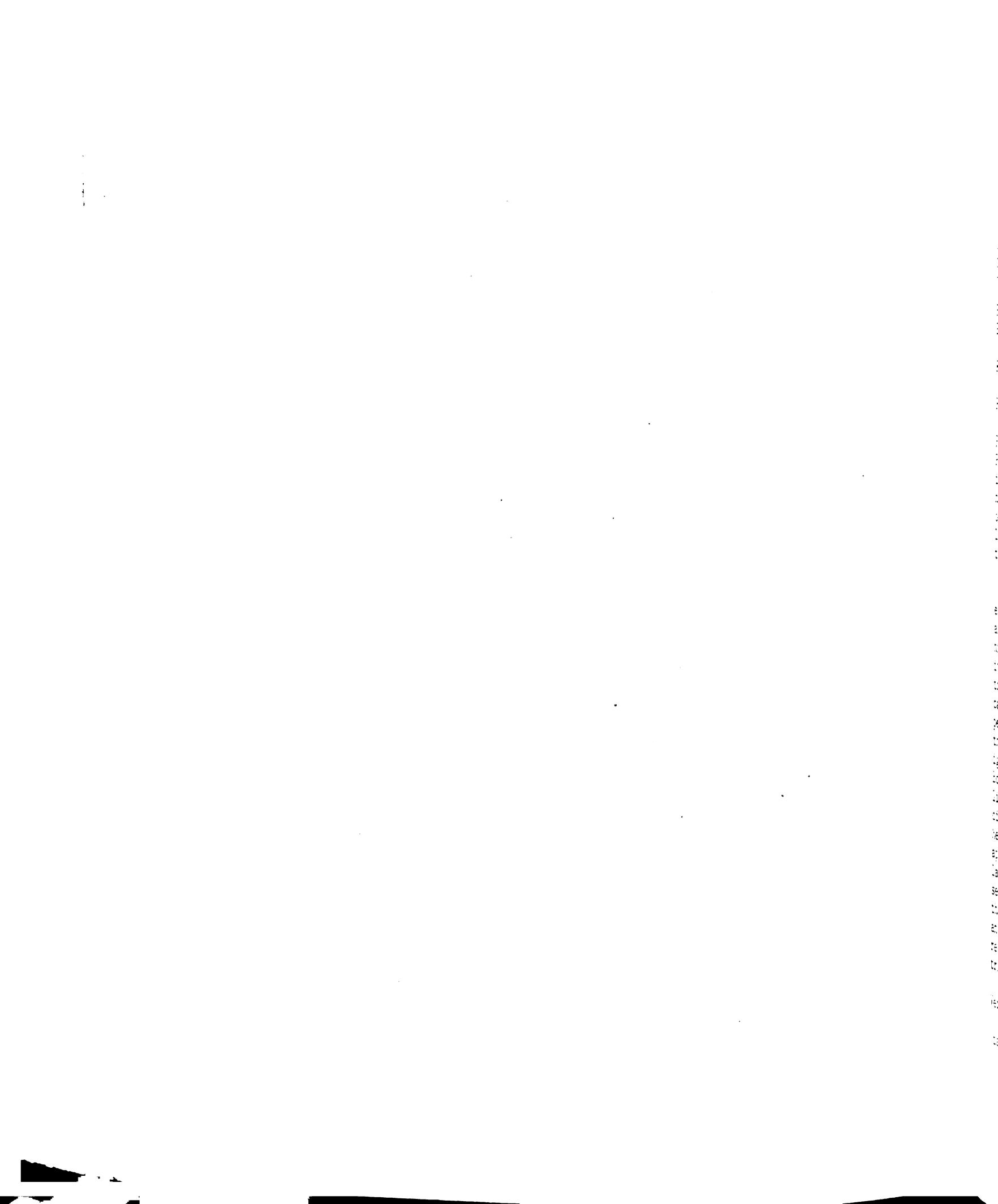
A very intrusive young woman repeatedly tries to come behind the nurses' station. The ward clerk's patience is wearing thin. Her admonitions seem to make the patient more persistent in her attempts not to gain entry to the nurses' area, but to irritate the staff. She tried to grab someone else's medication from the medication tray when an RN walked by, then brushed a pile of papers off of the desk. This patient is particularly disliked by the staff because of her repeated poking and grabbing of women. (Most of the staff are women. As accustomed as the staff is to male patients who exhibit hypersexual behavior, and to lesbian patients, they tend to be angered by this patient's persistent aggressiveness.) Often referred to as "repulsive" or "obnoxious," the patient's appearance does little to endear her. She is obese and sloppy, a White woman in her early twenties. Her curly hair is unbrushed. All one length, it

wildly bushes from her head in a manner that exaggerates the fatness of her face and body. Her not-unpleasant face is frequently spoiled by a toothless, mocking grin.

This patient is difficult to ignore and her laughter is loud when people respond negatively to her, as the ward clerk is this morning. This attention-getting noisiness intensifies the displeasure of her presence. If negative attention is not forthcoming, the patient comes behind the desk. To this the ward clerk is sure to react. Clad in a ragged, dirty sweatshirt and jeans, the odor from the patient's unwashed body adds olfactory to visual, auditory, and tactile assault. When encouraged to wash, she laughs, as if trying to get the staff desperate enough to try to bathe her. This patient is given to rude, vulgar remarks, often shouted. She has a long-standing therapeutic relationship with the program director, one of the few persons from whom she will accept limits to avoid estrangement and alienation. This morning she brags to the ward clerk, in a childlike taunt, that she will talk with the program director this afternoon, while the ward clerk will not. When the clerk seems unbothered by this, the patient continues, "She does not like you, you know. She told me she hates your rotten, fuckin' guts." The ward clerk walked away from the desk with her arms full of charts.

A patient became very upset when she was asked if she would wash and change clothes before the weekly staff-patient lunch. Discharged only a week ago, this patient immediately went AWOL from the three-quarter-way house to which she was discharged. Within two days she was readmitted, hungry and filthy, from the streets. She claims that no one objects to sitting with her in her present condition (which the staff described as "very, very ripe"). The patient continued, "In fact nobody even minded when I had my period and it went through all over my clothes." The RN at the desk asked, "Did that happen when you were outside?" The patient answered, "You bet it did. I didn't have any money and napkins cost two or three dollars. A woman picked me up and was going to help me, but that didn't work out. I've been in this damned place so long that I'm afraid to even have anyone pick me up anymore." The patient did not change clothes or wash before lunch. Sitting with the psychologist (who claims to have permanent nasal fatigue after several years on the unit), a medical student, and several patients, she noisily ate five heaping plates of food.

A patient who has been living on the streets and in backyards apparently does not know how to take a shower. He sat on the shower floor and let the water run over him, needing assistance to wash. In the shower and out, he coughs and expectorates on the floor.



Another patient repeatedly smears feces throughout the bathroom and shower. His soiled bedding and personal clothing were changed, and he was showered. But the staff complains that the area still smells, despite its having been repeatedly cleaned.

A patient came to the nurses' desk to report that he has showered.

RN: "What about your clothes?"

Patient: "They are fine. I've washed them twice already since I've been here. They're fine!"

RN: "How long have you been here?"

Patient: "Only since the 27th." (Today is the sixteenth of the next month.)

RN: "What about a pair of pajamas to wear and we'll wash the clothes again?"

Patient: "Oh, no need! Really, they've already been washed twice since I've been here. That's plenty!"

RN: "Well, what about your hair?"

Patient: "I didn't wash my hair." It is long and stringy. He is nearly bald on top, but pulls long hair from the back of his head up across the top to form uneven bangs in the front. Part of the bangs hang down to his nose in a sparse and somewhat ludicrous fringe. His large, prominent nose, jutting through the fringe, and his receded chin little help his appearance.

This interaction was interrupted when a large man, an ex-boxer with considerable organic damage, forced two LPTs aside, reached over the desk, opened a drawer, and helped himself to his cigarette lighter. The lighter has his name on it and is his property, but access to lighters is monitored on the unit. When the LPTs, both women, tried to stop him, he called them "Caucasian bitches." A woman patient who persistently begs cigarettes fueled the situation by insisting that the lighter was hers and not his. Everyone appeared to ignore her. Five staffpersons gathered around the man. Joyce Bowen-Smith, one of the LPTs, gave him a cigarette, offering to light it for him. He handed her the lighter and she lit the cigarette, then handed the lighter behind her to an RN. Meanwhile some of the staff talked in low tones about the best approach to use if the situation got to the point at which this large, strong, and unpredictable man had to be forced into the seclusion room. Instead, probably distracted by the arrival of the lunch trays, he said the angels told him to get the lighter and offered no further resistance. The staff sighed with relief; everyone there felt "he could send (them) flying if he tried."

Verbiage is frequently hostile, incoherent, and/or offensive. It also takes the form of litanies of non sequiturs. An example:

Patient Number 1: "What kind of fish is this?"
Patient Number 2: "There's butter on my chair."
Passing staffmember: "Tuna probably."
Patient Number 2: "Tomorrow maybe."
Patient Number 3: "When my doctor comes in."
Patient Number 1: "There's soup still."
Patient Number 2: "There's soup still."
Patient Number 3: "Before Christmas my doctor will come in."
Patient Number 1: "It might be salmon."
Patient Number 4: "Wednesday I go."
Patient Number 1: "Doctor Merritte knows what kind of fish
this is."
Patient Number 2: "I'd like to be a ship too."
Patient Number 3 (to plastic spoon): "Somebody got my soup.
I mean, somebody got my soul. Soul (sole?) soup. Soup
soul. Soul soup soul. Gotcha."

Even touch as it is used in ordinary interpersonal situations is modified in this setting. Staffmembers attempt to know each individual before intruding in his or her space in any way. One patient may be comforted and pleased by a touch on the arm, or seek affection in any way it can be obtained. For another, however, the same touch may be met with screamed accusations and prolonged agitation.

In addition to presenting an array of diverse behaviors, patients reflect many levels of functioning. Some can take fairly complete care of themselves; others need nearly everything done for them. Many have physical as well as psychological limitations.

Intensity

Interactions on City and County's psychiatric units are often sequences of highly charged situations in which patient emotions flare and staff emotions present as flattened, if they are apparent at all. At times, there is no foreseeable end to interactive involvement

except for personnel changes with the ends of shifts. The nurses spend most of their time talking to patients, doctors, each other, or at meetings. Relative to involvement on the unit itself, meetings are less intensive. They are used sometimes, therefore, as an opportunity to decrease attentiveness.

Despite the limitations imposed on proposed information sharing, meetings, for some, are opportunities to "tune out" and "recuperate" from "IPR (interpersonal relationship) overdoses." Otherwise, there is little time to think or rest. One nurse told me that he does not want to think about what happens on his unit. He copes by ignoring it, and planning to quit. Someone else pointed out that

"If nurses here were expected to think, somebody would have built in a little time for it. Now there is only time to be exhausted."

Outside of meetings, staff interaction is frequently interrupted by the demands of patients. By unstated rule, the patient nearly always has the interactive right-of-way. Meetings provide a place for uninterrupted discussion, but they are time limited and usually fully scheduled. Since nursing staffmembers often skip meals, eat on the run, or eat alone so that the unit remains covered, there is little additional time for communication.

The combination of the bizarre nature and the intensity of many staff-patient interactions is overstimulating and draining. Strains in relationships between staffmembers and patients are intensified by the rapid turnover of patients. With acutely ill patients who typically stay only nine to twelve days on the unit (and many less than that), there is little time to establish relationships, to view individuals

in a wider context than the unit itself, or to see substantial change.

Nurses complain of a lack of time to purposefully assess, plan, and intervene with patients. Although the need for each patient to be dealt with individually is recognized, there is scant time to develop, among three shifts of nursing personnel, a unified approach for a patient, to say nothing of nineteen concurrent patients with different needs at the same time.

While attempting to accept each new or recidivistic patient as he or she is at the present time, the RNs often limit their own views to the same time and space. The nursing staff tends to be less involved with pasts and futures of patients than are the therapists who spend hours reconstructing histories, predicting outcomes, and arranging placements. Although in-patient hospitalization is part of the community mental health system, it tends to be conceptualized by the nurses as a distinct and separate entity. Nursing here deals with the present. When away from the units, nurses sometimes speak in broader terms, but when on the units they focus, often exclusively, upon the present.

Several other factors encourage denial of realities beyond those of immediate import. These nurses freely acknowledge that what they do and the people they work with are little valued by society. Some nurses are discouraged by the prognoses of their patients. Patients' histories are unchangeable and often tragic; nurses sometimes want to "tune them out." Many patients are presumed to have futures that are no more optimistic than their pasts. Some patients are hospitalized dozens of times, often worse off on each admission. The goals

established for them tend to be extremely limited. The staff expects recidivism. They feel there is little reason to believe that any intervention on their parts will have a lasting effect.

This present-oriented perspective is physically reinforced by what may be the single most stress-provoking aspect of psychiatric nursing in this setting: being locked behind one or two steel doors with the patients for entire eight or ten-hour shifts. There are few opportunities for the nursing staff to leave this intense but rigidly boundaried physical environment.

The unpredictability and potential assaultiveness of many patients results in a wary staff that often prefers former patients who return to those who are new and unknown, and therefore even less predictable. Many of the nurses describe terrifying incidents that they have experienced, often resulting in serious physical or psychological injury. Acutely ill psychiatric patients may be desperate individuals. Always one must remember that it is their affect and/or rationality that is impaired, not their physical strength. The need to be continuously attentive to such basics as physical defense of oneself and others discourages the development of perspectives beyond the here and now.

Coping

The nursing staff uses a variety of conceptual and interactive strategies to deal with conditions on the units. Within the framework of the crisis-oriented present, staffmembers conceptualize their relationships to patients in different ways. Sometimes unconvinced

that their patients suffer from diseases that inherently alter them, nursing personnel question how different they really are from the people encountered in patient roles, and, therefore, how to behave toward them. Those who relate to patients as like themselves (that is, who feel that the patient happened to become ill, but any one else, including the staffmember, could as well) tend to work part, rather than full time.

Most staffmembers assume that everyone who is admitted is ill, and proceed to analyze all observable behaviors in search of pathology and/or changes in conditions. A professional, objective stance provides distance for evaluation and defense via limited psychological involvement. Lumping behaviors, diagnoses, and histories into classifications allows "individualized care" to become impersonalized. Even patients' complaints about the staff tend to be seen as symptoms of the patients' illnesses.

Wherever there are patients, systems develop for ranking them and for allocating attention to them (Strauss et al. 1981). The YAVIS phenomenon is well known in evaluation (Wilson and Kneisl 1984). This represents a preference for "young, attractive, verbal, intelligent, and successful" clients (Schofield 1964). Although the classic YAVIS individual is infrequently found in public psychiatric treatment settings, when he or she does appear, this individual tends to be treated differentially. This and other ranking systems were observed at City and County.

Relationships with patients are also shaped by individual preferences and priorities. Many staffmembers prefer working with

psychotic patients (the "real crazies" who are also the "most different from the staff") and resist patients with borderline or personality disorder diagnoses due to their "sharp tongues," unpredictability, and propensity for manipulation. Others say they rank patients by prognosis, typically investing their energies in "the young, potentially productive, and rehabilitatable" (the unit adaptation of the "YAVIS syndrome"), and "ignoring the burned out." One nurse says he relates

"only to situationally stressed patients, those whose circumstances have gotten the best of them, but who show no real pathology. The others are too different and too far gone. I can't help them."

Focusing on physical care, another RN takes "care of the sickest, the lowest functioning patients first."

The problems of patients who are relatively difficult to manage on the unit are most apt to be discussed in depth by the nursing staff. This conferring also allows the staff to verify and ventilate their feelings about particular patients or events. The simple ritual of shift report also serves to discharge some accumulated tension. Thrice daily, changes of shifts are accompanied by increases in spirited intrastaff interaction. Reports, primarily of patient behaviors, are made to on-coming staffmembers. These individuals are generally open to such information, and they understand its significance in much the same way that the reporting staffmembers do.

Coping strategies include the structuring of interactions and of relationships. Interactions are shaped by the nursing staff in a variety of ways which monitor their own involvements. A common

approach is to remain occupied with tasks that limit direct staff-patient exchanges. Other physical barriers are also utilized. The nurses' desk, charts, and the semi-partitions separating the day rooms from the area immediately in front of the nursing desk are a few.

Dyadic interactions are often fragmented by the flow of distractions and disruptions common to the environment. Interruptions by other patients, staff, tasks, and telephones help maintain superficial interactive levels. The disorganization characterizing two units, although wearying, also provides distraction. Attention to patients is likewise increased or decreased in accordance with the staffmembers need for "personal space" or "energy to invest." It is possible to remain aware of patient activities without being actively involved with them.

In the basic split between the larger managed group and the smaller supervising staff, relationships are generally characterized by limited mutuality. The formally prescribed social distance is great, and social mobility between the two strata is grossly restricted (Goffman 1961). This separation is not, however, always mutually desired. Patients grasp at the relatively rare opportunity for sharing experiences with, rather than simply in the presence of, the staff.

Following activities on the patio, a patient disappeared into an elevator and officially went AWOL. For many of the other patients it was the high point of excitement for the day. Shawn, who can neither speak nor hear, enjoyed this greatly. When we got back to the ward, he tried desperately to relate this news to Annemarie Baker, an LPT, who was unable to guess at the message he was trying to communicate with such amusement and excitement. Shawn came and tapped me on the shoulder. He charaded running feet, the opening elevator doors, the man getting in, and the doors closing, so that I would tell Annemarie what had happened. Since the missing

patient had been voluntarily admitted, security personnel were not notified and the staff was not especially upset about his unauthorized absence. To the patients, however, the situation was intriguing and energizing. Shawn and another patient (a young man usually irritable, volatile, and hostile) were particularly affected by the incident. They seemed to feel that they shared a common interest with the staff, as if they realized that for the brief time that the patient stayed away, the staff had no more control over him than they did.

Tonight I attended an orientation group which included four patients, two members of the nursing staff, a student nurse and myself. After introductions, we did simple exercises to share what had happened to each of us this day-- something good, and something bad. One patient pointed out that with equal numbers of patients and non-patients, and everyone doing the communication exercises, "It is like we are equal. I never felt that way here before."

While some staffmembers use social distance from the patients as a defense, others minimize it. They elicit patients' help and contributions, explaining this as being good for the patient, while enabling staffmembers to accomplish other goals.

Annette Himata, an RN, scrapes the remains from the lunch trays into plastic containers. She has a huge dog for which she takes home the leftover milk and food scraps. Most of the patients make sure that she gets the remains of their meals. The patient with a history of hepatitis reminds her not to include his. It seems to have become a group project.

A patient asked for some things from the "canteen." (Many patients who have been in state psychiatric hospitals refer to the cafeteria and small store downstairs as the "canteen.") Lori Eichelberg, the charge nurse, explained that there was no one available to go down now, and asked the patient to organize a list of wanted things. She gave him paper, pencil, and an envelop in which to collect money. He responded with "Good, that furthers my interests too," and set off to organize this effort. He did it well, making a list of desired items and collecting change from the higher functioning patients. Lori, meanwhile, spent fifteen minutes with a patient with a severe dystonic reaction, and then an equal amount of time explaining to an intern from PEC which orders he could and could not sign.

There is sometimes limited time to be spent with patients.

Interactions tend to be structured to obtain the necessary information

with a minimum of small talk. Humor, and numerous interactive techniques are used. These most commonly include focused listening, reserving focused interaction time, nonverbal communicative techniques, observation, talking to patients as if they will understand (whether they do or not), confrontation, supportive and protective measures, distancing, and using objects or concrete tasks as links to or barriers from patients.

Control is probably the most widely used coping mechanism on the units. In the therapeutic milieu, role socialization (that is, role training) is considered therapy; patients are expected to learn and abide by unit rules governing group behavior, and to behave responsibly toward other patients (Hall 1975). The staff has the authority to reward and punish behavior. Typically patients receive negative sanctions for being disruptive in the living situation, and, if considered capable of higher functioning, for not fully participating in unit activities (Hall 1975).

At City and County, patients who are evaluated as participating in the prescribed patient role are rewarded with status level changes that imply passes and privileges. The disruptive may have privileges revoked, and depending upon expectations and the situation (for example, the degree of threat involved), may be placed temporarily in restraints and/or the seclusion room. At City and County, "limit setting," paternalistic attitudes, and punitive responses to patient behaviors ensure some order in what is otherwise an often disordered interactive setting.

CHAPTER 10

NURSES, THERAPISTS, AND OTHER NON-PATIENTS

"It is worthier of man to rise in laughter above life than to bewail it. He is more worthy of the human race, who laughs at it, than he who sheds tears over it."

Seneca

"A merry heart doeth good like a medicine."

The Bible, Proverbs 17: 22

The Therapists

In addition to nursing personnel, each of City and County's psychiatric units has two therapy teams overseen by a psychiatrist (Appendix E, Figure B). Each team has another therapist, usually a part-time psychiatrist, as its team leader. A team is composed of its leader; a psychologist; a social worker and/or a therapist with an advanced degree in mental health; two or more trainees (usually one or two interns in their first year out of medical school; a doctoral level mental health or psychology trainee, and sometimes one or two medical students or social work graduate students); and a "disposition worker," who is an LPT or a social worker acting as the functional liaison between the team and the resources used for placement of the many discharged patients who cannot immediately reenter the community. Representatives from community agencies also participate on some teams. It is noteworthy that nurses (with the rare exception of a CNS) are not part of the therapy teams, although they are assigned to care for patients on either or both teams on their units, and they attend

team meetings.

The organization of the psychiatry department leaves nursing practice in a constrained and ambiguous position. It is nursing that is responsible for the milieu and that deals most frequently, and often most intensely, with the patient. Three shifts of nursing staff occupy the unit 24 hours a day, while therapists appear more sporadically, usually during the daytime, leave at will, and have offices located outside the units. With the exception of head nurses and clinical nurse specialists, members of the nursing staff do not have offices, and their desk areas are completely open in the center of each busy unit. Although responsible for other people's behavior, the nurses have little real authority. The authority rests with the therapists and ultimately with the physicians.

The Lamp and the Caduceus

Most of the psychiatrists employed on the psychiatric units endorse a traditional allopathic model which assumes that an individual suffering from emotional disturbances is sick and has an illness, disease, or defect; that the illness can be located in some part of the body (for example, the brain or central nervous system); that the illness has characteristic symptoms that can be diagnosed, classified, and labeled as an identifiable disease entity; that diseases run characteristic courses and have specific prognoses for recovery; that these diseases are amenable to physical or somatic treatments (such as the administration of drugs); and that the behavioral disorders called mental illnesses are within the charge of physicians and should be

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treated according to general medical practice (that is, a physical examination is given, a diagnosis made, and a treatment method selected according to diagnosis) (Wilson and Kneisl 1983, McQueen 1978, Hahn and Gaines 1985). The biomedical model provides a conceptual basis for the continued use of physical therapies in the treatment of psychiatric patients, the hospital as the care and treatment setting, research into genetic transmission of mental illness and biochemical and metabolic variables among diagnosed patients, and the dominance of physicians on the treatment teams (Wilson and Kneisl 1983).

On the tenth floor, most psychiatrists practice biomedicine with an overlay of attention to psychosocial considerations. The few physicians who used a predominately psychosocial or social-interpersonal model at times lacked support from above and below in the hierarchical system. Accustomed to predominately biomedically-oriented psychiatrists, members of the nursing staff, as well medical personnel, tend to question the competence of those therapists who do not overtly and assertively display a traditional medical approach. Those physicians considered most successful by the nursing staff combine biomedical with psychosocial orientations.

Nursing concerns the promotion of optimal health, rather than the alleviation of disease or illness. The official definition of nursing as the "diagnosis and treatment of human responses to actual or potential health problems" (American Nurses' Association 1980: 9) is directed toward both preventive and corrective impacts on health and illness. Psychiatric nursing is defined as

"a specialized area of nursing practice employing theories of human behavior as its scientific aspect and purposeful use of self as its art" (American Nurses' Association 1973: 3).

Primarily humanistic in tone, nursing is described as based upon principles and theories of behavioral, physical, and biological sciences, and dedicated to helping people cope with difficulties in daily living. The ultimate goal is to assist (through the nursing process of assessing, planning, implementing, and evaluating health status) the patient/client to maintain or regain the highest possible level of physical, social, emotional, and spiritual health.

The nursing department at City and County proposes to

"provide organized, comprehensive, safe, and effective nursing care to every client without prejudice, and with sensitivity to cultural, educational, economic, and religious background, as well as gender and gender identity."

Nursing objectives in the psychiatry department involve providing care that is standardized in practice, culturally and linguistically appropriate, and individualized. The idealized nursing process produces quality care, maximizes patient strengths, and uses a primary nursing model to encourage the patient's achievement of an optimal level of autonomous function and self care. Nurses have long expressed ambivalence toward the socially and economically more powerful biomedical influence. The discipline professes contrasting orientations, but most psychiatric nursing texts and many nurses continue to use biomedicine's disease nomenclature, and, to varying extents, its theories, as their organizing frameworks.

Nursing and Medicine: Relationships on the Units

The teams of therapists on each unit are more multidisciplinary than interdisciplinary. Physicians make the major treatment decisions and are responsible for the orders. Other team members depend upon the psychiatrists and provide input for their decisions. The role of nursing in the Department of Psychiatry is in large part to coordinate what the therapists (many being actually trainees) determine should be done to or for each patient, and to maintain the patient in a controlled environment until his or her condition improves and/or placement is found for him or her elsewhere. When patients do begin to "clear," it is typically attributed to the treatment given, not to the care and the milieu. Seldom is improvement in a patient's condition associated by the therapists with nursing intervention.

Experienced nurses sometimes resent limitations placed on nursing's autonomy in decision-making and lack of support of nursing decisions. Overt conflict occurs when physicians are viewed as having overstepped their boundaries into nursing territory, for example, by writing an order pertaining to when a patient is to be released from a seclusion room (a decision that is traditionally considered a nursing function). Nurses commented that they felt "expected to nurture, not think." Some complain that their impaired feelings of control make it difficult to trust their own perceptions. Many are convinced that the roles as prescribed both underutilize their abilities and are becoming increasingly constrained.

Underlying the "real or imagined negativity" that nurses say they experience from medicine are status differentials and limited

communication. Few nurses, although there are notable exceptions, can express their disagreement with the therapists, explain their rationales, and be dealt with and listened to as peers. Many nurses lack the self confidence to feel good about how they perform their roles. Accustomed to limited support from other nurses as well as from medicine, they look toward the controlling medical staff and/or nursing administration for acknowledgment of their accomplishments.

On each unit nurses tend to meet what is expected of them. Where they are given journal articles and expected to participate in discussions with the therapists, for example, they do so. Where they are given articles but not expected to actively participate, they "don't often have time to read them." At times the nurses complain that their input is actively discouraged. When a group studying assaultive behavior on the units had meetings that conflicted with shift schedules, for example, missing nurses were pronounced apathetic and the therapists went on without them. On other occasions a team leader's "Anything else from nursing?" provides a welcome opportunity for nursing staff to give input.

The physicians, frequently having only limited knowledge of nursing's role and potential, tended to judge a nurse's competence by their own medical standards. RNs, on the other hand, sometimes displayed limited understanding of medical phenomena, for example, information related to basic medications and procedures not routinely used on psychiatric units, but which come up in team discussions since nearly half of City and County's psychiatric patients also have significant physical problems. Some nurses display limited

familiarity with psychology and psychiatry. Due to nursing's emphasis on mental health, some nurses have had no courses in abnormal psychology.

The wide variability in nurses' educational preparation and experience confuses expectations. Differing amounts of medical knowledge, the apparent naivete with which some nurses display their limitations, the wide variation in quantity and quality of input from nursing personnel at team meetings, and unfamiliarity with the system due to nursing staff turnover contribute to physicians' doubts of even minimal nursing staff competence. Some therapists, unwilling or unable to discern the abilities of specific individuals, generalize their minimal expectations to the entire nursing staff. They also tend to assume that there is consensus among nurses and that they "understand how nursing feels."

Nursing sometimes reinforces its negative stereotypes. At team meetings, for example, members of the nursing staff record those parts of the discussion about each patient which are considered most important and most pertinent to nursing care. On the two units where head nurses infrequently attend team meetings, this direct communicative link between the disciplines is minimally utilized. The recording task is often relegated to the lowest ranking members of the nursing staff, despite the dislike some LPTs express for attending team meetings "Because," as one tech put it,

"the team makes you feel inadequate when your training is so limited and they have all those degrees, even at the same age. And they are so dogmatic. We have nothing to offer there."

The content and relevance of the report sheets vary substantially

according to the educational level of the recorder. This has significant impact upon nursing's understanding of and responses to therapists' plans.

Impression management varies widely among nursing staffmembers, some of whom are easily distinguishable from the therapists by their dress and behavior. Uniforms are not worn on the units except by consultants from medical floors or staffmembers visiting from the medical-psychiatric jail unit. Nametags are required, but in reality appear on substantial numbers of personnel only when the units are threatened with scrutiny by outside inspectors. Clothing generally varies with status and shift.

While house physicians and permanent therapy staff often appear in suits or sports coats with ties, male interns wear dress shirts and ties, with or without a coat. Female trainees wear tailored suits and a pot pourri of contemporary women's clothing. CNSs and head nurses, like the nursing administrators, tend to wear high heeled shoes and feminine dresses. Staff nurses are less formal with more practical shoes, loose fitting tops, tee shirts or dress shirts, and skirts or slacks, the latter usually corduroy, polyester, or denim. The afternoon staff, with few exceptions, take the clothing hierarchy to another level. Despite being those members of the staff most likely to be seen by visiting public, they tended toward jeans, old military uniforms, faded flannel shirts, and open-toed sandals with well-worn socks. One LPT, nearly always seen in corduroy slacks, described her decision to buy a new pair. She spent a long time shopping for "just the right pair," and then decided that they were "too good to wear to

work." Members of the night shift favor practical and relatively heavy clothes in layers for warmth. As one pointed out, "No one dresses up much once the therapists are gone."

Some members of the nursing staff distinguish themselves with obviously limited self care. Relative to many therapists, staff level nursing personnel may be less attentive to their social presentation. One nurse, seemingly little aware of the impression made on others, is described more than once in the field notes in the following manner:

Still not dealing directly with a stuffed-up nose and cold, one RN sniffled throughout the team meeting, occasionally using a sleeve as a tissue. Interjected were several unselfconscious belches. After the meeting a student commented that this individual is more "patient-like" in appearance and behavior than "therapist-like." Since others on the unit sometimes fail to individuate among nursing personnel, one can see how the nurses could acquire an unfavorable reputation for social awareness.

Communication patterns on the tenth floor refuel the old adage that "medicine's status comes from knowledge, and nursing's from control." Although the "doctor-as-God and nurse as drill sergeant" phenomenon (as one head nurse described her initial relationship with a new physician) has diminished in recent years, definite status differences remain. Nursing errors, for example, are openly discussed by nurses and therapists in any setting. Discussion of possible misjudgments by therapists, however, are avoided in the presence of nursing staffmembers. An example:

An intern made a remark at team meeting about one of the psychiatrists from PEC having prematurely removed sutures from a patient's self-inflicted wounds. Before the intern had even finished his comment, another gave him a sharp look and told him to "Hush!" while nodding toward the two members

of the nursing staff sitting at the end of the table.

Nursing at times underscores its secondary status by being solicitous of medicine. Nurses and LPTs may be grateful to physicians when they lighten the work load, for example, by ordering vital signs to be done on a patient three times a week rather than every day. Survival of the traditional superior-subordinate relationship is demonstrated by gushing displays of gratitude for such "favors."

Both oriented toward managing the patient, yet each reflecting its own disciplinary perspective, the medical and nursing staffs engaged in an ongoing debate over "the right way" to assess a patient's condition so as to predict his or her behavior with accuracy. On one unit in particular, medicine leaned heavily upon each patient's history, sometimes reconstructing it from fragmented data extracted from unreliable historians and supplemented by long-distance medical sleuthing. The nurses, generally less focused on psychiatric diagnosis than the physicians, were less inclined to base their opinions on a patient's past. In this setting, nurses, oriented to the present while drawing heavily on both knowledge and experience, utilize information about current patient behaviors in combination with traditionally adroit "intuition." Several nurses told me that "In psychiatry you either have it or you don't. You don't become a psychiatric nurse by the books alone." Since assessment by history and assessment "by feel" have each had predictive triumphs and failures, the issue remains essentially stalemated. Medicine, nonetheless, tends to censure nursing's lack of an apparent systematic and scientific approach.

Debates over diagnosis by history versus intuition versus

behavior occur on every unit. Many nurses also disagree with the practice of diagnosing by therapeutic response, that is, administering drugs to a patient and monitoring his or her response to establish or rule out diagnoses.

Both medicine and nursing seek diagnoses on which to base plans for intervention. While medical intervention tends to be physical with interactive adjuncts, nursing intervention is more often interactive and behaviorally oriented. Opinions about how and when to intervene (that is, in response to history, signs and symptoms, patient behavior, or when a patient expresses distress) varied widely. An example:

The program director got the staff meeting back to the recurrent theme of aggressive and assaultive patient behavior. Gloria Dansworth (an experienced and assertive evening shift RN who is fondly called "the shift mother") stated that she feels a general increase of fearfulness among the staff on the unit, that she thinks this is being reinforced by the therapists' preoccupation with "assaultiveness," and that "when people get frightened of patients they are more dangerous." She asked for others' comments on the matter.

Paul Merritte, a psychiatrist, responded by describing the patient over whom this debate most recently erupted as a "monster who needs to be in seclusion because of his history." He then criticized the nursing staff report for not having passed on the full history of the patient's violence and presumed dangerousness, adding, "If we can't go by history with psych patients, we really don't have anything." Nursing staffmembers pointed out that prior to his actually hitting a nurse, the patient's behavior on the unit had not suggested the need for further restraint. Paul recounted how, when the patient was transferred after the hitting incident to the maximum security unit, he "went wild until they put really firm limits on him, starting with another rapid tranq (tranquilizer) series."

Although nursing personnel discussed it later, at the time no one confronted Paul's "I-told-you-so lecture" with the possibility that the patient's increased agitation could have been stimulated by his having been removed from the seclusion room and then returned (upon doctor's orders)



without having acted out in any way, and/or being transferred without explanation to the jail unit.

At that point the intern who had been assigned to the patient said that he had "made sure" that nursing knew of the importance of the patient's history by telling Moses Lane and Mark Belshaw, both LPTs. The nursing staff and established therapists realized that having two technicians in the same room with the patient and telling them about his history does not assure its transmission to the rest of the staff. Since he had neither written an order nor asked for an RN's presence, the LPTs assumed they were "there to protect, not transmit." Megan Leacock-Ponds, the unit's CNS, explained that communicating such information involves contacting the charge nurse and perhaps posting a notice at the front desk, as well as writing pertinent orders and comments in the chart. She also pointed out that Moses was not the patient's primary nurse, so he was not responsible for getting this information into the nursing care plan, and that Mark had been working at City and County less than a week when this exchange occurred.

Moses and Gloria vouched for nursing's ability to make decisions about when to restrain or seclude patients by pointing out that few assaults actually occur "considering the assaultive histories of most of the patients." Paul retorted with "But we can't just go on history!" which he followed with a sarcastic and intimidating "Do people get a mental status exam when they come out of seclusion? Or do you (i.e., nursing) just feel how they are?" No one responded openly to his self-contradiction about the role of history in predicting behavior.

The issue of whether therapists should intervene on the basis of history, or on the basis of symptoms (in this case, knowledge of the patient's active command hallucinations), or on the basis of actual behavior remained unresolved. Further discussion brought up the question of whether one can accept patients' verbal agreements to tell staffmembers if they feel they are losing control. The therapy staff expressed little faith in using such an approach with these patients. Nurses, however, attempting to get "the patients out of seclusion as soon as possible," encourage such pacts.

Nursing and medicine frequently disagree on goals as well as means of patient care. Physicians on the units treat to return patients to their "baseline" conditions and work toward finding placements for them. Rehabilitation is seldom discussed. Generally convinced that

they have little real influence in goals set for patients, nursing staffmembers often feel that they are "merely instruments" in patient care and disposition. Some nurses experience significant difficulty with this aspect of their roles.

The staff disagrees with the disposition planned for a Filipino patient who is supposed to go to a half-way type of lodge rather than home. Several nurses told the intern in charge of the case that "In Asian homes it is okay to have an unmarried son at home, especially if he is crazy-- better home than in public." The intern thinks that the patient "will be crazy wherever he is and his mother should not have to take care of him."

A young alcoholic patient is being discharged to a program which is very confrontive in style. Several members of the nursing staff consider the patient "too fragile to survive such an environment." An intern who is known for his negativity toward nursing is the therapist for this case. The nurses did not, to my knowledge, communicate their feelings to him.

Shawn is a nice-looking young Black man who can neither hear nor speak. He is on his way to the state hospital because his unpredictable predisposition for assaulting others when he is angry has got him expelled from school and family, and renders him unacceptable in other placements. To a limited extent, he reads and writes, uses sign language, and reads lips. He is very observant and has spent the past three days hovering over Mr. Smith, who is sick in bed. Shawn talks to him, brings him drinks, helps keep him clean, and takes his temperature under Moses's guidance.

Annemarie Baker, an LPT, has been working with Shawn for several weeks. She says that she feels "real conflict" over her part in a system in which she believes Shawn is not being fairly treated. She especially resents the legal aspects of the system, whose representatives sometimes do not show up or neglect to bring interpreters when he is scheduled for hearings. Annemarie acknowledges Shawn's abilities, many developed against the odds. "His potential was," she says, "never given a chance." She sympathizes with a young man who grew up in circumstances in which no one learned to communicate with him beyond the most basic level. Annemarie got several library books on American Sign Language and spends her free moments practicing with Shawn.

When Shawn came to East, Annemarie explained to him,



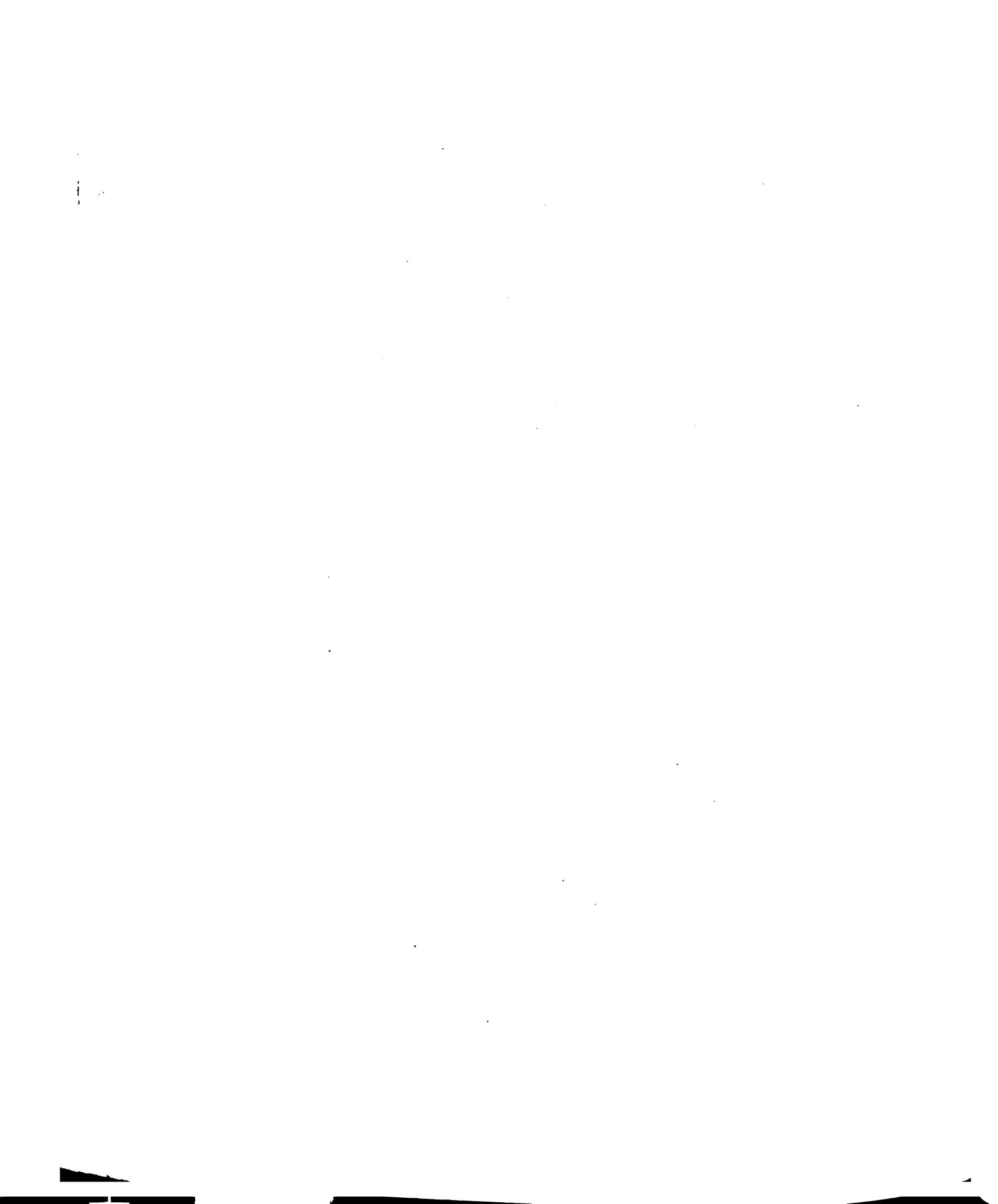
following the doctor's directions, that he would "be here a couple of weeks." It has now been nearly two months. "Shawn may be deaf and dumb, but he is surely not stupid. Now he is denying that he even has to go to court, let alone to the state hospital. He is so angry!" Annemarie adds that she does not want Shawn to "lie to himself." When she confronted him with the plans for his placement, however, Shawn turned his anger on the LPT, stomped away, and communicated to other staffmembers and patients that Annemarie had hurt him. He came to the desk for a paper and pencil, producing a note that said "SHiT No care Annemarie like NOT."

As angry as Annemarie is at the prospect of Shawn's stagnation in the long-term facility, she resents the way that he has had to wait for a bed before he can go. "Four weeks ago he was number twelve on the list, now he is number two. And the legal stuff is still not resolved. Shawn is simply not a priority on anybody's list. He is a mute pawn. There have to be other alternatives! Nobody fights for him. They just want him out of here and somewhere else."

Although both nursing and medicine express a desire to help patients achieve higher levels of functioning, the two disciplines typically approach this in different and sometimes conflicting ways. Medicine's treatment plan and nursing's care plan are separate for each patient. Communication between the disciplines tends to be one way. Nursing care plans and interventions are generally not discussed in therapy team meetings. Medicine and nursing, therefore, sustain essentially separate programs, although medicine typically gets fuller attention by all involved.

Nurses' Relationships With Other Therapists

Nursing's primary group contact with the therapists occurs during daily team meetings and weekly staff meetings (Appendix G). Other nurse-therapist interactions are typically dyadic. The therapy teams on each unit vary, with leadership and composition, in attentiveness



to community and family systems, biological foci, degree of authoritarianism, tolerance of bureaucratic control, cohesiveness, competitiveness, dependence upon translators, communication patterns, and general attitudes about patient care. The latter category refers primarily to underlying orientations toward convenience of the therapists or concern for patient care. These are evident in behaviors such as descriptions of patients, comments about religious or other cultural variables, punitive attitudes, and patient assignments.

In quantity and quality, nursing input on each team appeared to vary more with individual preparation of nursing staff members and with continuity of attendance than with team or team leader descriptors. For the most part, each team appeared to follow its physician leader without significant questioning. The most notable exception to that pattern was a team on North. Led by one of the department's most psychosocially-oriented physicians, the other professionals on the team shared input and decisions more equably than was observed elsewhere.

The Trainees

When nurses take jobs at City and County, they are often excited about working with a diverse patient population and in a teaching hospital. On exit interviews, however, these two factors are the most often cited reasons for leaving.

Each psychiatric unit has on its therapy teams several trainees, predominately but not exclusively physicians in their first year of internship. If the interns have had any previous post-graduate experience, it is in medicine. They are familiar with neither



psychiatry nor the psychiatric setting. Although they learn quickly once thrown into this, a great deal of nursing time and energy is spent socializing these and other trainees, usually at least six to a unit at a time, to the environment and to the legal and institutional policies required there.

The trainees are briefed by the medical staff on their therapeutic responsibilities to new and current patients. During their six month tenures, they are also exposed to the community mental health system as a whole. There is, however, limited systematic orientation to the specific in-patient units to which they are assigned. It is the task of the nursing staff to socialize the trainees to the routine requirements of the units. These include such legal aspects of unit business as proper charting and writing of orders, routines and communication procedures, and the unwritten rules of territoriality which allow a hierarchical and multidisciplinary subsystem to function. For many trainees this is an intense period of "reality orientation" during which they must absorb everything from new realizations about patients' lifestyles to learning not to sit in the ward clerk's chair (even when it is the only one around) unless they intend to repeatedly answer the phone. An example of the staff-trainee interactive socialization process:

Trainee to RN: "Which one is Syd?"

RN: "Syd who?"

Trainee: "Syd. A nurse. Which one is Syd?" (Points to Syd's name on the chalkboard.)

RN: "Oh, Syd. He works evening shift."

Trainee: "Who sees Betty Jones (a patient) during the day?"

RN: "Who 'sees' her? We all do. What do you mean?"

Trainee: "It says here that Syd is her primary nurse."

(Points again to chalkboard.)

RN: "Oh, I see. Here-- you can look on here to see who is assigned to her for shifts when Syd is not here. Dave is today." (Indicates assignment sheet taped to top of nurses' desk.)

Trainee: "Which one is Dave?"

RN: "Dave? He's tall, young, with green on today." (She does not mention that he is also the only Black male.)

Trainee: "Do you know where he is?"

RN: (Nodding) "He's in team (meeting) right now."

Trainee: "I need to talk to him. I want to know where Betty Jones is."

RN: "Betty Jones? You want to know where Betty Jones is? She's sitting right over there in the day room." (Acts surprised that that is all he wanted. The unspoken question might have been, "Why didn't you ask that to begin with?")

Trainee: "Is that her there?"

RN: "Yes, by the bookcase."

(Trainee walks over to patient. RN shakes her head and returns to the charts.)

For many trainees, this is the first extensive experience in a clinical setting and/or with a nursing staff. The nursing system of patient assignment and care obviously initially confuses some trainees. They quickly learn, however, to differentiate reliable from unreliable sources of information and support. Soon after each new set of trainees appeared (while some still carried around their reference books and note pads), I observed evidence of their carefully reading the nursing notes found in each patient's chart. When notes inadequately relayed what others, especially the unit chief physician, found out, however, their dependence upon this source of data visibly and rapidly dwindled. On several occasions house psychiatrists reported aspects of patients' behavior which were not recorded or were not fully described in the charts. The trainees, feeling a need to be as familiar as possible with their own two or three patients and learning to question the credibility and relevance of nursing's views,

were then observed changing their data collection tactics.

Although members of the nursing staff typically enjoy the vitality of these youthful newcomers, they sometimes also resent the deference expected of them. As non-physicians, and perhaps especially when women, the nursing staff must handle each new trainee in delicate and frequently oblique ways (Strauss 1975). The trainees often display tendencies toward the ardent practice of biomedicine and a preoccupation with pathology; a preference for extreme cases and disinterest in the "uneventful;" naivety, inexperience, and lack of "streetwisdom;" distrust of patients; and attitudes which lead some trainees to "talk to" and "work on" rather than with patients. Members of the nursing staff frequently complain of these characteristics. On the other hand, many trainees expect and seek inadequacies among non-physician staffmembers, complaining of these to the medical staff. Nursing experience and knowledge is sometimes observed to be rejected by the "Fledgling Freuds." An example:

Members of the nursing staff who have been on East for some time know many of the the recidivistic patients well. A patient who has been "painfully reconstructed over several weeks" until she was "fairly well compensated," is "showing signs of beginning to come apart at the seams." The charge nurse suggested that the physicians increase the patient's medications slightly to the dosage at which she has done well before. The intern in charge of the case refused to consider it. In report this afternoon, members of the nursing staff asked each other why this intern acted like any suggestion from a nurse is a personal challenge to his judgment and authority.

Occasionally nursing actually gets the blame for medical trainees' failures. The following example was recorded after a community meeting attended by nine staff members, eleven patients (four of them



asleep and two snoring), and myself. Only one staff nurse attended the meeting, and she, not having worked the day before, was unaware of what had happened.

One of the patients brought up an issue of his. An intern had drawn blood from him yesterday for the chemical diagnostic test for depression, which involves taking blood samples at times when the lab phlebotomist is unavailable. This proved to be an uncomfortable experience for the patient because the intern was unable to locate a patent vein, despite the ease with which others have done so. After considerable prodding in both arms, enough blood was obtained, but the patient has sore arms and memories as a result of the experience. The patient understood the intern to be an RN. He didn't know his name, but he was sure the man was an RN.

I did not know until after the community meeting that it was a intern who had drawn the blood. To my knowledge, the patients were not told. None of the physicians present (several of whom knew who had drawn the blood, although that individual was not there) corrected the identity of the person involved. Instead, one of the other interns made several comments to staff and patients alike about the nursing staff on psychiatric units being unpracticed in techniques of physical medicine.

Many staffpersons are bitter about what they perceive as the system's priority of trainees over patients. A relatively recent change in training programs accounts for the presence of first or second semester trainees on the units. Previously, trainees came to the in-patient setting after several years of clinical experience. The transition in rotation patterns is held partly responsible for increases in nursing staff turnover. It is also interpreted by some staffmembers as a symbol of serious devaluation of in-patient psychiatry.

The nursing staff misses few interactive details of these six-month intrusions "on our units" by "over-educated and under-

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experienced kids." The trainees are subtly supported or rejected by staffmembers according to criteria based primarily upon perceived attitudes toward the patients and nursing, interactive styles (especially joking behavior), and how often nurses are trapped by a trainee in uncomfortable positions with patients and/or familymembers. One student, for example, acquired a reputation for not relaying information to his patients. This forced the nursing staff to assume the task, since they felt the patient should be informed of plans about placement and so on. Other trainees told patients that they could have visitors at times, such as change of shifts, when the staff is unprepared to deal with additional persons on the unit or with other patients who resent such "preferential treatment." Each new set of trainees and each individual was quickly categorized by the staff as an acceptable or unacceptable addition to the unit. The trainees were expected to make mistakes, but also to quickly learn how to work with rather than against the nursing staff.

Of the several dozen trainees observed interacting with the nursing staff during the research period, only one was resolutely rejected. Based on his "uncaring attitude" (judged by such behavior as "reading the newspaper all the way through community meeting") he was written off as "PPP (piss poor protoplasm)" with considerable speculation about how "he must have bought his way into medical school" and how the education could have been better utilized by a more deserving individual.

Nurses commented often on trainees' adjustment to the units, but seldom upon changes as the trainees were socialized into their

therapeutic professions. Individual nurses, due to being limited to their units and the inconsistency with which most attend team meetings, usually observed only fragments of the students' struggles to grasp and deal with the broader system of public psychiatric and mental health care. This process was more accurately revealed in the trainees' responses, for example, to visits to state hospitals and facilities of each level of restriction; to finding out that the paperwork on which some spend considerable time and effort, and which supposedly assures continuity of care after a patient is discharged, often remains buried in the in-hospital records; at the realization that patients are expected to

"recycle after treatment in the hospital and be released from out-patient facilities because we can't make the facilities keep the patients, we can't keep them here, and they don't fare well on the streets";

when patients are rejected by follow-up programs because of their poor prognoses, assessed lack of motivation, or general "lack of fit;" or to their awed discovery of the tremendous variability in human behavior observed at City and County. Only the rare trainee openly shared these experiences with members of the nursing staff, who, despite whatever limitations perceived, were established and relatively experienced personnel.

Psychiatry posed new and unexpected challenges to the trainees.

An example:

At team meeting this morning the new trainees talked about their responses to their first week on the unit. Psychiatry had sounded very appealing to them because it involved less time than they had put in on the medical floors where they sometimes had to be on the floor at 6 AM and worked until 8 PM, as well as being on call every third or

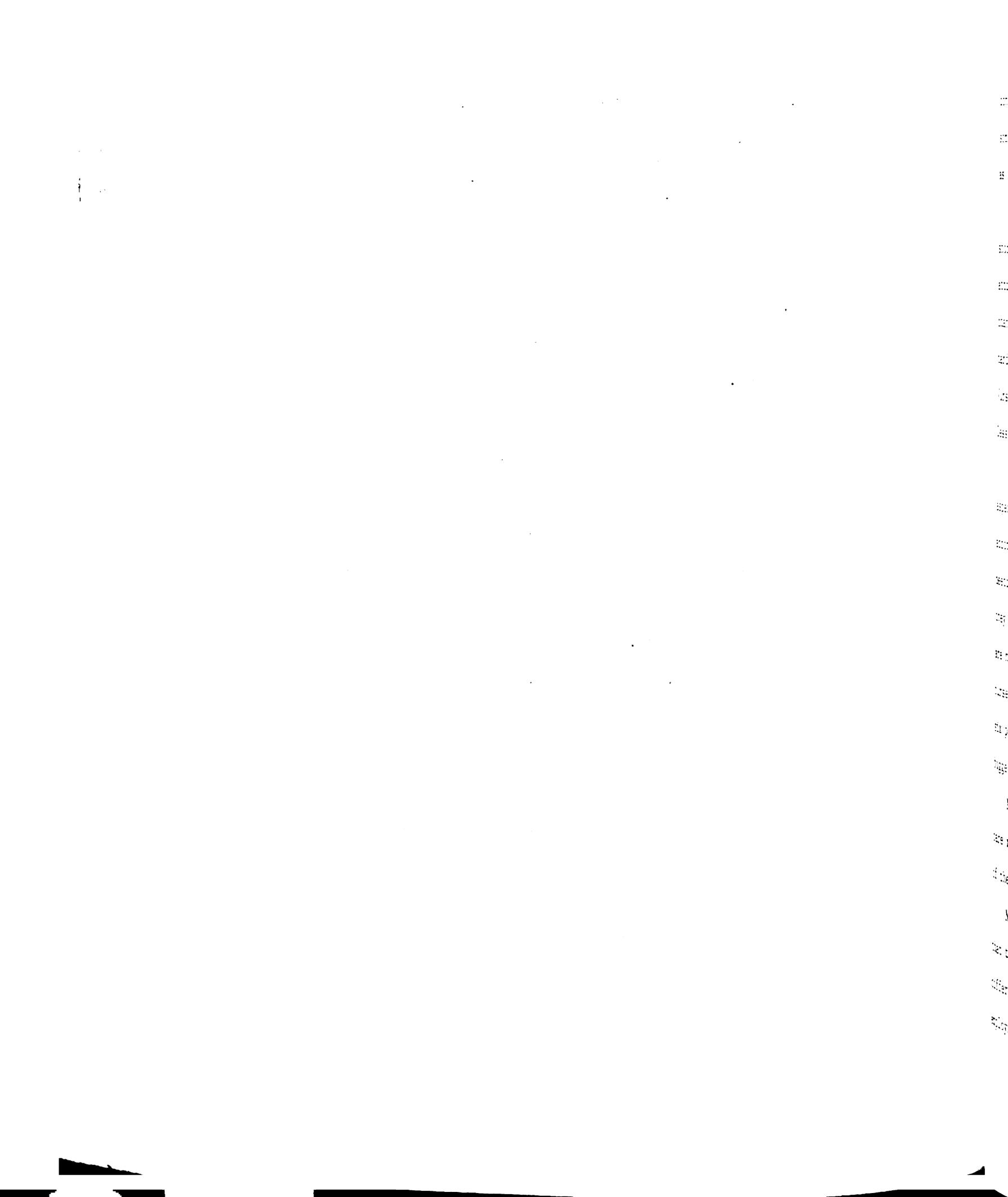


fourth night. Instead of better rested, however, they say they find themselves falling asleep right after going home at night. One intern, surprised to have been exhausted by the time the weekend came, said, "I thought, 'What's happening to me?' I felt like I'd been beat up or something. Something different is going on here."

As the trainees learn, they experiment with medications, techniques, and patient placements. With experience and modeling from other team members, they practice balancing the biomedical and psychosocial aspects of treatment and care, or become more steadfastly physiologically-oriented. Experienced nurses sometimes disagree with the treatment approaches used for patients, particularly the amount and types of medicines used and the dispositions made. One nurse stated, "First we give them (patients) meds and change their problems, then we send them out too fast and keep the wrong ones." Some question whether this treatment approach, characterized by "trainee experimentation," provides for the patient and society anything more than a chemical time out in a physically different space. But like the patients, "as soon as the trainees are functioning, they are gone."

Coping

The nurses cope in many ways with the dichotomy between their statuses and roles and those of the therapists. Some nurses, developing adversarial attitudes, discredit anyone with power, express general negativity toward the hierarchical system, or resort to viewing "lack of interference" as a sign of a positive relationship. They may discount medicine as "insensitive," as adhering too rigidly "to the book," or as responsible for the failure of the total system. Many



conceptualize the department as primarily for the trainees and idealize some other system for patient care. Most view the in-patient setting as detached from the broader mental health system.

Members of the nursing staff typically focus on current, short-range changes. Most, however, claim changes in their own attitudes since starting to work at City and County. Generally these changes include self-acclaimed increases in cynicism, negativity, hardness, confrontiveness, complaining, assertiveness, and anger. Nurses say they tend to be more volatile and frustrated, and to have less trust in their own perceptions and less respect for nursing.

Many nurses respond passively, avoiding competition, conflict, and aspects of the their jobs that increase contact with therapists. Some accomplish this by working evening or night shifts when there are "no meetings, no hassles" and staffmembers tend to express more openly that they care about each other. Some work part time, since per diem nurses are not expected to fill primary roles or to attend many meetings. One nurse explained that in a year's time he might experience only five or six positive experiences with patients. "Who needs," he asks, "to be bugged by docs too?"

Many nurses think that in-patient units should emphasize nursing care rather than medical treatment. All agree that the present format of the units effectively prevents realization of such a goal.

Nurses also cope by altering their views of their jobs. Some say that they deny reality by pretending to themselves that their jobs are different than they are (for example, more temporary). Some use their employment as a tool which allows them to further other interests.

Some seriously consider changing jobs and/or leaving nursing. Others compare the setting and/or role with others they have experienced, concluding that either or both are better or "no worse" than previous situations.

Many nurses describe involving themselves only in those aspects of their roles which are necessary. Often this means resisting change and trying to avoid situations which may entail additional duties. They tend generally to ignore the system beyond the unit level when they can, are reluctant to increase involvement with non-nursing staff, and prefer to deal with individuals rather than organizational parts (including, for example, the therapy teams). In limiting their investments of time and energy, the nurses ultimately defend themselves by avoiding leadership roles and by encouraging underreaction to events on the units.

Common Ground: Food and Fun

There are two aspects of life on the psychiatric units at City and County that nursing and medicine agreeably share. Both are described as integral to the maintenance of the system and its on-unit parts.

Food becomes a refuge for many staffmembers. There are graham crackers available for nearly every occasion. Open packages appear behind the nurse's desk, at team or staff meetings, and during shift report. In one chart room, its desk often littered with crumbs, hangs a large close-up of a graham cracker. This was ceremoniously presented by a departing intern who partook liberally of all available foodstuffs during his six months on the unit. There is a movement afoot to more

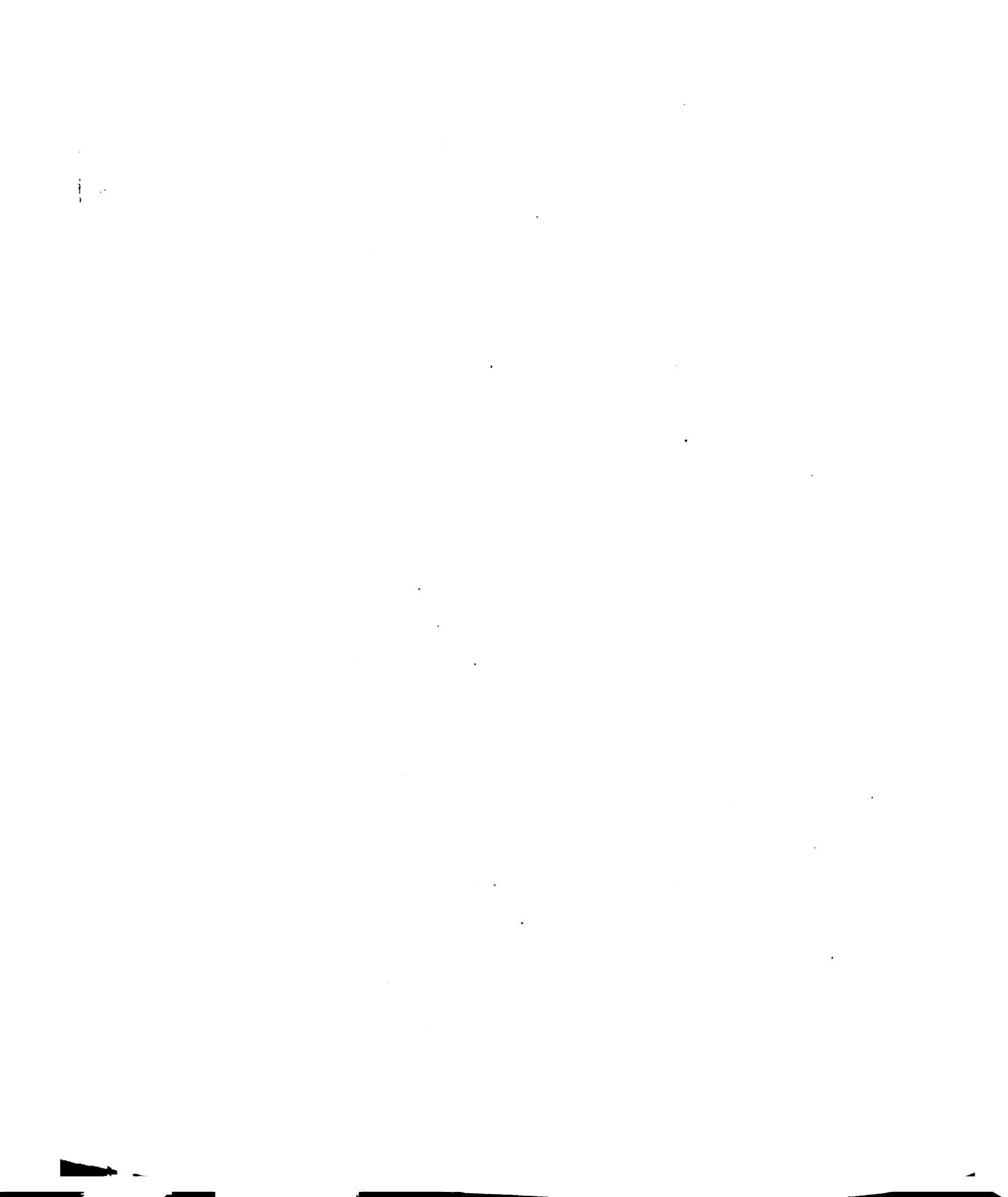


prominently display the photo.

Despite the sustaining role of the graham crackers, it is gummy bears that are the symbolic mainstay of one unit, although they are found from time to time on the others as well. Staff meetings begin with the ritual of passing around sacks of these little candies, with the green and yellow ones consistently the last to go. The staff communication book records an ongoing quest for sources of the preferred old, stale and chewy, German gummy bears. The chief physician refers to these sticky little teddy bears as "the glue that holds the unit staff together." These symbolic candies seem to have become a common, binding link in a group of people who work together in often trying and inequitable circumstances, a group whose composition changes almost continuously and which often gathers the energy to deal with its own interactions only during times of real crisis.

As communion rites draw on the experience of eating, sharing food symbolizes community in the sense of good fellowship, spontaneity, and warm contact (Douglas 1975). Each unit has weekly rituals in which staffmembers symbolize decreased social differences by sharing meals with patients. On one unit, the weekend nursing staff cooks, with patients' assistance, a relatively elaborate main meal for the entire unit population.

Food is likewise extended, on other occasions, to nursing and non-nursing staff to narrow or deny separations. Cakes celebrate leave-takings, even when staff turnover is dreaded and other occasions are overlooked. After the therapists were prodded by the nursing administration into funding a "Nurse Appreciation Day" buffet, one



unit rewarded theirs with a bountiful home-cooked "Therapist Appreciation Day." One intern, long reputed by the nursing staff to be "uncaring" and thoroughly maligning himself by refusing to contribute to an appreciation day for nurses, was invited to "Therapist Appreciation Day" only after the nursing staff decided, however bitterly, to "avoid coming down to his level."

Although patient care is often food oriented, "patient snacks" sustain the staff as well. The patients usually receive hot water and packets of instant decaffeinated coffee. Occasionally the kitchen mistakenly sends up urns of "real coffee." Most of this the staff consumes to "save the patients from caffeine highs." An important task for a new LPT is to learn how to obtain and maintain a plentiful supply of snacks. Twice during the research period the supply of readily accessible patients' snacks was decreased because "too many patients gain weight up here and too few eat their regular meals. They just fill up on 'grahams' and fruit." The staff fretted over "anticipated graham withdrawal" until someone assured them of a continued supply.

Nursing staffmembers express their oral needs in several ways. Many are significantly overweight and/or smoke heavily, both features generally distinguishing them from the therapists. Food is used to appease stress and release tension. Following the assault of an RN by a patient, East's ward clerk glanced at the television in the dayroom and sighed, "Oh! I wish I could be Miss Piggy right now!" The LPT with her went to the kitchen an hour after lunch "to raid the extra trays and see what's there." On a tense day, three or four staffmembers on a unit will be observed chewing gum. On one

particularly hectic shift,

While one nurse frantically tried to reach her Overeater's Anonymous "coach" on the phone, another asked me if I had any gum, claiming that "I either get some or I am going to need restraints!" I found some sugarless gum and a roll of peppermints in my bag. The nurse exclaimed, "Thank God! Ask me anything! What do you want to know?"

Humor

In addition to symbolically shared food, humor as a vehicle of communication frequently functions as a cohesive mechanism. At times nearly any diversion is appreciated for its ability to break up the routine, however varied (albeit unpredictable) that may be. Even a change of shifts is typically accompanied by an increase in staff laughter, joking, and levity. Such occasions provide the opportunity for superficial and predictable interaction with people with relatively intact defense systems. In the nebulous business of distinguishing "weird" from "pathological" personalities and behaviors on the units, behavior that is considered harmless and "funny crazy," no matter how incongruent it is, may be surreptitiously enjoyed by the staff. As one nurse put it: "Everybody wakes up for a good pun, or even a decent Freudian slip. Actually, the indecent ones are better."

Humor, permitting the acting out of aggressive behavior (Levine 1961), provides a medium for fantasizing staff revenge for patient hassles. The staff enjoyed, for example, warning already paranoid patients that the candy machine in the dining room would shock them if they touched it (when it really would). This provided "a real reason for a patient to be paranoid," whether or not s/he touched the

machine. The staff played with the notion that when patients' paranoia is rational, it is not really paranoia. Meanwhile, a neatly printed sign under one nurse's desk asked: "How do you spell relief?" The answer was "H-A-L-D-O-L," the medication most commonly administered to agitated patients.

A patient came to the desk: "Ex-ex-excuse me. Excuse me. The toi-toi-toilet just overflowed. The toilet just overflowed. The toilet just overflowed."

LPT: "Wonderful!" Finding it stuffed with sanitary napkins, she called maintenance as the intern sitting at the desk growled: "Better give it a probable cause hearing before you do anything else. Legal coverage you know."

Trainee, after commenting that he feels destined to go into psychiatry since his parents are psychoanalysts: "I tried some other stuff, like a stint in neurosurgery, but that wasn't for me."

CNS: "It's hard to analyze anesthetized patients, huh?"

Trainee: "Naw, about like here."

Shared humor dilutes the pain and frustration of the work setting.

When a discussion of nursing ethics involved the many severely disturbed patients who are discharged, often directly into the community, the city was cited as "the world's largest out-patient clinic" and its buses suggested as "mobile units. It's as close to care as we can get out there sometimes." On another occasion, expressing his helplessness, a weary trainee pointed a finger at his team and said, "All right. Who took Mary's Äa very delusional and confused patientÜ five hundred dollars the last time she was locked up in a dungeon on Maple Street?" Responses to announcements of impending inspections inevitably included remarks about "dusting off the crash cart in honor of the occasion." With multiple messages, humor allows venting, verification, and support.

Trainee: "Mr. Smith shows an increased ability to consolidate his feces. He complains of constipation, in addition to having many other unacknowledged-- by him-- psychological problems. He also talks dirty."

Psychiatrist: "Does that mean he is getting his shit together? He sure was loose when he came in. Diarrhea of the mind."

Levity lightens and brightens all ranks. It also provides a safe vehicle for showing that one cares. An LPT cut out of the newspaper and taped to the psychiatrist's mailbox, during the latter's appearance at a distressing court session: "It's one of those days. I call them borderline days." It cheered the entire staff.

At team meeting the leader reported that he asked a well-educated patient to name some eighteenth century literary works. "She did all right, except that she thought Moby Dick was an opera." The psychologist responded: "Well, she says she was on her way from Iowa to Algeria to work in the resistance when she got slammed into the hospital the first time. She may have missed that one." A trainee quipped: "Is it too late, or can we still get her a ticket for Algeria?" The psychiatrist continued: "By the way, she says it was not a knife she was waving about at the Corner of Main and Roosevelt. Not a knife at all. She says it was a screwdriver and she was trying to fix her portable radio after a truck hit it." The entire group enjoyed their images of this scene.

Humor supplies a way to take safe stabs at the administrative system. For example, a page from a bookkeeping ledger, with hundreds of tiny squares and complicated columns and margins, appeared in the staff communication book. Labeled as "The ultimate form with each square to be filled in with something every day for each patient," this provided smiling, but pointed, comment on the dreaded mountains of paperwork involved in documenting what seems like everything on everybody all of the time. In one chart room, itself a windowless refuge from the unit, the bulletin board holds, among a mass of old and new notices, two glossy eight-by-ten inch photographs of the Chief

of Psychiatry and the Director of Psychiatric Nursing in Groucho Marx masks. On the bulletin board on the staff lounge, an invitation to a staffmember's New Year's Eve party instructs those accepting to bring

"your own substances, friends, dancing shoes, witty chatter, chic party outfit, lack of restraints, and ID (Freudians only)."

Sarcasm frequently crept in, venting deeper feelings. The administration was alternately referred to by some as "The Powers That Be" and "The Gang of Four." An administrator's primary qualification for her job was proposed to have been her history as a Candy Striper. When someone left a portable small animal carrier in the staff lounge to loan it to another staffmember, the charge nurse, upon seeing it, remarked, "Finally, a second seclusion room!" When the fire inspector decreed that the staff coffee pot, an essential complement to the graham crackers, did not meet safety standards, a nurse questioned why the coffee pot should have to be grounded when the patients certainly were not.

Humor purifies insincerity, pomposity, and ignorance (Douglas 1975). It functions as a status equalizer. A nurse's comment after having been read a heavily jargoned and detailed report from a consultant: "I find it hard to trust a neurologist who looks like Bert on Sesame Street." A well-timed quick wit is appreciated by all levels of the hierarchy, and the opportunity to display it is free of the constraints placed upon many other skills. A defense against perceived social inequality, the ability to successfully supply such comments denies educational and status hierarchies and flaunts ranklessness.

Joking attacks control by expressing in its social context that

something is happening, but not going beyond that to directly challenge authority (Douglas 1975). When head nurses "came down too hard" with new policies unbalanced by positive acknowledgment of efforts already made, the glum staff frequently responded by devoting more time to teasing each other and joking, at times being so preoccupied with jest during meetings that few heard the information being presented. Having overstepped the bounds of propriety by overloading an unacknowledged staff with new demands, the "bosses" were temporarily, wittily rejected in a manner against which they had few effective defences.

While structure and hierarchy differentiate and channel authority through a system, joking denotes equality and sharing. The frequent use of joking behavior suggests that achievement of consonance between varying realms of experience is a source of significant satisfaction (Douglas 1975). Age, ethnicity, and perspective alter reactions to humorous stimuli (eg., Vinache and Smith 1951). A shared response indicates a shared worldview and experience. While relieving deep tensions, humor allows unconscious identification (Skeels 1954, Hes and Levine 1962).

Joking connects widely differing concepts. By connecting, it disorganizes the standard structures. While the standard communication implies that the current patterns of social life are inescapable, the message of a joke is that they are flexible (Douglas 1975). The joker symbolizes creativity; his success implies that anything is possible. On the psychiatric units, the pleasing denotation of alternatives breathes hope into situations that may otherwise seem impossible to change.

Humor frequently functioned as a tool for manipulation. By framing intentions in a pleasant wit, those with power could also have control, while those with the capacity to control could buffer their approaches. Humor provided, for example, a delaying tactic. It less often covered denial of a situation than it gave a staffmember time to come up with a reasonable approach to a new set of circumstances. Logical thinking sometimes does not go far enough fast enough. Humor rescues when there is doubt that one's pronouncements are conclusive, or about what the response to them will be. While seriousness seeks to exclude play, play can include enough seriousness to remain acceptable (Huizinga 1955). One nurse summed up her philosophy with:

The only way to get through life with any semblance of sanity is by joking about it, and taking responsibility for it at the same time. 'Angels fly because they take things lightly.' Around here you have to survive. If we couldn't laugh, we might all decide that we hate our jobs and each other.

Marginal Staff

Nursing interaction with other hospital personnel is not limited to administrators and therapists. Relationships also exist with individuals who clean and maintain the units, provide supplies and meals, monitor the need for hospitalization, keep records, provide laboratory services, and so on. Among these auxiliary service providers are security guards and deputies from the county correctional system. The latter, generally focused on the maximum security unit, are required to escort any patient classified as forensic when he or she leaves the unit. Security guards work for the hospital and are

utilized, often solely as a show of force, to supplement staff efforts to control potentially violent situations involving non-custody patients. Despite the common interaction and obvious dependence of the staff upon the guards and deputies, some members of either force are less sensitive to or trained in interpersonal and communication skills than are unit staffmembers. An example:

Today a deputy came to get a patient to take him for oral surgery. The deputy was met at the door and his gun secured in a locker prior to his entering the unit. While he stood waiting at the desk for a staffmember to bring the patient to him, he tried to joke with the other staff. They in large part ignored him because his attempts at humor, perhaps due to his discomfort at being on the unit, were clearly at the expense of the patients. (When attempts at humor are made at the expense of patients, they fail to evoke camaraderie unless they are made where they will not be overheard by patients and by someone with whom staffmembers feel they share the frustrations of patient care. The same behavior was observed at off-unit parties. In this regard, staffmembers cohesively express values of shared common experience and of protection of patients from external forces.)

The first patient brought to the deputy turned out to be "the wrong Jones." Mr. Jones, looking even more confused than usual, pointed out that there was nothing wrong with his teeth. The second man arrived at the desk. The deputy, who was White, stood in front of the young, nicely groomed, bearded Black man. He stretched to make himself taller as he looked the patient over with overt contempt. The patient stared out the window. The deputy, motioning slightly toward the door, said "Get going." The patient turned in that direction. The deputy growled, "Over here," now motioning toward the day room. The patient complied. To the deputy's "Sed down," the patient sat on the sofa indicated. Then the deputy really towered over him.

The RN and the LPT at the desk studiously ignored the scene and left the deputy and patient alone in the day room. (The other patients, with the exception of those asleep in the opposite day room, disappeared when the deputy arrived.) The deputy ceremoniously removed his handcuffs from his belt and dangled them in front of the patient's face. Despite his relatively severe thought disorder, the patient handled himself in a way typically adaptive in confrontations



between dominant and oppressed individuals. He remained composed, as if trying to avoid antagonizing the deputy who proceeded to handcuff him. To do this, since the patient was sitting, the deputy told the man to get up. Allowing the patient to get only part way to his feet, he continued to dominate him by keeping him off balance. Once handcuffed, the patient sat back on the couch. The deputy said, "Wait," and approached the desk.

As if on cue, the LPT, who had not appeared to be attentive to any of this, went toward the door to let the deputy out. With the deputy standing between the two doors, the LPT opened the gun locker, allowing him regain his weapon. Locking the deputy between the two doors, she reentered the unit and helped the patient to his feet. She later commented that "standing up with your hands cuffed behind your back is no mean trick. Especially when you're full of Thorazine."

The tech guided the patient to the door and into the space where the deputy was waiting. Then, after locking the inside door, she released them both to the outside hallway. When the LPT returned to the desk, I asked if all of this was common procedure. She continued looking down at the desk and said, "They aren't all so disgusting. But what can we do? Sometimes we need them."

CHAPTER 11

ETHNICITY AND THE PSYCHIATRY STAFF:

INSENSITIVITY OR OVERLOAD?

"Man has three ways of acting wisely. Firstly on meditation; this is the noblest. Secondly, on imitation; this is the easiest. And thirdly, on experience; this is the bitterest."
Confucius

Social inequality is important in many ways: behaviorally because people act on their evaluations; interpersonally because of the social context in which these actions occur; materially because evaluative behavior influences access to goods, services, and opportunities; and existentially because people experience their statuses and respond to them cognitively and affectively (Berreman 1981).

City and County's Department of Psychiatry is a socially stratified segment of a broader socially stratified society. Within this framework, inequality is a significant part of each individual's life. People are ranked by class, status, and power (Weber 1947, Ritzer et al. 1982). At City and County, these are reflected in hierarchical position, occupation, income, lifestyle, education, and labels indicating mental health or illness. Some members of the staff would discredit the idea that they are also ranked by ethnicity.

This chapter discusses relationships among the behavioral, interpersonal, material, and existential dimensions that characterize the experience of social interaction. The data present ethnicity as

an undercurrent in City and County's psychiatric nursing staff's interactions with patients, the non-nursing staff, and each other. The focal point is the manner in which interactions dealing with ethnic issues, unless pertaining to specific patients, tend to be closed and constrained.

Ethnicity

Members of ethnic groups share distinct cultural features while conforming to a culture which is common to the entire population (Cohen 1974). The U.S.A. has subgroups of at least 22 million Black, 12 million Hispanic, 3 million Asian-Pacific Americans, and 1 million American Indian and Alaskan Native individuals (Olemedo and Parron 1981). Members of minority groups compose approximately one-third of the nation's total population (American Council on Education 1977).

In order to provide a scientific rationale for white supremacy, Whites for centuries believed that the plight of non-Whites resulted from a simple collection of individual characteristics. Advances in the physical and social sciences and the redefinition of race as a social rather than a biological phenomenon have left racist themes of inferior mentality and of abnormal personality untenable.

Contemporary explanations for continued occupation of lower social strata by members of non-White ethnic groups are not biological, but economic and social. In American culture a unique and debilitating stigma, long ago placed on the status of many ethnic groups and in particular those whose members have relatively dark skin, is manifested in social inequalities that are maintained today.

Ethnicity and Psychiatry

Psychiatry has been accused of ethnic and racial prejudices in diagnosis and treatment (Thomas and Sillen 1979). The discipline's preoccupation with pathology led to a lack of acceptance of the variability with which individuals of ethnic minority groups respond to racial and ethnic stimuli. When an individual's internal environment is focused upon, the social nature of human behavior may be neglected (Zola 1972). Such was often the case in psychiatry.

This problem has been met in recent years with an increased awareness that definitions of abnormality and insanity are culture-, class-, and time-bound (Kleinman 1977, Marsella 1979). Within biomedicine, awareness of social and emotional factors in illness and treatment is most prominent in psychiatry (Johnson 1985). There is, for example, generally increased attention to sociocultural variables in diagnosis and treatment, patient-practitioner relationships, and underlying value orientations and explanatory models (Kleinman 1980).

Psychiatry is also experiencing a trend toward specialization in the handling and treating of certain groups (Castel et al. 1982). Increasingly aware that a universal scientific psychiatry (analogous, perhaps, to penicillin, which treats pneumonia in any cultural context) cannot be assumed, many practitioners of psychiatry and psychiatric nursing are looking beyond the disease model to conceptualize abnormal behavior.

Ethnicity In Interactions Between Patients and Staff

Although therapeutic treatment is in large part limited to

medication, there is a general conviction among staffmembers at City and County that each patient is an individual to be dealt with as comprehensively as possible. Ethnic identity and background are examined for significance in the patient's past and/or present. Therapy trainees are encouraged to be attentive to psychosocial aspects of treatment and care. During one staff discussion, for example, an intern reported his initial attempt to assess cultural factors relevant to a patient's condition by asking "Do all Greek men have these burn spots on their arms?" To this the patient replied, "And do all Jewish doctors have so much trouble tying their ties?" Although seldom dependable anywhere, stereotypes may be of even less value on psychiatric units where there is decreased predictability of orientation or behavior.

City and County's patients are diverse in many ways. Their ethnic backgrounds challenge the staff linguistically and behaviorally. Non-English-speaking patients are common; bilingual staffmembers translate. Official and handmade booklets of translations of common hospital-oriented phrases are available on the units. Two therapy teams specialize in problems of members of particular ethnic groups. One has developed an extensive library of background information about the cultures and societies most frequently represented by their patients. In-service presentations not infrequently deal with culture-specific topics.

The staff struggles to distinguish cultural and linguistic differences from impairments of affect or thought. Diagnoses, frequently complicated in intracultural situations, are more complex

when they cross cultural boundaries (Draguns 1984). In crosscultural psychiatry, behaviors related to folk beliefs must be distinguished from those that are irrational. On several occasions patients who used folk remedies from other systems of health beliefs stimulated staffmembers to find out more about these. The following excerpt provides an example:

A Chinese Vietnamese woman repeatedly pinched her neck to let her body lose its excess heat. Some of the American staff that this was "crazy" behavior, but Asian staffmembers explained it as part of a Chinese home remedy.

Team meetings often dealt with racial or ethnic issues related to the circumstances of specific patients. One team, for example, interviewed a young Black woman whose initial psychotic episode allegedly followed a gang-rape. The discussion following this interview elicited comments from nursing staffmembers, most of them females, about the sexual vulnerability of Black women in the U.S. Members of the therapy team, predominately White, male, and from middle or upper middle class backgrounds, were, for the most part, unaware of the potential significance of these factors or unwilling to initiate this discussion. Although uncomfortable talking about racism and about rape, the therapists acknowledged the nursing staff's observations and contributions.

Issues related to ethnicity frequently surface for nursing personnel. The nurses deal closely with patients from diverse backgrounds. Many of the patients lack the inhibitions typically observed in interpersonal relations. Some vehemently express negativity toward members of specific ethnic or racial groups. One

Black patient, for example, convinced that White members of the staff were from the Ku Klux Klan, responded to nearly every attempt at care with a growled "You always do this to us niggers." A White patient on the unit at the same time seized every opportunity to make derogatory comments about others who were Black. Exposure to and intervention in such situations is routine on the units.

Although typically they intervene when patients express negativity toward the ethnicity of other patients, the staff is generally tolerant of patients' accusations and confrontations involving staffmembers' ethnic backgrounds. At times personnel are so tolerant of patients' behavior that their responses are shaped by the disabilities of those with whom they work. This results in a skewed sense of "normality."

Another example from field notes:

A young Asian-American nurse was sitting at the nurses' desk. She was approached by an extremely hostile and aggressive Caucasian woman in her forties. Snarling, and spitting on the desk top, the patient asked the nurse if she was from China. The nurse calmly replied, "No, but my family was." To this the patient shouted "Go back!" and stomped down the hall. The nurse commented, "You know, she really is much better, isn't she? That's a pretty sophisticated remark for her to make. And it sure beats being called 'bitch' and 'whore' all the time."

Ethnicity and the Staff

The therapy staff and the administrators, although cognizant of past and present ethnic conflicts on the units and of the patients' need for an ethnically diverse staff, less often than the nurses dealt directly with ethnic issues. These individuals rarely if ever openly discussed such matters from an intrastaff perspective. Despite sensitivity to the danger of stereotyping patients, physicians and

others in managerial positions seemed to assume that psychiatric professionals and paraprofessionals are, or should be, immune to personal involvement in ethnic differences.

The medical staff tended to lead discussions involving all unit personnel. Ethnicity, however, was not brought up by the therapy staff; apparently it was seldom viewed as a priority item. The topic was seldom introduced by nursing staffmembers, on the other hand, unless it involved an immediate problem with a specific patient. When it has been otherwise brought up, some nurses claim, "no one heard it; it was ignored." The following occurrence illustrates this.

The physicians wrote an order for one of them to be contacted before a specific patient was released from the seclusion room used to isolate unruly individuals. The writing of this order immediately followed an intern's description of the patient as extremely violent, unpredictable, and homicidal. The Black man's delusions focused on his hatred of Whites. He claimed to have command hallucinations that told him to kill people. He also rejected everything that was white, refusing to converse with White staff, take white pills, eat off a white tray, or sleep between white sheets. His therapist was a frightened young White man who was inexperienced in dealing with violent patients.

The patient was held for several days before a Black member of the night staff let him out of the seclusion room without notifying a physician. Although the patient's behavior on the unit was not at that time a problem, the physicians became upset that their order had been disobeyed and that the nursing staff had allowed the patient to

move about freely. Members of the nursing staff defended the action by pointing out that the order was an unusual one; releasing people from restraints or from seclusion is traditionally a nursing function, not a medical decision.

A medical decision was made to return the man to the seclusion room by virtue of his violent history and continued paranoid delusions with command hallucinations. Arrangements were initiated for his transfer to the prison unit. Meanwhile, the physicians ordered, the patient was to be put into, and to remain in, seclusion.

The staffmembers on the unit at the time, with the exception of an Asian-American female nurse and a light-skinned Black male psychiatric technician, were White. The latter was immediately chosen to return the patient to the seclusion room. The same LPT had earlier spent time with the patient and elicited information that the therapist had been unable to obtain. The LPT was told that he could have the assistance of deputies from the jail unit if he desired it. He declined the help, found the patient, explained to him that the staff was afraid that his command hallucinations would get the best of him in spite of this efforts to control his impulses, and led him to the seclusion room without incident.

Members of the nursing staff were later asked about their reactions to this series of events. Many expressed a vivid resentment of the limitations placed on autonomy in their jobs, and again complained that their impaired feelings of control made it difficult to trust their own perceptions. Some members of the staff also expressed strong feelings about the racial overtones of the situation. The technician who had

returned the patient to the seclusion room stated with disappointment,

"He didn't need to go back in there. I'm used to working in places where they give patients the benefit of a doubt. If they act out, okay, then they go into seclusion. I don't like it. It bothers me."

Others, Black and White, more openly expressed their convictions that the man was resecluded in part because his threats were directed against Whites. They recounted incidents in which White patients had threatened Blacks without significant repercussion. Various members of the staff, although uncomfortable with the refusal of the Black man to interact in a non-threatening manner with Whites, also noted that this rejection is less unprecedented than reversed.

During staff discussions, disquietude over this episode continued to surface for many weeks. It was not, however, usually couched as a racial incident, but rather as one involving medical versus nursing territoriality, or under the rubric of concern about assaultive patients. During one staff meeting, a nurse tentatively suggested that the ongoing issue might be based in ethnic or race relations on the unit. To this the chief physician responded that he was "certain that it is not a racial problem at all," and again defended having ordered the patient back into seclusion because of his history of violence. A Black LPT reinforced this denial by stating that he hoped everyone on the staff was "above race problems."

On other occasions the issue of Black-White relations came up at meetings, but was not followed up. In one situation the patient over whom the matter was raised had been willing to form, with Black staffmembers but not with White, a verbal contract regarding his

behavior. The problem surfaced because, although the night staff with whom the patient had made the contract is predominantly Black, the staff scheduled for the next day was entirely White. Again the discussion deviated from one of ethnicity to a less sensitive topic, specifically, whether the nursing staff should expect or depend upon contracts made by acutely ill patients. No one mentioned the apparent disparity of ethnic distribution by shift assignment.

Racial and ethnic questions at times emerged via the grievances of disgruntled staffmembers who defended themselves with protests of prejudice on the parts of those others who occupied positions of more authority than their own. Extending beyond the nurses, staffmembers of various ethnicities also expressed discomfort with the animosity that they perceived representatives of other groups to express. Some Asian groups, for example, were described as "down on" others, some Blacks as "defending their own" regardless of the circumstances, and Blacks who were "paper sack brown" as negative toward those who were "high yellow." Latinos were described as discriminatory against gay staffmembers, foreign-born staff as "knowing when to switch languages" so as to exclude Americans from conversations, and American-born minorities as discriminative against immigrants and in particular those not fluent in English. The combinations and complaints were diverse and many.

Despite the general sensitivity toward ethnic factors associated with patients, on each unit several members of the nursing staff also claimed to observe subtle but distinct differences in the treatment of patients according to ethnic background. A mute man who is Black, for

example, according to some nursing personnel, is more likely to be interpreted as potentially assaultive than is a mute man who is not Black. Several individuals stated that ethnicity remains "the real measure of who is placed on assault precautions." Most nursing staffmembers did not feel such differential treatment was intentional on the parts of those in authority, but "just the way things are." Acting toward change by increasing others' awareness, however, was generally not viewed as a viable option. "Just the way things are" relates both the degree of entrenchment of discriminatory practices and the absence of perceived opportunities to increase others' cognizance of them. Such examples of institutionalized racism (Jones 1974) are felt by the researcher to be significant because of their insidious consequences.

Ethnicity was expressed as an issue for staffmembers in other ways as well. One nurse, for example, described discomfort with her belief that, because she is Black, she must repeatedly prove to the staff and patients alike that she is all right before they will let her "be a nurse or a therapist." Others described experiences such as verbal abuse dispensed by a Black man who refuses to complete his work, "but only when there are no Whites around."

Not all individuals of relative power and status overlooked the fact that ethnic issues played a role in interactive processes among staffmembers on the units, although they tended to consider dealing with them nonessential. One head nurse, for instance, commented several times that the staff on her unit often "bring to work their own issues," specifically those dealing with race, ethnicity, or sex. This

inclination was not regarded by her as evidence of something that could or should be dealt with openly, but as a sign of lack of professionalism and maturity on the parts of the staffmembers involved. Ethnic issues tended to be ethnocentrically perceived as the problems of those who differ from those with authority, not shared concerns.

Although increasingly (but not completely) sensitive to the threats posed by ethnocentrism in the treatment and care rendered to patients, the mental health professionals in this setting have not looked as critically, deeply, or systematically at the function of ethnicity among the nursing and therapy staffs on the units for which they are responsible. The following sections present an analysis of this important but relatively covert aspect of the total context.

Ethnicity, Status, and Class

American social ranks are organized, albeit unclearly. Levels of status are based on culturally specific criteria of differential honor, prestige, and privilege shared by members of particular social categories (Berreman 1981). Race and ethnicity are status categories. Class strata, in contrast to status strata, are based on access and economic relationships.

Status phenomena tend to be confounded with class differences in ethnically diverse and stratified societies. In the U.S.A. income, occupation, education, consumption patterns, and lifestyle are affected by ethnic classification. Two types of ethnic minority groups coexist with the dominant Whites. These include subordinate minorities such as

the American Indians, Mexican Americans, and Blacks who were incorporated in the U.S. more or less against their wills, and immigrant minorities who came to the U.S. basically for the same reasons as the dominant Whites, political or religious asylum and economic opportunity (Ogbu 1974).

Within the American two-category (that is, White/non-White (Daniels and Kitano 1970)) system a minority individual's chances are strongly affected by his or her specific ethnic minority category. Subordinate categories are to a significant degree confined to positions of low status in which individual mobility is limited. Historically these groupings have been restrained by legal and economic means. Members of other groups are more likely to assimilate into mainstream society after one or two generations. Based on census data, American Indians, Mexican Americans, and Puerto Ricans as well as Black Americans have, for example, generally fewer years of education and fewer educational opportunities than has the majority population (U.S. Commission on Civil Rights 1978). Asian Americans typically have more education than the majority population (U.S. Commission on Civil Rights 1978).

In ethnically stratified societies, increased social mobility is difficult to achieve (Shibutani and Kwan 1965). Earlier in U.S. history, minority individuals were either excluded from occupational opportunity or advanced only accidentally as it suited political or economic needs (Curtis 1971). Generally low educational attainment of many non-Whites has inhibited training for highly skilled employment. Black Americans, for example, tend to be hired into menial or low-paying jobs, and to stay there (Glock and Siegelman 1969).

Members of minority groups in the U.S.A. are becoming increasingly aware of their rights and opportunities, and of discrepancies between their own statuses and those allowed by law. With less tolerance of the jobs traditionally held by minority individuals, there is greater recognition of a need for positions with significant personal and social status. Some of these positions may be less valuable to the middle-classes than they are to individuals from lower-middle class backgrounds for whom they represent upward mobility (Strauss 1975).

Institutionalized Racism

Myrdal (1944) pointed out years ago that the dividing line between Blacks and Whites in the U.S.A. is exceedingly durable if not permanent. Others have described social attitudes among White Americans that have blocked assimilation of Blacks into mainstream economic and political society as analogous to the rigid boundaries formed by castes in other societies (Berreman 1981).

Racism is a multidimensional social process that

"... results from the transformation of race ethnocentrism and/or prejudice through the exercise of power against a racial group with the intentional or unintentional support of the entire culture" (Jones 1981: 28).

As a social process, racism is psychological, institutional (that is, part of the social organization or structure), and cultural. For many Americans, racism is not so much rooted in individual psychology as it reflects the social structure and culture (Bowser and Hunt 1981).

Cultural racism has been a reality in the U.S.A. since the acceptance of an ideology of White racial superiority more than four

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centuries ago. In this century, racism has been, for the first time, seriously challenged. Traditional offensive stereotyping and rigid segregation have been replaced by newer forms of expression. Although expressed attitudes are less negative than they were three decades ago (Jones 1981), the new White consciousness (Terry 1970) still tends to overlook many of the realities of ethnicity. Discrimination remains, within the covert intricacies of institutionalized social, economic, and political organization, more disguised than diminished.

Racist and other prejudicial attitudes and discriminatory behaviors continue to be culturally conditioned and to lend themselves conveniently to special interest groups in their struggle to gain or maintain power (Bowser and Hunt 1981). Once institutionalized, discriminant practices (for example, educational and job ceilings) may be perpetuated regardless of the actual attitudes of those with authority. Like contemporary negative ideation about ethnic categories, discrimination is typically more subtle and more selective than it once was (Bowser and Hunt 1981).

Sometimes the source of influences on social position may not be apparent even to those who experience them. Many people, for example, perceive their limitations as the result of their own failure to achieve the criteria for higher status, rather than the effect of the systems of which they are parts (Sennet and Cobb 1972).

Despite the employment of a large number of Blacks and other minorities at City and County, these tend to hold predominately lower ranking staff positions on relatively undesirable shifts. The nurses, however, seldom complain. Professional and technical jobs such as

theirs pay well in civil service, and are above the job ceiling confining many minority individuals (Ogbu 1981). Special interest task forces in which many staffmembers are involved work toward increasing numbers and statuses of minority employees within the institution.

While people in low statuses may feel inadequate or unfortunate, those in elite categories often do not perceive the presence or depth of the resentment those in the lower categories feel (Berreman 1981). Failure to deal with ethnicity as a significant variable may reflect the fact that members of dominant groups often can essentially ignore their own ethnicity. It has been said that "to be white in America is not to have to think about it" (Terry 1981: 120). Many Whites equate personal avoidance of interethnic conflicts with freedom from racial prejudice and discrimination. They may at the same time, however, uncritically accept the premises of the dominant, albeit institutionally racist, culture.

To a significant extent, awareness of the consequences of this ideology has led to changes in staff-patient relationships. Attempts at systematic evaluation of the appropriateness of care and treatment at City and County is increasingly based on the criteria of the recipient as well as those of the nursing and therapy staffs. Awareness of social and cultural differences has become part of dealing with patients. The same sensitivity has not always been applied, however, to staff-staff interactions.

Ethnicity and Nursing

The history of nursing reflects early and continuous progress in

the recruitment and retention of individuals from minority groups. The proportion of Black RNs, for example, doubled between 1962 and 1972 (Altenderfer 1976). Reflecting the consequences of institutionalized discrimination, however, this increase was limited to diploma and associate degree programs. In baccalaureate programs the number of Black graduates increased, but the proportion of Blacks has actually declined (Altenderfer 1976).

Although minorities remain a small and underrepresented proportion of the total, training and employment of non-Whites in nursing has increased faster than that of Whites (American Council on Education 1977, Russell 1968, Melnick and Hamilton 1977). Efforts to integrate minorities into nursing have also been more successful than those to increase the numbers of men.

In the U.S.A., occupation plays a primary role in determining an individual's position in the status system. Education has long been a prime concern of nursing in its efforts to increase occupational status.² From 1908 until it was disbanded in 1951, the National Association of Colored Graduate Nurses (NACGN), formed at a time when professional organizations excluded minorities, served minority nurses (Staupers 1961). That organization was instrumental in encouraging education for nurses who were otherwise frequently discouraged from advanced study. Even in those institutions that accepted Blacks, opportunities were limited for rising above the level

² Somewhat ironically, it was three nursing schools established for Blacks before 1892 that were the first to focus on education rather than staffing of hospitals (Sloan 1977).

of staff nurse. Faculty members, therefore, typically believed that it was futile for Black nurses to prepare for positions they could not attain in teaching and administration. The first Black American graduate nurse finished her training in Boston in 1879, but it was 1944 before the first Black earned a Bachelor of Science in Nursing (Staupers 1961).

Nursing, Sexism, and Racism

American society long ago decreed the Black, and especially the Black female, invisible. This orientation deprives individuals of self-respect and social status, while maintaining social distance between groups. Nursing, as a traditionally female occupation, shares many commonalities with ethnic minority groups.

World War II taught the American public that "total war" meant total involvement of all Americans. Women were no longer the "frosting on the cake" that they had been considered during World War II (Kalisch and Kalisch 1981). With the Second World War, concurrent with increased need of nurses, came the high point of public attention to organized nursing and nursing's most positive and progressive image. Peacetime society, however, soon turned toward pre-war attitudes toward women and toward nurses (Kalisch and Kalisch 1981).

Nursing's acceptance of minority group members in its ranks has paralleled societal attitudes toward women and toward nursing roles. National nurses' associations integrated Blacks into their organizations long before the American Medical Association credited its Black counterpart (Gilb 1966). It is, likewise, to the credit of the

American Nurses' Association (ANA) that it adopted a platform that included working to remove barriers against full employment and professional development of minority group nurses in 1946, and has been on record since 1954, ten years before the Civil Rights Act was passed, with a policy in support of civil rights legislation (Thompson 1972). By 1962, all of the ANA's state level organizations were integrated (Gilb 1966).

When World War II started in 1941, few schools of nursing accepted Black students. By the end of the war, this number had nearly tripled (Staupers 1961). A perusal of the American Journal of Nursing from the mid 1940's until the early 1960s indicates many editorials and articles on intergroup and minority relations, integration, and civil rights. Articles with these foci are infrequent, however, since that time.

Despite nursing's early involvement in the civil rights of ethnic minority individuals in the U.S.A., there is little evidence of this in the literature today, although this does not imply that nurses were inattentive to the problems of minorities prior to the 1940s or after the 1960s. Awareness and action have refocused instead toward issues of personal and professional concern to women and, less intensely, toward issues of international scope. Nursing has become increasingly aware of and militant against sexism at individual and institutional levels. With this refocus of attention, many members of the relatively sexually homogeneous discipline have come to take for granted ethnic differences within nursing.

There are, however, definite trends toward women and minorities in health care in the U.S.A. (American Council on Education 1977).

Nurses commonly experience and/or encounter the consequences of institutionalized sexism and institutionalized racism, and each of these continue to undermine personal integrity and organizational authenticity (Terry 1981). Discriminatory practices directed at sexual and/or ethnic minorities distort the efforts of individuals to make sense out of their worlds and to act purposefully in it. In short, organizational reality is distorted and open, honest communication is compromised.

Ethnicity, Bureaucracy, and Interpersonal Relationships

Ethnicity affects social interaction at multiple levels. During the decades prior to Affirmative Action programs, many members of minority groups (although numerically a vast underrepresentation of that part of the total population) entered nursing as part of the mainstream of students. The movement of minority workers into the middle class was furthered in part by the expanding bureaucracy in which programs and policies helped minority persons enter the white collar world (Jones 1981). Despite persistent discrepancies, this has been most evident in the government sector and in public facilities such as City and County.

Formal organizations, such as bureaucracies, provide continuous structures within which various relational systems operate. They force people into sets of rule-regulated relationships (Britan and Cohen 1980). Whereas traditional relationships involved multifaceted ties between total personalities, bureaucratic relationships tend to be functionally specific (Denich 1980). Such relationships between

individuals are usually defined by and limited to roles within a single context. In theory, bureaucratic relationships also minimize emotional involvement (Britan and Cohen 1980). Impersonalization supports precision and speed, and lessens ambiguity.

In reality, more goes on within a bureaucratic organization than might be expected on the basis of formal rules alone. Informal organizations persist in making bureaucracies into living systems as human actors adapt and attempt to achieve their own goals. Organizational dynamics reflect personal interests, affinities, and emotions as situations bring people occupying roles into close contact. This leads to such interactive phenomena as consultations, friendships, intimacies, factionalism, competition, and hostility (Britan and Cohen 1980). Regardless of its visibility, informal organization has a strong and continuing effect on everyday organizational activities.

Ethnicity and Communication

On the psychiatric units at City and County, as previously discussed, humor is a common vehicle of formal and informal communication. Under nearly any circumstances on the units, staffmembers stimulate themselves and their co-workers by making light of the behaviors of patients, administrative idiosyncracies, and the physical world which they share. This allows experiences to be shared and renders them more tolerable.

Ethnicity poses a communicative conundrum in an environment which depends heavily upon the symbolism of joking. Once popular, ethnic

(like gender-oriented) jokes are now considered a sign of poor taste and insensitivity not befitting persons whose occupations emphasize how others feel about themselves. When staffmembers are together away from patients they joke freely about many topics, but they tend not to talk about, and seldom joke about, ethnic differences.

In any formal organization, the prestige of positions varies with respective power to give orders (Landecker 1981). Lower level positions on the chain of command are subject to the most specific regulations. They also have the least discretionary power, that is, ability to choose among different courses of action (Landecker 1981). Ethnic jokes have become unpopular, but the staff continues to depend upon humor as a substantial medium of communication. Humor, furthermore, is shared across hierarchical strata, while ethnicity is not. Ethnic issues have become, in this context, more difficult to communicate. The tendency then is to avoid them.

Conclusion

Although a concern in patients' circumstances and staff-patient relationships, ethnicity among the staff tends to be ignored, except by those who cannot ignore it. This selective colorblindness may inhibit useful introspection.

The staff is generally aware that an overemphasis on differences can and does create social divisions. There is acknowledgment, for example, that many Blacks have reasons to act paranoid around Whites, and that the rigors of migration may produce depressions that are not typically pathological. An effort is made to avoid discrimination

against any patient due to cultural background or ethnic heritage. Among staffmembers, however, differences often are minimized. In part, this neglect of ethnic issues is a comfortable adaptation to an emotionally tense, physically hurried, and overstimulating environment. It may also reflect a generalized philosophy of acceptance.

There is an intimate and ongoing interaction between an human organism and its culture. It is not possible to completely extract an individual from the culture which helps shape it. This is reinforced where minority persons are persistently reminded of their differences, as they are in American society. The assumption that one's ethnicity becomes a secondary phenomenon in the process of psychiatric training and/or experience risks denial of significant differences in the experiences of others. Such a stance implies that the impact of racism on certain (that is, non-patient and upwardly mobile) personalities is superficial and subordinate to other psychodynamic factors.

Social inequality and stratification are cultural artifacts. Learned and socially transmitted, they are subject to change. Ignoring such issues prolongs the current, subtly discriminative situation. It also constrains potentially productive interpersonal and interdisciplinary exchanges.

CHAPTER 12

PSYCHIATRIC NURSES' SIGNIFICANT RELATIONSHIPS:

PERSONAL SOCIAL NETWORKS

"We must all hang together, or assuredly we shall all hang separately."

Benjamin Franklin, at the signing of the
Declaration of Independence

"Let there be spaces in your togetherness."

Kahlil Gibran, The Prophet

When an individual takes a new position, that is, assumes a status and its concomitant role, he or she interacts socially to adapt to the culture of the group. In some cases the company of the groupmembers is found to be more comfortable and enjoyable than that of outsiders. Within the subculture, for example, communication may be facilitated by shared vocabularies and experiences. The question dealt with in this chapter is to what extent the psychiatric nurses at City and County participate in a shared subculture.

Fischer (1982), in an extensive study of patterns of social interaction among rural and urban dwellers, found that urbanites typically interact across several subcultures, rather than within one. That this characterizes the nurses at City and County might be expected, since they are city dwellers. What is unexpected is the limited interaction with and significance of relationships with co-workers. This does not conform to expectations found in the literature regarding occupational cohesiveness.

Nurses are a predominately female but otherwise heterogeneous aggregation. Their socialization histories, socioeconomic backgrounds, educational accomplishments, ideological approaches, and role interpretations vary widely. Their personal lifestyles are likewise diverse. Although closely associated with a broader medical/hospital subculture, the evidence of a separate or cohesive nursing subcultural group that extends beyond the workplace, or is strongly significant within it, is limited.

Group Cohesiveness Among Nurses

It has long been assumed in nursing that group cohesiveness plays an important part in performance of nursing roles. Beland (1980), for example, describes a cohesive work group as essential to a satisfying professional life because of the acceptance, recognition, friendship, respect, and trust that such a group is presumed to provide.

Several hypotheses have been posed regarding why nurses might develop intensive group networks. These individuals are presumed to share a common job, work experiences, and employment conditions in areas often physically isolated from other hospital units (Hay and Oken 1977), as is City and County's psychiatry department. It has also been suggested that the stressful conditions in which nurses work foster close ties and supportive relationships (Asken 1979).

One reason that nurses are assumed to function as a group is that members of other occupations form strong alliances. Henry et al. (1973), for example, demonstrated a cohesive worldview widely shared by psychotherapists who formed, for the most part, a community with a

shared language and support system. Their sample of 4,300 psychoanalysts, psychiatrists, clinical psychologists, and psychiatric social workers was predominantly male, urban-based, and socially and economically homogeneous (Henry et al. 1973). Although representing different disciplines, training routes and professional labels, the psychotherapists held similar beliefs and ideologies, participated in similar professional activities, shared similar professional and personal goals and gains, and tended to interact with their colleagues on personal as well as professional bases (Henry et al. 1973).

Although group cohesiveness in the work setting has been suggested as a logical solution to some practical problems of the job and for the provision of essential emotional support, it is not universally lauded in the literature. Some authors have speculated, for example, on the disadvantageous consequences of a work group that takes on the roles of family and friends, thereby interfering with personal autonomy and outside social relationships (Hay and Oken 1977), introspection needed for positive adaptation, and normal emotional responsiveness.

Whether positive gain occurs from a cohesive work group, and whether such camaraderie typifies nursing, has not been substantiated by empirical research. Evidence of efficient networks of contact and communication among student nurses (Olesen and Whittaker 1968) encouraged speculation about the extension and implications of these networks in employment situations, but the interactive alliances of employed graduate nurses have not been studied. This situation is of particular relevance to the study of psychiatric nurses at City and County because, although the literature assumes and generally

advocates group cohesiveness, the nurses, as was discussed in Chapter 4, described their experience of camaraderie, collegueship, and cohesiveness as very limited.

Social Support

Cohesiveness is a slippery construct to try to assess. It is frequently associated with perceived supportiveness, a more individually relevant concept. Social support provided by social networks and the contribution of support to the maintenance and promotion of health are popular ideas in the helping services (for example, Froland et al. 1981, Collins and Pancoast 1976, Gottlieb 1983). In dealing with psychiatric nurses, we are looking presumably at the helpers rather than those helped. The fundamental phenomenon is, nevertheless, the same:

"the manner in which human attachments are structured as systems of support and the resources that are exchanged among the members of of these systems" (Gottlieb 1981: 11).

The study of coping and social adaptation requires examination of the interactions resulting in the perception of social support, which is associated with patterns of social interdependence related to the structural characteristics of people's social worlds (Hirsch 1981, Wellman 1981). Access to social support is influenced by many factors. These include, among others, such variables as social competence, need for affiliation, locus of control, and network orientation (Tolsdorf 1976, Gottlieb 1981). Differences in the size, density, composition, proximity, and stability of personal interactive systems have implications for the quality, amount, and accessibility

of support.

Support is of particular relevance to nurses because of their caregiver roles. In academia and agencies, complaints are increasingly voiced against impersonal treatment from efficiency-minded practitioners, bureaucratic organizations, and fragmented services (Gottlieb 1981). The psychiatric nurses at City and County generally echo these concerns about the health care system. They are, however, in the positions of mediators between the system and the provision of care, personal or impersonal. They remain, on the other hand, human beings who need to receive as well as to give support. A basic question to be dealt with is where and from whom, in the personal community each nurse creates with his or her social network, does the nurse derive social support?

Networks of Social Interaction

Social interaction is more than a medium for behavior. Meaning is assigned by individuals when they interpret others and relationships (Blumer 1969). Unlike children, adults have considerable freedom to choose and build networks of relationships that they consider important (Fischer 1982). Analyses of those relationships can convey the symbolic meanings emerging over time in interaction (Stephens 1980).

Social networks were originally described as sets of actually existing human relations conceptualized in a metaphorical (for example, Radcliffe-Brown 1952) rather than an analytical sense which allows properties of the interconnections between and among people to be specified. The analytic use of social networks involves the

interpretation of the social behavior of persons through specific sets of linkages among defined sets of persons (Mitchell 1976). The actual subject of network analysis is the social context, rather than the individual behavior or dyadic connections per se.

Social relationships characteristic of large scale societies fall into three orders: the structural (representing, for example, the institutionalized hierarchy on the psychiatric units), the categorical (reflecting social categories such as class or ethnic group, or the societal stereotype of "nurse"), and the personal order (Mitchell 1976). Individuals do not limit their interactions to organized groups. A focus on interaction in social context does not exclude formal social structure, but attempts to look at the core of social systems, formal and informal, structured and unstructured, by cutting through domains such as hospital hierarchies or ethnic categories to follow interaction as it ramifies throughout the social context (Whitten and Wolfe 1973). This allows the "non-group" (Boissevain 1968) to be studied.

When combined, interactive and network approaches allow description of simultaneous individual and interpersonal levels of interaction (Tolsdorf 1976). This reflects the reality of the individual and his or her network in constant interaction, each influencing and being influenced by the other. Networks illustrate how individuals use roles, rather than the traditional approach of roles using individuals. There are many ways of combining roles, and of abstracting networks.

The ego-centered nature of social organization in urban settings

presents a strong argument for distinguishing real from potential links through network analysis. The analysis of social networks is especially relevant in societies such as ours in which the trend is toward increased role differentiation and decreased social density (that is, decreased interconnectedness of actual relationships). Not everyone who could interact does. The range and choice in forming networks is influenced by, but not necessarily limited by, socially patterned factors such as occupation, work schedules, and mobility (Fischer 1982). Although many potential relationships do not actually occur, social exchange is too complex to study all of the interactions that do take place (Barnes 1954). The type of network actually created and the degree of connectedness or "mesh" (Bott 1955) among its members reflect an individual's adaptation of the social context.

The study of social networks is a tool in the understanding of social organization, the dynamic aspect of society. Like social interactionism, network analysis is not a systematic theory of society but a series of techniques used to arrive at an understanding of social relations.

The Study of Social Networks

The links between people who form networks of social interaction were used to clarify the number and types of relationships among a sample of RNs at City and County's psychiatry department and those others considered by the nurses as most significant in their lives. A social network, the consequence of various interconnecting relationships between and among individuals, is defined here as the

assemblage of people who are of primary importance in the life of a specific individual, regardless of the type or direction of the relationships involved. Only first order or primary relationships, that is, direct connections between each individual and others (Mueller 1980), were examined. Collective network formation and consequences were emphasized, in contrast to the impact of any single network member (for example, a confidant).

Analysis of the structure and function of work-related and non-work-related networks of psychiatric nurses at City and County involves examination of dyadic interpersonal structures, network size and density, network homogeneity and heterogeneity, interaction type and frequency, membership dispersion, and the complexity, direction and strength of relationships. Of particular relevance are the implications of the nurses' social network characteristics for occupational identity, ideology, and role expression. The articulation of private (non-work-related) and public (work-related) portions of networks, the extent and effect of overlap of these, and the significance of each for individual nurses were explored. Associations were sought between characteristics of nurses (for example, education, sex, marital status, employment characteristics, and geographical mobility) and properties of their social networks.

The nurses' evaluation of the supportiveness (whether potential or tested, mutual or unidirectional) that they perceive in their most significant relationships, and the extent to which this relates directly to the work group, as well as their basic assessments of which persons have the most significance in their lives is entirely

subjective. Although the small sample limits analysis to simple numerical computations, the subjective data accurately portray the broad diversity of the nurses' social network and support systems and substantiate data obtained through participant-observation.

Delineation and Description of Networks

Structural, content, and process variables are used to characterize social networks. Summaries of the size, shape, and distribution of points and linkages (Tolsdorf 1976) are presented for individually determined (that is, ego-centered) networks (Mitchell 1976). Patterns or clusters are sought among the characteristics that describe the relationships involved.

During interviews, a sample of thirty-five Registered Nurses employed in psychiatry at City and County completed network analysis maps, grids, and support scales (Appendix B). The interviews were held, whenever possible, away from the work setting to encourage each nurse to relate to him or herself as an individual who has roles and statuses in addition to those associated with occupational nursing. The objective was to collect data related to nurses' adaptation of their occupational careers and integration of their public (work) careers with their private lives. Social networks are acknowledged to be important in private (Froland et al. 1981) as well as occupational roles.

Each of the nurses in the interview sample has been employed in in-patient psychiatric nursing (although not necessarily at City and County) for a minimum of four years following completion of his or her

basic RN program. With an average age of 38.8 years, this group included three head nurses, three clinical nurse specialists, seventeen full time staff nurses, two half time staff nurses, and ten nurses hired per diem. These employment classifications were equably distributed across the three units from which the sample was drawn. Ten of these nurses have lived most of their lives within one hundred fifty miles of City and County; six of the ten have lived continuously in the immediate area. Twenty-one moved as adults into the area from other parts of the country, and four immigrated as adults from other countries. All have been in the U.S.A. for at least seven years.

Morphological Characteristics

The size of a network is designated as the number of persons indicated in its membership (Tolsdorf 1976). The parameters used to limit these were impact and time. Each nurse was asked to identify those relationships considered most important or significant to him or her "at this time." It was made clear that any number of persons of any age and in any location could be indicated, and that significant relationships might be negative as well as positive.

Each interviewed nurse marked, on a circular map to which he or she was central, the initials, titles, or first names of those others who represent his or her most significant primary relationships. These were separated into three categories: relationships that are associated only with the nurses' occupational roles (i.e., work), those that are not work-related at all, and those that are combined (that is, both personal and work-related ties). The distance of significant

others from the center (i.e., ego) symbolized interactive distance from the informant. Significant relationships which are described as close and positive, therefore, were typically positioned near the center of the map, while negative relationships often approximated the outer rim of the circle.

The interviewed nurses averaged a total of 12.1 relationships judged as particularly significant at the time of the interviews. Of these, an average of 8.7 (71.9%) were not related to their occupations in any way. An average of 1.6 (13.2%) were work-related only, and 1.8 (14.8%) were both job-related and personal relationships.

Although a total of 28% of the total number of relationships considered most significant in the thirty-five nurses' lives' were perceived as work-related, most of those relationships were not associated with the nurses' present positions at City and County. Many of the nurses' current significant relationships involve persons with whom they went to nursing school or have worked in the past. Some of these past co-workers are reflected in relationships that are now characterized as both personal and occupationally related, but some alliances are maintained (psychologically and/or behaviorally) as co-worker relationships. These relationships were not eliminated from the morphological analysis of the networks because they are important to the informants. They could not be incorporated into the non-work category because they remain conceptualized by the nurses as relationships with others in work settings, not as more generalized personal connections.

Thirteen nurses (37.1%) indicated no relationships in the

work-only category. Ten (35%) placed none in the combined category. Four (11.4%) RNs noted no one in either of these subgroupings. With two exceptions, four was the largest number of work-related relationships shown. (One exception had 5, the other 11; the latter individual pointed out that some of those relationships are significant only because very few existed in other categories.)

Most nurses noted three or fewer combined (work-related and personal) associations. Four, five, six, and eight individuals were represented in the combined categories by one nurse each. In three of the four cases, these were masters-prepared individuals.

The average numbers of work related, non-work related, and combined relationships were examined for patterns related to education, sex, age, ethnicity, marital status, and employment status (full or part time, time in position, and shift assignment) at City and County (Appendix I). No great differences among groups were noted. The conspicuous overall conclusion is that a relatively small portion of the nurses' networks of significant relationships involves persons from their current workplace.

Although it has been suggested that network size is associated with years of education (Fischer 1982), with an average of 11.9 total significant relationships, the masters-prepared nurses did not differ markedly in network size from the diploma graduates who averaged 13.3, the associate degree nurses who averaged 13, or the baccalaureate nurses who averaged 11 significant relationships (Appendix I, Table 1).

The seven males in the sample averaged more work-related ties (2.3) than the twenty-eight females (1.4) (Appendix I, Table 2). The more

significant difference, however, was that the female nurses' job-related relationships were likely to be associated with previous jobs, while nearly all of the male nurses' significant work-related relationships were current-position linkages. This difference may reflect the men's generally more recent graduations from nursing schools, although both subgroups have held similar numbers of previous positions. Male and female subgroups had similar average numbers (1.7 and 1.9, respectively) of combined (work/non-work relationships), but the females had slightly more non-work (8.9 versus 7.5) and total (12.2 versus 11.5) significant relationships.

The average numbers of relationships, when examined by nurses' ages (Appendix I, Table 3), indicate little patterning in either total network size or in the work, non-work, and combined categories. Less than 50% of the significant relationships in either the work-related or the combined groups were associated with current jobs at City and County.

Twenty-five of the interviewed RNs are of Anglo-White ethnic backgrounds. This subsample has the smallest average total number of significant relationships (11.4) (Appendix I, Table 4). The two individuals of Asian-Pacific heritage indicated an average of 12 in their social networks, while the six Black and two Hispanic nurses averaged 15 and 15.5 respectively (Appendix I, Table 4). Although combined work/non-work-related connections for all ethnic categories were primarily not associated with the nurses' present positions, work-related relationships held significant by Black and Asian-Pacific nurses generally were associated with their current employment. The

fact that the RNs of Asian-Pacific backgrounds indicated the fewest non-work relationships and the most work-related relationships may be an artifact of the small subsample size ($n = 2$) and/or their being immigrants to the U.S. The reversal of that apparent trend by the nurses of Hispanic background, one of whom is an immigrant, is as likely to reflect their small number ($n = 2$).

Examination of network size by marital status (Appendix I, Table 5) led to the conclusion that the eight married nurses averaged the smallest networks (9.5), 75% of the average for the total sample, as well as the smallest proportions of non-work-related relationships. The two widowed nurses indicated substantially larger total networks and numbers of non-work-related bonds (24 and 21.5, respectively), but the limited subsample in that category may be misleading. The fifteen nurses interviewed who have never married and the ten who are divorced (which does not represent several who have remarried) had total network sizes of 11.8 and 12.1 and non-work-related subgroups of 8.5 and 9 respectively. With the exception of a slight increase in work-related ties among the married nurses, all categories of marital status showed similar average numbers of work-related and combined work/non-work-related connections.

The total network size of full time and part time RNs varied little (12.2 and 12.5, respectively) (Appendix I, Table 6). The part time nurses had eleven percent more non-work-related relationships. Both groups showed 1.9 alliances in the combined category. In both cases more than half of the work-related connections were not associated with current employment at City and County, but the numbers of work-related

links differed. (Since several per diem nurses are concurrently employed elsewhere, some work-related relationships were associated with those settings.) While full time RNs indicated an average of two significant job-related ties, part time nurses averaged only 0.7.

The twenty-one interviewed members of the day shift staff averaged nearly 20% larger total networks than did the eight evening shift or the six night shift RNs (Appendix I, Table 7). Although all three subgroups demonstrated that less than half of their work-related and combined significant relationships were associated with their current jobs at City and County, the day shift noted 11% more in each of these categories than did the evening or night shifts (both of which classified 21% of their relationships in the work-related categories). It is noteworthy that some members of the day shift included as significant others supervisors and administrators with whom the other shifts have less contact. The implications of these relationships, not all of which were characterized as positive, are discussed in the sections dealing with network content variables.

Of the three units studied, West is generally considered, according to staff assessment, to have a more cohesive staff than are the other two, North and East. The nurses from West who were interviewed, however, categorized only 8% of their networks as work-related ties, while East's and North's nurses indicated 12% and 20%, respectively, in that sector (Appendix I, Table 8). The relative dimensions of these ties of supportiveness will be discussed later.

Network sizes appear to be related to length of employment at City and County in only two respects, neither of which is in any way

conclusive. Despite their having come from other jobs and most of the total sample's work-related links not being connected to their current jobs at City and County, those eleven nurses employed a year or less at City and County indicate the smallest numbers of work-related connections (4.5% of their total networks, while the other time groups average 10.3%) (Appendix I, Table 9). The three RNs who have worked there between six and nine years show a similarly small number of job-related ties, but they balance this with a substantial increase in the average number of combined (work and personal) relationships.

The five nurses who have remained at City and County for ten or more years indicate total networks which average 32% smaller than those of the nurses employed there up to nine years (Appendix I, Table 9). It is unclear why this is, except that five of these nurses are among the seven 45 to 54 year old women who indicate the smallest networks of the total sample. This subgroup represents a cross-section of the other variables examined. Whether the smaller network size is an artifact of sample selection or size or may be related somehow to life-stage is unknown. The proportion of their networks which is work-related and combined (both public and private) is 6.1% smaller than that of the nurses who have worked in psychiatry at City and County between six and nine years.

Network Density

Network density or connectedness reflects the extent to which members of a social network know and contact one another independently of the focal individual (that is, ego) (Walker et al. 1977). It is

assumed that high-density (tightly-knit) networks are well-integrated, relatively stable groupings, while low-density (loosely-knit) networks are more fragmented and uncoordinated (Wellman 1981). Although both densely knit and sparsely knit networks have their uses, the implication is that dense networks enhance the ability to maintain, control, and mobilize their internal resources (Wellman 1981). In other words, the resources available from the networks can move more quickly through dense networks.

This measure provides only intermediate-value results because social networks with the same density may have dissimilar characteristics in structure and heterogeneity. Both tightly and loosely-knit networks have advantages and disadvantages. The densely-knit network may, for example, limit the ability of members to acquire additional external resources (Wellman 1981).

Each interviewed psychiatric nurse completed a network grid that indicated which of his or her significant others know each other well, know each other but not well, know each other only slightly, or do not know each other at all (to the knowledge of the informant). Group averages indicate that 24% of each nurse's relationships know each other well, 13% know each other but not well, 11% know each other only slightly, and 53% of the nurses' most significant others do not know each other at all. Percentages and ranges were calculated to show association between loosely or tightly knit networks (Bott 1955) and education, sex, ethnicity, marital status, ages, mobility, and shift assignment of the nurses (Appendix I, Tables 10-17).

Network density was the single variable studied in Fischer's

1982) analysis of urban networks which indicated an inverse relationship with education; increased years of education were associated with decreased interconnectedness or relationships. This result was reproduced in the data from the interviewed nurses as well. The largest proportion (58.8%) of significant others who did not know each other was among the masters-prepared nurses, followed by the BSN nurses (55.1%). These networks, however, did not contain the smallest proportions of those who know each other well. The nurses with associate degrees and those with baccalaureate degrees indicated smaller proportions of their networks who knew each other well than did the masters-prepared RNs (Appendix I, Table 10).

The diploma graduates nearly balanced their networks with 36.5% of relationships who knew each other well and 37.8% who do not know each other at all. Having the lowest proportion of network members who are unconnected to one another and the highest who know each other well, they are considered to have the most dense or tightly knit network of the four educational backgrounds characterizing the nursing sample (Appendix I, Table 10).

Examining network density from the perspective of sex of the nurse produced an interesting pattern. More than half of the persons indicated on the male RN's networks know each other, but less than twenty percent of these know each other well (Appendix I, Table 11). The women's networks, in contrast, indicate that a high percentage of their alliances know each other well, but there are also more who do not know each other at all. The men were more likely to indicate intermediate dyadic relationships, that is, those characterized by

links of moderate or slight familiarity.

Examination of network size by the nurses' marital status produced new distributions. The small number of widowed nurses ($n = 2$) in the sample may or may not distort evidence of their having the most connected networks of significant others (Appendix I, Table 13). The eight married nurses indicated the next highest amount of interconnectedness among their networks with 30.3% who know each other well and 43.5% who do not know each other at all. Both divorced and never married nurses show less network density; more than half of the persons with whom they have significant relationships do not know each other, and less than a quarter of those individuals know each other well (Appendix I, Table 13).

Examination of the density of significant relationships by nurses' ethnicity (Appendix I, Table 12) suggests that the Anglo-Whites in the sample may have the most dense overall networks, but this is confounded by increased mobility (probably the most significant variable investigated) among the Black, Asian-Pacific, and Hispanic nurses in the sample.

Many nurses indicated significant relationships with persons who are located in distant parts of the U.S.A. and other countries, as well as with individuals in the immediate vicinity of City and County. The six nurses who have always lived near City and County average only 24.2% of significant others who do not know each other and several indicated that all of their significant others know each other. The four foreign-born nurses, in contrast, average 73% relationships who do not know each other (Appendix I, Table 15). Time in the area appears

of predictive value only in terms of always or not always having been there. The distinction is diminished but still marked among those dyads who know each other well (14.2% of the networks of the immigrant nurses and 38.6% of those of the "native" nurses) (Appendix I, Table 15).

The density of networks, when distributed by assignment to day, evening, or night shifts, indicates that day shift nurses tend to have the fewest significant others who do not know each other (48.7%) (Appendix I, Table 16). Night and evening shift nurses have similar proportions of their networks which are unknown to others in the networks (56% and 56.3%, respectively), but the night shift RNs indicate twice evening shift's number of significant others who know each other well. The difference lies in the greater number of less well known dyads in the evening shift nurses' networks.

Exploration of relationship density by the ages of the nurses produced no notable patterns (Appendix I, Table 17).

Network Homogeneity and Heterogeneity

The extent to which network members share social attributes (for example, similar occupation or interests) is another characteristic of social network morphology and function (Walker et al. 1977, Mitchell 1976). The psychiatric nurses' networks were examined for the prominence of specific categories of significant relationships among those designated as most significant in their lives. A sizable number were family members or kin. On East, 43% of the relationships considered most important were noted as family or kin. On North this

category represented 32% of the total, on West 25%.

Another substantial category of network members was that of RNs. Despite the number of nurses who noted no work-related significant others, each nurse of the sample of thirty-five averaged three other RNs in his or her network. Of a total of 424 relationships, 105 involved other registered nurses. Many friends were RNs met in nursing school or on other jobs. Approximately one-third of these practice psychiatric nursing, one-half are involved with other work related to nursing, and the rest are not involved at the present with occupational nursing. It is of note that, although the 35 interviewed nurses all work on the units themselves, few co-workers appeared among their networks of significant others.

On one unit, North, where twelve nurses recorded 164 significant others, 31 (19%) of these were RNs. Twelve of the 31 work in the psychiatry department at City and County. Six of the twelve are not associated with work on the units themselves, however, but with supervisory or administrative positions. The unit's CNS and head nurse were also cited once and three times respectively. One RN on another unit was listed, and, perhaps most significant of all, only one actual co-worker was included among the 31 significant relationships.

On Ten East, twelve nurses noted relationships with 32 other RNs among their total of 130 others who have the most impact on their lives at this time. Of the 32, 24 (25% of their total) were associated with the Tenth Floor. Seven of these are nurses in supervisory or administrative positions, and one is a staffnurse on another unit. Of the sixteen relationships connected with the unit itself, ten involve

the head nurse (4), the CNS (3), and the program director (who is also prepared as a CNS) (3). Six relationships were directly linked to co-workers on East.

On Ten West, eleven nurses listed 42 (32%) other RNs among their total of 130 significant relationships. Thirteen of the 42 work in City and County's Department of Psychiatry. Three of these are on units other than West, and one is in a supervisory position. Of the nine ties associated directly with the unit, one involved the CNS and one the head nurse. Seven relationships with co-workers were designated as significant.

In sum, 49 (46.7%) of the 105 relationships with other RNs involve nurses at City and County's psychiatry department. Of these, 35 (71%) are RNs (head nurses, CNSs, and staffnurses) who work on the units, 14 (29%) are relationships involving the clinical supervisor (9), the Director of Psychiatric Nursing (3), or the psychiatric nursing administrator (2). Five relationships are with RNs who work on units other than those of the individuals who identified them as significant others. Of the 29 RNs who work on the units with those who consider them important, sixteen relationships (55%) involve individuals to whom the designator is subordinate. With the exception of one head nurse who considers her relationship with one of the staffnurses on her unit significant, no nurses above the staffnurse level indicated significant relationships with the staffnurses anywhere in the department. (This data is limited to those nurses who work on the units; the networks of administrators and supervisors were not elicited.) With the one above-mentioned exception, the head nurses' and clinical nurse

specialists' significant others who were nurses at City and County were exclusively other head nurses, CNSs, and supervisors and administrators. Although associate degree and diploma-prepared nurses noted a total of ten relationships with LPTs, no such ties were indicated between baccalaureate or masters-prepared RNs and the technical component of the staff (ADNs and LPTs).

A substantial number of significant relationships represent non-RNs associated with psychiatry and/or biomedicine. Comprising 13.4% of the total number of bonds, these include psychiatric technicians or aides (ten at City and County and two elsewhere), psychiatrists (eight at City and County and six elsewhere), five personal therapists of a variety of psychotherapeutic backgrounds, five physicians with non-psychiatric specialties, five non-psychiatric medical technicians, four social workers (including one at City and County), three psychologists (all female and none at City and County), and a melange of others associated with medical settings: former patients, a hospital administrator, a medical student, a unit clerk, and a deputy. Of these 57 ties, only two (with psychiatrists at City and County) were identified as negative in tone.

Thirty-six percent of the relationships considered most important by the interviewed RNs on North, 16% on East, and 32% on West did not fall into the family, other RN, or other medically-related categories. These individuals were generally characterized as friends or, less frequently, acquaintances. Many of the significant others designated as family members, fellow RNs, or non-RN members of medically-related categories were also described as friends.

Significant others who were not associated with the health services represent a plethora of backgrounds and interests. They range from painters to park rangers, bank executives to prisoners, engineers to mystics, priests to bicycle messengers. Ages vary from infancy to old age, and from those who require total care to those who take care of others. In several cases involving family members, relationships have remained significant after the deaths of the significant others themselves. Fifty-seven percent of the total number of significant others was female and 43% male.

Network Duration and Dispersion

Although frequency of interaction is not necessarily an indicator of the content or quality of a relationship, accessibility or the extent to which an individual can contact and depend upon the people significant to him or her is potentially important (Kaplan et al. 1977). Of the individuals considered important by the interviewed psychiatric nurses, 55% were classified as "nearby" and 45% as "far away."

Durability or consistency of relationships has also been delineated as a hallmark of supportive social ties (Caplan 1974). The nurses' relationships indicated as most significant ranged in duration from one month to the lifetime of the nurse. The average non-familial relationship had lasted 7.7 years at the time of inquiry. Some friendships had lasted as long as thirty years.

Despite the durability of most of the relationships, networks sometimes change. Seventeen (49%) of the nurses indicated that their

networks had not changed in the past year, but eighteen nurses noted changes in their networks. In many cases the alterations were relatively minor increases or decreases in emotional intensity of one or two connections, but they also included the loss of fifteen significant relationships. These breaks, nearly all in the work-related and combined categories, were attributed primarily to shift and job changes. One friend was lost from the personal category, and eighteen new relationships (six work-related, two combined, and a variety of personal relationships such as a baby and its pediatrician, two fiances, several caretakers of an elderly parent, and new friends) were added.

Three nurses had moved from other cities within the year. Each of these noted greater losses than gains in the work-related and combined categories, but few changes in personal or non-work-related bonds. One commented that

"It takes a lot longer to make new friends at work than it does to lose them when you move. And if you don't move, they do."

Satisfaction

The extent to which the nurses' personal networks were found satisfying was approached through the question: "How would you change the content of the circle (the network map) if you felt free to make it any way you wanted it to be?"

Eleven respondents indicated no desire to alter their social networks in any way. Some nurses commented that they do not and would not consciously consider manipulating members or components of their

personal communities. Although individuals are chosen or rejected as potential partners for relationships, whether or not relationships develop is claimed to "just happen."

Several individuals indicated, on the other hand, a desire to maintain separate work and personal networks and work actively toward this. Explanations for this approach varied. One nurse expressed the opinion that "my co-workers are not my peers," and many the conviction that they share few commonalities with those with whom they work. Others observed from experience that "shifts make it too hard to get together," or stated that remaining personally uninvolved protected them against burnout.

For the most part, nurses who desired changes in their networks hoped to expand and add relationships in the combined (work/non-work-related) category. Foremost among these were married nurses, nearly all of whom lamented the lack of opportunity to discuss their work at home, although the desire to increase the number of significant others who share or could understand the nurses' work experience was expressed by others as well. These RNs do not indicate a desire to intensify or increase the number of work-only relationships. While remaining uninvolved is the approach some take to ward off burnout, others commented that work-only relationships are associated with "faster burnout because you can't get away from the job." It is work-based relationships with significant personal overtones which the nurses value.

The nurses' reasons vary for wanting to change their networks in this way. Some miss the "intense connectedness" associated with

former (usually first) jobs. Some believe from experience or otherwise that positive combined (work/personal) relationships "help you feel better about work." Others felt simply that their networks "ought to be," for no expressed reason, balanced in all three categories. Several again brought up differences in backgrounds and lifestyles as the primary hindrance in the creation of a substantial number of combined relationships, although "shifts don't help." Most nurses stated, however, that they are least interested in all work-related relationships.

Several nurses had specific hopes or plans for their networks. Some of these involved relatively minor changes in the affective dimensions of personal relationships, but some are working toward broader changes. One indicated a desire to improve current work relationships (all of which are negative) and to add several personal relationships (there are none who are readily accessible and this individual's spouse was not included in the network as a significant other). Another hopes to replace several negative personal relationships in her network with combined (work/personal) relationships. Four nurses were actively attempting to "improve" their social circles in response to recently experienced stressful events in their personal lives (for example, moving, the death of a family member, and an offspring's leaving home). Another is preparing for the anticipated death of an elderly parent by actively building a supportive personal and combined social network.

Supportiveness and Nonsupportiveness

The content of network relationships is associated with the meanings attributed to the relationships (Mitchell 1976). The content influences and is influenced by relationship types and activities. Content, therefore, relates to the flow of communication and exchange (Mitchell 1976).

Generally positive or negative orientations toward significant relationships are associated with the perception of stress and/or support, choice of coping style, coping outcome, and the overall meaning of network involvement. This relates to the emotional dimension, intensity, intimacy, and degree of reciprocity (immediate and deferred) attached to the links between persons in a network (Granovetter 1973, Walker et al. 1977). The strength of ties is analogous to the strength of commitment between individuals.

Social support is integral to relations between the social environment and health (Gottlieb 1981). It also allows a naturalistic focus on social adaptation and insight into coping behavior. The study of support requires examination of complex interplays between the characteristics of individuals, the social networks in which they are embedded, and the situational and sociocultural environment so as to distinguish between persons with high and those with low access to social support (Gottlieb 1981).

Social support means different things to different people. The nature, meaning, and measurement of social support as a construct is intensely debatable (Gottlieb 1981). Family and friends may not always be supportive, nor must co-workers or bosses. The asymmetrical,

multifaceted characteristics of real life ties are important. "When one looks only for supportive ties, one finds only supportive ties" (Wellman 1981: 179). Support may or may not be a dimension of a specific relationship at a given time.

Supportiveness is limited here to that related to the network of significant social others as designated by the interviewed psychiatric nurses. It is the result of resources existing in these significant relationships and assumes that these resources may be either mutually or unidirectionally dispensed and that they function to buffer the impact of psychological stress. The construct is equated with that dimension of each relationship that affects one's life by facilitating it (implying supportiveness) or making it more difficult (implying non-supportiveness). Although the network of most significant relationships may not include all of an individual's sources of support, it is assumed to contain the majority of the most important sources, both formal and informal.

The nurses were asked to answer, regarding each individual they had placed in their network maps, the following question: "Does he or she generally make your life easier (better) or harder (worse)?" The responses were used as an assessment of the directionality (that is, mutuality or unidirectional dependency) of the relationships and of the extent of supportiveness experienced by the nurses in that dyadic bond.

The RNs' responses to the above question were plotted on a continuum ranging from +3 (very supportive) through 0 (neutral) to -3 (very non-supportive) (Appendix B). Although a somewhat elementary approach to evaluating perceived supportiveness, the data gathered

from the scale validated qualitative descriptions provided about relationships and allowed comparison of otherwise incomparable descriptive evaluations.

The results were calculated by converting the ratings to a +6 to zero scale and dividing each nurse's total score by the number of relationships indicated. Six then became the highest attainable number (complete supportiveness). This approach avoided the problem of negative and positive ratings cancelling each other, which occurs if they are computed algebraically. The assumption is made that the weight of positive against negative relationships is more important than the simple numbers of either.

Only 28% of the represented relationships are in any way work-related, less than half of those are directly associated with the current work setting at City and County, and the vast majority of negative ratings were associated directly with current work-related relationships. It is apparent, therefore, that a large portion of the total perceived supportiveness stems from personal (non-work-related) linkages. This is an important aspect of the integration of nurses' occupational and private lives.

The interviewed sample's average supportiveness score was 4.8 or 80% of the possible score of 6 (100% supportiveness). Neither educational background nor shift assignment indicated much variation. Masters-prepared nurses noted the greatest amounts of supportiveness in their networks (4.87); diploma graduates followed with 97% of that, associate degree nurses with 95% and bachelors-prepared RNs with 94%. Although the baccalaureate nurses indicated the smallest supportiveness

scores, the difference is not great with only six percent variation. Since many of the RNs with bachelors degrees are part time employees, the score may reflect less supportiveness at work (a common complaint of per diem nurses) and/or generally less structured lifestyles.

Nurses assigned to the night shift indicated the highest average supportiveness score (4.9) of the three shifts. The evening shift nurses had 99% and the day shift nurses 97% of this total. Again the differences were not remarkable.

Greater variation was observed when the scores are examined by marital status and by the units to which the nurses are assigned. The married nurses scored the lowest rates of supportiveness. The never-married nurses assessed their significant others as providing 18% more supportiveness than the married nurses. The never-married nurses also experience 8% more supportiveness than do the divorced nurses.

Marital status confounds analysis by unit assignment because of an unequal distribution of married and never-married nurses. Each unit has the same proportion of divorced nurses. Ten East has the highest proportion of married nurses and North the lowest; West's is intermediate. North, if marital status was predictively significant, would then have the highest supportiveness scores. It is West, however, which has an average score of 5.01. North's is 16% and East's 7% less than that. It is apparent that other factors influence the total picture.

Supportiveness ratings for significant others who are psychiatric nurses at City and County were examined separately from those of the rest of the networks. As earlier noted, West had the fewest

work-related ties, but the largest number of co-workers (7) listed as significant others by staffnurses. It is noteworthy that on West all co-workers rated on the supportiveness scale received positive ratings, while on North and on East all significant staff-level co-worker relationships (one on North and six on East) received negative supportiveness ratings.

Since social networks were not elicited from the four nursing administrators and supervisors who were cited a total of sixteen times as significant others by nurses who work on the units, it is not possible to analyze those dyads for mutuality. Among the thirty-three relationships involving on-unit RNs, it is of interest that none was mutual. That is, no two nurses listed each other as significant others. One head nurse listed one other head nurse and one clinical nurse specialist included three other CNSs in their networks, but these all work on separate units and both head nurses and CNSs more typically indicated as significant relationships with supervisors or administrators. Staff nurses tended to record positive relationships with head nurses and clinical nurse specialists (on their units and off) with whom they have one-to-one supervisory sessions. On two units the on-unit head nurses tended to be rated as non-supportive unless the scoring individual received consistent, personal supervision from her. Similarly, supervisory relationships with CNSs were rated as positive, but non-supervisory relationships as neutral. At all levels the strongest indicated positive bonds were unidirectional links between nurses and their individual immediate supervisors. The trend toward selecting hierarchical superiors as significant may be influenced

by higher turnover among co-workers. Administrators and supervisors tend to change jobs less often.

When asked who among their significant others viewed life most similarly to themselves, fifteen of the thirty-five nurses (43%) mentioned RNs. Of these nurses who shared their worldviews, only two were at City and County (one on a unit other than that of the designee, and the other the Director of Psychiatric Nursing). Among the non-RNs cited were 23% who were family members and 20% noted as friends. Two social workers and one LPT were given this distinction. Three nurses concluded that no one within their networks could be so described.

The question "Who shares ideas most similar to yours about mental health and mental illness?" elicited a diverse group of answers. A co-worker was cited, as were the Director of Psychiatric Nursing twice, three psychiatrists, two therapists, a social worker, an LPT, family members, a medical student, a psychiatric case manager, and "no one" (2).

Each nurse was also asked which significant other(s) most closely shared his or her perspectives on nursing and psychiatric nursing. Regarding nursing in general, family members (a small percentage of whom are RNs) were cited almost as often as other RNs were. Of the RNs, only one was a co-worker. Several represented relationships established in nursing school. One LPT was included.

In noting which of their significant others most closely shared their views on psychiatric nursing, seven co-workers were among the thirty-four RNs designated (a substantial number of whom were from nursing training programs). City and County CNSs, the Director of

Psychiatric Nursing, two administrators, and a head nurse were also listed a total of seven times. A former patient was cited once.

Network Impact

Each nurse was asked which portion of his or her network, the work-related, the non-work-related, or the combined (work and non-work-related), had the greatest overall importance in or impact on his or her life. One nurse's response indicated a belief that all three areas were equally important. Another considered the combined and personal (non-work-related) sections equivalent.

Seventy-two percent of the other nurses assessed the non-work (or personal) portions of their networks as overall most significant in their lives. Nineteen percent felt that their combined (work/personal) network relationships had the greatest impact, but several of these individuals noted that the actual number of relationships recorded in that part of their network maps did not reflect the intensity or importance of these collective relationships. The combined relationships were described by one nurse as

"... the connections between work and the rest of the world. People I can talk to about the craziness in both places. They help keep me together."

Nine percent of the nurses evaluated their work-only relationships as most important in their lives. In most cases, however, these work-related ties did not focus on relationships at City and County. This was especially prominent when the interviewed RNs were also full time students pursuing advanced nursing degrees.

The associate degree nurses were spread evenly across the three

categories in their assessments of overall impact of relationships. Two-thirds of the diploma-prepared nurses evaluated their non-work related connections as most significant; the others chose the combined category. Nearly 88% of the bachelors-prepared nurses considered their non-work-related networks as most important. The rest were divided evenly in the other two categories. Fifty-seven percent of the masters-prepared RNs assessed the non-work-related portions of their networks as most significant. Twenty-nine percent designated their combined relationships that way.

Seventy-one percent of the never-married nurses and 78% of the divorced nurses evaluated their non-work-related bonds as most prominent. Twenty-three percent and 11% respectively assessed the combined (work/personal) areas of their networks that way. Fifty-seven percent of the married RNs value their non-work-related bonds as most significant; 29% viewed their combined (work/non-work) ties in that light.

Male and female nurses were nearly identical in their evaluations of the relative impact of categories of their social networks. In both cases about 70% judged their non-work-related connections and 20% their combined relationships as most significant. The same percentages applied to the nurses from each of the three units studied.

Relationships described as only work-related were considered least significant by 60% of the nurses. One individual felt that the three categories are evenly balanced in her network, and several have significant relationships in only the non-work-related sector. Taking these into account, 35% of the RNs determined the combined

(work/non-work-related) category to be least important. Several nurses described, however, desire and/or effort to increase the size and importance of this grouping.

Networks of RNs

The fact that many RNs who are not co-workers are significant others stimulates questions about the roles that these individuals play in each others lives. Most of the non-co-worker nurses are characterized as friends with whom interaction is sporadic but meaningful at least in part because of an occupational commonality often shared with few others within ego's personal community. Frequently these relationships are maintained by correspondence, telephone conversations, or occasional visits.

Networks are sometimes used by professional, technical, and management personnel to acquire and improve positions (Granovetter 1977). When there is an opening for a nursing job at City and County, staff members are often asked by the administration to encourage qualified acquaintances to apply. Many of the interviewed nurses associate information about potential jobs with personal networks. One nurse met, for example, the administrator in charge of nursing recruitment through a friend who owned a farm on which the administrator boards horses. Another nurse remembers being asked, thirty years ago when she was in nursing school, by an instructor to return to City and County after graduation. She has been with the system ever since. Other nurses shared comparable experiences.

Nurses are word-of-mouth advertisers; their communications about

what it is like to work in a place influence who applies. Some nurses describe contacts made by themselves or other RNs when considering a move to a new locality. These do not necessarily represent emotionally intense relationships but stimulate questions about the considerable "strength of weak ties" (Granovetter 1973). This is an aspect of nursing networks that merits further research.

Conclusion

Two themes permeate the results of the foregoing analysis of psychiatric nurses' networks of significant relationships. One is the paucity of meaningful relationships characterized by positive emotional links between and among co-workers. The second is the desire for personal and supportive bonds between subordinates and their hierarchical superiors.

Twenty-five percent of the RNs' total networks were composed of other registered nurses, but, among 424 dyadic relationships, 35 nurses recorded a total of only seven positive significant connections with peers on the units on which they work. The majority of work-oriented relationships, positive and negative, were unidirectional ties between a subordinate and his or her immediate superior. Where this relationship involved systematic direct clinical supervision, it was most often perceived as supportive and positive. When not involving personal supervision, the relationships were likely to be viewed as significant but negative or neutral, depending upon the authority invested in the superior's role. Relationships with head nurses which did not involve individualized supervision, for example, were

generally negative, while those with CNSs were more often neutral. It may be noteworthy that when a head nurse was perceived as non-supportive, co-workers were rated the same way.

Despite differences regarding the quality of work relationships on the various units, nurses from each unit attached similar amounts of significance to the work-only and work-personal (combined) relationships originating there. In other words, relationships associated with the work experience are equally significant whether they are seen as positive or negative, supportive or non-supportive. The implications of this affective variability for nurses who work concurrently but not cohesively in the same stress-provoking environment deserve further exploration. The data suggest, however, that the line and middle manager roles are focal in shaping staffnurses' attitudes toward hierarchical superiors, coworkers, their work, and perhaps themselves as nurses.

The majority of the psychiatric nurses assessed their personal (that is, non-work-connected) relationships as both most significant and most supportive. Very few relationships receiving negative valances occurred outside of the current work setting. The data suggest that the psychological resources provided by personal, non-work-related ties may function in many situations as reserves to maintain the nurses on the job. Despite recent concern expressed in the literature with directing support from professionals through informal helping networks to those in need of it (Gottlieb 1981, 1983, Lenrow and Burch 1981, Froland et al. 1981, Mitchell and Hurley 1981), supportiveness in the case of the psychiatric nurses at City and

County indicates their being in need. The data indicate that support is a resource that tends to flow in the other direction, that is, from primarily informal helping sources (excepting the half dozen significant relationships which involve unidirectional roles with nurses as clients of therapists and counselors) to the nurses who work on the psychiatric units. This does not imply that the nurses are not mutually supportive of these significant others, or that they are not providing support for patients and others in need, but serves to underscore the paucity of supportiveness perceived in relationships at work.

Evidence from the network analyses verifies data from a wider sample of nurses on the units regarding the desire for more supportive and individualized associations between levels of the psychiatric nursing hierarchy. The nurses want supportive leadership. The strongest and most supportive bonds indicated were between nurses and their immediate supervisors and the Director of Nursing who is generally viewed as a non-clinical role model. The significance of relationships on two units studied flows generally upward. Nurses on the third unit reported the smallest proportion of work-related ties and the largest proportion of relationships with co-workers and work-related connections characterized by positive connotations. It was on this unit that occurred the only instance in which a nurse in a position of authority rated (across substantial differences in educational and ethnic backgrounds, and in lifestyle) a subordinate among her most significant others. That unit is the same characterized by the nurses as the most tolerant, as providing the most leadership,

and that on which staffnurses' relationships with middle and upper management involve the least vulnerability. It is also the unit documented as having the least turnover and as using the smallest numbers of per diem nurses each month. (Extra shifts are often worked by regular staffmembers who are willing to do so.) Although burnout was not measured, the general atmosphere and individual staff interactions on this unit tended to be less strained than on the other units. This is not to imply a conception of a totally satisfying work situation; as one nurse put it: "Ours is simply the unit of least discontent."

In sum, the people with whom the nurses work are not typically as significant in their lives as are those who are not connected with their jobs. Combined (work/personal) relationships were most prominent among the masters-prepared nurses, but many other nurses expressed a desire to expand that aspect of their networks.

CHAPTER 13

STRESSES AND REWARDS:

COPING WITH WORK, COPING WITH LIFE

"I felt caught in a dilemma that was new to me then but which since has become horribly familiar: the trap of adult life, in which you are held, wriggling, powerless to act because you can see both sides. On that occasion, as generally in the future, I compromised."

Mary McCarthy
Memories of a Catholic Girlhood

"... experience provides a key to understanding central truths of adult life. ... the fact that in life you never see it all, that things unseen undergo change through time, that there is more than one path to gratification, and that the boundaries between self and other are less clear than they sometimes seem."

Gilligan 1982: 172

Why Psychiatry?

The vast majority of nursing students enter the field for nurturant reasons (Cohen 1981). When City and County's psychiatric nurses were asked why they elected nursing as an occupation, most of them answered with predictable statements about wanting to help people. When asked why they selected psychiatric nursing, however, there was no such agreement; the explanations varied widely.

Psychiatric nursing was chosen by a few nurses because they came from backgrounds they described as "marginally organized" or "pathology-ridden," and which impressed them with a need to understand the interactive processes and problems that people experience. Others chose the area of practice because parts of its image met their own

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needs and desires.

"It had better days off than medicine offered (fifteen years ago) and more autonomy. I don't need to wear a uniform and the hierarchy is a bit less rigid than what I met on the medical wards."

"I prefer using my head to using my hands."

"I liked to listen."

"I had all the machines I ever want to deal with in the military. Technology gets in the way of nursing for me. Psych is low tech."

Some RNs sought refuge in psychiatric nursing following experience in other areas of the discipline.

"I got tired of patients dying, especially children."

"Medical nursing was not exciting. In fact it was boring. But psych is intriguing. It lets you understand people's problems."

"Med-surg was maid's work, which is what my family warned me about. I had to prove to them that nursing was not what they said. I excelled in psych in school, liked to play bridge and pool, and am a good talker."

The majority of the nurses feel that they have talents in the area of human relations. Many of these also point out that they lack the opportunity to fully develop and utilize the skills and abilities that they feel predisposed them to psychiatric nursing. They have "always wanted," however, to care for persons with "real," "psychological," or "mental" problems "related to living:"

"From my early teens I was the supportive, helpful one and tried to understand how people worked. I studied nursing while temporarily disillusioned with music, and because my father discouraged me against the long study associated with medical school. I wasn't very interested in nursing, but I liked psychiatry."

"I was always interested in psychiatry, but I had never met a

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psychiatrist or a psychologist. I wasn't at all interested in medical nursing. Nursing was a way into psychiatry."

"I need to know the nitty-gritty about everything, always did. I am interested only in process, the most inside story of all. It took me seven years to graduate from nursing school, but I knew from the beginning that I wanted psych."

Other RNs "wandered" or "gravitated" into psychiatric nursing from such diverse orientations as classical archaeology and post-divorce therapy, work in children's camps, industrial management, and psychology. Some followed friends or job opportunities that led to psychiatric nursing. Several nurses were motivated in part by the support they felt from psychiatric nursing instructors in troubled times during nursing school. A few mentioned, as factors in the decision to enter psychiatric nursing, aptitude test scores or employment counselors who verified their potential for dealing with people and for problem solving.

Why In-Patients?

Numerous nurses who identify with a psychiatric or mental health specialty work in out-patient settings. Each City and County nurse, when asked why he or she works on an acute care, in-patient psychiatric unit, presented one of three rationales: excitement and challenge, a rejection of the community-based setting and the practice of mental health nursing, or a preference for the community setting but lack of opportunity to work there.

Many nurses like what some call the "psychiatric ICU" with its challenges of working with patients who, "being in the hospital, have a rougher time," "are more troubled," or are "in crises." These RNs

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find the setting exciting. One described the units as stimulating because they provide an opportunity for "high acuity nursing (that is, with patients who are acutely and severely ill), but it's not like medical ICU or working with terminal patients." Another likes to deal with "really crazy, psychotic, and jail patients, but not sociopaths." Others described the challenge of the "hard core problems" dealt with at City and County on the units, and/or special interests in schizophrenia or suicidal patients.

One nurse considers the entire system of out-patient care to be as "just a ploy for funds; it has no substance." For that individual, and others, "in-patient is where the action is." Several nurses expressed the conviction that little can be or is being done for patients in the community. One added,

"At least here in the hospital we can do something for them, clean them up, talk to them, listen."

Five of the RNs who discussed their motivations for public work explained that working in the in-patient setting is not their preference. Several firmly stated that they do not enjoy in-patients, but that they have taken "the job that was available" or have been transferred to the Department of Psychiatry as a result of shrinking community-based resources. The salary and benefits are viewed by some as "too good to give up" after several years in the system.

Why a Public Facility?

Questions about the decision to practice nursing in a public facility elicited answers focused upon two themes. One of these is

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the challenge posed by working with the types of patients frequently encountered in public settings.

"Working with the middle class is not rewarding; working with indigents is. The reward is the challenge."

"We serve a population no one else will. That's challenging."

"My graduate school classmates think the people I work with should be shot. I am the only clinically-oriented student in my whole (nursing doctoral) program. Here we care for the social rejects. You can't judge the value of the work with either a monetary or a social perspective. These are the folks who struggle against great odds and suffering. To work with them is a privilege."

"My interest is in the 'unwashed masses,' in the underserved. These patients' lives are valuable, even though they are socially devalued. City and County is where my practice can make a difference."

The second theme involves expectations of camaraderie. Public psychiatry is alleged to provide "team-oriented" experiences that reduce professional isolation and encourage close interdisciplinary efforts (Wile 1984). One nurse described "a genuine friendship and camaraderie," which she feels is mutual among nurses who share her interest in working with psychiatric in-patients in public settings:

"We see the world as very complicated. Nothing is simple. Everything is relative, qualified."

The foregoing reasons for practicing psychiatric nursing in a public facility are highly idealistic. They are all also, it is important to note, responses given by nurses with masters degrees in nursing or related fields. With few exceptions, those nurses with other educational backgrounds, who answered the question directly (and many did not), did so by pointing out that psychiatric nursing pay at City and County is better than at the state hospital; that other types



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of nursing are too exhausting, strenuous, or routinized; that they "simply like psych," and/or that job opportunities are limited; or with a perfunctorily shrugged "Why not? It's a job."

The Psychiatric Mental Health System to be Dealt With

Confined for long periods of time with severely ill psychiatric patients within the rigid confines of locked units, the nurses at City and County tend not to share the medical staff's optimism that the overall system is working. Nurses are disturbed by the suspicion (if not belief) that psychiatry, as they view and experience it, is essentially ineffective.

Many RNs consider the issues associated with mental illness in contemporary society as too complex and overwhelming to be dealt with on any level except that of the individual patient, and, from their perspective, the system precludes effective involvement from that approach. The nurses freely acknowledge that what they do and the patients with whom they work are little valued by society. Even when they think that what they do may be important, there is a nagging conviction that its impact is lost in the long run. The nurses say there is little reason to think their interventions have a lasting effect. The patients who remain on the units long enough to become more than superficially familiar do so because they are awaiting beds at the state hospital or in other long term facilities. Usually chronically ill, their conditions tend to change little while they are hospitalized. Typically it is the "failures" who return to the hospital, often repeatedly admitted on obvious downward trajectories.

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The "success stories" remain in large part unseen. Summing up a predominate attitude, one nurse (despite having idealistic motivations for working at City and County) stated:

"We are tinged with failure. We forget anyone ever gets better. -- Maybe they don't."

Some nurses describe psychiatry in its present form as self-defeating. Several questioned whether the psychiatric system (and, therefore, perhaps themselves) makes any significant contribution to society. Nurses at City and County describe psychiatry with such pessimistic phrases as "making stabs in the dark," "putting Band Aides on the cancer of society," and "hopelessly overwhelmed." Patients are viewed as "more and more, coming in sicker all the time." The psychiatric emergency clinic (PEC), which admits most of the units' patients, five years ago screened about one hundred patients a month. Now it struggles with seven or eight times that number. The patients must be "kept moving;" there is continuous pressure to discharge them as soon as possible. Staffmembers cited many versions of

"Smith called from PEC to find out if we have anyone to discharge. Anyone who can walk and talk up here is supposed to go. They have about a dozen downstairs who can't."

Couched in sardonic humor, analogies were made between the public psychiatric system and the functions of assembly lines, warehouses, and "meat factories."

Members of the staff sometimes question their occupational goals. More often, however, they say it is easier to ignore a long term perspective and "just deal with daily life on the units." The integrity of a clear mission shared across hierarchical levels is

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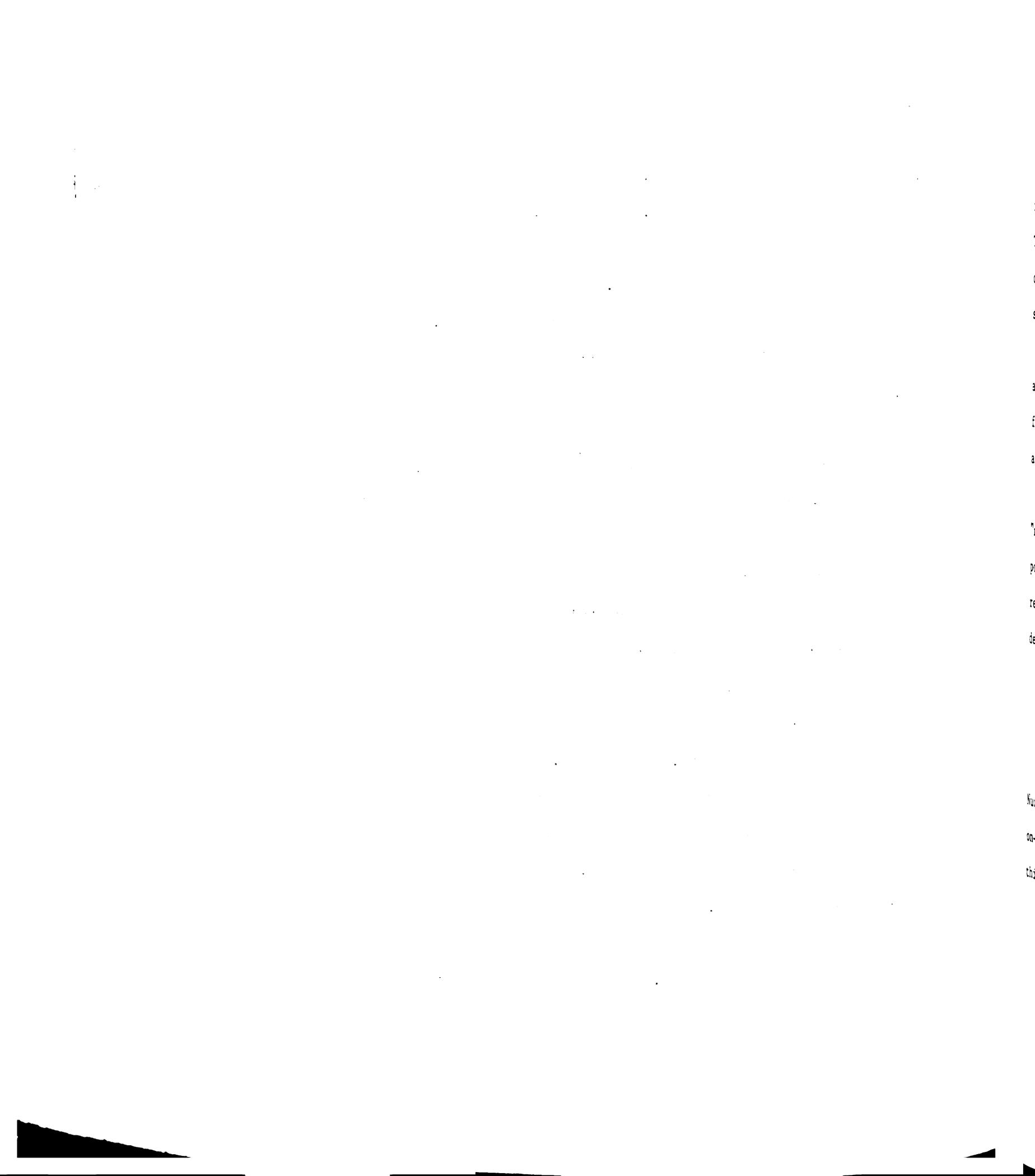
missing. No one pretends that rehabilitation is the goal; that responsibility is left to out-patient components of the community system. Nurses often express, however, a belief that rehabilitation should begin in the in-patient setting. Meanwhile, they question whether the "real" departmental objective is "controlled support maintenance" or "getting patients out fast."

Symptoms are dealt with; basic problems typically are not. The time allowed for hospitalization does not correspond with illness processes. One physician pointed out that

"Only toxic psychoses clear fast enough to do it in the time the patient is allowed to be here. And they are the primary diagnosis for a relatively small percentage of our patients."

Nursing and non-nursing staff alike acknowledge that "We just don't know how to treat people in such a short time yet." The RNs resent being dictated by cost effectiveness rather than by therapeutic response. Patients may be returned at hospital expense to other cities, states, or countries to avoid long term expenditure of local treatment funds on "no locals," that is, people without local addresses. A high percentage of the patient population is transient, acute, and/or potentially dangerous. In general, variations in numbers of assaults by patients on the units are assumed to be attributable to changes in the patients admitted, rather than in the milieu of the units. Many of the patients are recidivistic. The approach is at best fragmented, at worst iatrogenic.

Patients are subject to reclassification, decertification, and discharge without adequate placements. The "dumping syndrome," well known in public psychiatry, results in admissions of "leftover



misfits" from other agencies to the units. Mentally retarded, elderly, severely physically ill, and other individuals difficult to manage, but inappropriate for the psychiatric setting, may be housed on the units for extended periods until alternative placements become available. The staff complains less about the additional work these patients create for them, than they do about the inadequacy of a health care system that allows persons to be "so casually dumped."

Paperwork is a primary source of complaint lodged by the staff against the present system. Requiring large amounts of time, mandates for extensive documentation are viewed as competing with patient care as the focus of effort and attention.

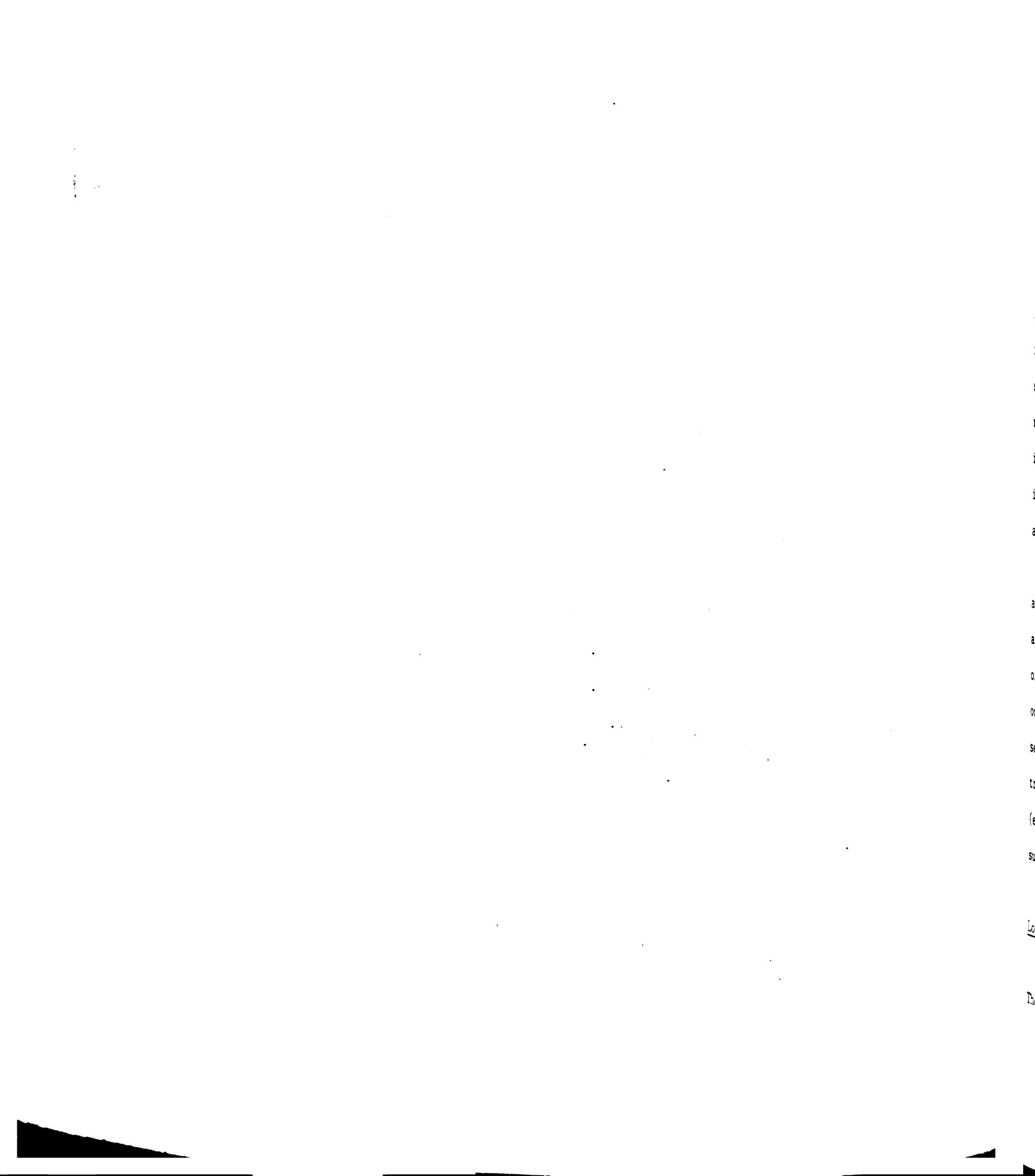
Nurses sometimes feel trapped by the necessity of producing "negative documentation." For example, a patient who is described in positive terms, as interacting appropriately, may be quickly reclassified as no longer requiring hospitalization and released, despite his or her continued serious illness. One nurse stated,

"I try to see patients in a positive way. That's important for my relationships with them. But if I don't make them sound desperately crazy in the chart... Zap, out they go, when they are no where ready for discharge yet. It's like if you make any sense at all, if you stop trying to hurt yourself or somebody else, you are all right."

Nurses find themselves monitoring students' notes to ensure evidence of on-going illness. A clinical nurse specialist put the problem like this:

"We tell students to feel good about their patients, and then tell them to look for the pathology. No one can afford to get better in this system. All of your support disappears at the first sign of health. Now, that's sick!"

"Very little can really be done in in-patient psychiatry" phrases

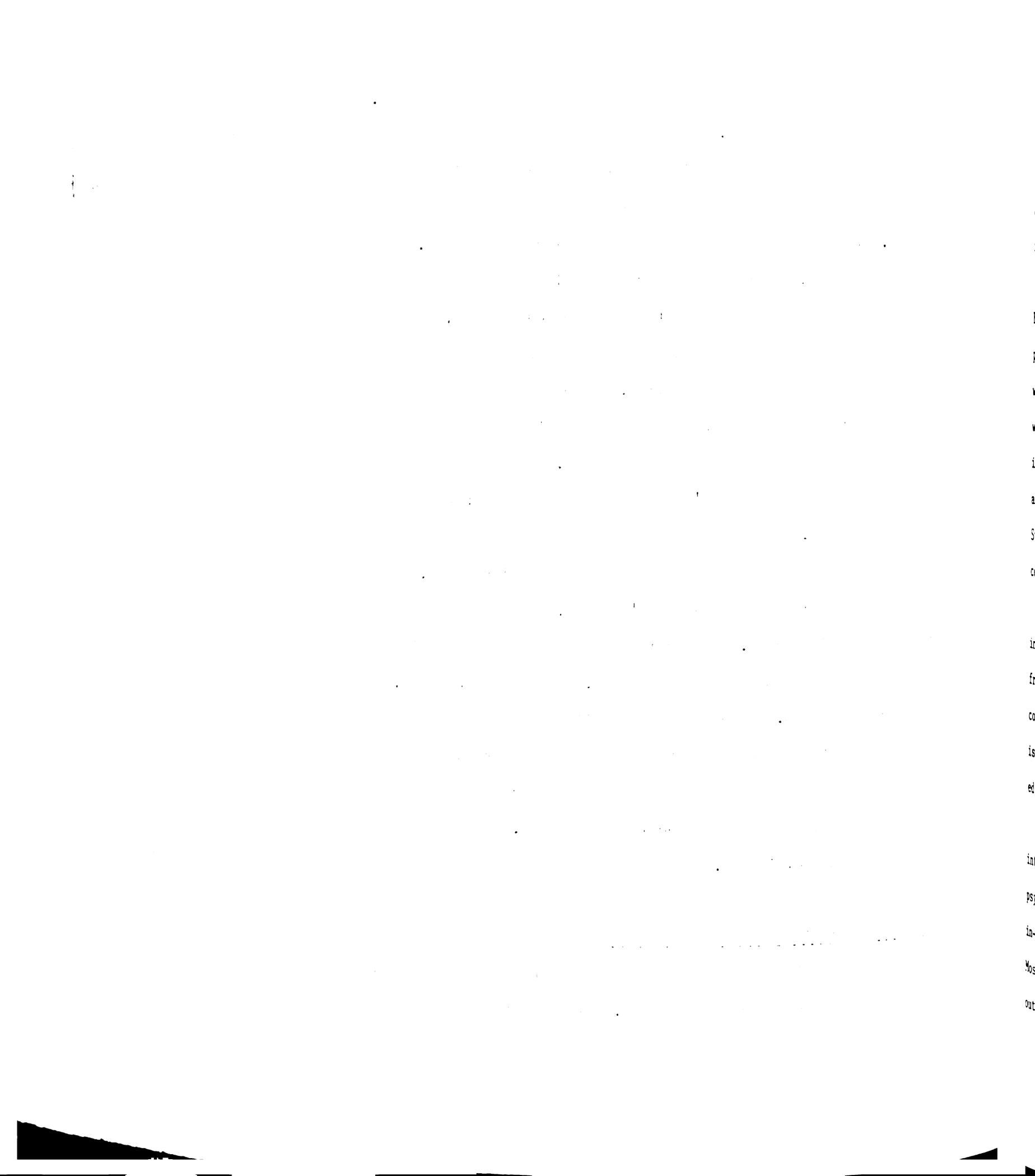


a recurrent theme in in-depth discussions with nursing staffmembers. From the nurses' perspectives, the reasons for this lack of productivity focus on treatment limited to medications (which is considered by some as analogous to putting "Band Aides on an unset fracture"), inadequate preventative and rehabilitative efforts, limited patient contact time, the routine return of patients to the same settings and circumstances in which they became acutely ill, lack of individualization, a treatment process that reinforces uselessness in a society which highly values productivity, inadequate placement resources (especially the lack of "step-down" facilities between acute in-patient setting and living in the community), and what is interpreted as the health system's focus on chronic rather than on acutely ill patients.

Nurses also express fears of anticipated legislation which, although supposedly increasing patients' rights, may limit staff rights and compromise patient care. Of particular concern is the possibility of not being allowed to medicate or restrain, against their wills, out-of-control patients. Some nurses know clinicians who have left settings in which they felt unable to deal with patients when traditional mechanisms of control over socially unacceptable (especially violent) behavior were no longer allowed, and adequate substitutes were not available.

Local and In-Hospital Issues to be Dealt With

Other aspects of life at City and County also require adaptation. These include conditions such as crowding, which may intensify



emotional responses (Freedman 1975), provoke attentional overload (Langer 1983), and foster difficulties in anticipating conditions and coordinating behaviors with others (Milgram 1970); limited equipment and supplies; marginal maintenance and cleanliness, and variable in-hospital backup services and communication.

Civil service presents further and often unappreciated challenges. Benefits may be unclear and/or difficult to get. The thoroughness of pre-employment evaluations varies with the degree of urgency associated with filling a position. Staffmembers sometimes resent having to work with personnel who are inexperienced or otherwise considered inadequate. There are no overlaps of new hirees with those leaving, and hirees receive limited systematic orientation to the units. Staffing patterns fluctuate, and long vacancies occur due to budgetary considerations or while sick leave is utilized prior to a retirement.

Clinical evaluation of nursing practice is frequently viewed as inconsistent and representative of "the personal ups and downs" of front-line managers. There are no clear status increments for competence, no clinical series or systems of peer review. Seniority is, at times, more highly rewarded than is competence, experience, or education.

Staffmembers are assigned positions according to need rather than interest, ability, or experience. Several of City and County's psychiatric nurses have vacillated with systemic changes between in-patient and out-patient components of the mental health system. Most of the nurses who have worked in the clinics prefer the out-patient setting, but as civil servants they have been reassigned



to in-patient psychiatry. Increasingly limited funding is the most often cited evidence of societal, systemic, and local devaluation of mentally ill patients, their care, and their caretakers.

Many of City and County's psychiatric nurses do not believe that the community mental health system, society, or the psychiatry department values their efforts. They perceive a focus on the negative and feel vulnerable to administrative whims and changes in a broader system from which they feel generally estranged. The medical hierarchy is alleged to prize psychiatry and psychology while tolerating nursing, social work, and occupational therapy. The hospital administration is not viewed as prioritizing patient care. Many problems are attributed to the facility's complex, tripartite government.

Having to Deal With How the System Deals with Patients

Other aspects of the psychiatric system, as it has been experienced by those working within it at City and County (although their experience is not limited to that setting), are considered particularly insensitive to the needs of patients. Depersonalization, infantilizing, and disrespect are characteristics frequently attributed by the nurses to public psychiatry. Some perceive their jobs as "series of rescue operations" that "perpetuate the system."

A recurrent concern involves a crisis-oriented system which is seen as "unable to relate to where the patients are coming from." Staffmembers often express feelings of powerlessness in their efforts to function as patient advocates while maintaining their own integrity. Following an incident in which several staffmembers saved



a patient's life, for example, the nurses were threatened with legal action because the patient was injured in the episode he instigated. The frequent confusion of legal issues with illness conditions, labels, and stigmas complicates clinical practice. An example:

A middle-aged woman, brought to the hospital by police because she had been "trespassing and acting vague," returned to the unit after her court appearance. She was very upset because she had been transported to and from court in hand and ankle cuffs by the deputies, "Like a criminal!" she cried. She had originally been "mortified" by the reality of being admitted to a psychiatric unit, and then again at this public display of her social unacceptability. Despite the long time she was in court today, the case was not resolved. The woman fears the dehumanization of having to go there again much more than she fears any sentence that could be levied upon her.

Many nurses complain about the "skimpy" program offered to patients. Specifically cited are a paucity of recreational and occupational resources, lack of administrative budgetary and other support, and minimal support for the staff-patient groups initiated and sustained by nursing personnel.

Another concern involves discharge procedures. The suddenness with which placements become available and patients are discharged is viewed by the nursing staff as a substantial problem in patient care. With discharges occurring without notice or on a primary nurse's day off, relationships between staffmembers and patients may be unexpectedly severed without appropriate termination. Despite the efforts of disposition workers to avoid rejection of patients, they are at times discharged to facilities which do not accept or keep them. It is also common for discharges to be resisted by the patients.



Coping With the Role

There are a variety of ways to deal with challenging and difficult situations. Typically, effective coping and long range adaptation involve information acquisition, direct action, inhibited action, and/or intrapsychic defenses (Lazarus and Launier 1978). At City and County, information is sometimes limited and/or distorted, or at least perceived as such. Action may be thwarted by ambiguity, conflict, and/or a sense of helplessness. Withdrawal may be considered the safest approach. Intrapsychic responses are common when other action seems pointless or has been proven ineffective.

Members of the psychiatric nursing staff at City and County employ many coping mechanisms in their adaptation to the work situation and in the integration of their occupational and private lives. Foremost among these is the monitoring of involvement with and investment in their jobs. Although those co-workers considered "non-workers" are resented, most of the nurses describe, on their own parts, a conscious passivity associated with their own job performances. Many involve themselves only with those activities essential to their roles, thus avoiding leadership positions and use of their managerial skills, while rationing energy. Examples include discussing at work virtually anything else but work, calling in sick, tuning out during meetings, staying away from the desk or retreating from the unit's open area to side rooms, being task oriented, forming barriers between themselves and/or themselves and patients, or varying the amount of attention given according to characteristics of specific patients. Remaining on the fringes of the system reflects the common convictions that the



system undermines employees, does not adequately support them, is ineffectual and disorganized, and is not deserving of the risks taken by the employee who invests his or her full participation.

Many nurses manipulate their schedules to allow "enough mental health time; that means time away from the units doing something else." Some work by the day (that is, per diem) and avoid taking regular positions, thereby sacrificing employment benefits and continuity for the option of choosing how often they work. Others refuse to work double shifts despite the opportunity for additional income. A few work part time in several facilities in preference to full time in one; this dilutes the intensity of any one setting. Many prefer to work evenings, nights, or weekends, which minimizes requirements for meeting attendance and interaction with patients, therapists, and/or administrators.

Reflecting the limited cohesiveness and community spirit that they perceive, some RNs view themselves as unique on the staff, and use this conviction to justify both separateness and limited involvement. They say that they deal as individuals, not as members of teams ("because there are no real nursing teams" and nurses are kept marginal to the therapy teams), and with individuals, not with groups. The here-and-now orientation prominent among the staff encourages former staffpersons to be quickly forgotten or discredited, and current circumstances to be denied. Temporal perspectives are altered by some long term employees to find satisfaction in change over time and to help ignore immediate problems. Others focus on change: "Surely things will get better."



In response to the work environment, nursing roles are redefined in a variety of ways. Bunch (1983) observed, among psychiatric nurses working with schizophrenic patients, that they employed strategies resulting in nurse-patient interactions which ranged from active to passive. It was noted that strong institutional requirements and business demands resulted in decreased use of nurses' professional training in patient care (Bunch 1983). The same descriptions are applicable to the psychiatric nurses at City and County. At least in part due to non-nursing demands, many nurses have coped by redefining their roles along active-passive or expansion-contraction continua.

Most RNs do not believe that it is possible to effectively accomplish all aspects of the nursing role: interacting with patients, attending all of the required meetings, being a primary nurse, and completing other required tasks. The role is altered, therefore, by minimizing those parts found distasteful or unrewarding.

Parts of the job may be ignored and changes resisted. Often the role is contracted by ignoring the system beyond the unit, or by becoming less interactive while conforming to requirements to emphasize monitoring and documentation. Many nurses tend to seek information from their subordinates and to avoid superiors, politics, and issues which extend beyond the scope of the immediate shift or unit. Head nurses sometimes cope by focusing on their roles as nurses rather than as front-line managers. The nurses who adapt by passivity or contraction tended to avoid newer nursing models and to seek continuity and organization in a system which they perceived as fragmented and disorganized.



Concerned with administrative support of individual nursing decisions and personal situations, some nursing staffmembers struggle for more control and closer monitoring of patients, more rigid policies, and decreased responsibility for individual decision-making. Other nurses challenge this with attempts to increase patient rights and opportunities to develop self-care. In a setting where patients are acutely impaired, yet interventions must be made quickly or not at all, both arguments are theoretically supportable. Administratively, double messages are projected: keep the patients under control and increase self care. The nursing staff tends to divide into those who advocate more structure and those who want less.

Some nurses expand rather than contract their nursing roles. They increase their educations, adapt nursing and non-nursing skills for unit use, develop new skills (for example, learning to lead patient groups, identifying with and learning from role models (in-house or elsewhere), and/or benefiting from individualized supervision sessions). Some attempt to deal actively with "disorganization" by simplifying routine tasks, building flexibility into the schedule, and "generally creating order out of disorder." They work toward changes that may resolve troublesome staffing issues or refine nursing processes, role distinctions, and job descriptions. A few work actively toward the development of a clinical series and other methods of recognizing levels of nursing competence, and attempt to deal with the "delicate politics" associated with the system. Some are involved in improving the physical and/or psychological environments of the units. For example, Ten East's rancid carpet was at last removed and



replaced with innocuous tile. After the staff held a fund-raising baked goods sale, plants and wall hangings markedly brightened and softened the otherwise austere unit atmosphere.

It is an oversimplification to say that all nurses adapt by either expanding or contracting their roles, that is, with increased activity or passivity. It is more accurate to state that some generally expand their roles, some tend to contract them, and most of the nurses may do either, depending on the situation at hand and their own resources. A few RNs remained on the passive end of the continuum, but more vacillated between passivity and varying amounts of activity in role definition and performance.

Although the evidence might be interpreted as suggesting that more educated nurses are more likely to expand or more fully develop their roles within the allowable framework, it must be pointed out that the vast majority of the nurses who work part time at City and County are baccalaureate-prepared, yet many of these work there only part time. These are, by virtue of their part time employment and consequent job descriptions, less involved with continuity in patient interactions and with the overall system than are those nurses who work full time, regardless of educational or experiential background. An additional, very significant factor involves the "uses and abuses" of the associate degree or diploma nurse who is not trained to take initiative (Weisensee 1979), but who is expected to perform in a manner indistinguishable from that of the BSN.



Burnout: A Way of Coping

A great deal has been written about burnout since the term began to be used a decade ago. A popular and complex concept, definitions of the phenomenon are plagued by the same ambiguities that are presumed to foster burnout itself. The construct is, nonetheless, relevant to an accurate discussion of psychiatric nursing at City and County.

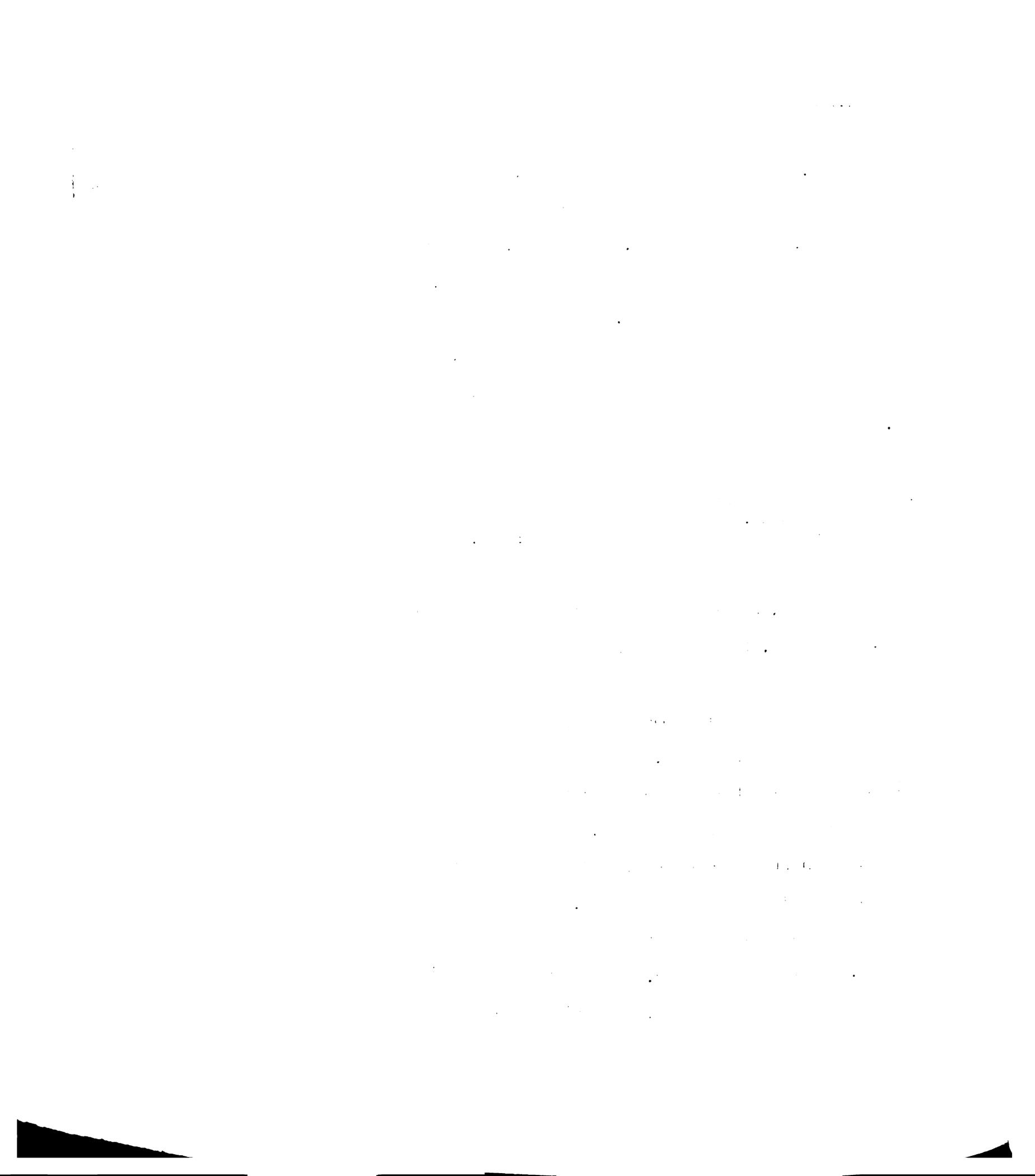
"Burning out" is one approach to adapting. A strong argument can be made for conceptualizing the psychiatric nursing department, or even public psychiatry as it is experienced at City and County, as a burned out system.

Burnout is associated with a

"... state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward" (Freudenberger 1981: 13).

The experience essential to burning out is discrepancy between expectations and reality, while continuing to try to fulfill those expectations. Burnout is, in other words, a way of adapting when physical and mental resources are exhausted by efforts to reach unrealistic expectations imposed by oneself and/or by society (Freudenberger 1981). It is, however, an inadequate coping mechanism for reducing the stress involved in the conflicting situation (Maslach 1982). In health care settings, furthermore, burnout affects the quality of care and treatment provided to patients, the work experience of individuals, and administrative functioning.

Nurses, despite a lack of uniformity among their expectations for goals and roles, tend to be idealistic. They want to have an impact on the lives of those with whom they deal. They also strive for an



idealized professional mystique which professes that credentials connote competence; that practitioners should be personally effective and autonomous; that others will cooperate and appreciate what they do; that their work will or should be interesting, meaningful, and stimulating; and that co-workers will support each other (Cherniss 1980). Such aspirations carry a high price in health service occupations where their achievement is unpredictable and frequently unrealizable.

Burnout is best conceptualized within an ecological framework (Carroll and White 1984). Factors associated with burnout are found at different levels of experience within the biological-psychological-sociological context. Those discussed here are specifically pertinent to psychiatric nursing at City and County.

Social and Cultural Factors in Burnout

At the level of society, individuals must deal with the positive or negative values attached to them as representatives of specific statuses and roles. These include (among others) occupation, gender, education, and ethnicity, which have been discussed in previous chapters. Also important is affiliation, that is, identification with and membership in an organization.

With a generalized decline in small, personal communities, individuals are increasingly expected to cope on their own. Ambiguity is increased, faith in public institutions has declined, and criticism results in decreased public support of employees and confidence in their effectiveness. According to City and County's psychiatric



nurses, there is little sense of a unified mission among the various components of the community mental health system which they officially compose.

Within City and County, the tenth floor is minimally integrated with the medical center proper, the latter being commonly referred to as "the main house." Despite long-standing efforts within psychiatry to reduce the isolation of psychiatric facilities (for example, see Galioni et al. 1957), the department's lofty location symbolizes its marginality to the rest of the social organization. Even orientation tours for new employees in other parts of the hospital stop on the floor below. For some nurses the tenth floor is both temporally and spatially an island.

City and County as a public health facility was viewed by the public with mixed results. Due to complaints and problems in areas of the medical center not directly involving the psychiatry department, the facility was scrutinized and criticized by medical authorities and the mass media during the period in which the research data reported here were collected. Threat to the integrity of a program with which one is identified has been demonstrated to be a source of job stress and interpersonal conflict (Sarata and Reppucci 1975). Although the Department of Psychiatry was not implicated, when City and County as a medical facility was, all of its employees experienced increased negativity from the community.

During the research period, multiple changes were initiated at City and County in response to outside pressures. Many of the changes were perceived by the staffmembers as "wheel spinning," temporary,



crisis oriented, and superficial. Attempts at implementation often occurred too rapidly and too unexpectedly for assimilation. The purpose of the changes was not always clear or substantiated, and the staff was typically involved in neither the planning nor the evaluation of changes affecting patterns of operation. Staffmembers' concerns about possible failure, and other indications of insecurity and anxiety, were only occasionally elicited or dealt with. For some nurses, multiple changes superimposed new layers of impossibility upon a situation already considered to be hopeless. The strain was especially apparent when attempts to adjust to changes were followed by requests or demands for more transitions, rather than by acknowledgment of efforts already made.

The Workplace and Burnout

Many nurses say that burnout is a constant threat to them. Most claim to have experienced it at various times in their careers. Typically the phenomenon is associated with their work and the workplace.

Within the work setting, burnout reflects organizational design, leadership and supervision, and social interaction among staffmembers (Cherniss 1980). Interrelated, each of these is relevant to psychiatric nursing at City and County, where many factors contribute to the possibility and incidence of staff burnout.

The RNs complain that psychiatric nursing roles have become increasingly constrained as the department has attempted to become more accountable. Adaptation to the broader system and to the immediate



work environment requires repeated role adjustments by expansion and/or contraction. For the most part, the RNs attempt to meet new expectations, but they resent those responsibilities which are perceived as lacking in substance. They frequently respond by minimizing personal involvement in the work situation. Perceiving few signs of positive change in relationships with patients, with management and administration, or with medicine, the nurses project resentment toward the latter two groups.

A centralized, hierarchical power structure limits decision making and demands a high degree of formalization. This affects the philosophy of treatment (not to be confused with goals) employed in the setting, reinforces bureaucratic control, potentially inhibits the production of new knowledge, and sets the norms for delineating organizational and staff needs (Cherniss 1980). An alternative arrangement might be based on cooperation, which works differently from control by allowing establishment of a sense of fairness and equity (Martin 1983). Public managers, however, often lack the freedom and decision making powers to fulfill the image of the ideal manager who is a conceptualizer and leader, deals with the external environment, and engages in long range policy planning and making (Martin 1983). Most effort goes instead into structural maintenance and focuses on resources, procedures, and control. Lower levels of management spend the highest proportion of time in organizational maintenance (Martin 1983).

Organizational structure influences the supervisors and administrators within it. Supervisory practices reflect skill,



attitudes, and the structure of supervisory roles (Cherniss 1980). These roles at City and County are often characterized by conflicts and large numbers of demands. Enmeshed in organizational maintenance processes, psychiatric nursing managers tend to be "paper" rather than "people-pushers;" people-oriented aspects of the roles may surface only in response to crises. Managers, removed from the unit core, may not make decisions directly relevant to the unit context or individualize policies and procedures. Members of the staff, meanwhile, feel that they must protect themselves, "since no one else does."

Most of City and County's psychiatric nurses expressed commitment to the patients, patient care, and to nursing. Many were, however, too little committed to either the mental health system or to the hospital which employs them to risk full participation there. The realities of public psychiatry, as it is observed and experienced by the nurses, have resulted in little faith in the overall mental health system and grave doubts that it is effective and working. That conviction, coupled with what is perceived as a need to practice nursing defensively due to inadequate organizational support, results in many nurses seeking autonomy in passivity and avoidance. These RNs associated satisfaction with successful resistance of the organization and avoidance of activities such as meeting attendance and interdisciplinary or superior-subordinate interaction. They view achievement as diminished defensiveness on the part of patients, or as nonintervention in the nursing process by hierarchical superiors. Success, then, is measured in negative rather than positive terms.

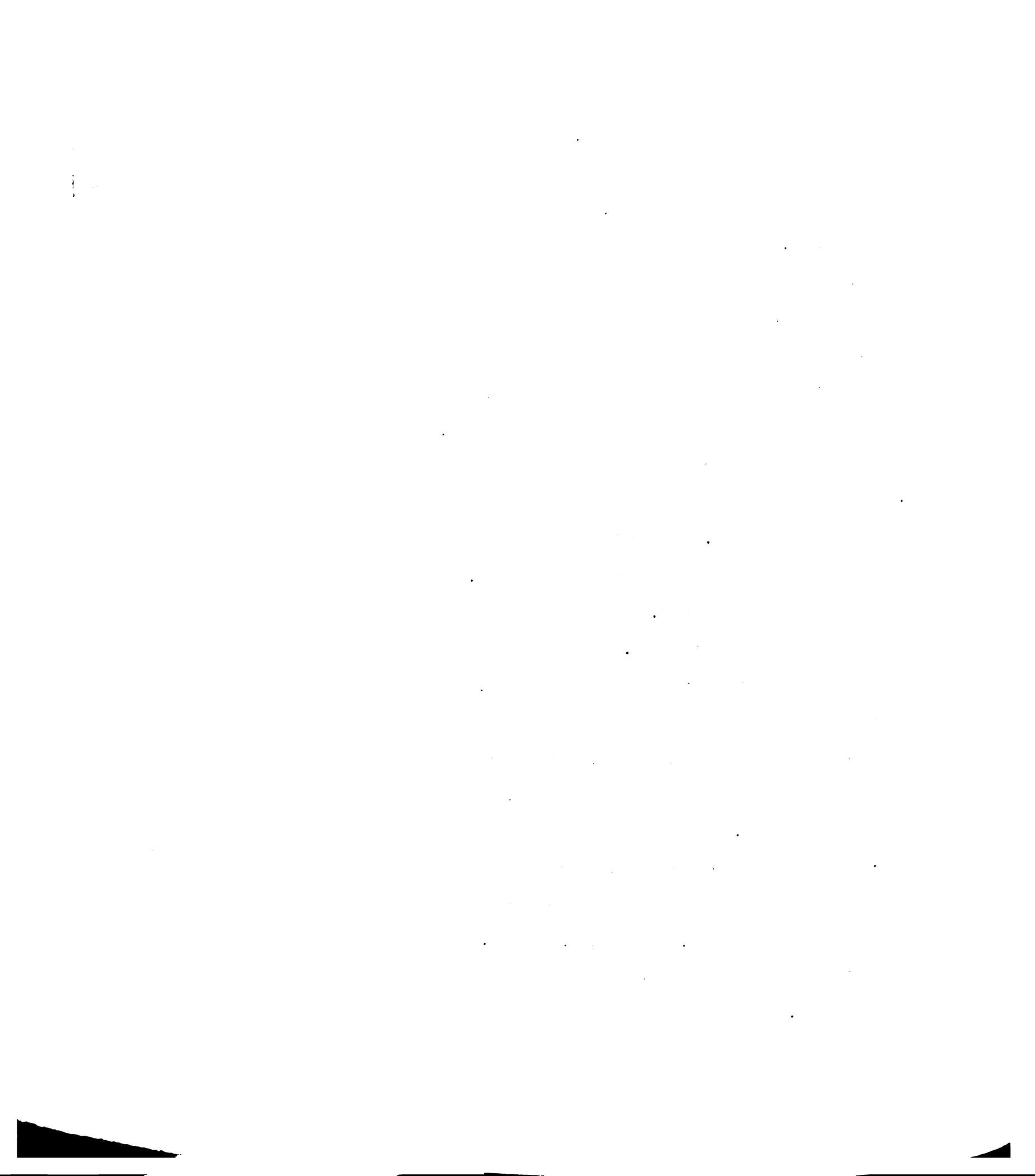
The nurses at City and County complain about lack of clarity of



"real goals" and about the discrepancy between departmental and unit goals, and actual treatment modes and patterns. While goals relate to appropriate treatment and care aimed at facilitating recovery from mental illnesses and psychological problems, circumstances dictate that patients be kept moving. Treatment is often limited to pharmaceuticals, and symptoms and behaviors rather than underlying problems are attended to.

For nurses, the development of new knowledge is limited by constraints on opportunities to discover, make decisions, improvise, hypothesize, and experiment. Although a teaching institution, the hospital is viewed as in large part separate from formal educational resources. Most nurses feel that they have limited work-related support for continuing education. In-service education leads frequently to neglect of nursing and attention to medicine. Medical knowledge is, according to some nurses, less ambiguous than nursing knowledge, and more likely to be rewarded.

Role structure is another important factor in burnout. Although service programs are held increasingly accountable for their approaches and productivity, traditional organizational structures inhibit effective shouldering of responsibility by individuals. Many nurses feel that they are trained as, but are not treated or utilized as professionals. They are (or were) willing to perform their roles in a manner for which they can be held accountable while maintaining professional and personal integrity. In reality, however, vague roles and perceived lack of support limit opportunities to use learned skills and to develop new ones.



Theory distinguishes professional from technical practice. Many of City and County's psychiatric nurses are educationally prepared for nursing roles which are considered professional. They say that they lack the opportunity, however, to demonstrate what they can do, or even to be clearly differentiated from personnel prepared in other ways. On the other hand, many nurses are unclear about what it is that they are not allowed to do that they think they should be able to do. In general, they seem to seek the freedom and safety that would allow them to make the nursing decisions for which they were trained (which vary, therefore, with training) and the opportunity to trust in their own abilities and perceptions to make valid decisions. This requires that their decisions be respected. Many express frustration because they do not feel trusted to make significant nursing decisions.

Organizational structure influences social interaction and support among staffmembers. However, differences in values and in occupational and theoretical orientations; competition for limited resources, status, and authority; heavy work loads; and the structure of work which allows little opportunity for informal interaction produce barriers between staffmembers. Occupational isolation heightens the effects of stressful aspects of work (Cherniss 1980).

Group burnout is associated with lack of acknowledgment, tendencies to focus on breaches of cooperation, generalized disillusionment when hierarchical levels are not perceived as grounded in the same reality, and significant imbalances between efforts invested and rewards received (Freudenberger 1981). The pessimism associated with a social organization characterized by confused expectations and defeat is



contagious. One psychiatric nurse summarized the situation as

"... like being part of a team that always loses. After awhile you don't even want to go to practice anymore."

The Individual and Burnout

Another RN described City and County's psychiatric units as

"... always stressful places, but sometimes it gets to the point that it is distasteful. Then it's not stress we are talking about, but distress. That's when you realize that you no longer like what you are doing."

Pronounced work-related stresses and strains indicate an imbalance between an individual's resources and the demands placed on them. Job stress leads typically to more meetings, rules and regulations, supervision, conflict, bureaucratic control, and intergroup conflict (Cherniss 1980). These, in turn, encourage individual coping mechanisms of a defensive nature. Typically the over-stressed individual responds with short term changes characterized by anxiety, tension, fatigue, and exhaustion (Cherniss 1980). When conditions do not improve to the extent that the deficit can be corrected, changes in attitudes and behaviors occur. Although continuing to be conscientious and hardworking, the nurse adapts by becoming less empathetic and/or sympathetic (Maslach 1976), by increasing resistance to suggestions or changes, by developing behaviors that discourage interaction with other people (Freudenberger 1981), and/or by looking for someone or something to blame for his or her problems. In short, as enthusiasm and idealism are dampened, detachment and cynicism creep in. Behaviors become more mechanical, more concrete in orientation. Humor may be the only dependable cross-strata medium of communication.



Burnout, a consequence of pressures that we take on ourselves, results in denial of feelings of failure, which may take many forms (Freudenberger 1981). At City and County, increased apathy was observed, as was withdrawal (from patients, unit activities, other staffmembers, and/or broader aspects of the work context). Both were rationalized by judging the patients, work setting, co-workers, superiors, or system as inadequate.

Some detachment from the work setting is realistic and positively adaptive. Many RNs say that they find it important to separate their work lives from their private lives. For some nurses at City and County, however, detachment has become predominant in their interactive styles. Some have separated their work from themselves. Feeling unappreciated, increasingly irritable, bored, depressed, impatient, and critical, individuals sometimes resorted to crutches such as overeating, smoking, psychosomatic symptoms, or other "false cures" (Freudenberger 1981).

Burnout, although neither permanent nor necessarily total, at the individual level has been characterized as feeling "dull or dead," empty, depleted, or disappointed (Freudenberger 1981). Although one's work ideally provides self-fulfillment, the burning-out or burned-out individual realizes a decline in the enthusiasm, optimism, and involvement necessary for success (Cherniss 1980). Discouragement and withdrawal become a self-reinforcing cycle headed for further failure.

In the work setting, nurses may feel surrounded by negativity. Wanting to make a positive difference, in reality they take on taxing work with few visible rewards; they are confronted with red tape,



harried administrators, and intractable cases; and they experience what they perceive as a lack of support, security, organizational integrity and stability, and basic courtesy (Freudenberger 1981).

Individual characteristics such as tendencies toward anxiety, dependency, unrealistically high standards, conflicting motivations, competitiveness, willingness to take on too much, and introversion are associated with a propensity to adapt by burning-out (Cherniss 1980). Many of the same descriptors typify staffmembers in human service organizations (Cherniss 1980).

Like other health care providers, nurses are trained to succeed and have few provisions for failure. But they work in social systems in which the success for which they are prepared is likely to be compromised. For many nurses this is further complicated by the confidence-depleting attitude common among women, which is to sacrifice the credit for successes, but to shoulder the blame for failures (Tavris and Wade 1984).

Traditionally, caring was encouraged via moral directives to caregivers. This implies that caring attitudes and behaviors be inherent in nursing practice (Gustafson 1984). Since nurturing roles were assigned by society primarily to women, later social and economic factors led to a predominance of females in nursing occupations. Expected and encouraged to be self-sacrificing yet self-developing, feminine yet assertive, professional yet nurturing, nurses are faced with the societal value conflicts which are central to contemporary sex role discussions. Without in-depth exploration of such issues, these subtle contradictions encourage self-blame and confusion. However,



the experience of positive role modeling and interactive sharing, important in minimizing problems with these conflicts, tends to be limited on the psychiatric units.

Job Satisfaction

Staffmembers' attitudes about their jobs vary widely. Some complain about their co-workers' lack of commitment and motivation toward patient care. Some dislike the discomfort of watching personnel mark time, abuse sick time and sick leave, or leaving City and County. "Working with burned-out staff" was cited by numerous nurses as a stress-provoking aspect of their jobs. Burned-out individuals were characterized as "excessively frustrated," "angry," "unhappy," "displacing their problems," and resorting to "the-punishment-is-treatment-mode."

As in most occupations, the dissatisfactions, frustrations, and stresses inherent in psychiatric nursing are counterbalanced, to greater or lesser amounts, with satisfactions and rewards. These come from patients, from accomplishing the job, and from the system.

It is important to note that job satisfaction and dissatisfaction are not necessarily opposite ends of the same dimension (Herzberg 1966). Treating these as distinct and separate phenomena reduces the discrepancies apparent when the same nurses complain angrily, cite multiple sources of frustration, and still feel adequately rewarded and supported to maintain themselves in their jobs for long periods of time.

Dissatisfaction at work can be viewed as dependent primarily upon



extrinsic factors (Herzberg 1966, Robertson 1980). At City and County, those factors most vehemently cited included administration, supervision, and working conditions (physical and psychological, although not generally focused upon the patients). A more remote but still significant source of discontent was the broader system of public psychiatric treatment and care.

Satisfaction, on the other hand, depends upon intrinsic factors (Herzberg 1966, Robertson 1980). These effect an individual's perception of the situation, coping skills, resilience, and ability to balance internal and external sources of stress with those of support. Most notable among sources of job satisfaction is a sense of achievement, of having made a difference to someone, usually a patient. Other sources of satisfaction involved interpersonal relationships, negotiation of the system, the challenges realized, and/or personal growth and development not directly related to work.

Rewards From Patients

Many nursing staffmembers associate their greatest satisfactions with their ability to relate to others, to empathize. One nurse describes this in the following way:

"People who are good at psych have a genuine gift. It is more than describing behavior or even knowing what to do about it. It is understanding how the patient feels."

The nurses describe relating to others, connecting with them, and forming trusting relationships as the most satisfying aspects of communication with patients. They fill their own needs to help and feel that their interventions with patients (who are positively



described as "diverse," "difficult," "exotic," "challenging," and "exciting") may be significant, even if only on a temporary basis. Some RNs stated that their work with City and County's patients has taught them to appreciate the "basics of life."

Positive feedback from patients is not a common experience, but it is meaningful when it does occur. The nurses are pleased when patients remember them upon readmission or when encountered elsewhere. Several mentioned notes and poems that they value as expressions of patients' gratitude and "connectedness" with them. More often, subtle changes in patients' conditions were cited as rewarding to the caretakers. These included behavioral changes such as decreased resistance to interaction with and intervention by the staff, increased reality orientation and rationality, being cleaner and "looking like they feel like persons again," and "just plain survival." The RNs' pride in themselves as practitioners and "good nurses" often hinged on these limited signs of change, despite awareness that responsibility for the change (or for lack of change) may or may not be associated with nursing intervention.

Rewards From the Job

Satisfaction that comes from the job may be equally as tenuous. Feelings of camaraderie, the occasional "positive stroke" from a co-worker, and other evidence of peer support, are valued but described as "occurring in minimal doses." The nurses say that especially rewarding are opportunities to share with others their unique experiences, however fatiguing, frustrating, and/or satisfying. A sense of teamwork when nurses have cooperated toward some objective



is considered rewarding. After Ten East's "unit beautification baked goods sale," for example, the staff felt gratified with their success. (The ultimate accomplishment was coaxing a psychiatrist into donating seven dollars to round off the total.) Real pride was taken in the subsequent physical improvements to the unit.

Although the nurses frequently claim to share few commonalities with their co-workers, the occasional need to rally around the "social rejects" for whom they care forms the basis of a notable sense of "groupness" or community. The similarity of their worldviews at least temporarily overshadows differences in backgrounds, ideology, and lifestyles. These times of conscious connectedness are considered rewarding by nearly all of the nurses.

"Keeping the unit running smoothly" is a source of satisfaction for many RNs. "Getting all the tasks done" and "picking up what others missed" were considered areas of accomplishment, but that most often cited was "getting along with the head nurse" and/or supervisor. Smooth interpersonal relations with medical and administrative personnel was another source of feelings of achievement, although successful efforts to change the opinions or behaviors of individuals in those statuses was even more rewarding. A CNS and a head nurse each reported especially satisfying experiences in which they had caused physicians or administrators to alter their approaches in dealing with the nursing staff. The fact that these two nurses recounted their two events to the researcher a total of seven times reflects not only the major significance that such coups represent, but the rarity of those triumphs.



One other aspect of unit business was noted to be a primary reward related to the job. Six nurses considered successful avoidance of meeting attendance to be among their most satisfying achievements.

Work is considered exciting, busy, and/or stimulating by about half of the psychiatric nurses at City and County. The environment is described as one which can stimulate flexibility, tolerance, and introspection (as well as various negative consequences). Several nurses compared their current jobs with previous, less satisfying endeavors. A few felt rewarded with the support of their charge or head nurses, and/or the administration. A few more found satisfaction in recognition of their intuitive abilities, their nursing skills, their being "bright and quick," and/or in making a positive difference in patient care or in how the unit functioned.

Some nurses feel that they are significantly learning and growing in their jobs in psychiatry at City and County. They tend to be those who have positive and supportive relationships with their immediate supervisors. The atmosphere of a teaching institution such as City and County was credited with being a source of satisfaction because of exposure to a challenging and diverse patient population, contact with nursing and therapy students (who some nurses consider more stimulating than the patients and staff), the stimulation of team meetings and other multidisciplinary events, regular one-to-one supervision sessions, opportunities to lead groups and to participate in group consultation sessions, and providing patient care that is "more than just custodial."

Contact with the therapy teams was depicted by several nurses as a

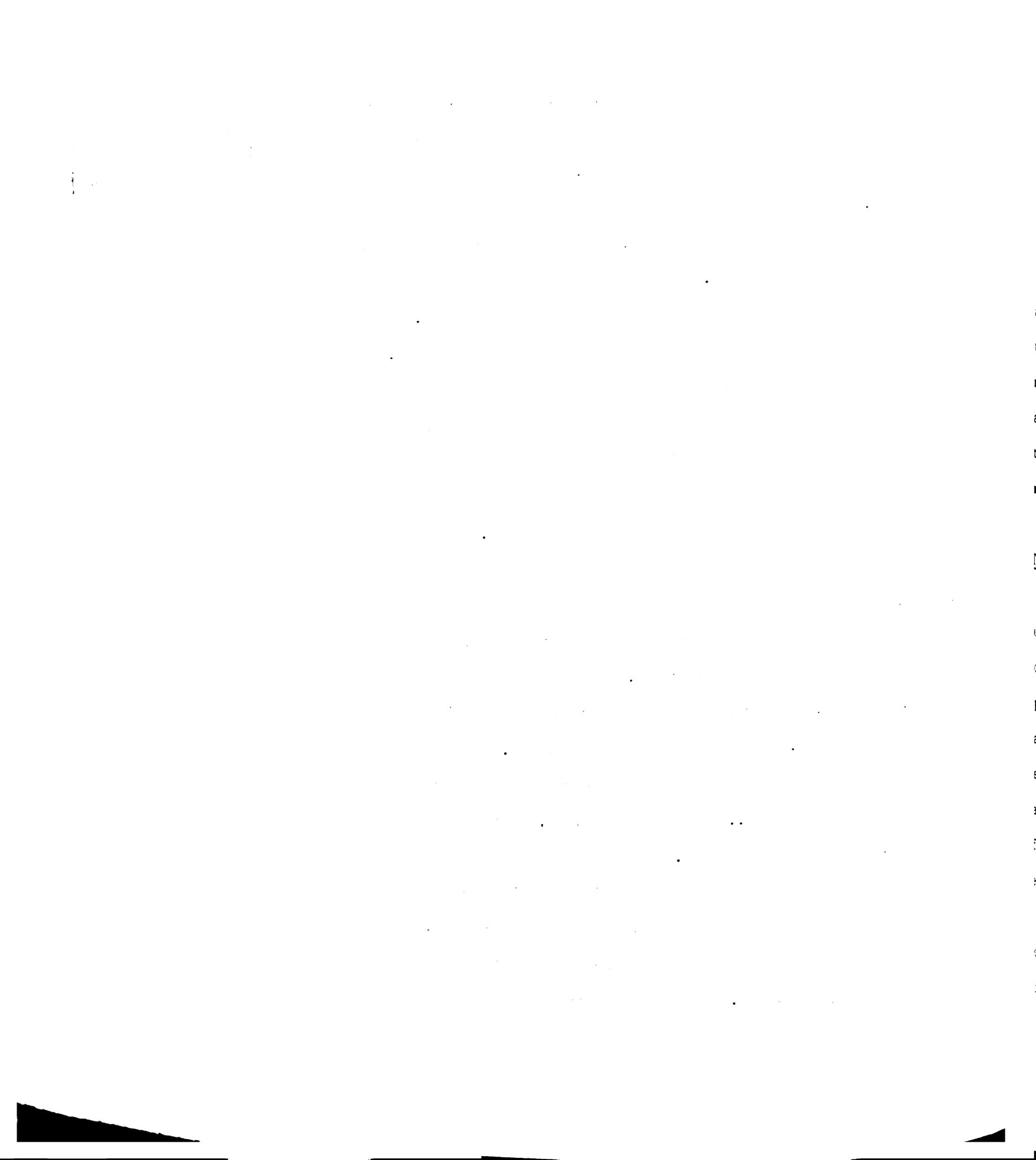


source of potential support and satisfaction, and, therefore, of hope. These RNs aspire to making significant patient care and treatment contributions that are recognized by the teams, although few examples were provided. (Several nurses described instances in which they felt they had influenced therapists' decisions, although, according to them, this was not always acknowledged.) Occasionally nurses receive positive feedback from the therapy teams for their nursing notes. Several nurses cited this as a significant reward for their efforts.

The three head nurses provided a consistent but different view of what was rewarding about psychiatric nursing at City and County. For them, seeing the unit improve over time, realizing moderate rates of staff turnover, and the rare opportunity to work with primary patients were the most substantially rewarding parts of their jobs.

Rewards From the System

The civil service system of which the nurses are a part, despite typically disgruntled attitudes toward it, was also cited as a source of reward. Foremost, and according to many nurses the system's only real positive attribute, is the income that it provides. The psychiatric nurses at City and County tend to complain less about money than RNs in many settings (eg., Moses and Roth 1979, Hallas 1980, Donovan 1980, Levine and Moses 1982). Nursing pays better than it has previously, although many staffmembers are quick to point out that they consider the pay commensurate with neither the role (for example, charge nurses are at times paid staff nurse salaries) nor the "stress and grief that the job entails." At least a third of the nurses working on Ten



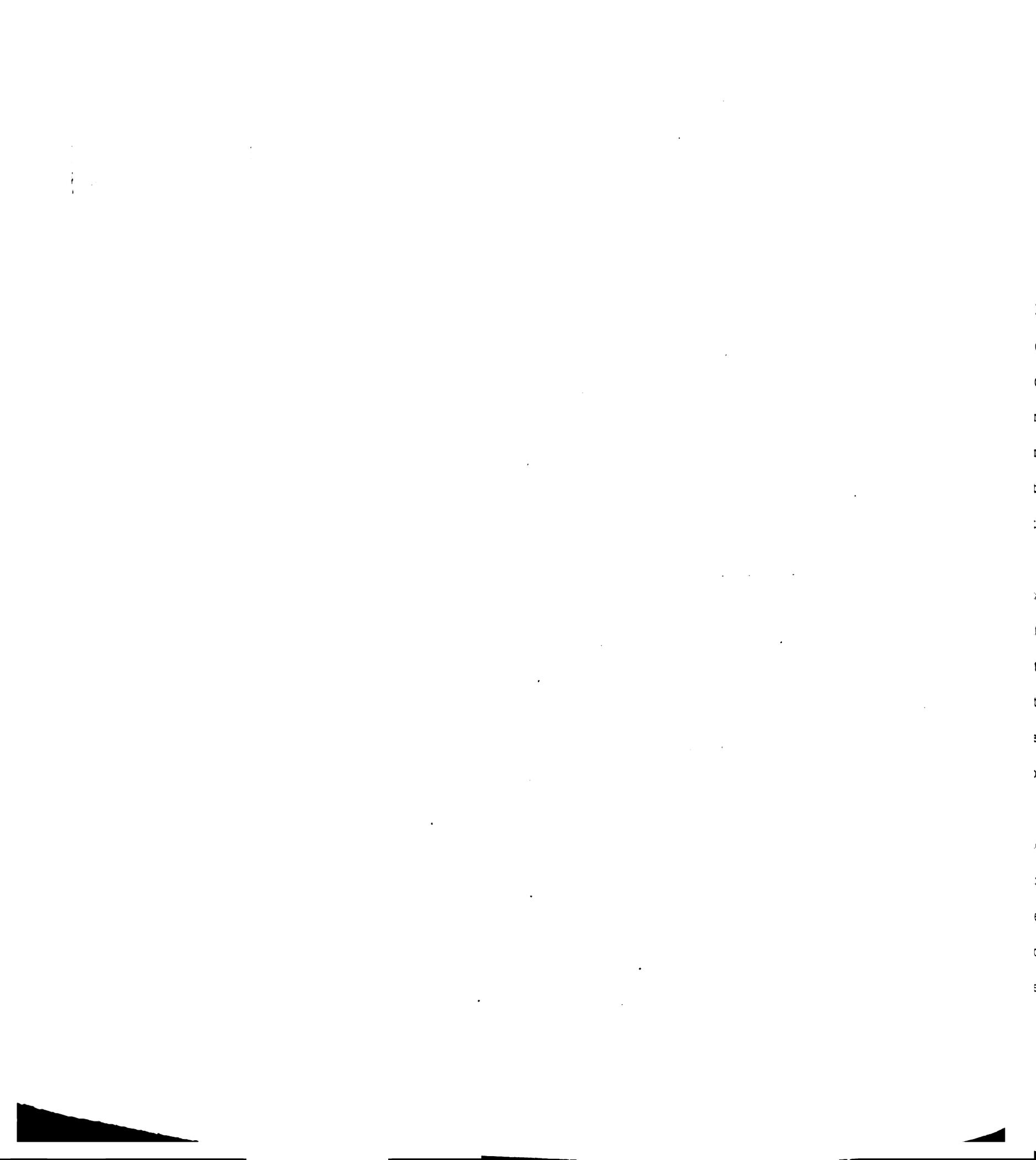
East, North, and West, however, consider their pay as the main incentive to get through the shifts. They acknowledge, nonetheless, that pay alone is inadequate compensation and/or motivation for long term occupational nursing.

Job security and benefits were each specified by two RNs as rewards that they consider important. Two others stated that they felt good about working where resources are limited and waste less profuse than they had experienced elsewhere. Several nurses pointed out that the major benefit of the system and a significant reward of the limited autonomy they experience within it is the freedom they feel to focus the bulk of their energies in non-work-related areas, which they find more satisfying.

The Personal Side of the Equation

The RNs at City and County are individuals whose occupations are only part of their lives. Like other people, they experience personal problems, as well as those involved with the public, occupational sphere. Many state that the stress-provoking nature of their jobs makes it difficult to maintain non-work relationships, although the network analyses described in Chapter 12 clearly indicate that the majority of the RNs' significant relationships lie in that area. A few of the nurses experience problematic interactions with close family members and/or others, but they are a small minority.

Psychiatric nursing is often described as unique because of its tendency to become "more than just a job." Some nurses feel trapped by this. "When process becomes a way of life," explained one, "you

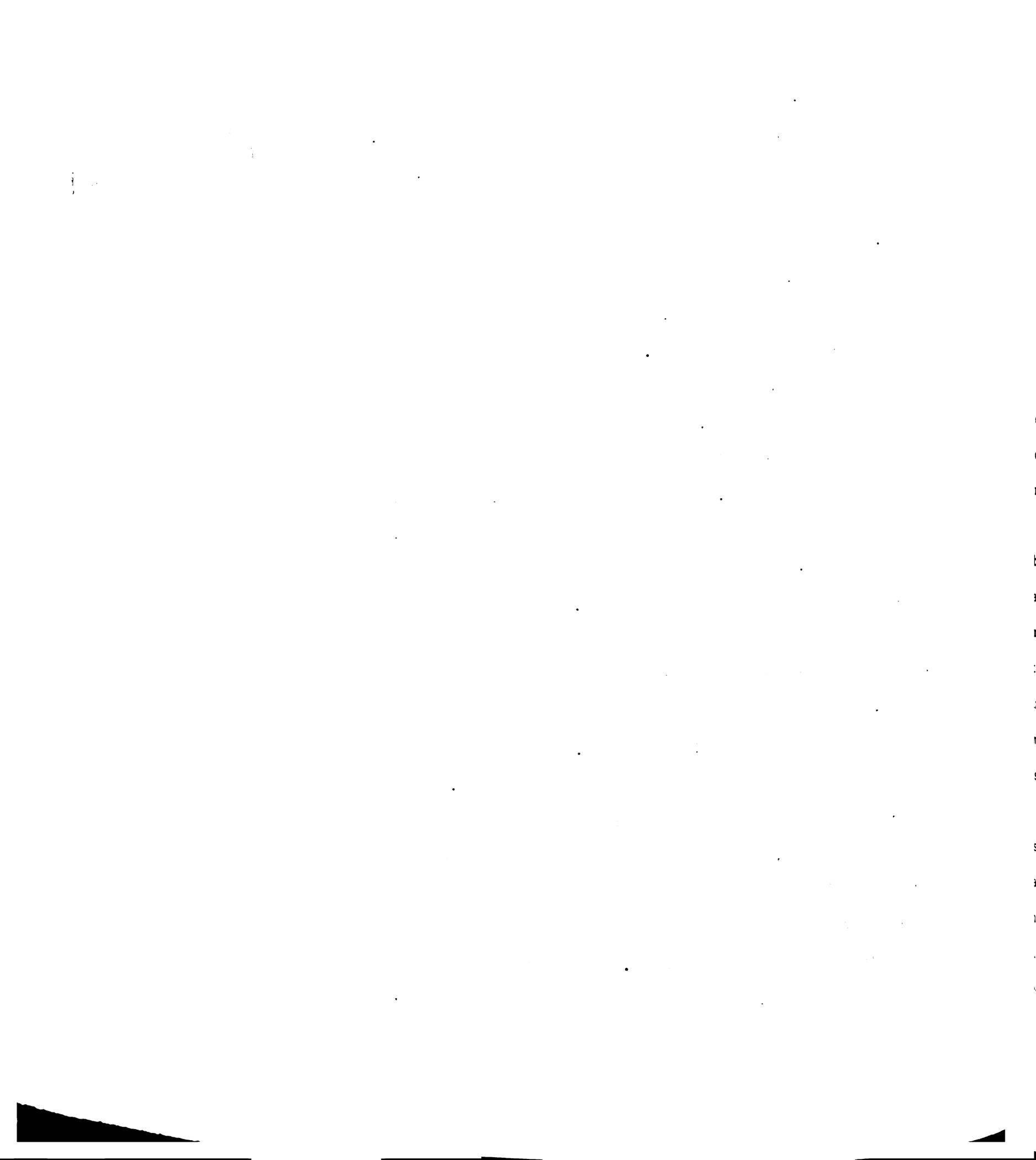


can't get away from it." Involvement with the job is described as crucial to staying in it, yet as increasing the strains related to it.

City and County psychiatric nurses complain often of fatigue, of needing more time off, and of receiving inadequate rewards for the efforts made. Their expressions of dissatisfaction with the situation are frequently physical. A considerable number of the nurses smoke heavily, are significantly overweight, ignore their appearances, or otherwise show evidence of self-neglect. A group of nursing students one day pointed out to me, during an informal discussion of psychiatric nursing roles on one of the units, that they observed psychiatric nurses to be "less healthy-looking" than "the other kinds of nurses" they had met at City and County. The students concluded, therefore, that psychiatry was a dangerous subfield with which to get involved.

Physical illnesses, many of them falling into the psychosomatic categories, were common among the nursing staff. Most staffmembers attributed their physical conditions to work-related incidents and/or stress. Some use their sick leave for "mental health days" as fast as it is accrued. It is noteworthy that the greatest amounts of sick leave were used by the lowest ranking personnel. Absenteeism attested to a need to resort to the sick role as a maintenance measure.

Nervous, task-oriented habits (such as repeatedly wiping the desk, picking up bits of debris, flipping aimlessly through charts or Kardexes, or mislaying and searching for things) were observed frequently. Other habits, such as nail-biting and gum chewing, increased in prominence during busy shifts. Some nurses described themselves as hypervigilant, constantly wary of everyone around them.

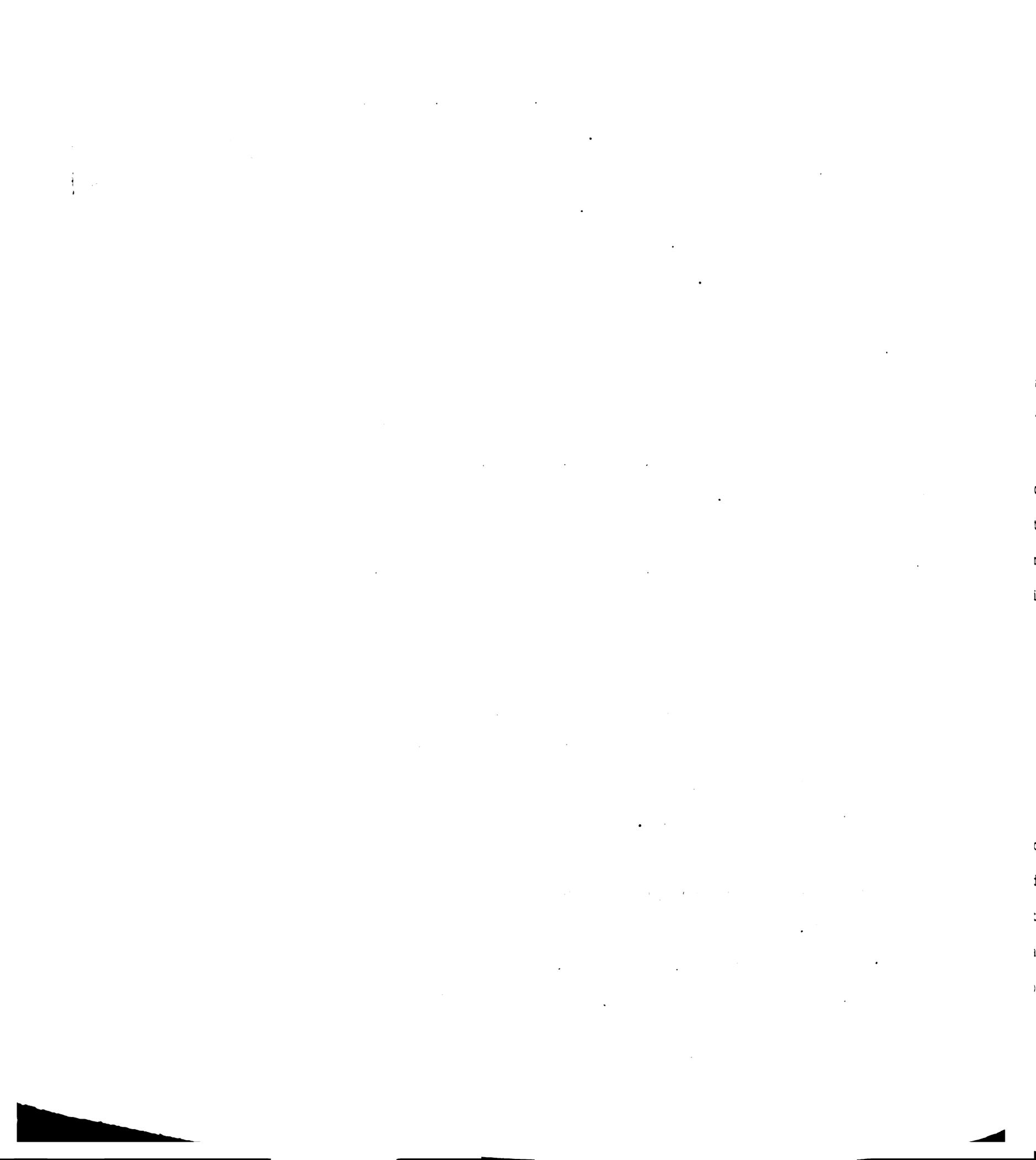


(At times this extended beyond the hospital setting.) Inertia, apathy, and feeling "run down" were common complaints.

Seldom, if ever, does one description serve to characterize all of the nurses observed on the three units studied. Again, this is the case with their health and self-care. Many nurses did take active responsibility for their own care. Often this was manifested by their having set limits on themselves and monitoring their occupational involvement. Some cited physical self-care activities focused on food preparation, diet, eating and/or fasting (9); the avoidance of caffeine, alcohol, and/or tobacco (3); swimming (3); working out (3); other physical exercise such as jogging, cycling, walking, horseback riding, and skiing; and resting.

Some nurses described "personal systems to safeguard against burnout." They created their own goals, sought knowledge and support, and channeled their needs in directions in which they were likely to be met. Most nurses depended upon their non-nursing activities to provide the psychological support that they needed to work in the acute in-patient setting. Nearly all said that diversion and compensation must be built into their lives if they are to maintain involvement with psychiatry and psychiatric nursing.

A popular retreat is into the future. Conceptualizing their jobs as temporary, more than half of City and County's psychiatric nurses have developed and maintain goals and plans for other, typically more independent, endeavors. For some this involves related work in other circumstances, in a private practice, for example, in another geographical area, or in another type of job. Several nurses hope to

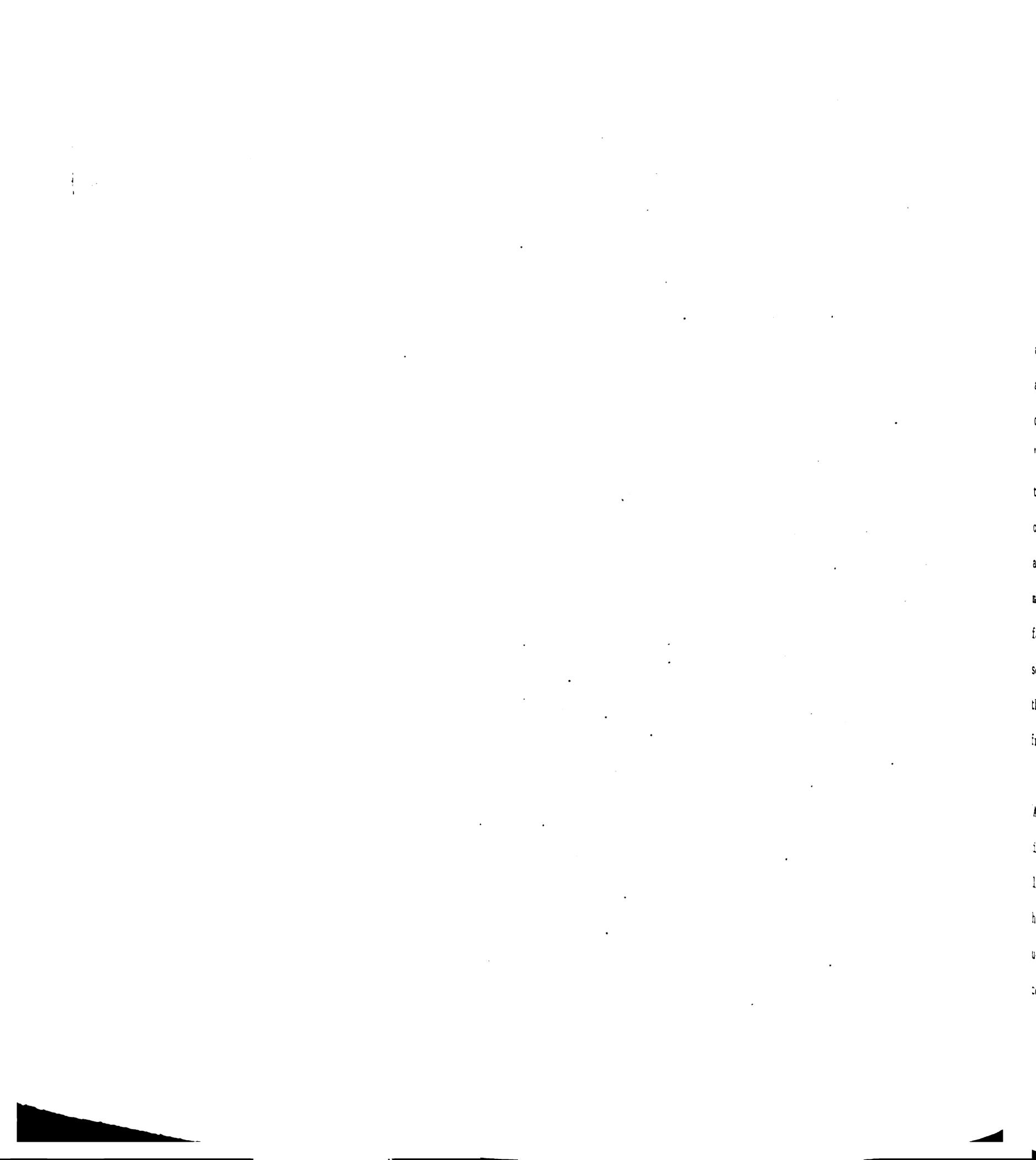


become therapists. Six others indicated goals of establishing health services careers as a school nurse counselor, a hospital administrator, a psychiatric consultant, a researcher, a nursing home owner and operator, and a half-way house director. Others are developing second career options in the fields of real estate or travel. One is studying ecology and the pest control business. Several seriously pursue the arts through drama, dance, or music. Four additional nurses indicated vague goals of having "lots of power and authority," "independence," or money (2). Two stated simply that they hope to "feel better" about their work.

Some of these nurses say that they realize they may never fully develop or use these second career options. The fact that they are there, however, provides support that helps them deal with what they now do. One nurse, a talented musician who "virtually never performs in public," stated

"I've studied music for years, a lot of years. That's a part of me that really feels good. My instructor has become one of the most meaningful people in my life. I've worked here at City and County for quite a few years too. I'm good at what I do here, like I am at my music. But here I have little recognition and less freedom. I don't even have to make music in public to know that I contribute something special. Those who hear me let me know, and I know. It's different at work."

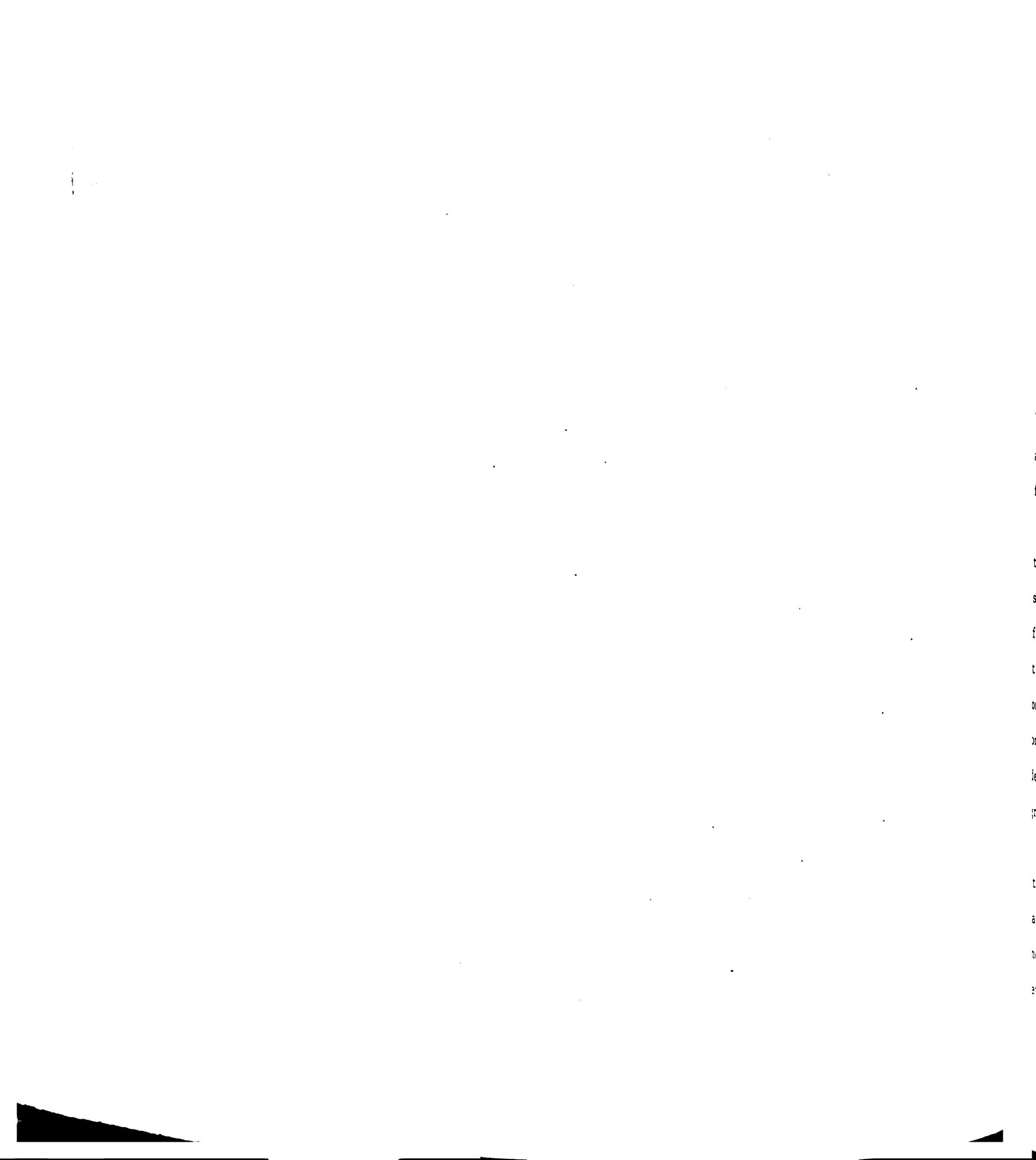
Education plays a significant role in the goals, plans, and activities of the nurses. Most of those involved with current educational programs hope for MSNs or PhDs. One hopes to combine the study of psychiatry with that of acupuncture. Schooling involves various motivations. Commonly it is seen as a positive action to take for oneself and one's future. Many RNs also value increased education



as an avenue to public recognition, accomplishment through work "that is easier than nursing is," an arena in which one can express oneself "on neutral ground," and an idealized source of feelings of "reprieve" from work and the work setting as they were being experienced. For some, increased education is also a source of further frustration because "with work, school is always fragmented."

One of the most often mentioned means of coping with work was the attempt to balance the job-related parts of one's life with the private aspects. Many of City and County's psychiatric nurses advocate the development of separate public and private lives. For a few, the "non-work" part of life involves nursing in other places. In addition to the part time nurses who practice psychiatric nursing in more than one setting, one nurse volunteers for a Hospice program and another as a nurse at a private school in her neighborhood. One RN runs mother-baby, midwifery, and parenting programs at a different health facility. More frequently, separating work from private life implies separation from or even avoidance of "people from work" while away from that setting, and participation in activities that provide distance from the occupational atmosphere.

Nurses tend to live relatively autonomous and independent lives (Acker 1973). For some, however, families provide goals and means for distractions from work. Although none of the staffnurses indicated plans to have families (some, of course, already have done so), half of the head nurses and clinical nurse specialists hoped to establish nuclear families with children. These individuals anticipate accompanying marriage and parenthood with jobs that are less



stress-provoking than they viewed their present roles.

Numerous other activities are utilized as ways to offset the stresses and strains associated with employment as a psychiatric nurse at City and County. Many nurses describe seeking "peace and quiet," most often through solitary activities such as reading, listening to music, taking long walks, meditation, sleeping, the study of art and/or music, spending time in a forest cabin, or pursuing a variety of one-person projects such as needlework or nature hiking.

Often the RNs' non-work activities involved significant others. "Spending time with people I care about," developing social networks, and going out with or telephoning friends were repeatedly mentioned frequent and favorite activities.

One nurse is a member of a choir, another of a religious cult. A third plays the organ at a church; still another teaches Sunday school. Other than two descriptions of having "grown out of" and "away from" religious upbringings, these activities were the only references to religious involvement at any time during the research project. No one cited a religious belief system as a source of support (although one nurse included a priest as a significant other). Each nurse described his or her involvement in terms of social interaction with a group of people with whom, for various reasons, he or she likes to be.

Five RNs are currently in elective therapy or counseling. Two others participate in support groups. One has taken a series of stress management courses; another does relaxation exercises. One takes what she called "all sorts of growth classes." Three others say that they set aside specific periods of time which are theirs alone to "regroup."



Although aspects of self care which they associate with their private lives, each nurse indicated that these activities were in part designed in response to his or her nursing role.

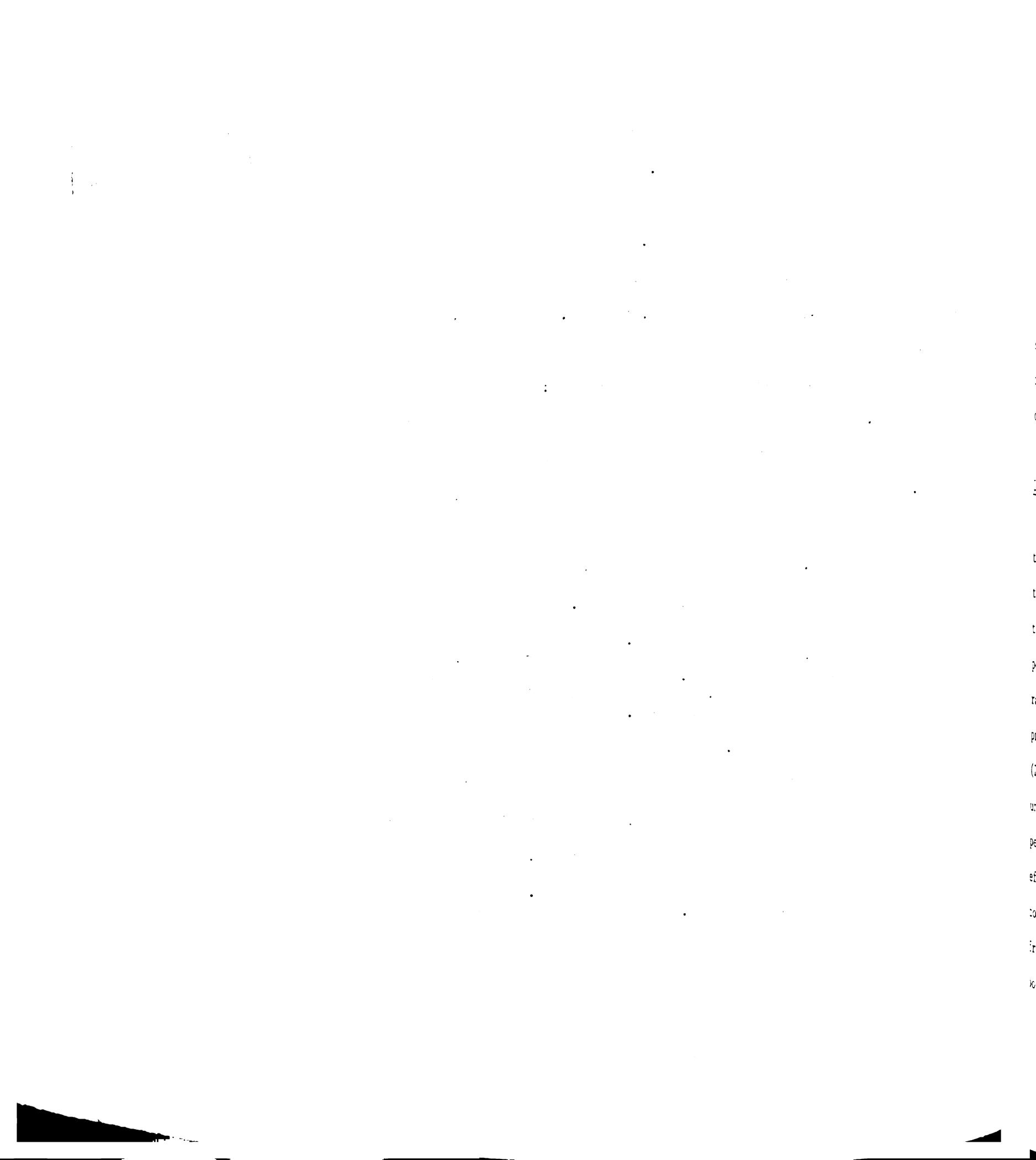
Numerous other activities were indicated as resources to use as "leverage against the onslaught at work." These included (in no particular order) music, painting, drama, and/or dance (Several RNs are accomplished artists.); attending opera, theater, symphonies, and movies; traveling; learning about and exploring the physical natural environment; spectator sports; watching television; keeping pets (usually cats, sometimes dogs); gardening; and making house repairs.

One of City and County's psychiatric nurses developed a business as a clown. I watched him one day quell several young patients, whose behavior threatened to erupt into violence, by teaching the energetic antagonists to juggle. In response to my acknowledgment of his effective handling of the situation, he replied,

"This is the good part of nursing, not being so different from the patients, letting them see part of the real you. You can't do this very often though. There's not enough space to do the work and enjoy it too. It seems to be written in stone somewhere that it should be either-or. It's like a juggling act, but one you never get too good at because the conditions change faster than you can."

A few months later this RN resigned from his position, as did several others during the research period. The nurse/clown decided to try another area of nursing and to go back to school.

"Here my sense of humor is an endangered species. The negs outweigh the (positive) strokes. I need to rebalance while I can."



CHAPTER 14

CONCLUSIONS

The preceding chapters detail the experience and context of psychiatric nursing at City and County. It is important to examine that data within a broader perspective. This chapter relates the situation at City and County to three directly relevant and interrelated aspects of society: America's systems of values, of occupational nursing, and of psychiatric/mental health care.

Dominant American Values

The members of every society learn its values and beliefs and tend to act, think, and feel in ways that are consistent with those cultural traits. Florence Kluckhohn (1963) astutely assessed focal values in the U.S.A. as mastery over nature, materialism, rationality, work, and personal achievement. This composite, rooted in eighteenth century rationalism and the Protestant ethic, presents oppositional propositions which are consistent with Western European cultural values (DuBois 1955). They are manifested in a tendency to conceive of the universe as mechanistic, and of mankind as both equitable and perfectible. Industriousness, thrift, power, individualism, efficiency, personal ambition, the accumulation of goods or money, competition, and an orientation toward status are characteristics frequently used to describe American society. Our "ideal culture" is both Christian and democratic, although many aspects of American

life are clearly neither. Variant values are both permitted and required, and the interplay of dominant and variant values is an outstanding feature of the society (Kluckholn 1963).

Allopathic medicine provides an apt example of human determination, and significant but partial success, at conquering rather than living with nature. Improved living conditions, supplemented through knowledge and medical resources, have contributed to longer and healthier lives for a greater proportion of the population. The relative success of the medical model has encouraged its wholesale acceptance. "Madness," once falling under the jurisdiction of religious or legal systems, like many other social phenomena, has been medicalized. Although psychiatric problems are less amenable to treatment and cure than are many physical conditions, a variety of approaches continue to pursue efficacy through professional medical intervention in human and social problems.

Americans and Science

The determination with which health is sought is not new to the U.S.A.'s ideological repertoire. The will to believe in the efficacy of science is deep in American culture. It derives from the utilitarian ethic and from beliefs in the intrinsic value of truth, in the merit of cognitive activity, and in the consequences of that activity. America's technological drive has been associated with cultural uncertainty since, despite a propensity for monolithic judgment and "truth," anything we think about may turn out to be inaccurate (Henry 1963).

Pragmatics characterize the U.S.'s approach to science, and perhaps life in general. In the late nineteenth and early twentieth centuries, science was elevated from a gentleman's advocacy to a vital part in the Industrial Revolution's striving for increased productivity and decreased labor costs. Pragmatic America dealt with the problem of transforming medical resources into effective instruments for improving the population's health by embracing modern medicine (Brown 1979).

Rationalization, the underlying process behind industrialization, stimulated the replacement of spontaneous and traditional methods of social organization with routinized and systematic procedures characterized by impersonality (Robertson 1980). Basic components in the development of U.S. technological genius are the view of the human being as a working machine and the attitude that there is more security to be found in dominating materials than in dealing with people, as well as that security is desirable (Gorer 1948). These features persist in science and in medicine, including psychiatry. Although psychiatry, when compared with many aspects of medicine, is relatively independent of technology, it is heavily dependent upon the use of psychoactive chemicals and is ambivalent in its acknowledgment that mental health cannot be mass produced.

The American Culture of Work

Jobs, like other social statuses and roles, are evaluated according to the meanings learned as representative of a specific culture. The nature of work was redefined by Protestant thinkers, such as Luther and Calvin, who accepted the Biblical Old Testament view that toil is

divinely imposed, a form of service to God, and a moral obligation upon which rests one's salvation (Weber 1904). According to Weber (1904), such Puritan ideas underwrote the transformation to modern, industrialized society. In any event, with the Protestant ethic, work, more a duty than a grim necessity, became potentially dignified and purifying (Robertson 1980).

Today the historical virtues of "a good, hard day's work" remain more than a means of achieving material ends. Labels of immorality are attached to laziness and of irresponsibility to lack of productive employment. The contemporary view is modified, however, and the work ethic is compromised, if not declining, in some contexts. Individuals as workers still respect self-denial and discipline as intrinsic to employment, but the same individuals as consumers, expecting work to be a beneficial experience, also demand gratification and pleasure (Robertson 1980).

In affluent societies, self esteem and self actualization are psychological expectations of employment (Robertson 1980). Although workers today remain committed to doing their jobs well, they look for rewards that typically include those characteristics, such as autonomy, which are associated with professions (Roznak 1978, Ellis 1980).

Bringing order and meaning, work is central to the lives of most adults and a significant contributor of social identity and self esteem (Roznak 1978). Social identities are those aspects of the self which determine how one's rights and duties are distributed relative to specific others (Goodenough 1965). There are strong links between occupational status and perceptions of personal worth (Robertson

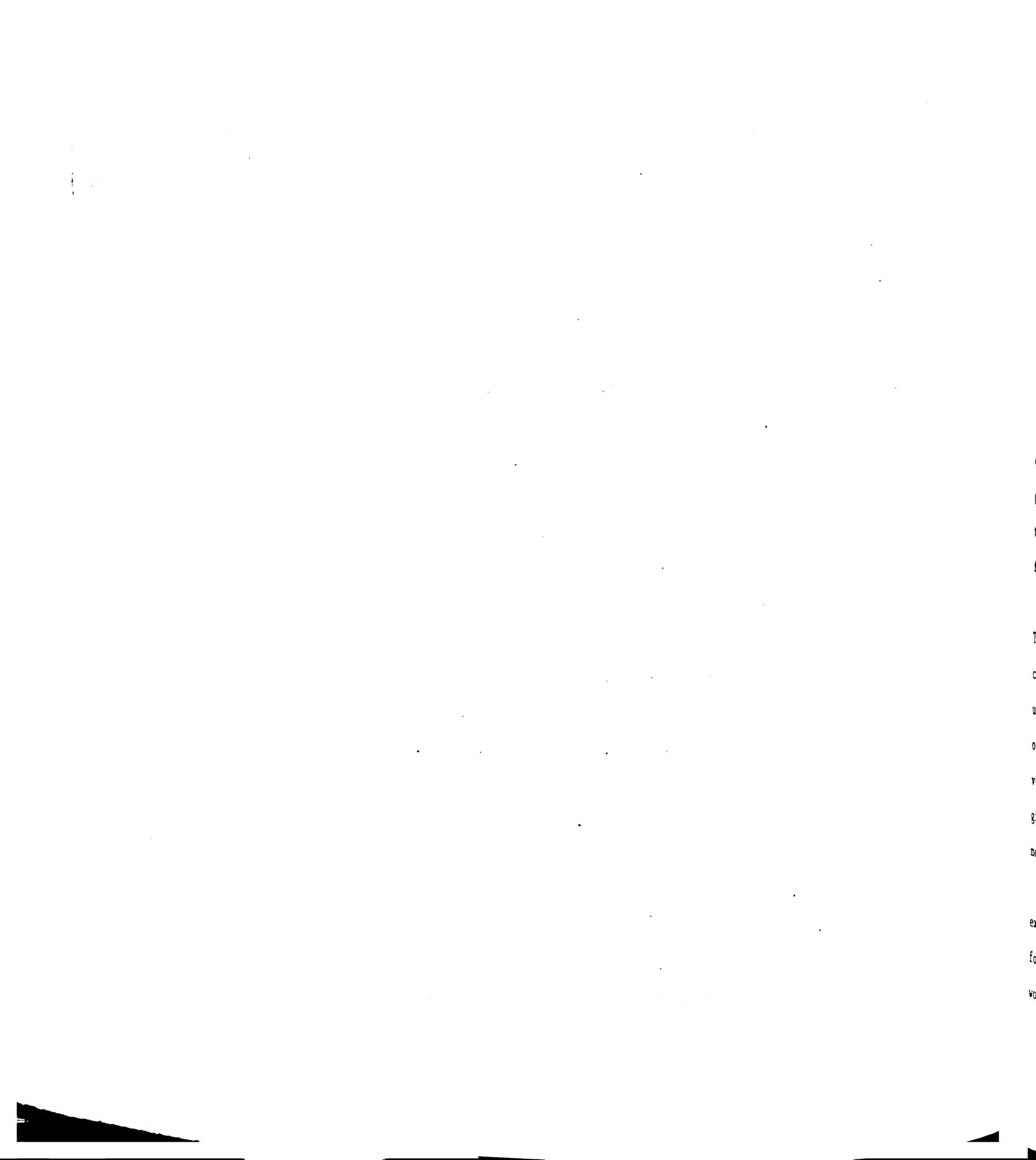
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1980). Practitioners of a given occupation tend to value themselves and their work as larger society values both these and the goods or services that they produce (Liebow 1967).

The occupational realm is increasingly differentiated, complex, and sophisticated. Despite a thirst for job-related personal pleasure and satisfaction, a "pecuniary philosophy" (Henry 1963), an institutionalized preoccupation with technology, and conflicting values and norms contribute to potentially tense and ungratifying work situations. Many Americans are alienated from their work, which comes to be seen as dehumanizing. Heightened and rigid expectations of productivity increase stress and strain for the worker. Occupational diversity and task specialization by and within disciplines utilize only parts of an individual's talents and potential. Intellectual and manual aspects of work tend to be segregated. Individuals often experience little control over their immediate environments, although autonomy is a well known factor in job satisfaction (Roznak 1978, Perry 1978, Robertson 1980, Lewin and Olesen 1980).

The result is that the activity of work becomes enforced, rather than creative and fulfilling (Robertson 1980, Ritzer et al. 1982). The meaning of work then becomes mere employment, rather than a source of pride and an object of commitment (Roznak 1978). This condition, closely akin to the contemporary phenomenon of burnout but labelled alienation by Karl Marx, is experienced as powerlessness due to the domination of others, meaninglessness because of a lack of apparent significance and recognition of a role, isolation resulting from a lack of feeling of belonging and identification with the work setting, and



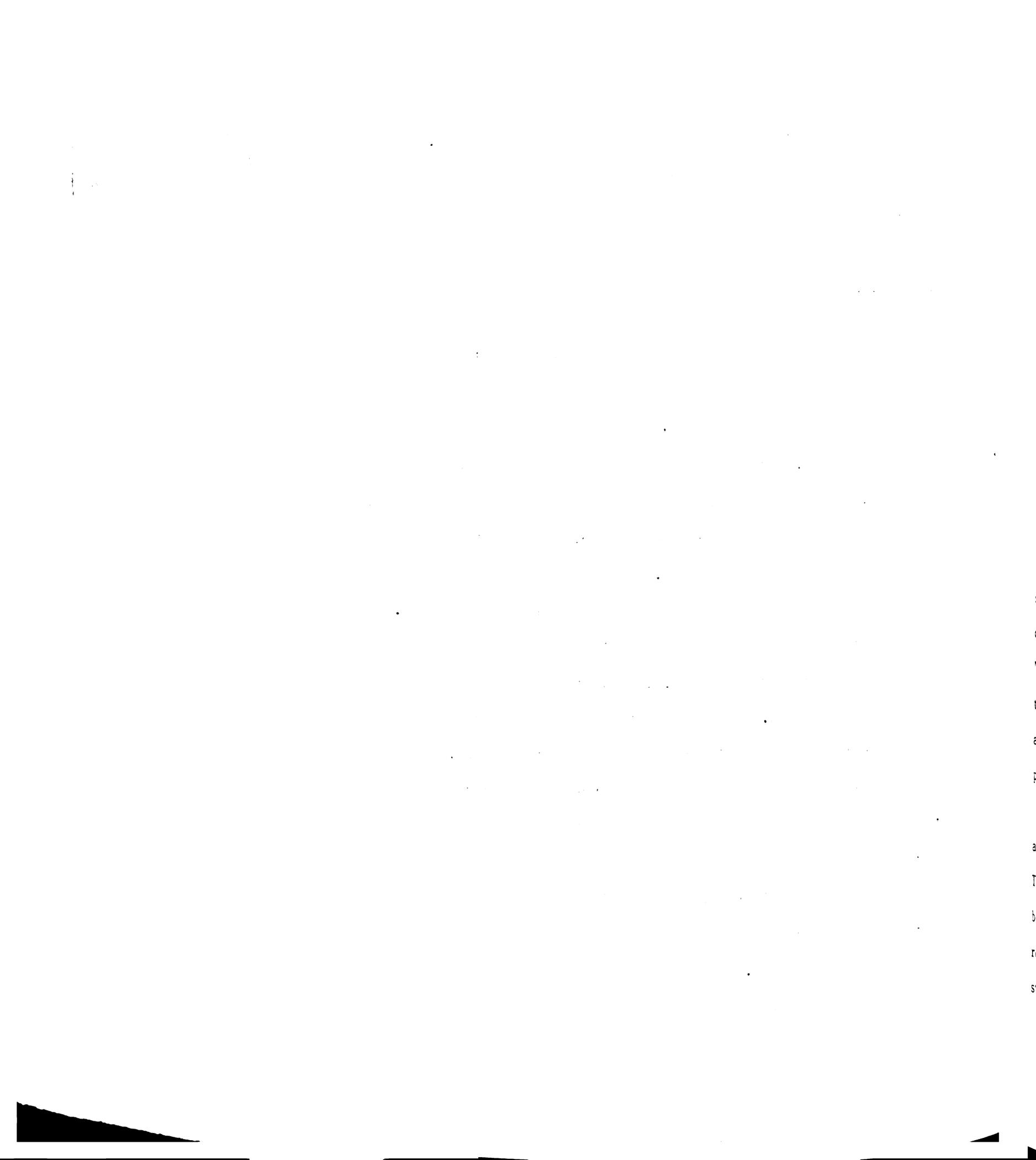
self-estrangement consequent to being uninvolved with a job which does not allow unique abilities to be expressed (Ritzer et al. 1982). One's significance in society may seem to be questioned or threatened with dismissal.

Nurses As Workers

Much of the discussion in this and earlier chapters deals with problems in and disillusionment and dissatisfaction with City and County's psychiatric units as a workplace and as a setting for the practice of nursing. Occupational adaptation is a matter of pitting costs against benefits, stresses and strains against satisfactions and gratifications. In the long run, many of City and County's nurses say, their work is associated with a deficit balance, which is to be made up for through non-work-related resources.

Nurses are vulnerable from all sides (Kalisch and Kalisch 1976). They are held accountable for ward management and behavior that is caring and therapeutic (Strauss et al. 1981), even when they are unrecognized as therapists. They are criticized if they are overinvolved or underinvolved with their work and/or patients, and are vulnerable to innumerable counts against delivery of the care they give, despite that being a product few dare to try to define or measure.

Nurses often express limited confidence in themselves. For example, some with associate degrees or diplomas downgrade themselves for their limited educations, as if this were a measure of personal worth. During interviews, many of City and County's psychiatric nurses



volunteered explanations of why they had gone to nursing schools rather than more highly valued medical school. A few tried desperately to make favorable impressions with accounts of accomplishments in their non-work lives. Many were open about their feelings of inadequacy; repeatedly implied was that being "just a nurse" does not amount to much. Their generally constrained self and occupational evaluations are often repeated in society at large.

Other individuals, in contrast, maintain positive self-images of themselves and their work, even if it is based in part on deceptive assumptions, for example, that a lack of criticism from superiors implies approval and, therefore, constitutes positive feedback. Many take pride in their intuitive abilities (the development of which traditional nursing encouraged), sensitivity to patients' needs and situations, and success in establishing positive relationships. Some state that their values, when compared with those disciplines which dictate nursing, and with those of a society enamored with science, are "different but worthy." A common response by the nurses is to consider their limits upon the system's control over them to be a major accomplishment. It is a way of denying what seems to them to be prostitution of their work.

Many RNs are caught in indecision about whether self development is a greater or lesser achievement than self sacrifice (Gilligan 1982, Tavris and Wade 1984). They were socialized to be self sacrificing, but self development is increasingly culturally valued, socially rewarded, and viewed as necessary. Some nurses described their struggles to feel good about their work. They know they are

specialists who work with challenging, stimulating, and difficult patients, but they sometimes can only weakly reassure themselves that their part in this effort is important. Further complicating matters, the RNs' willingness to give deference to others in the administrator-nurse, physician-nurse, and nurse-patient hierarchies at times conflicts with their own needs for self respect (Goffman 1961, 1963).

The management of nurses traditionally reflects limited knowledge and understanding, and generalized exploitation by the medical and hospital industries, which, for example, have resisted university education of nurses in part because educated nurses tend to challenge and question rather than to be awed by status and authority (Weisensee 1979). Arbitrary assignments, limited managerial resources and practices, and role diffusion and conflict perpetuate the underutilization of professional nurses. Technical nurses, prepared in different ways for different roles, are frequently expected to function interchangeably with other RNs. On the psychiatric units at City and County, it is difficult to discern what an RN does that an LPT does not. It is often impossible to differentiate roles of staffnurses who are ADNs and diploma graduates from those who are BSNs and MSNs.

Nurses are not institutionally protected the way that physicians and other therapists are (Strauss et al. 1981). They have less knowledge, but are expected to be caring, technically competent, and "therapeutic." They are subordinate to most positions of power and authority in a hospital, but spend much more time on the units and with patients than do those with more power and authority. In the

workplace, the nurses at City and County are openly accessible with little or no opportunity for retreat to private offices or other sanctuaries. Least mobile among the psychiatric personnel, they may be the most vulnerable to stagnation, especially when educational stimuli are limited.

Nurses are typified as people who want to help others, and who are conscious of what others think of them and fearful of making mistakes. They are compliant, due to a desire to be safe and correct (Menikheim 1979), and politically naive and unable to reject medicine's paternalism and control (Lovell 1980, Bagwell 1980). Stereotypically, they tend toward passivity (Weisensee 1979). Today's nurse is told, nonetheless, that proper performance of his or her role is as an assertive, autonomous, and responsible individual. Meanwhile, authority/subordinate relationships between medical/hospital hierarchies and nurses, and between men and women, reinforce traditional attitudes and roles. From that perspective, "handmaidenhood" is still encouraged; assessing and making decisions remains equated with troublemaking "resistance."

Women and Work

Closely related to the impact of societal views of nursing are those of women (Glass and Brand 1979). Like all industrialized nations, the U.S.A. is class stratified. Status, wealth, and power are unequally distributed. Until recent judicial changes, the general approach to women was that their rights and responsibilities, opportunities and obligations were essentially determined by their

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positions in families as wives and mothers (Freeman 1984). Prior to the 1960s, women's roles in American society were delineated by a "feminine mystique" which, celebrating the experience of domesticity, enforced dependence and service production (Margolis 1984). The male complement of society, meanwhile, dealt with the public domain, individuality, successful accomplishment, and opportunities for social mobility (Hoffnung 1984).

The situation is changing. Women now have more economic equality, although most have not changed significantly in status, income, or opportunity (Tavris and Wade 1984). Most women are socialized to achieve, but that socialization is ambivalent and contradictory, as they tend still to learn to be concerned with the needs and wishes of others (Weitzman 1984). So women are particularly prone to conflict between other-directed and subordinate giving versus self-directed achievement of rewards as individuals in the working world (Tavris and Wade 1984).

A high degree of occupational segregation persists; most employed women in the U.S.A. work in twenty of the census bureau's 440 occupational categories (Blau 1984, Tavris and Wade 1984). And women predominate in those occupations, such as nursing, which typically are low paid and non-prestigious (Robertson 1980, Moore and Marsis 1983, Kaufman 1984, Margolis 1984), and which offer only limited social mobility (Blau 1984, Margolis 1984). Yet the majority of women do not consider job discrimination to be an important issue. Only when the state has intervened has employment policy made significant progress in narrowing the gap between women's work and men's work (Moore and Marsis

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1983).

More than half of American women are in the workforce today, but they tend to be committed more to work than to specific jobs (Glenn and Feldberg 1984) and to have series of jobs rather than intact careers (Tavris and Wade 1984). Many have limited worker consciousness, so they do not see their positions as long-term (Glenn and Feldberg 1984). As long as women experience limited opportunities for career and self development, it is realistic that they not put their total energies into occupational goals (Weitzman 1984).

For many women, achievements are simply channeled into different directions, due to limited structural opportunities and positions in which performance and capabilities remain unrecognized, or the experience of frustrating jobs below their abilities (Weitzman 1984). In the case of nursing, a field of notoriously limited socioeconomic mobility, the laterality of careers may provide some rewards of intensification (Lewin and Olesen 1980).

Nurses and Work

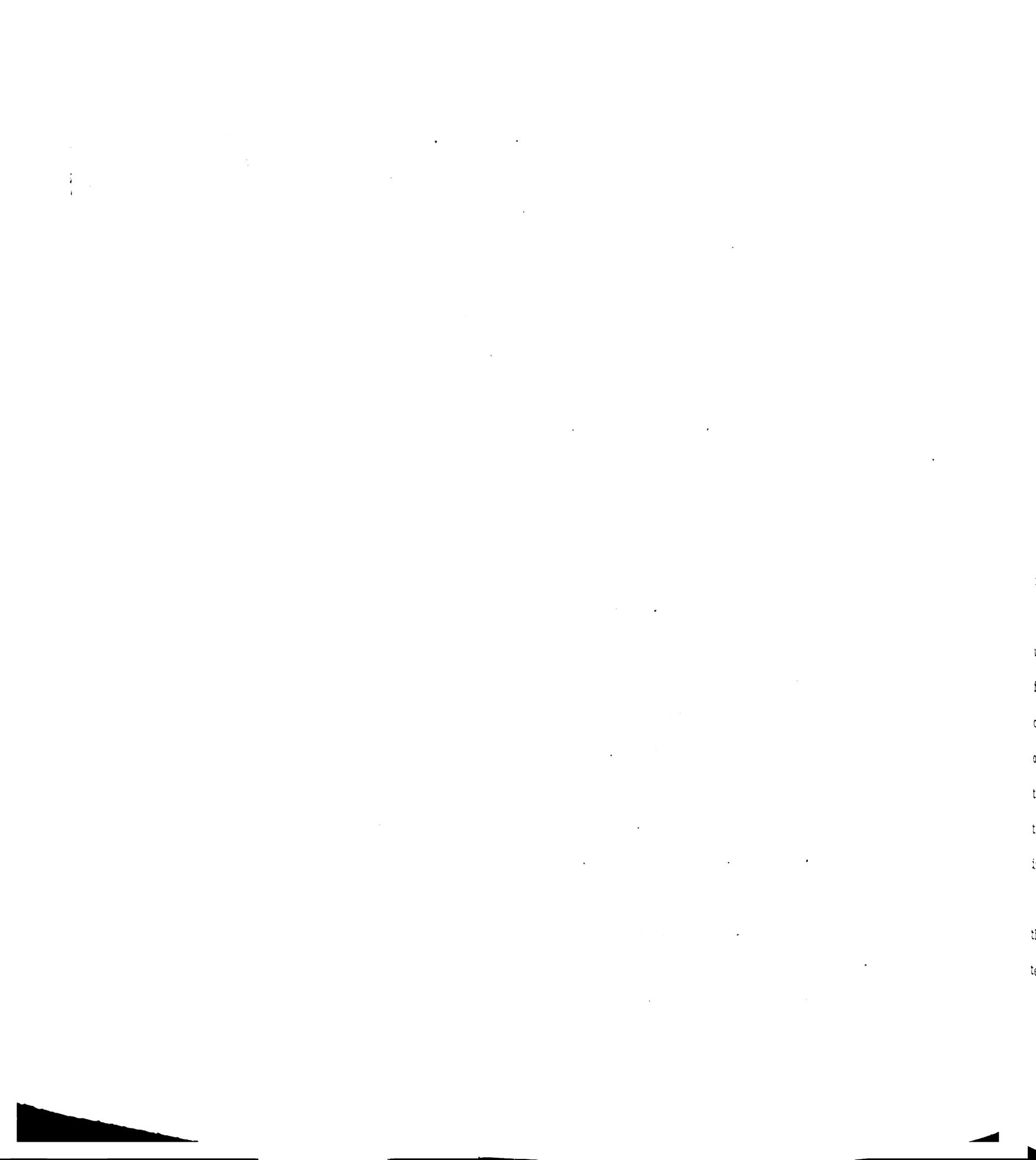
A sense of powerlessness experienced by many nurses is associated with gender identity formation, personal experience, and social norms and values regarding their work (Greenwood-Audant 1984). Prior to the Great Depression, most nurses worked as private and independent entrepreneurs (Wagner 1980). They were unregimented and unaffected by rigid divisions of labor and the intense supervision characteristic of modern hospitals. Now most nurses are in positions in which their work does not belong to them and accountability may not reflect their

own standards. They remain dependent upon and entrenched in hospital and medical systems which determine what they do, when, and how.

Although expanded roles for women may imply power and/or control, that often is not accompanied by adequate authority to confidently fulfill the role (Sanday 1983). Nursing provides a prime example of that phenomenon. Due to cultural definitions of sex-appropriate behavior, even when occupational groups composed predominately of women, as nursing is, do gain authority and/or power, their activities tend to be regarded as less important than those of dominant male groups (Rosaldo and Lamphere 1974, Weitzman 1984, Tavris and Wade 1984).

Ultimately the challenge of nursing involves balancing structural requirements (which may conflict) and operationalizing knowledge of care and therapy (which may be ambiguous), while dealing with patients who communicate abnormally (Bunch 1983). To this picture is added a mandate to achieve specific complex goals within highly constrained circumstances involving, despite many amenities, bureaucratic impositions, a surrealistic atmosphere due to both the patients and the system, and little authority and recognition.

There is a generalized societal lack of respect for nursing and negativity toward mental health employees. Nursing is seen, many feel, as "a quasi-profession, at best." Historically, nursing has epitomized a low-status female occupation and has been stereotyped as non-cognitive (Weisensee 1979). Contemporary assessments have only begun to change. One psychiatric nurse at City and County summarized her view of the dilemma she experiences this way:



"It's hard to value yourself as a woman when society puts you down as 'not a man.' It's harder to value yourself as a working woman when most of society still tells you that you are depriving your children of mothering (My husband is gone more than I am; is he depriving them of fathering?). And it's damn hard to value yourself as a nurse when nurses are stereotyped and treated (ever see the nurses in the soaps and movies?) as a gaggle of ignorant low-lifes."

Nursing and nurses, considered by the media to be the least powerful of the psychiatric/mental health service providers, have limited credibility among members of non-nursing disciplines (Finch 1986). It is probable that instituting numerous practices for blunting discontent in the workplace (for example, flextime scheduling, job sharing, more breaks and time off, greater variety of assignments, more participation in decision making, and better benefits and pay (Roznak 1978)) could not compensate for the public devaluation of nursing as a female occupation and psychiatric nurses as caretakers of socially rejected mental patients.

Nurses, however, often do not see their employment situations as unfair. They, like occupants of most statuses which are stereotyped as female, are therefore unlikely to organize in opposition to authority or to challenge the situation (Glenn and Feldberg 1984). Like members of most oppressed groups, highly individuated nurses tend to blame themselves for their conditions and learn to cope in various ways with the contradictions inherent in paid altruism, compromised personal independence, and the relationship between the individual and society.

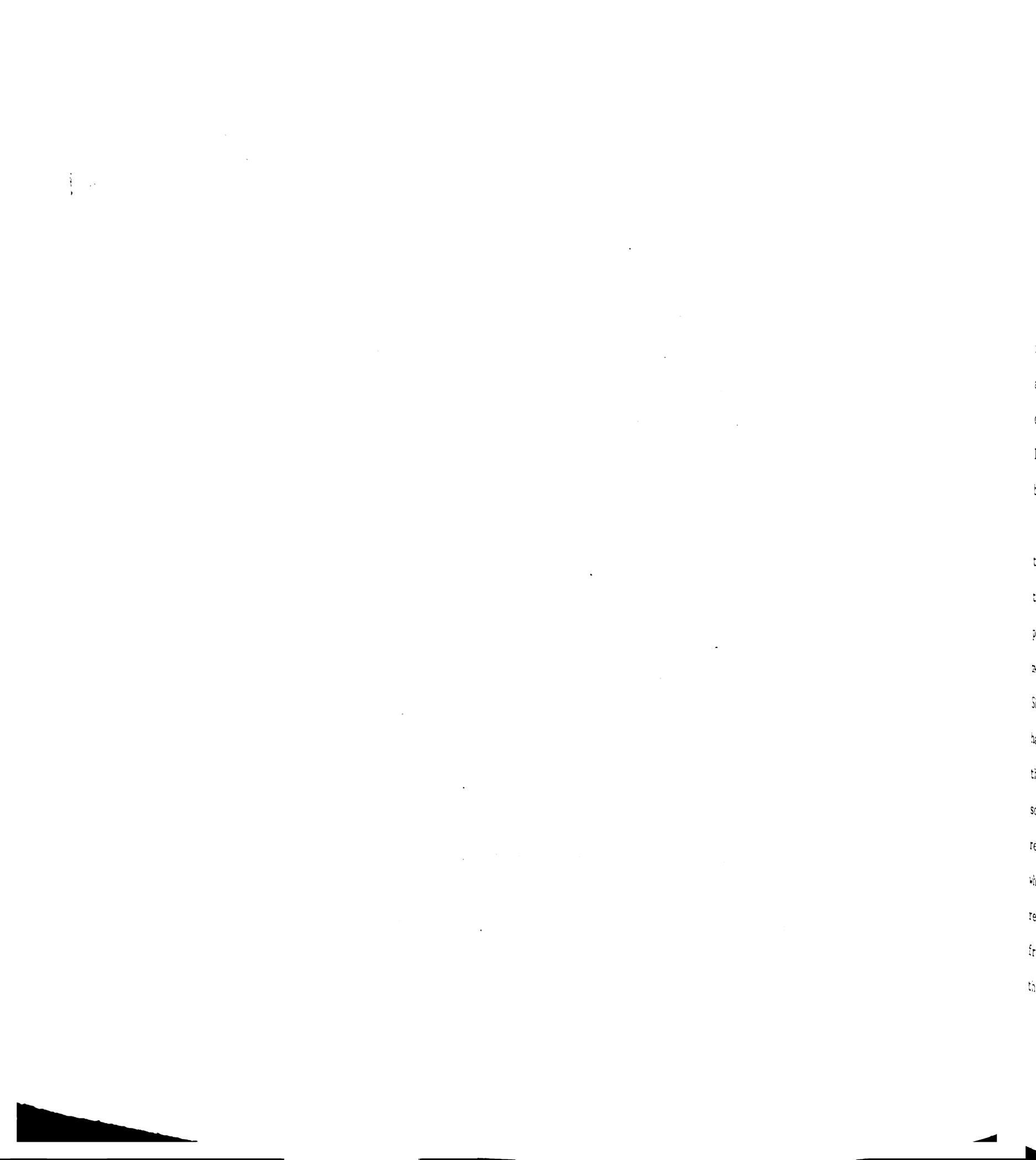
Women and nurses have not generally learned to value or to care for themselves (Bush and Kjervik 1979). They learn to care for others, and tend not to nurture their own self images. Self concepts are further

stressed by incongruent expectations to perform professionally and autonomously while associating femininity with passivity (Bush and Kjervik 1979).

Large-scale social transformations in the past two centuries have altered community ties and social networks. Work provides opportunities to form and maintain social connections; for women it also allows development of identities separate from those attached to family roles (Glenn and Feldberg 1984). Although the majority of psychiatric nurses at City and County do not consider themselves notably constrained by family responsibilities, nursing as a discipline demonstrates characteristics associated with roles which are expected to remain flexible enough to care for others' needs.

Personal communities have been examined in recent years as important indicators of social support systems. Most ties are not with close friends or significant others, but in daily interpersonal relationships (Granovetter 1982). Women more often than men are found in jobs where they do not share the social backgrounds of their peers (Lorber 1984). Coming from a variety of socioeconomic, educational, subcultural, and experiential backgrounds, they often lack a sense of shared, common identity as workers (Glenn and Feldberg 1984). Those traits were replicated at City and County where, of more than four hundred dyadic relationships cited by the psychiatric nurses, one fourth of ties were composed of RNs, but only seven involved meaningful and positive emotional links with coworkers, and, of those, none were mutual.

"Weak ties" are considered vital for individual integration into



modern society. They provide a cultural context in which norms and values are maintained and recreated as large numbers of individuals, most of them having no long-term ties with one another, share and sustain understandings and meanings. These connections are also a potential medium for social support, although denser networks of more significant relationships are associated with greater support. The importance of formal and informal social support has been recognized for a long time (for example, Jones attempted to bring it to nursing's attention in 1962), but only now are serious efforts being made in the discipline to foster networks as a means to strengthen nursing leadership (Bagwell 1980) and to decrease the impact of medical and bureaucratic delegation.

Awareness of the importance of sharing personal experiences related to work, and of fostering relationships with coworkers, is a step toward occupational cohesion. For most of City and County's psychiatric nurses, however, relationships which were seen as meaningful and supportive occurred outside of the context of work. Sharing little sense of common history or of common destiny, the nurses have looked elsewhere for the relationships they needed. But only a third of the psychiatric nurses expressed satisfaction with their social networks, and those who sought changes generally did so in the relationships they have with their superiors and/or in connections which are both personal and work-related. The desire to make work relationships more meaningful is apparent. Perceiving little support from others within the present work context, the nurses who practice on the psychiatric units at City and County have a hard time reassuring

themselves that their roles are important and that they perform them well.

Psychiatric Nursing: Learning To Juggle

Strongly characteristic of American culture and society is social ambivalence toward negatively different individuals. One expression of that is the asymmetry and differential access to power and resources which occur in relationships between staffmembers and patients (Estroff 1982). Psychiatric deinstitutionalization was defended as a mechanism for avoiding loss of personal freedom and assuring placement in less restrictive settings (Clark 1979), yet stigmatization of the mentally ill continues to demoralize, isolate, dehumanize, and curtail the development of support systems. Because of the limited values placed by larger society on both nursing and the mentally ill, for psychiatric nursing to represent a highly valued occupation poses a massive challenge.

In our society, nurses, not being exceptions to basic human needs, often experience limited senses of self and of self-value, of control and authority over themselves, and of the ability to communicate their needs and desires to others (Kjervik 1979). Despite their familiarity with mental health ideology, and in many cases with the need for development of these constructs in their own lives, many psychiatric nurses at City and County indicated conflict between their occupation and their self-actualization. Most have discovered ways to develop themselves away from the work setting, although that does not change the fact that so many consider psychiatric nursing at City and County

to be an inhibitor of individual growth.

Nursing's image and roles are primary, interrelated concerns within the discipline today. A major obstacle to changing either, however, is that many nurses may not want or are not ready for more professional statuses and roles, due to incongruences between those and familiar and traditional nursing norms (Cohen 1981).

The socialization process leading to licensure for nursing practice does little to prepare the aspirant for the subtler realities of nursing roles. The focus during training is on behaviors associated with caring and therapeutic intervention. Baccalaureate programs present these within a framework of related background theories and therapeutic models, which, in a setting such as City and County's, nurses can only marginally operationalize.

Nursing texts, in a concerted effort to become less focused on mechanical tasks and skills, have become increasingly oriented toward the patient. A perusal of psychiatric nursing textbooks printed during the past thirty years (for example, Kalkman 1958, Steele and Manfreda 1959, Hofling and Leininger 1960, Burd and Marshall 1963, Neal et al. 1981, Clunn and Payne 1982, Wilson and Kneisl 1983, and Beck et al. 1984) verifies this trend. Dozens of chapters outline problems that patients experience, the process of identifying and assessing patient needs, and the provision of appropriate care. Despite attentiveness to the effects of hospitalization on the patient (for example, Neal et al. 1981), little mention is made of the stresses imposed upon nurses in that environment.

The popular emphasis on the integration of psychosocial principles

in the nursing process generally sidesteps the application of this knowledge to nurses themselves. Some texts provide insight into nurses' reactions to the behaviors of psychiatric patients. One, now a classic in the field, goes so far as to state that the

"... most difficult problem in psychiatric nursing, the nurse discovers to her surprise, is not the care of the psychiatric patient per se, but her own reactions to psychiatric patients and psychiatric situations" (Kalkman 1958: 262).

A popular modern text states that

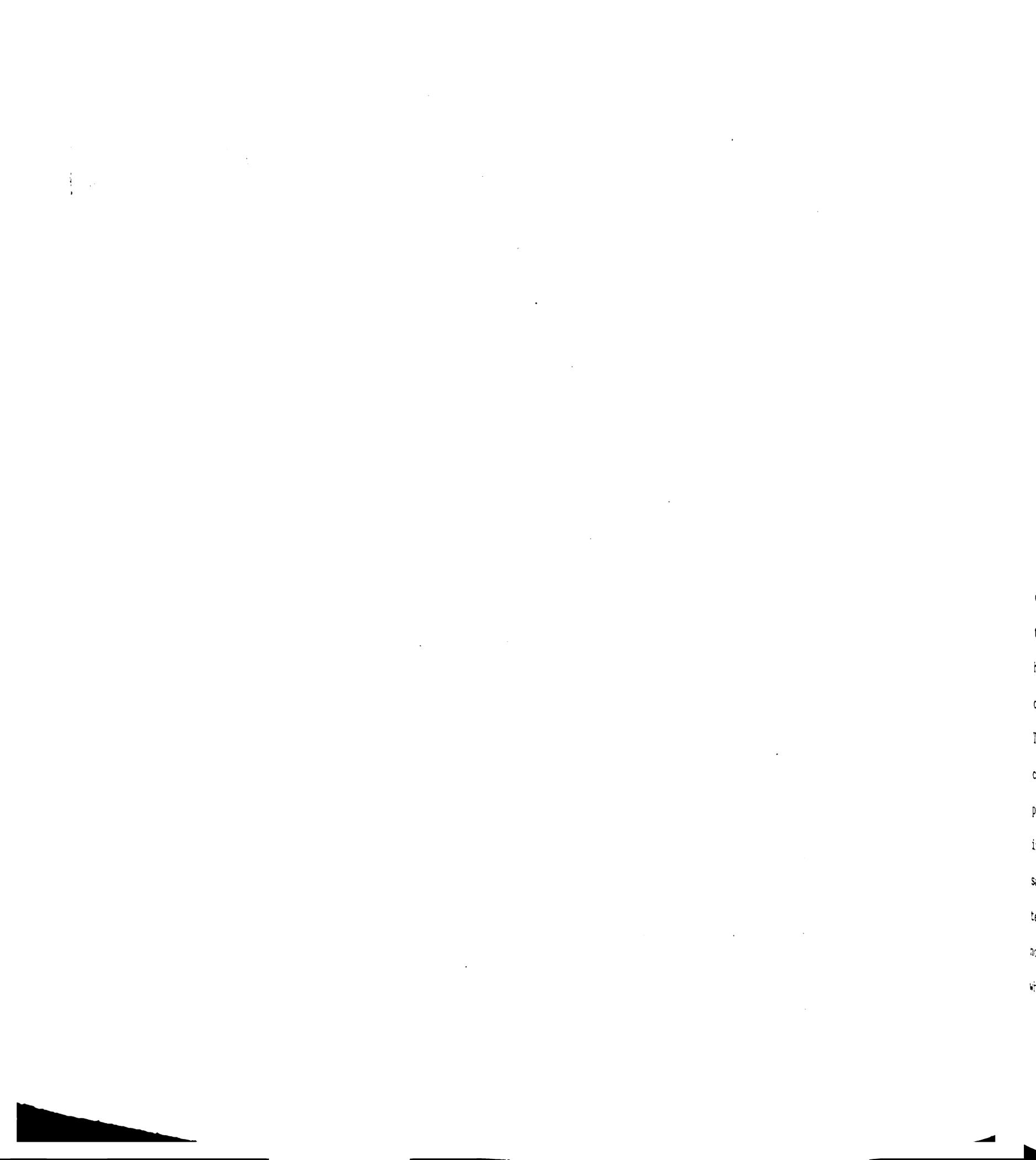
"Somehow dealing with people whose personal integration is fragmented, dissolving, divided, or alienated puts the nurse's own identity on the line as well" (Wilson and Kneisl 1983: 42).

The same authors devote nine pages (of more than nine hundred) to

"... the stresses experienced by nurses attempting to relate fully to clients while maintaining their own personal integration" (Wilson and Kneisl 1983: 42).

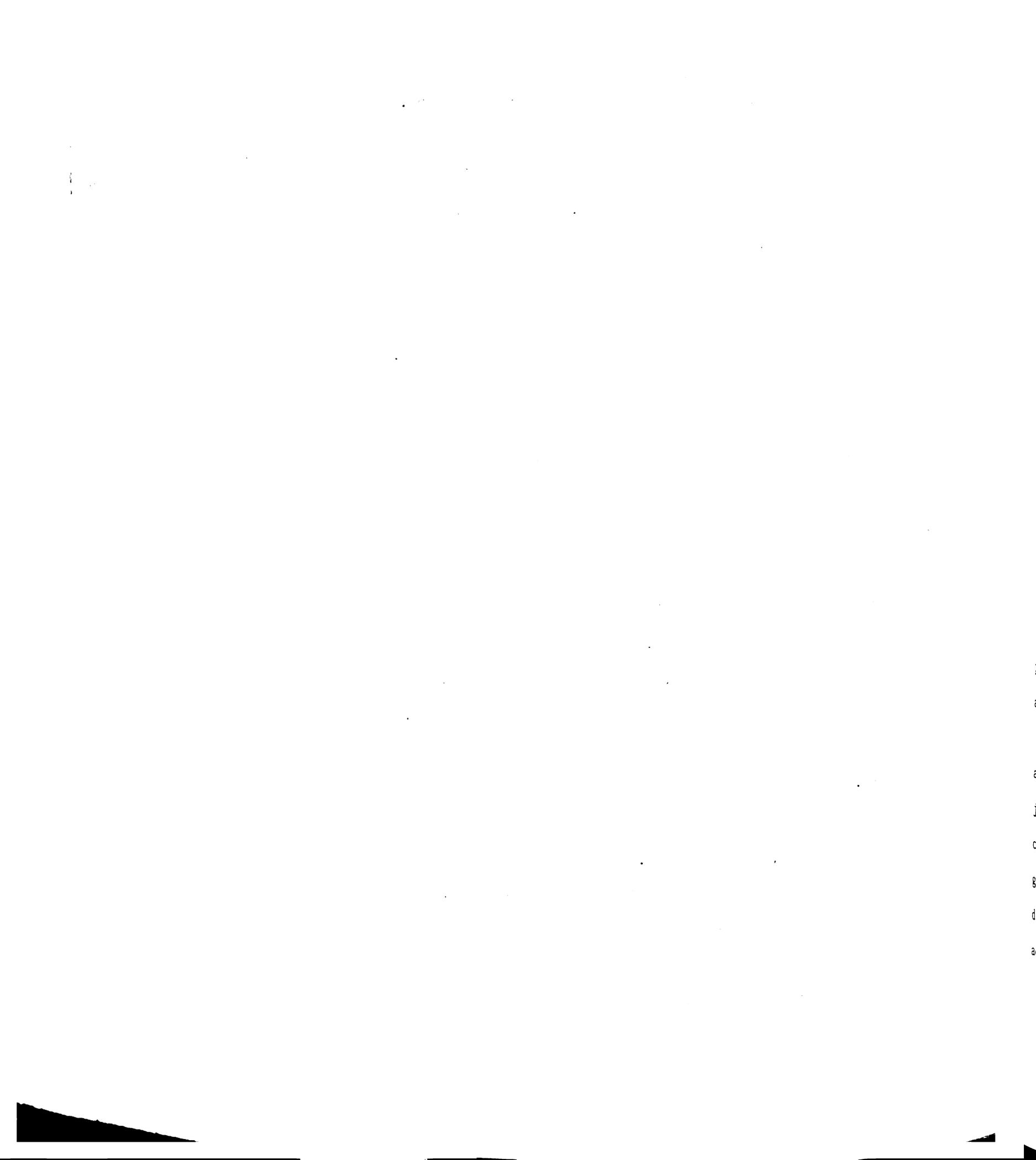
Such concepts as detached concern, negotiated realities, and self awareness of feelings are discussed. Taking care of the self is associated with assertiveness, solitude, personal physical health, and attending to internal stress signals (Wilson and Kneisl 1983).

These indications of the necessity for nurses' self care, although significant contributions, remain inadequate preparation for prolonged encounters not only with patients (about whom City and County nurses relatively seldom complain and with whom they feel generally prepared to deal, despite the traditional problem of compromise between functionally specific impersonality in nursing roles and therapeutic expression of interest, warmth, kindness, and sympathy (Thorner 1955)), but with other aspects of the context within which they work. This involves aspects of psychiatric nursing which are not directly



associated with patient care, but which may be as or more strenuous. These include a workplace in which nurses have little control over their nursing and are presented with paradoxical situations in which they often feel that they are nursing physicians, supervisors, and the system rather than patients. Work with acutely ill psychiatric patients is challenging, but the failure of the non-patient-related aspects of the workplace to provide adequate psychological compensation (and often to be further draining) may be a greater source of stress. Nursing is in a position of mediator between the provision of care and the system, between the patient and the system, and between professional and technical personnel. This complex role needs to be examined, as do implications of the discipline's internalized dependent status.

In some circumstances, familiarity with skills increases feelings of control that are essential not only to psychological well-being but to physical health as well (Langer 1983). Psychiatric nursing, however, as was previously pointed out, is relatively "low tech." Many of its goals and values are abstract and in large part immeasurable. The effectiveness of the subdiscipline, beyond the realm of custodial care, is elusive. Some nurses are unprepared for or cannot afford psychologically or economically to take the risks associated with innovation (Weisensee 1979, Germain 1979). They learn to find satisfaction within the confines of tradition and subordination. They tend to feel less competent toward traditional nursing skills than do non-psychiatric nurses (Finch 1986), and accepting of custodial roles which are less threatening than are vaguely defined roles of



accountability which assign more freedom, but also more responsibility, to both the nurse and the patient. Nurses frequently proclaim that the situations from which patients come are complex, that psychiatry falls short of dealing with them directly, and that caring, to be effective, must extend beyond the hospital unit. Yet nurses tend to accept these circumstances as they are; in the struggle between individualization and efficiency, efficiency usually wins as a given.

In the ongoing search for appropriate ways to deal with mentally ill members of the population, nursing has been and is a battleground for many polarizing issues. Some nurses become casualties. Others, those with the resources to adapt, find personal fulfillment away from the fray, develop support systems within and beyond the work setting, and learn to balance the sources of strain in their lives with the sources of success and support. The nurses whose adaptive strategies have been described have, for the most part, learned how to live with their nursing roles. Many have maintained psychiatric nursing positions and roles for substantial periods of time, although most attest to considerable personal strain in doing so.

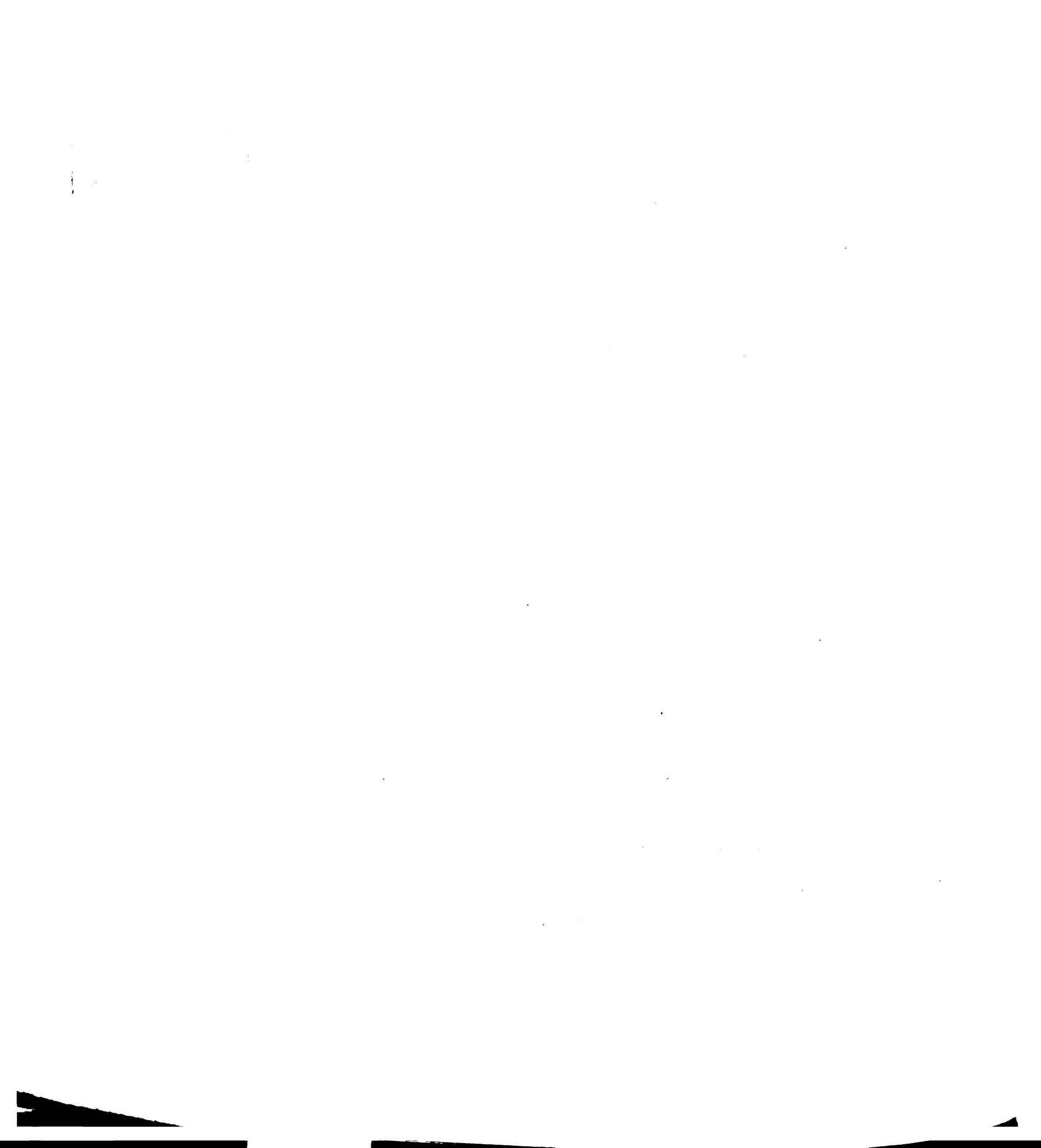
Reversing conditions which encourage this strain requires concerted and sustained effort (Cherniss 1980). External demands attached to jobs can be reassessed, for example, and probably reduced. Assistance can be made available to help nurses determine and maintain reasonable goals and expectations. Individual nurse's resources for meeting demands and fulfilling expectations could be increased with administrative attentiveness, recognition, and support.

The typical nursing job pattern supplies advancement and

recognition only through graduate education or transition from nursing practice to management and administration. Role models are scarce because nurses who advance in the hierarchy are less apt to do more complex or sophisticated levels of nursing than they are to do non-nursing tasks.

Nurses want more managerial and administrative involvement through supportive, individualized leadership. Leadership requires attention to followers (Hollander 1980). The most positive work-connected relationships reported by the psychiatric nurses at City and County occurred between staffnurses and their immediate supervisors when the interactions involved regular one-to-one sessions. Many of the most negative relationships occurred between members of the same categories when the relationships lacked individualized leadership components. Whether or not the alliances included any off-duty involvement was irrelevant to the supportiveness associated with them. It is significant, however, that at City and County only one psychiatric nurse above the staff nurse level identified a relationship with a staff nurse as particularly meaningful.

Any serious challenge to unsatisfactory conditions involve first coming to terms with the social factors that produce those conditions. Focus on the relationships between individuals and organizations are of limited value by themselves; nursing's difficulties are deeper than that. As a discipline, nursing faces ambiguities about its very nature and its place in the changing nature of health care, as well as social and political questions about nursing and the nurse as parts of wider society (Prophit 1985).



The issues that have haunted the discipline for decades remain unresolved. A variety of educational trajectories and credentials confuses and segments occupational membership and directs alliances, while members of powerful non-nursing disciplines remain understandably intolerant of this melange of levels of abilities and limitations.

Another problem is the multiplicity of explanatory models held by nurses. These reflect a variety of social and cultural influences within the discipline, and affect expectations of caring, support, needs, outcomes, and goals. Nurses are exposed to numerous ideological models. They generally do not agree upon what they do, how they do it, how they differ from other psychiatric/mental health workers, or what they have to offer that is unique (Finch 1986). Role distinctions are muted and position assignments often incongruent with professional, technical, or non-RN training. Attempts to demonstrate or even describe the nature of clinical practice produce images of varied and dependent practice, which is often presented in psychiatric or other medical terms, illustrates little cohesiveness, and involves little relevant modeling. Management remains too preoccupied with the maintenance of traditional hierarchical bureaucracy to lead an effective work group or to focus on developing the potential of each group member.

The many explanatory models elicited from nurses recount identity conflicts between nursing and psychiatry, and between medical and social psychiatry. Representing a basically pragmatic discipline, but relating to complex human interactions and conditions, little evidence of nursing theories appears among the opinions expressed about the

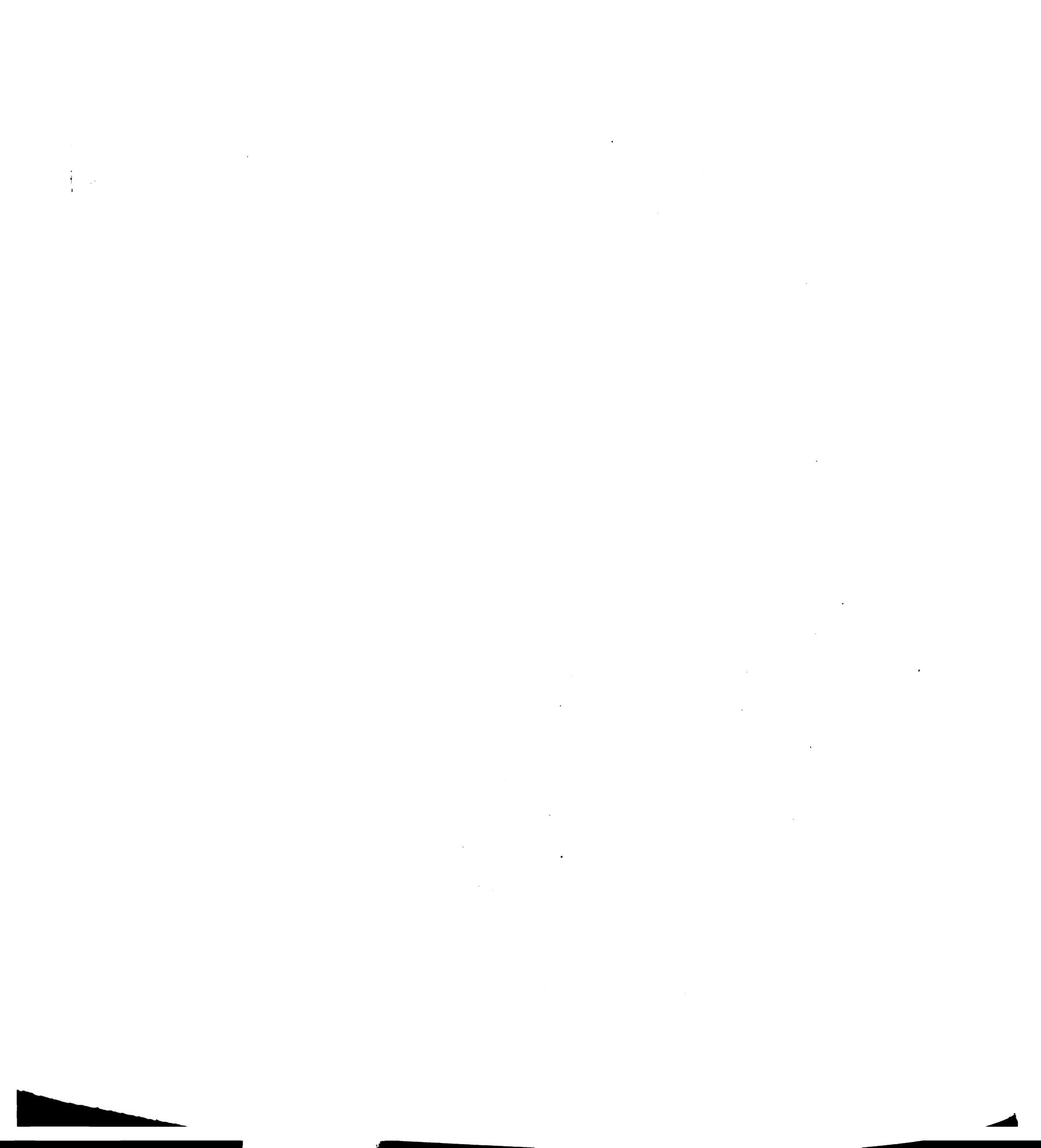
etiologies of mental illness, caring processes, nursing and psychiatric roles, prognoses, or interventive approaches. While theorists debate the existence and significance of theory in nursing, its practitioners rely upon non-nursing conceptual models. At City and County, for example, a gap persists between the managerially imposed patient self care model for nursing, and most nurses' perceptions of realistic and beneficial care. The opinions expressed speak to an orientation toward illness rather than toward health, yet nurses present explanatory models which also differ from those of therapists and technical staff. Only in voicing pessimism for expected outcomes do the three groups approximate agreement.

There is little evidence at City and County to support the assertion that

"Both the nurse's professional ideology and the hospital's general philosophy support her professional self regard" (Strauss et al. 1981: 213).

The former is in reality too fragmented and tenuous to provide such strength. Nursing's ideological lack of commitment reflects and perpetuates the ambivalence with which the discipline is treated within the health care system. There is no single, common set of perspectives, assumptions, or cognitive orientations which finds its way into applied nursing. Obvious instead are theoretical pluralism and doubts about the contribution of theory per se. The hospital, meanwhile, imposes a social organization and structure which defeats attempts at professionalization and constrains individual actualization.

Psychiatry's role in social control provides a vivid example of the



conflict between theory and practice and between the needs of nurses and those of patients and the health care system. At City and County, most members of the nursing staff engage in an ongoing debate over the relative merits of dependence and independence in the care of patients. The nurses are, meanwhile, in a position which requires their deference to medical, nursing, and hospital administrative hierarchies. While physical experience on the units speaks to a need for control, theory dictates minimizing this. To provide what they are told is good nursing care, that is, to encourage independence and self care among patients, they must abdicate familiar modes of care and their only aspect of control, as well as a primary mechanism in their own protection against hierarchical reprimand: control over the patients. They may doubt, all the while, that patients can care for themselves and believe that the most solid evidence of their having a role of their own is to provide that care.

Despite varying orientations and backgrounds, nurses, like members of other disciplines, tend to share similar ideas about conditions and what is to be done about them (Davitz and Davitz 1980). In summarizing multidimensional attitudes about mental illness, Cohen and Struening (1962, 1963, 1965) found twenty years ago the same conflicts between permissiveness and control among eight blue collar and white collar occupational groups as exists among the therapists, nurses, and LPTs at City and County now. In both cases the RNs were found to differ most from the other groups, to be less inclined toward authoritativeness and social restrictiveness when dealing with patients than were the technicians, but more inclined toward benevolence than



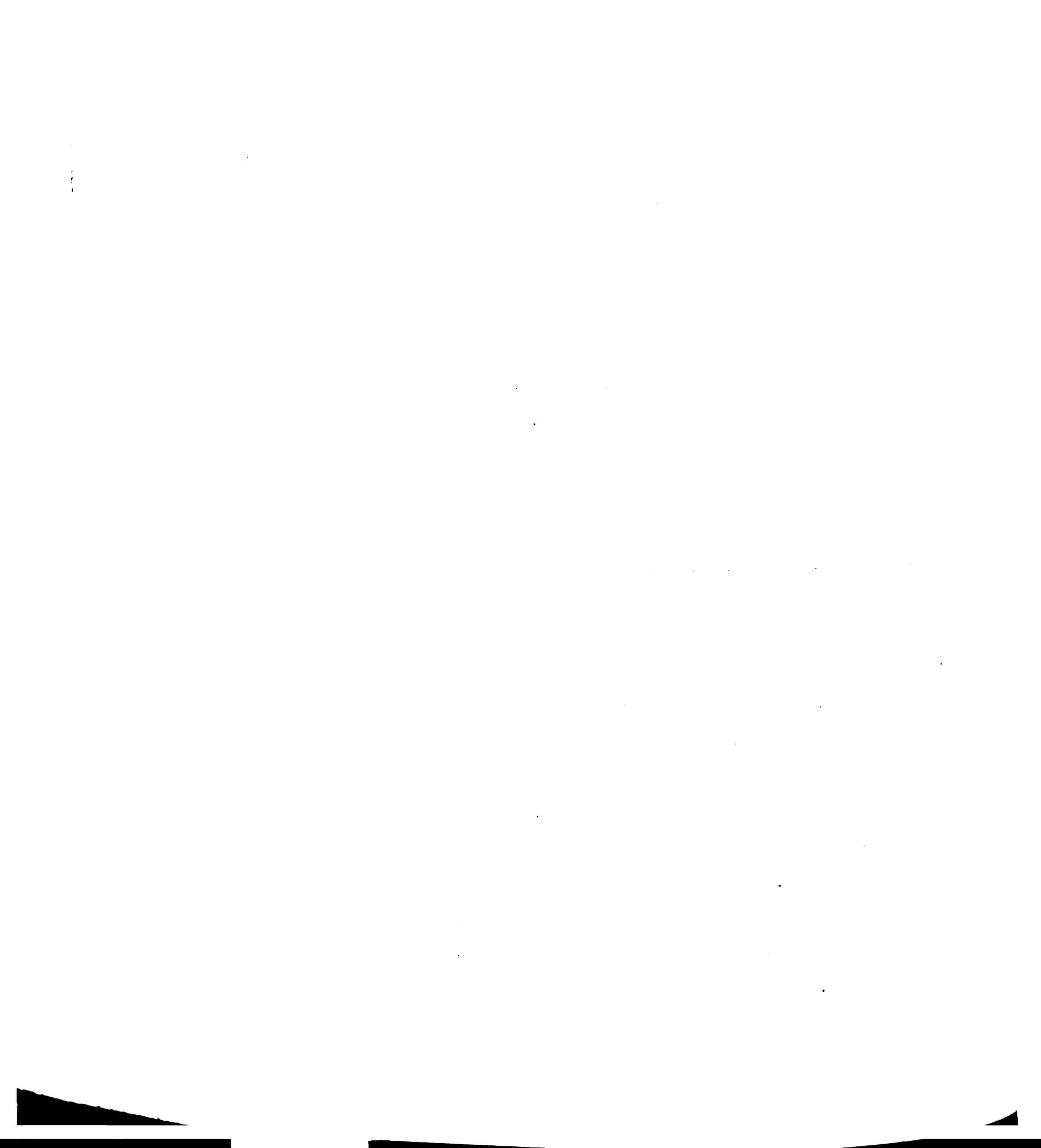
either the psychiatrists or technicians.

On the other hand, extreme variability typifies the nursing staff. There are many realities, multiple personal and public explanatory models to be reckoned with, various conceptual orientations to nursing and to psychiatry, a myriad of reactions to experiences in practice, and differing perceptions of social realities in an atmosphere that is often bizarre and intense. The data presented here represent the experience of nurses who work within the close confines of three units of a single hospital department of psychiatry. However, the impact of these circumstances extends beyond the medical center. It is imperative to examine psychiatric nursing at City and County as part of the broader mental health care system.

The Community Psychiatric/Mental Health System

Today's mental health services reflect a major trend in post-industrial society toward service and communication (Molitor 1981). In an attempt to balance the effect of living in a highly technological society, and one overtly preoccupied with the collection and distribution of information, there is a demand for recognition of and attention to individual social and psychological needs, quality of life, and interpersonal relationships (Naisbitt 1981). Psychiatric and mental health services are among those required and provided in modern service-oriented societies.

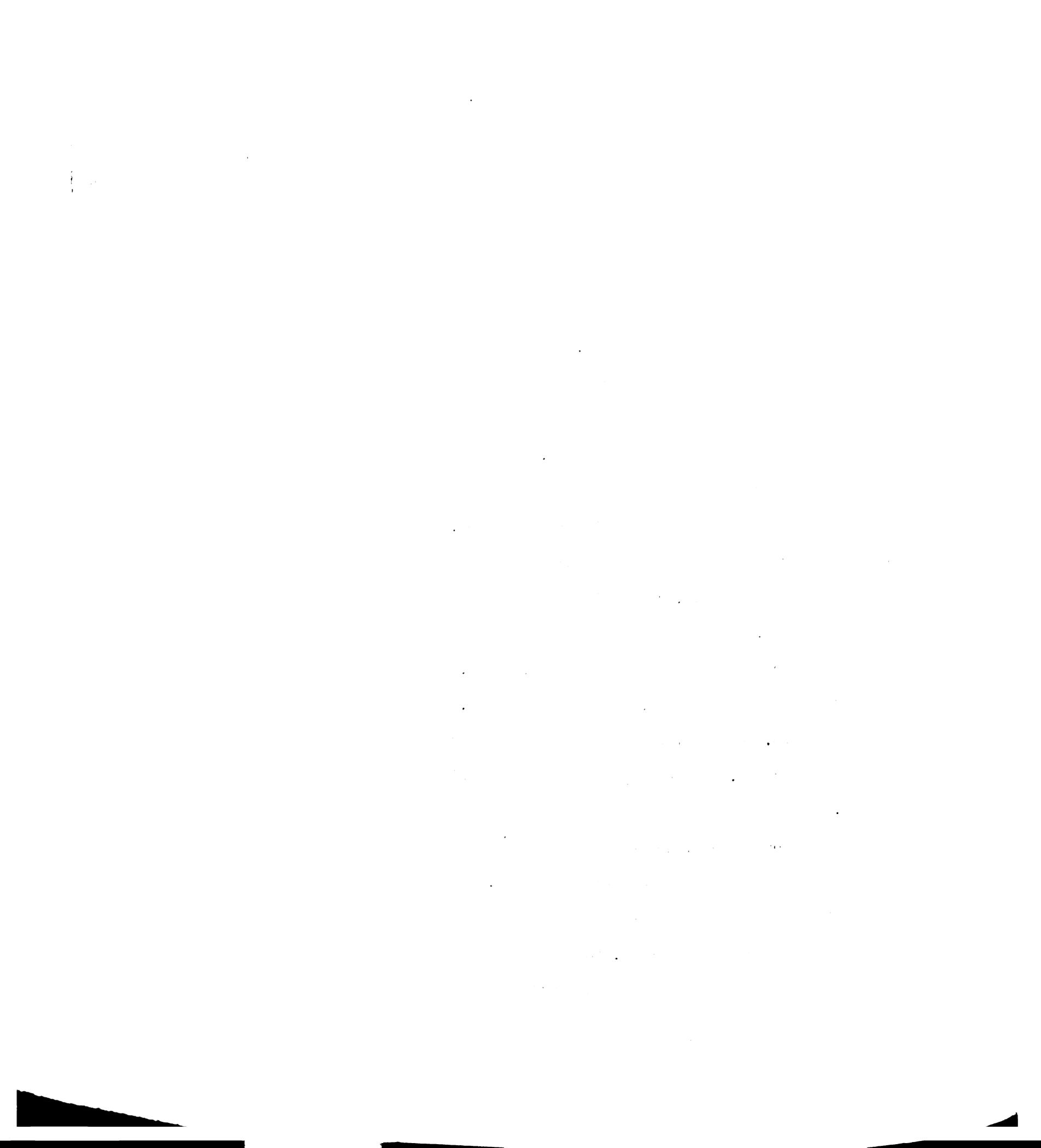
Mental health is viewed as a major American social problem. Emotional disorders are widespread; one in every ten Americans, about twenty million people, is affected sometime during his or her lifetime



(Alcohol, Drug Abuse, and Mental Health Administration 1975). It is widely held that "prompt professional treatment can help most sufferers back to normal living" (What Everyone Should Know About Mental Health Services 1978). This help comes in the form of out-patient, in-patient, consultation, emergency, screening, follow-up, transitional, and special group services available in a wide range of agencies which, funded in large part by federal, state, and local sources, form the community mental health system. Since 1963, due to public programs and widespread use of psychoactive drugs, persons identified as mental patients have been allowed and expected to remain in the community and to need minimal hospitalization.

An ambivalent shift toward social psychiatry underlies the development of current mental health and psychiatric resources. In theory, the community approach emphasizes socialization and social disorganization as explanatory models, and social cohesion as a goal (Dunham 1968, Mechanic 1969). Psychiatric practice was to be brought as close as possible to real social life (Castel et al. 1982), yet be made available to massive numbers of diverse groups of people. The effects of multiple factors, and the interaction of host and ecology, provided an overall perspective. General systems theory contributed a major analytic tool.

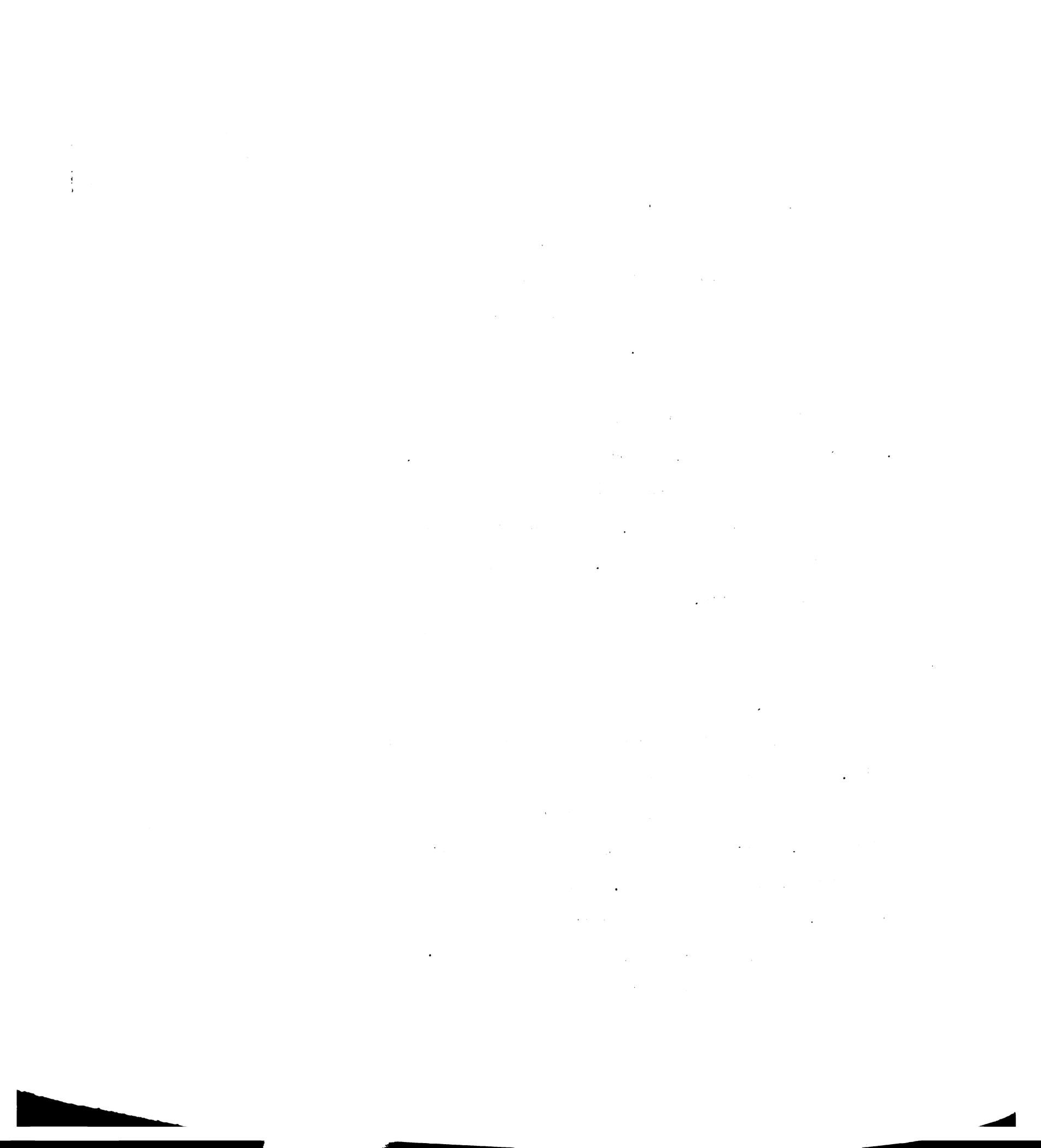
By the late 1970s regional mental health centers were the leading providers of public mental health and psychiatric services. These decentralized facilities were developed for those patients judged capable of living outside of state hospitals, total institutions which had met with increasing criticism due to the inadequacy of treatment



and care there, their costs to the state, and the production of apathetic, over-institutionalized, and dependent inmates (Mollica 1983). In the community, general hospitals provided most needed hospitalization services, despite basic incongruences between the hospital and the community parts of the total system. Brief admissions and therapies dominated the hospitalization experience. The expectation was clear that patients be only temporarily and briefly unable to function outside of the hospital.

The goal of relieving the inadequate state mental hospital from its role as panacea for socially unacceptable but non-criminal individuals has been met. Domiciles and shelters, although varying in adequacy, were developed for those patients who lacked social stability and refused traditional services (Mollica 1983). Many inequities in the distribution of resources have been dealt with. The social psychiatric approach is culturally relativistic, and mental health services were made available to broader spectra of subcultural and socioeconomic groups, although increased access has never ensured appropriateness or effectiveness (Mollica 1983).

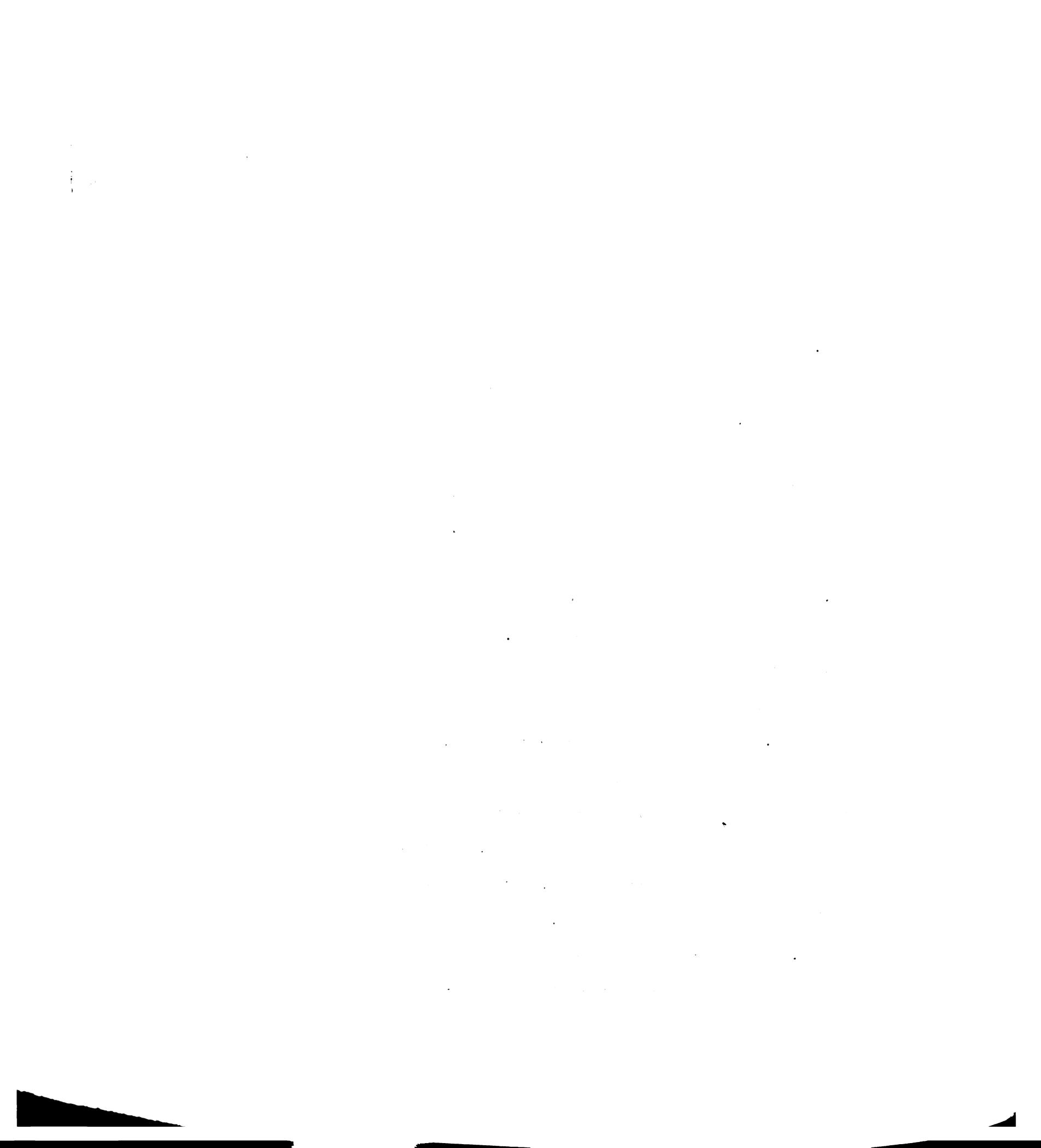
The social and community psychiatry orientation attends ideally to problems of living. People are adaptive; they cope according to the amounts and strengths of the stress and the support that they experience (Murray 1975). Increased support can keep some people functional who otherwise would not remain so. Levels of function are ever-changing, however, so an effective system must be flexible enough to accommodate these changes (Bachrach 1980, Scheper-Hughes 1981). In reality, public psychiatry deals with multiple populations: those



deinstitutionalized, those in need of care but never institutionalized and those in need of institutionalization, as well as persons with chronic or recurrent conditions and others with acute, transitional problems. The conviction that chronicity would be decreased by immersion of patients into the community has proven to be naive, especially when community services remain inadequate and inflexible reinterpretations of the traditional psychiatric approach (Scheper-Hughes 1982).

Public psychiatry has improved the scope and quality of the treatment and care it provides, yet there are many signs that neither the services nor the service providers function as comprehensively as was promised in the idealistic times of the system's inception. The system remains plagued with numerous problems and inadequacies. To many, the integration of care seems more mythical than fact; services work best separately, but the task of conforming to each and of putting them together has often been the patient's (Denner 1974). Fragmentation and interdisciplinary conflict complicate an already unwieldy social organization.

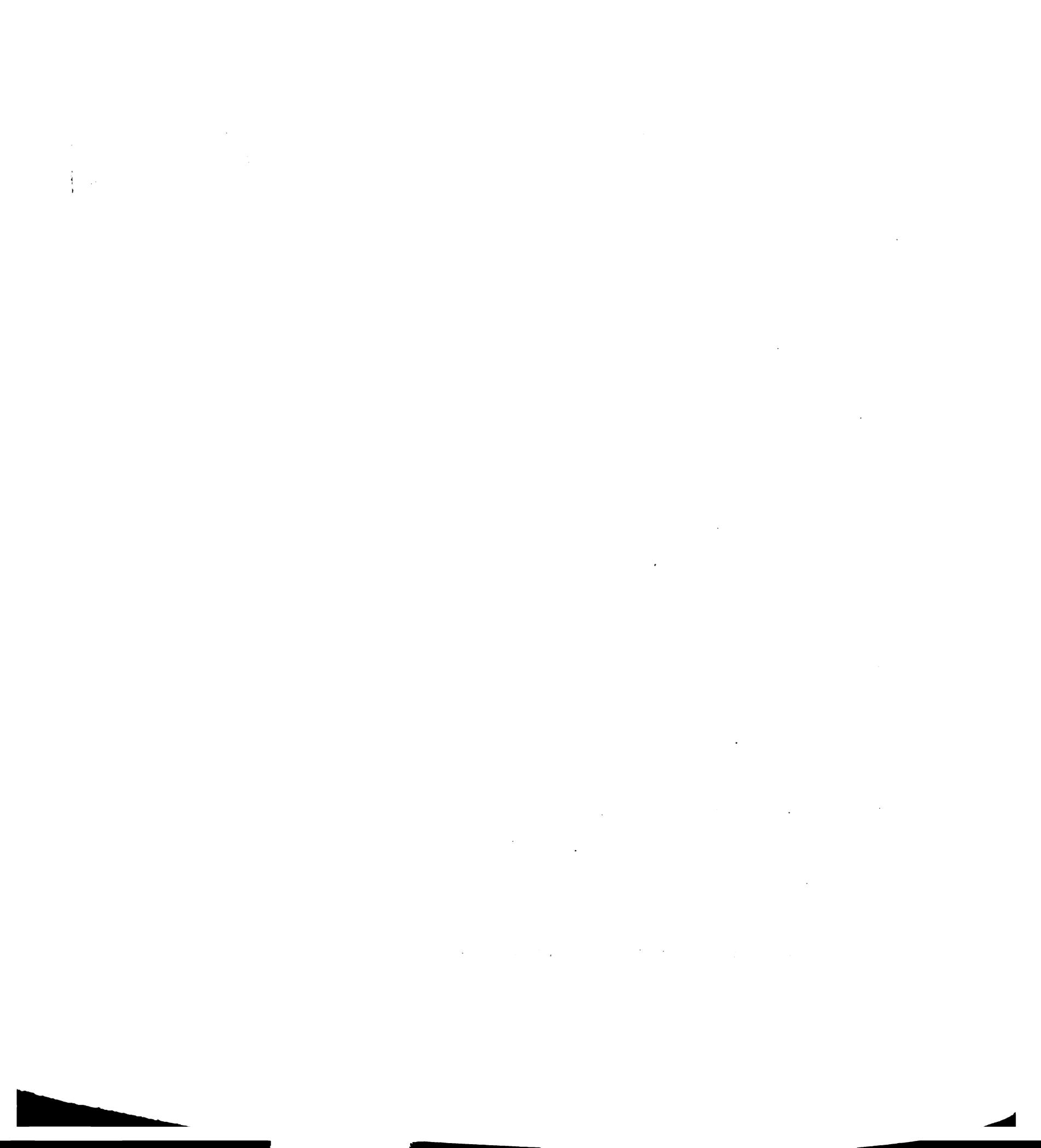
A major problem is that, despite its considerable resources, the system must deal with a plethora of problems, many of them beyond its scope. There are those associated with society in general (unemployment and underemployment, poor and crowded housing, poverty, and institutionalized and attitudinal discrimination, for example); personal problems of living which vary in intensity, type and duration; and psychiatric diseases. The sources and manifestations of distress dealt with are as diverse as the descriptors of the affected.



Although the community system can assist with various personal developmental and situational adjustments, its goals are limited to provision of mental health services and do not include alleviation of social problems which underlie many problems identified as psychiatric. The system's concept of community, of catchment areas and social cohesion, further limits its ability to deal with the high mobility associated with its patient/client population (Murray 1975). Symptoms can be controlled, but complex etiological factors have not been. The focus of attention, then, has remained in the areas of probable success, not in prevention or rehabilitation.

The transition to community-based care was intended to alleviate the burden upon public coffers by encouraging private systems of treatment and care (Bennett 1979). Profit-making enterprises may conflict with therapeutic goals, however, and the need to make a profit requires facilities too large and too visible to comply with society's need for denial and insulation from the conspicuously mentally ill (Bennett 1979). Large residential facilities in urban areas compromised care and community integration of patients, yet effective alternatives have not developed.

Although prolonged hospitalization isolates patients from responsibility, self care, and decision making, wholesale freedom and choice leaves numerous patients in need of asylum. Flexible alternatives are needed, oriented toward the individual and his or her negotiation of the path between the role and identity of "patient" and individual responsibility. "Least restrictive" environments are not synonymous with "most therapeutic" for all patients; many patients make

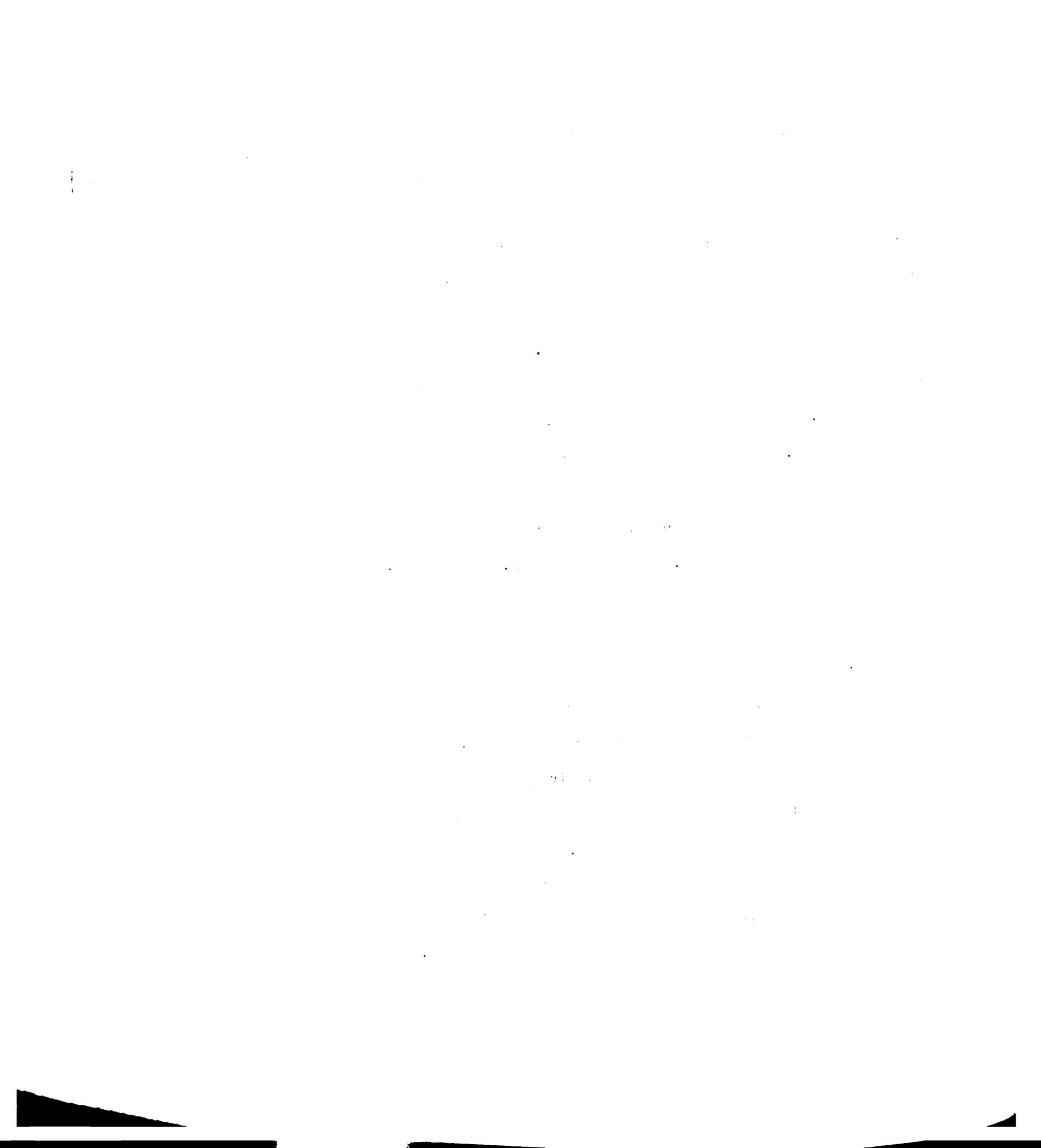


errors in judgment and are conspicuously negatively different in the community (Bachrach 1980). The ghettoization of these stigmatized persons is a major symptom of the inadequacy of the present system.

Other types of community programs have been explored and are known to work (eg., Weisbrod et al. 1980, Polack and Kirby 1976, Fenton et al. 1979), but their costs approximate those of hospitalization. A particular need exists for transitional or "step-down" facilities to ease the transition from hospital to community living. This gap persists, despite nearly twenty years during which the community has been the locus of care. The system remains directed, ultimately, by cost and legal priorities, and not by patients' needs or therapeutic response.

For those invested in the medical model, the psychosocial perspective threatens demedicalization. There is concern, for example, that clinical standards and treatment goals were compromised by dependence upon paraprofessionals and private franchises for many community services. Medical methods of treatment are often inefficient and ineffective, but they provide dependable instruments of social control, utilize statuses and roles that are valued by society, and allow attention to remain on the familiar and relatively tractable aspects of mental illness: diagnosis and treatment of symptoms, rather than on broader and less mutable social situations.

Individual therapy and nursing staffmembers are oriented toward various points along the social-medical continuum, and agencies and personnel sometimes confuse or work at cross-purposes (Denner 1974). One response to the threat of failure of the mental health system has

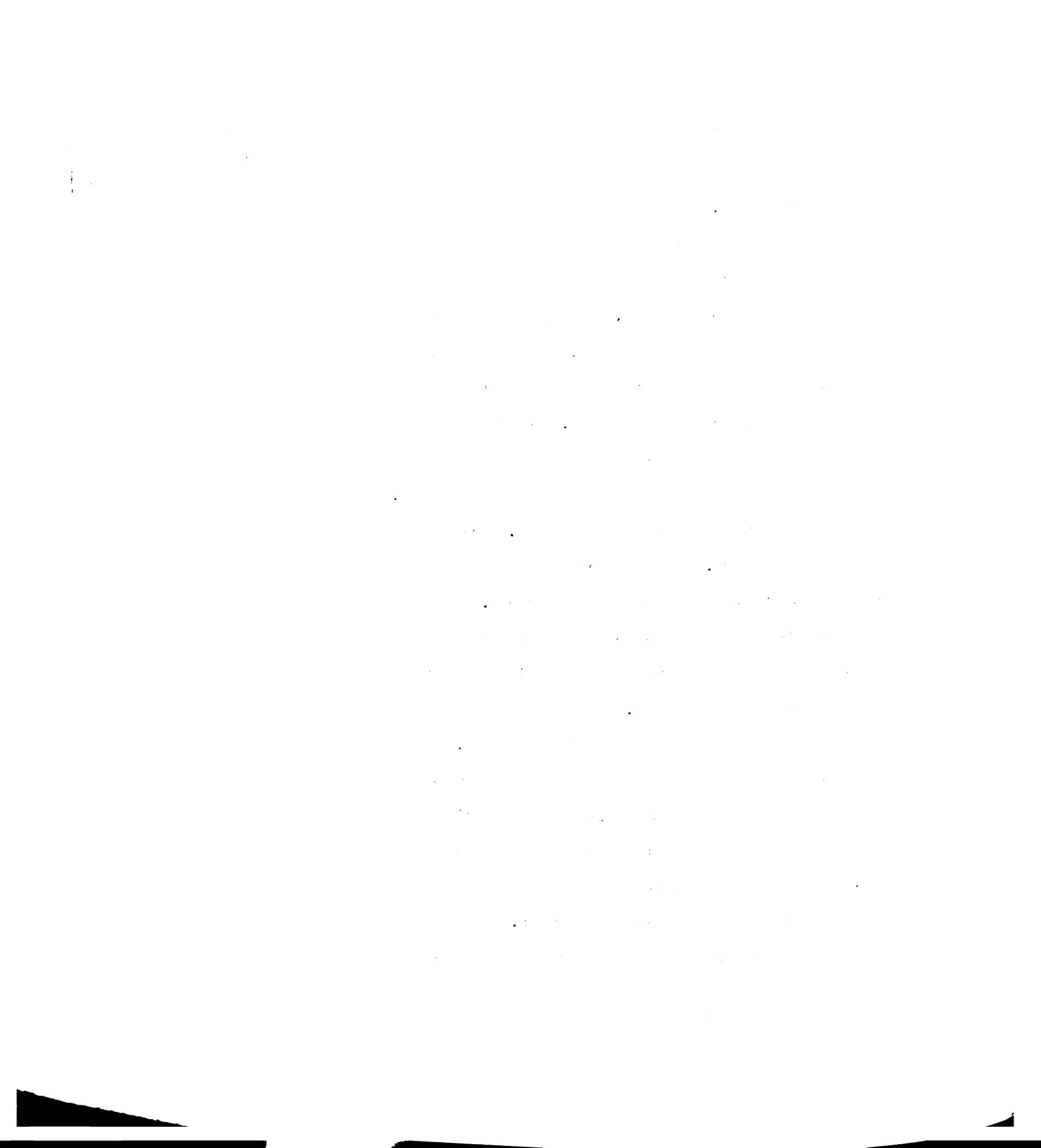


been a decline in popularity of both social psychiatry and the experimental community programs with which it was associated (Castel et al. 1982), and a return to the less ambiguous, and more valued by mainstream society, medical model.

Disillusionment with the present system has been around for years now, but the process of massive institutional change, requiring motivation, resocialization, and opportunity, is very slow (Weitzman 1984). Interagency coordination is still limited. The benefits of keeping patients in the community remain questionable from the perspectives of both the patient and the community. Severe funding constraints inhibit change and encourage crisis-oriented organizational maintenance as resources decrease while demands for services increase.

The attempt to produce mass mental health has failed. Mental health is not a measurable product. Appropriate therapy and responsible care cannot be reduced to recipes of techniques. The system is struggling to avoid being totally overwhelmed, but it lacks the federal, state, and local support crucial to effective response to pressure to do more and more community care.

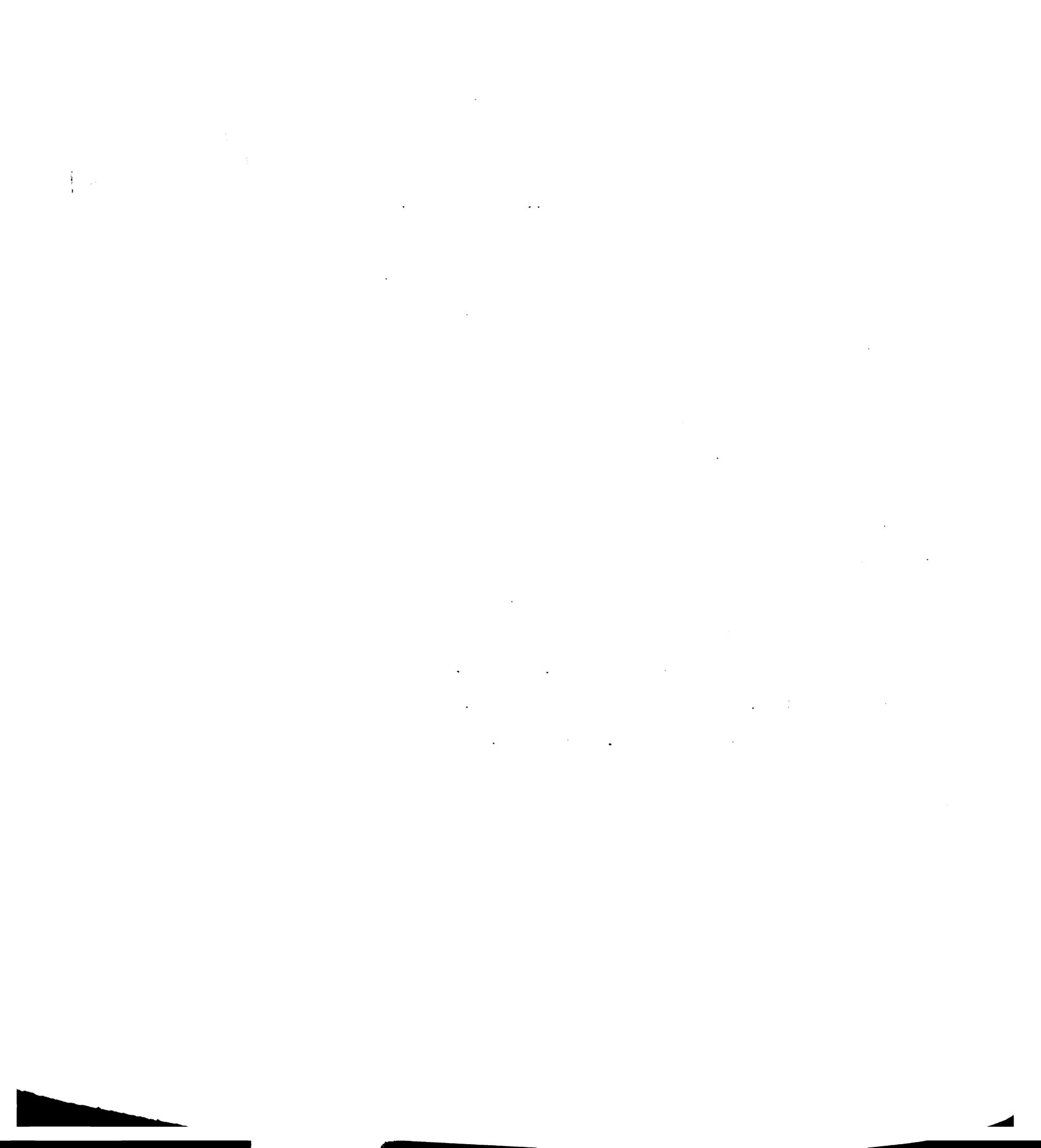
Nursing is an integral part of that sorely strained system. Many nurses see in themselves the potential to provide the type of mental health worker described by Scheper-Hughes (1981) as a new species of patient advocate who can and does deal with community aspects of problems and care. They also, however, see nursing as dependent upon the established system for an arena in which to practice, and the system as dependent upon nursing to sustain its service provision.



And nurses tend to accept things as "just the way things are."

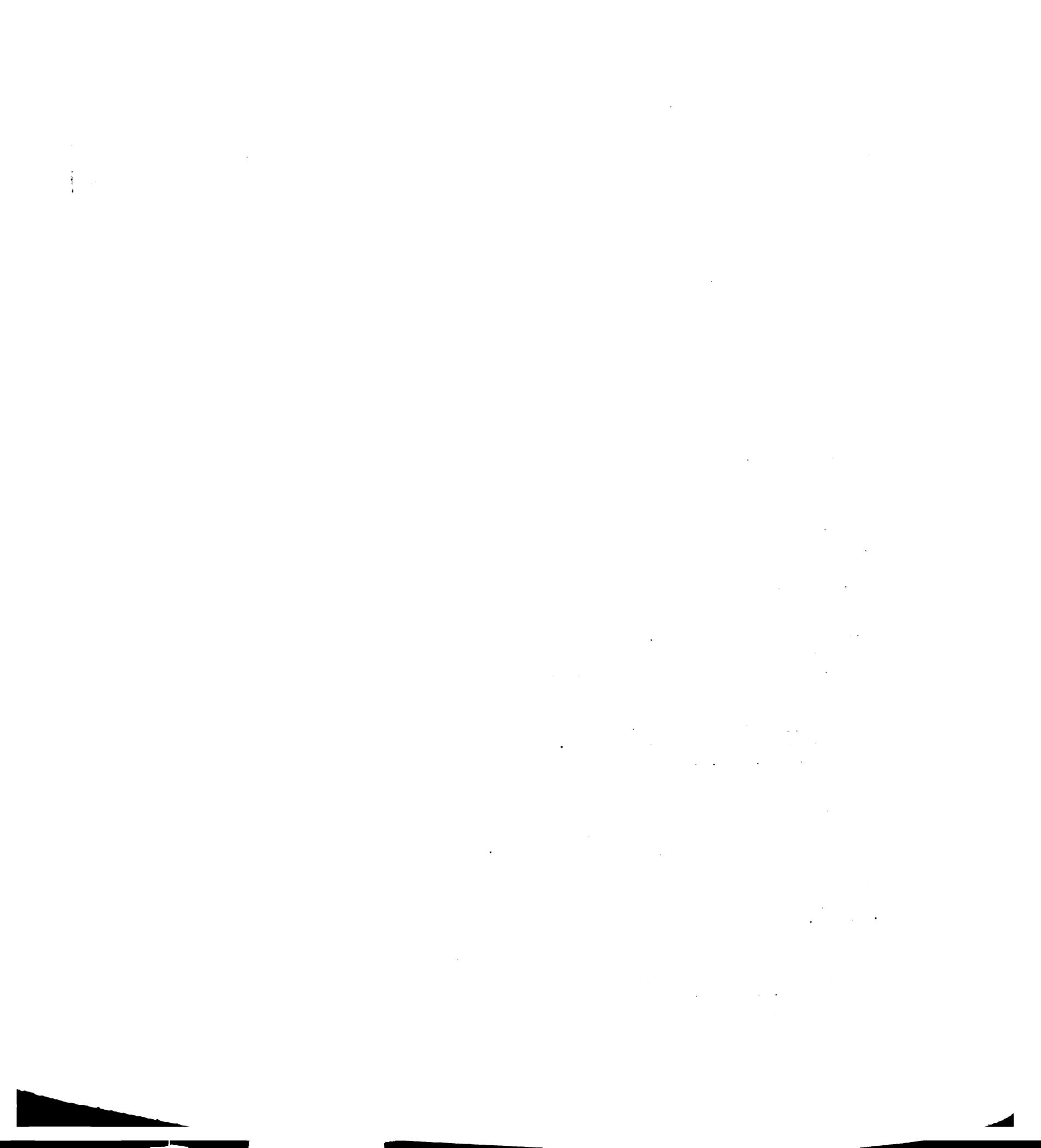
Many feel that psychiatry transplanted into the community is not enough because it does not deal with the culture, definitions of deviance, stresses, or supports of that community (eg., Murray 1975). Others maintain that the transformation to an adequate community system of treatment and care depends upon convergence of ideologies, policies, programs, interventive approaches, and economic resources (eg., Aviram and Segal 1977).

We are left with the question of whether nursing can and will follow medicine's lead and adopt an orientation which does not seem in the long run to be very effective, or will develop alternatives. As some nurses at City and County avoid involvement beyond the rudiments of their jobs, nursing in general has tended to avoid the broader picture. Indeed, avoidance has been a major mechanism for dealing with problems throughout the psychiatric/mental health system. But if nursing is to proceed to more autonomous and professional distinction, it will have to coordinate and get actively involved. Divided, nursing barely stands. Its potential, if organized, remains untested. But the need for the various expressions of awareness, sensitivity, and expertise characteristic of members of that discipline will not go away.



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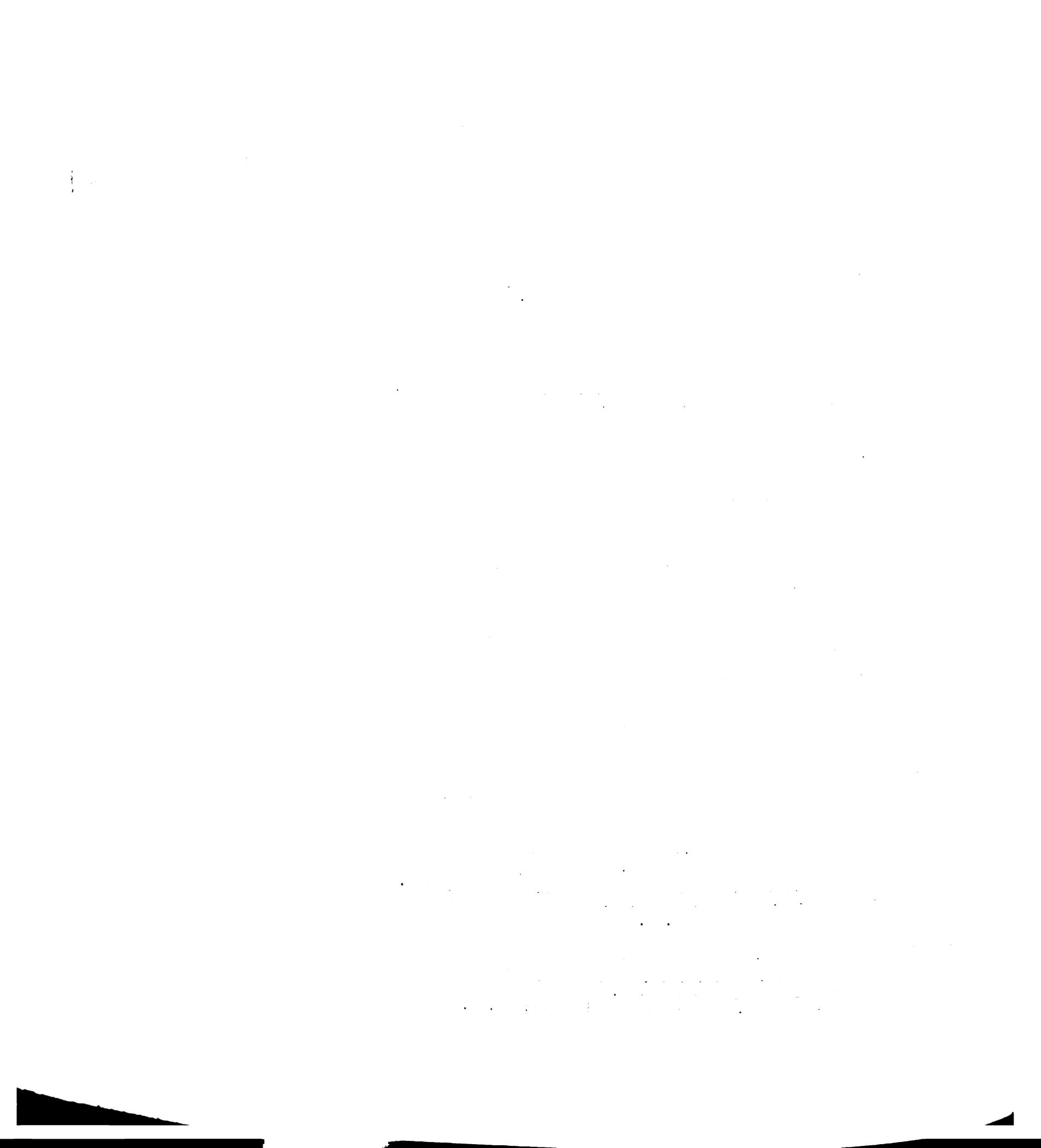
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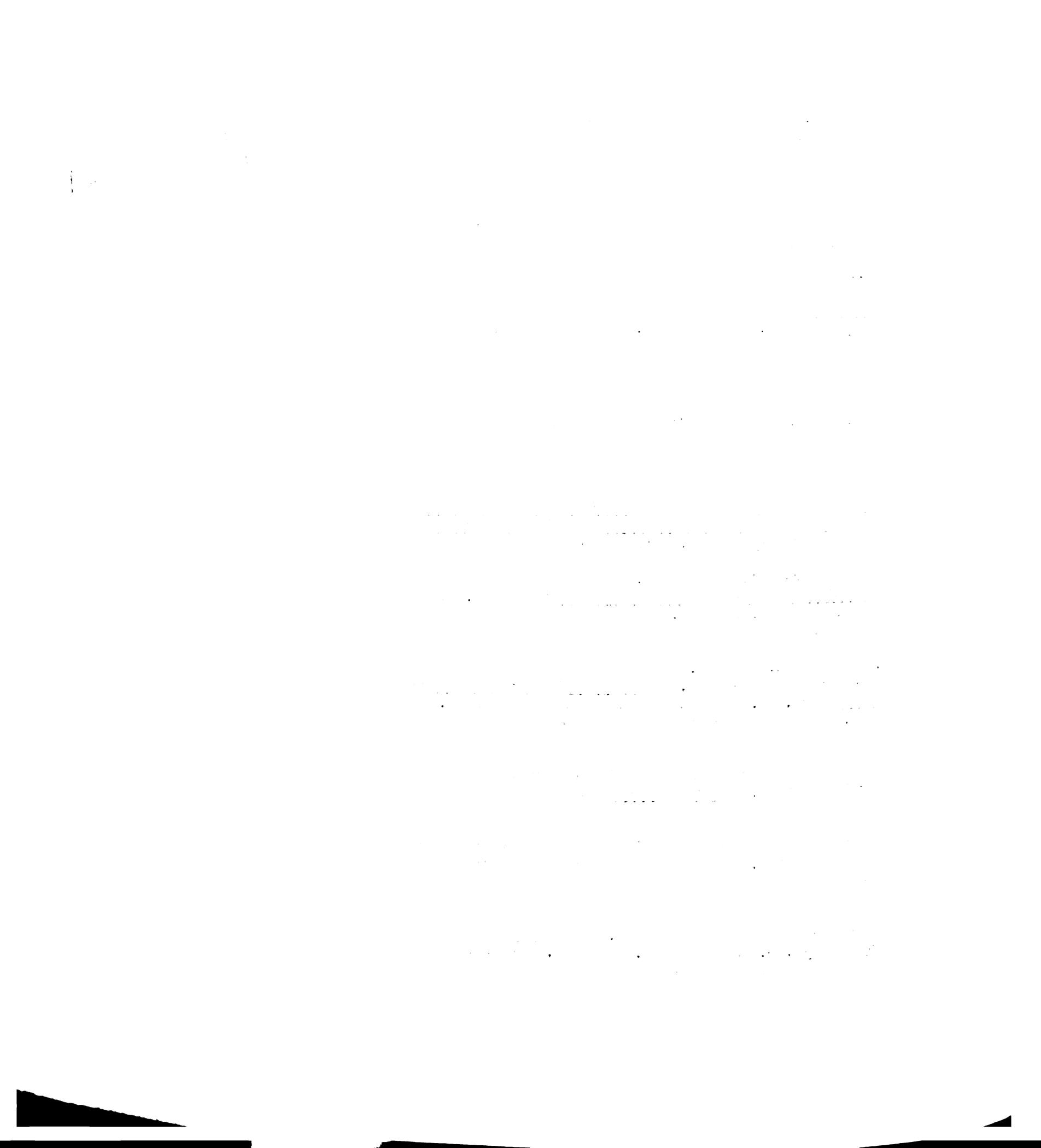
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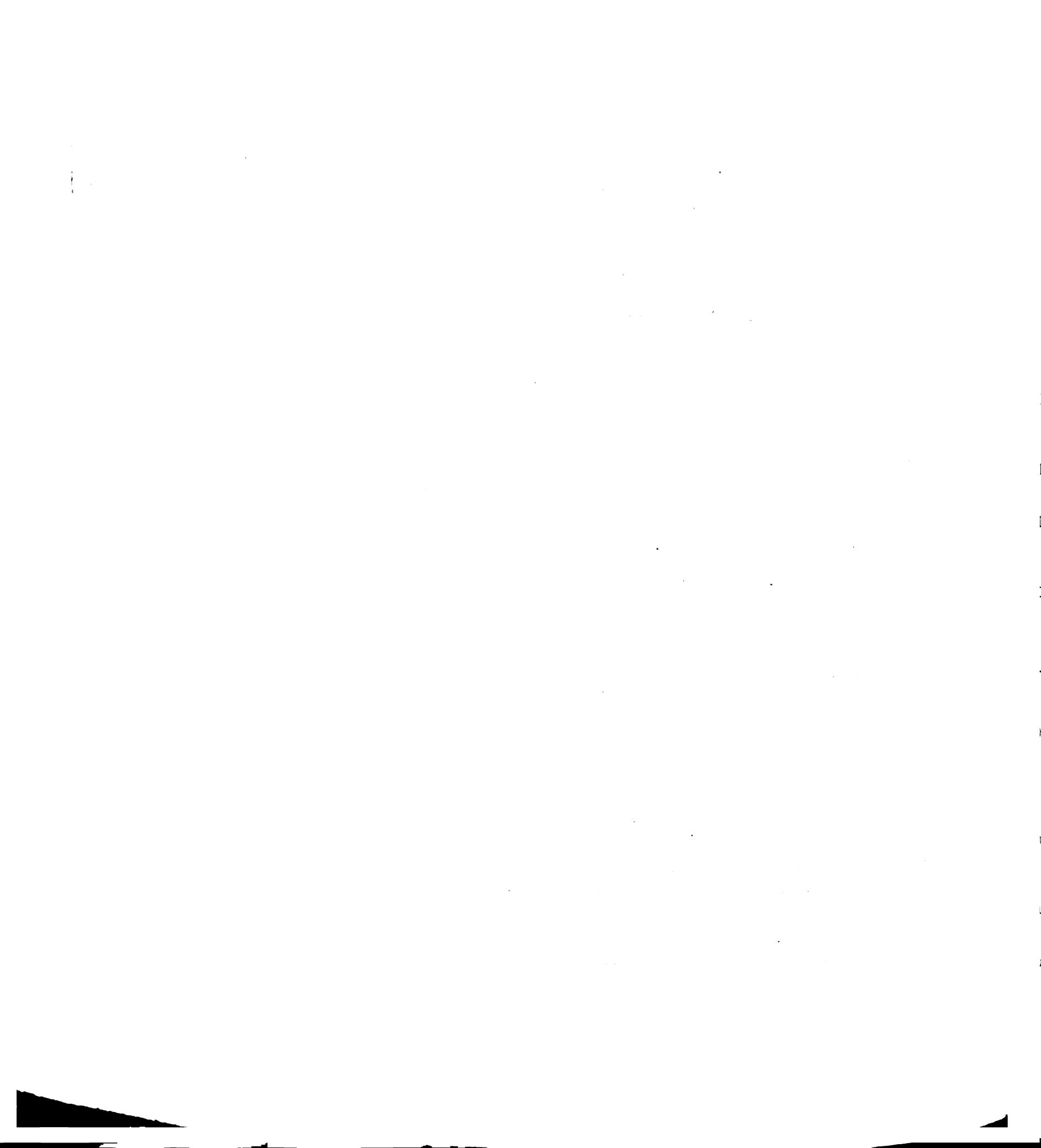
3. The third part of the document focuses on the role of technology in data management and analysis. It discusses how modern software solutions can streamline data collection, storage, and processing, thereby improving efficiency and accuracy.

4. The fourth part of the document addresses the challenges associated with data management, such as data quality, security, and privacy. It provides strategies to mitigate these risks and ensure that the data remains reliable and secure.

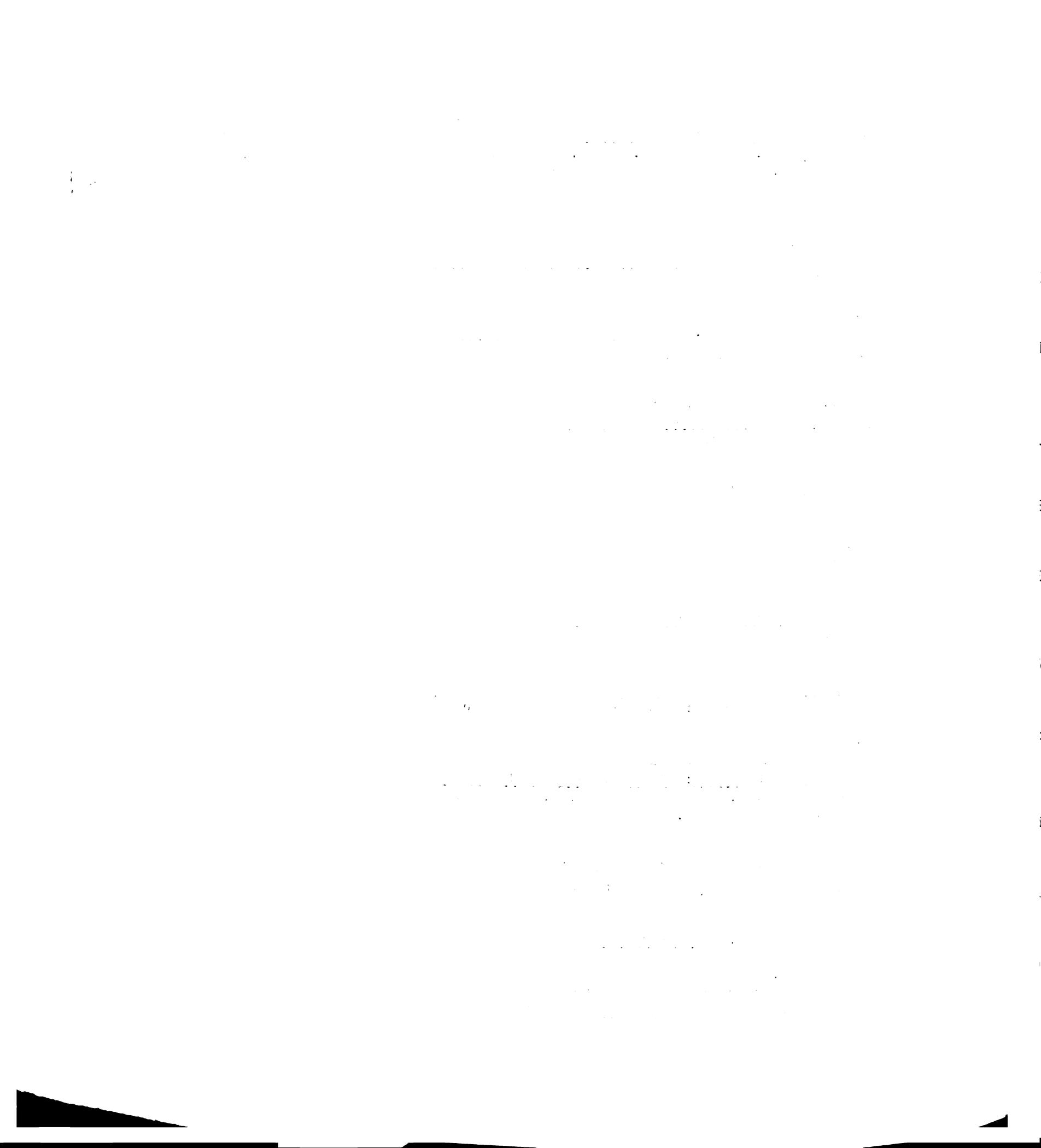
5. The fifth part of the document discusses the importance of data governance and the role of various stakeholders in ensuring that data is used ethically and responsibly. It emphasizes the need for clear policies and procedures to guide data handling practices.

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3. The third part of the document describes the results of the data analysis. It shows that there is a significant correlation between the variables studied, which supports the hypothesis of the research.

4. The fourth part of the document discusses the implications of the findings. It suggests that the results can be used to inform decision-making and to develop strategies to improve the organization's performance.

5. The fifth part of the document concludes the study and provides a summary of the key findings. It also identifies areas for further research and suggests potential future studies.

6. The sixth part of the document provides a list of references and sources used in the study. It includes books, articles, and other relevant materials that have informed the research.

7. The seventh part of the document is a list of appendices, which include additional data, charts, and other supporting information. These appendices provide a more detailed look at the data and analysis.

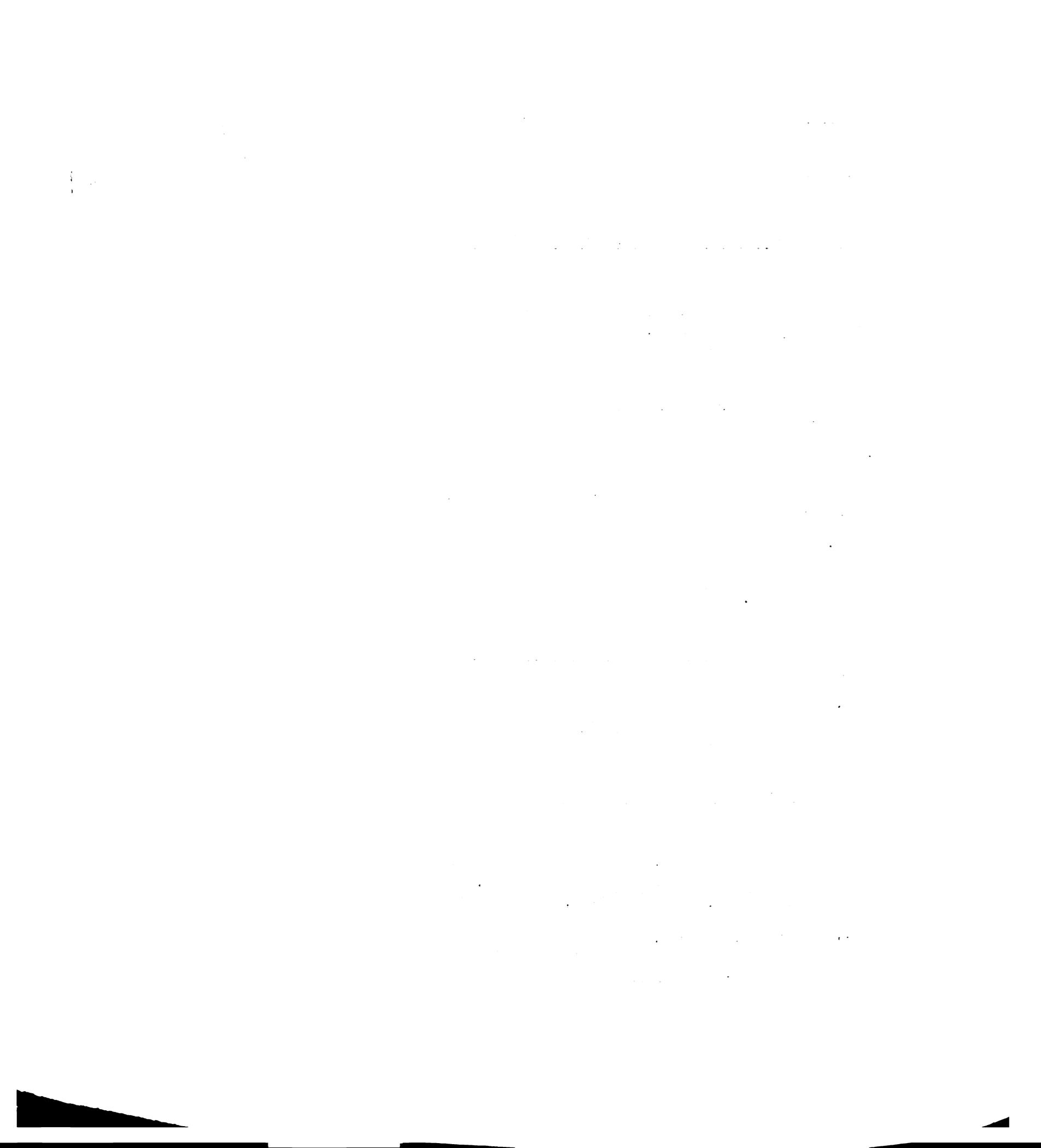
8. The eighth part of the document is a list of figures and tables. These visual aids help to present the data in a clear and concise manner, making it easier to understand the results of the study.

9. The ninth part of the document is a list of footnotes and endnotes. These provide additional information and clarification on specific points mentioned in the text.

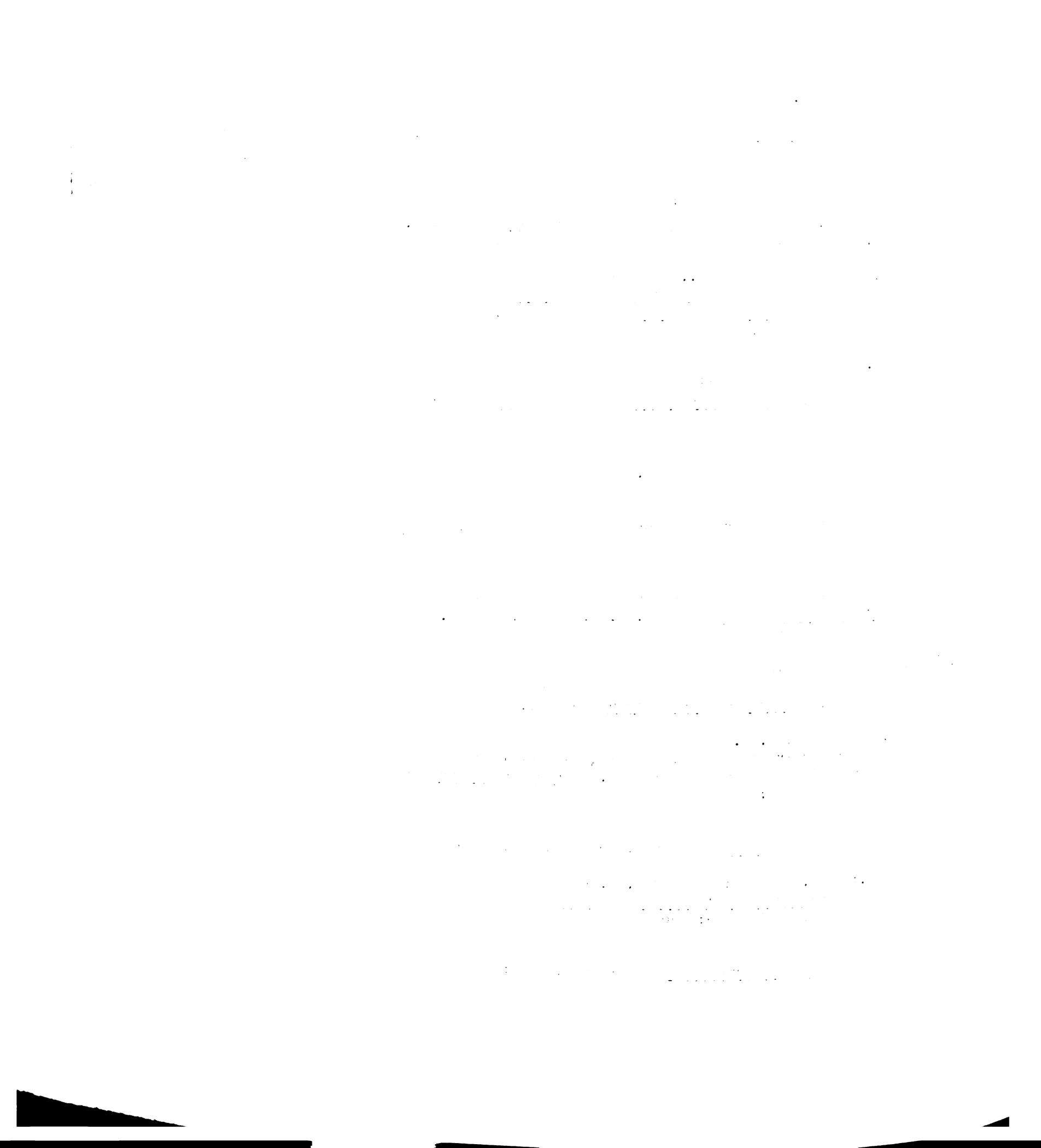
10. The tenth part of the document is a list of acknowledgments. It expresses gratitude to the individuals and organizations that have supported the research and provided valuable feedback.

11. The eleventh part of the document is a list of contact information for the author and other researchers involved in the study. This allows readers to reach out for more information or to discuss the findings further.

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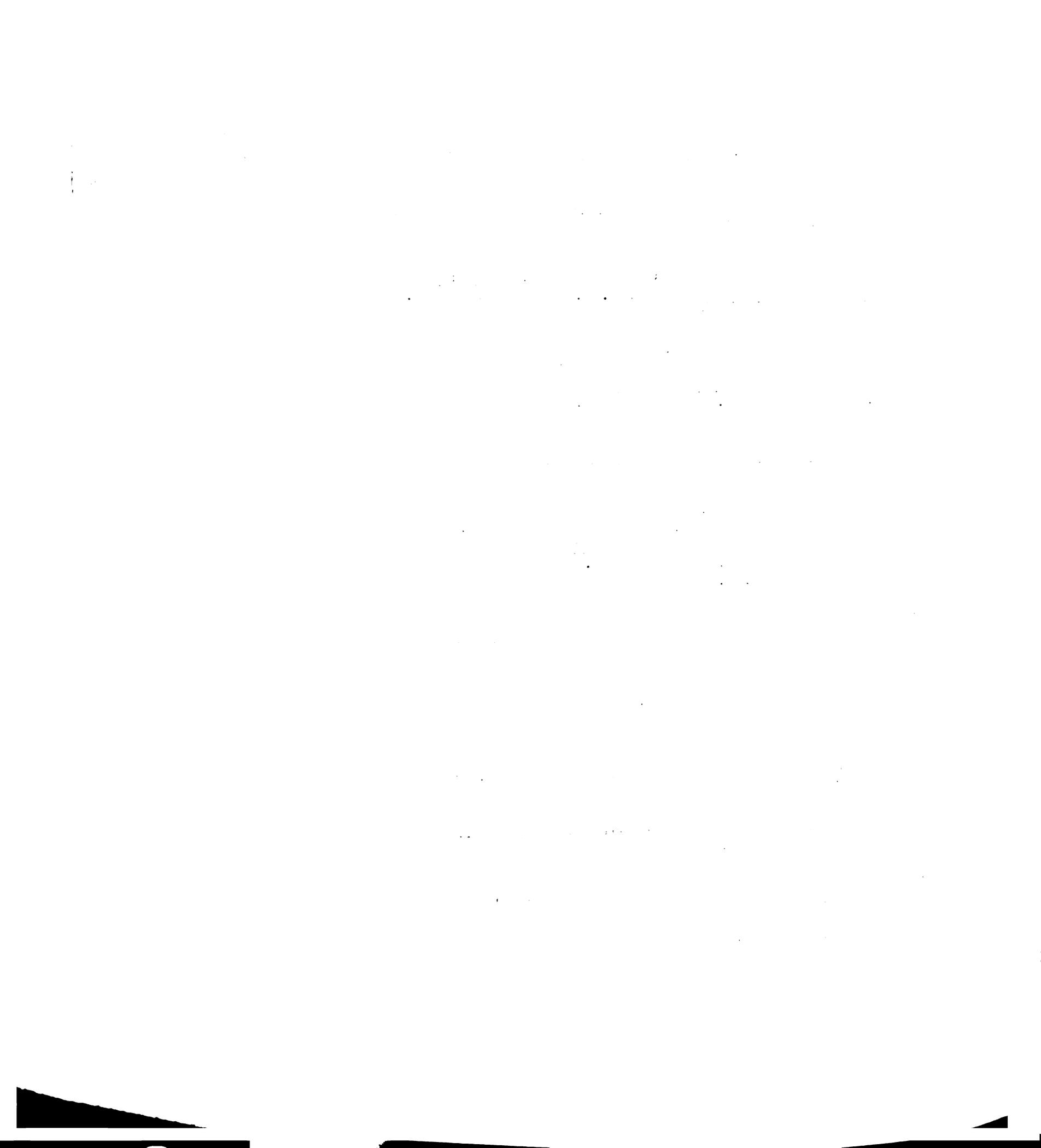
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1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is crucial for ensuring the integrity of the financial statements and for providing a clear audit trail. The text also mentions that proper record-keeping is essential for identifying and correcting errors in a timely manner.

2. The second part of the document focuses on the role of internal controls in preventing fraud and misstatements. It highlights that a strong internal control system is necessary to ensure that all transactions are properly authorized, recorded, and reviewed. The text also notes that internal controls should be designed to be cost-effective and to provide a reasonable level of assurance.

3. The third part of the document discusses the importance of segregation of duties. It explains that this principle is essential for preventing fraud and misstatements by ensuring that no single individual has control over all aspects of a transaction. The text also mentions that segregation of duties should be implemented in a way that is practical and efficient.

4. The fourth part of the document focuses on the importance of regular reconciliations. It explains that reconciling accounts and statements is a key component of the accounting process and is essential for ensuring the accuracy of the financial records. The text also notes that reconciliations should be performed on a regular basis and should be reviewed by a separate individual.

5. The fifth part of the document discusses the importance of maintaining up-to-date documentation. It explains that all transactions should be supported by proper documentation, such as invoices, receipts, and contracts. The text also mentions that this documentation is essential for providing evidence in the event of an audit and for ensuring the accuracy of the financial statements.

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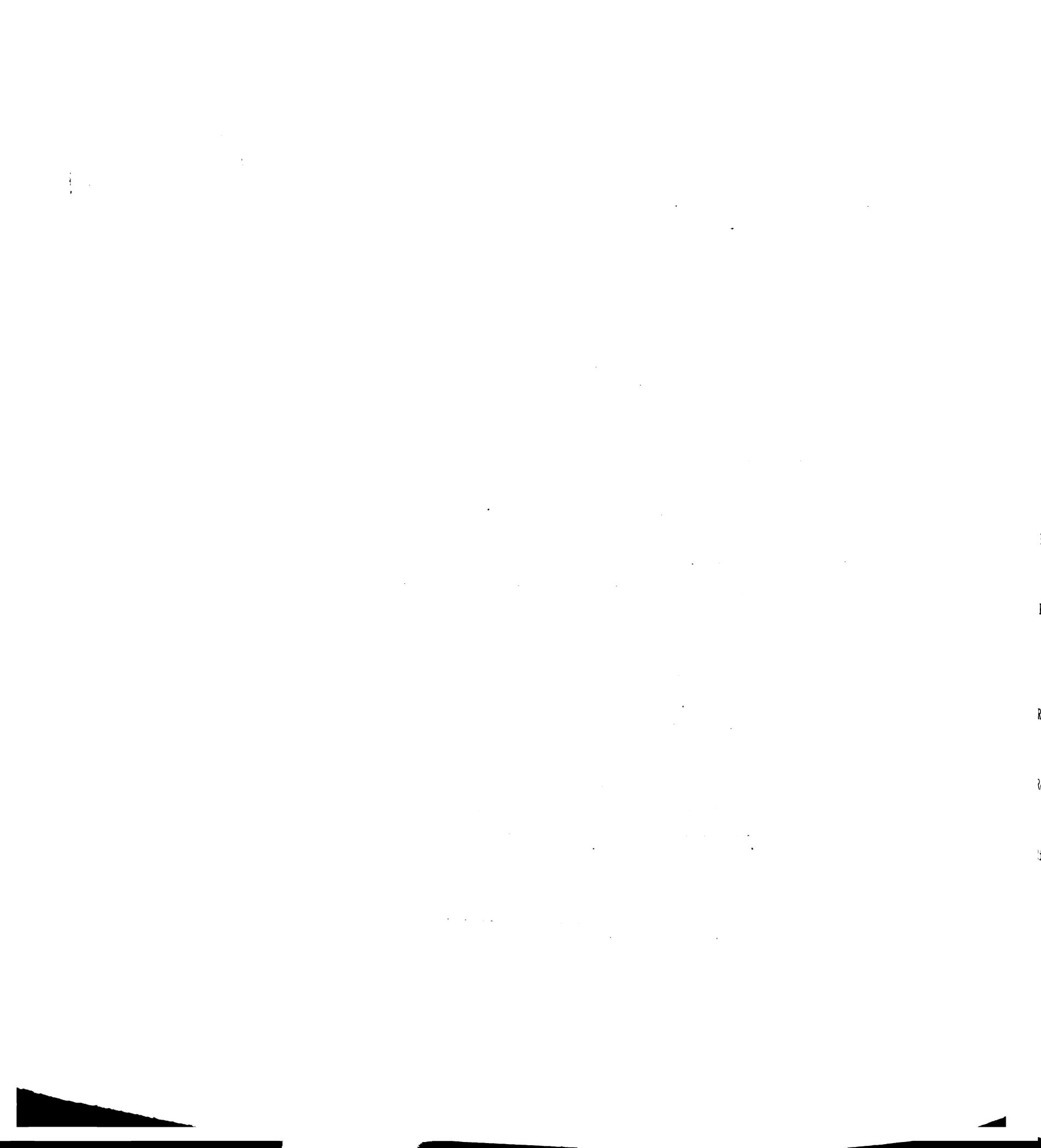
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1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities. It emphasizes that this is crucial for ensuring transparency and accountability in the organization's operations.

2. The second part of the document outlines the various methods and tools used to collect and analyze data. It highlights the need for a systematic approach to data collection and the importance of using reliable sources of information.

3. The third part of the document focuses on the analysis of the collected data. It discusses the various techniques used to identify trends, patterns, and anomalies in the data, and how these insights can be used to inform decision-making.

4. The fourth part of the document discusses the importance of communication and reporting. It emphasizes that the results of the data analysis must be clearly and effectively communicated to the relevant stakeholders in order to ensure that they can take appropriate action.

5. The fifth part of the document discusses the importance of ongoing monitoring and evaluation. It emphasizes that the data analysis process is not a one-time activity, but rather a continuous process that must be repeated regularly to ensure that the organization remains up-to-date on its performance.

6. The sixth part of the document discusses the importance of data security and privacy. It emphasizes that the organization must take appropriate measures to protect its data from unauthorized access, loss, or disclosure, and that it must also ensure that its data handling practices comply with applicable laws and regulations.

7. The seventh part of the document discusses the importance of data quality. It emphasizes that the organization must ensure that its data is accurate, complete, and consistent, and that it must take appropriate measures to address any data quality issues that arise.

8. The eighth part of the document discusses the importance of data integration. It emphasizes that the organization must ensure that its data is integrated across all systems and departments, and that it must take appropriate measures to address any data integration issues that arise.

9. The ninth part of the document discusses the importance of data governance. It emphasizes that the organization must establish a clear framework for data governance, and that it must ensure that all data handling activities are governed by this framework.

10. The tenth part of the document discusses the importance of data literacy. It emphasizes that all employees must have a basic understanding of data and data analysis, and that the organization must provide appropriate training and support to ensure that its employees are equipped with the skills and knowledge needed to work effectively with data.

11. The eleventh part of the document discusses the importance of data ethics. It emphasizes that the organization must ensure that its data handling practices are ethical, and that it must take appropriate measures to address any data ethics issues that arise.

12. The twelfth part of the document discusses the importance of data innovation. It emphasizes that the organization must embrace data as a key driver of innovation, and that it must take appropriate measures to ensure that its data is used to develop new products, services, and processes.

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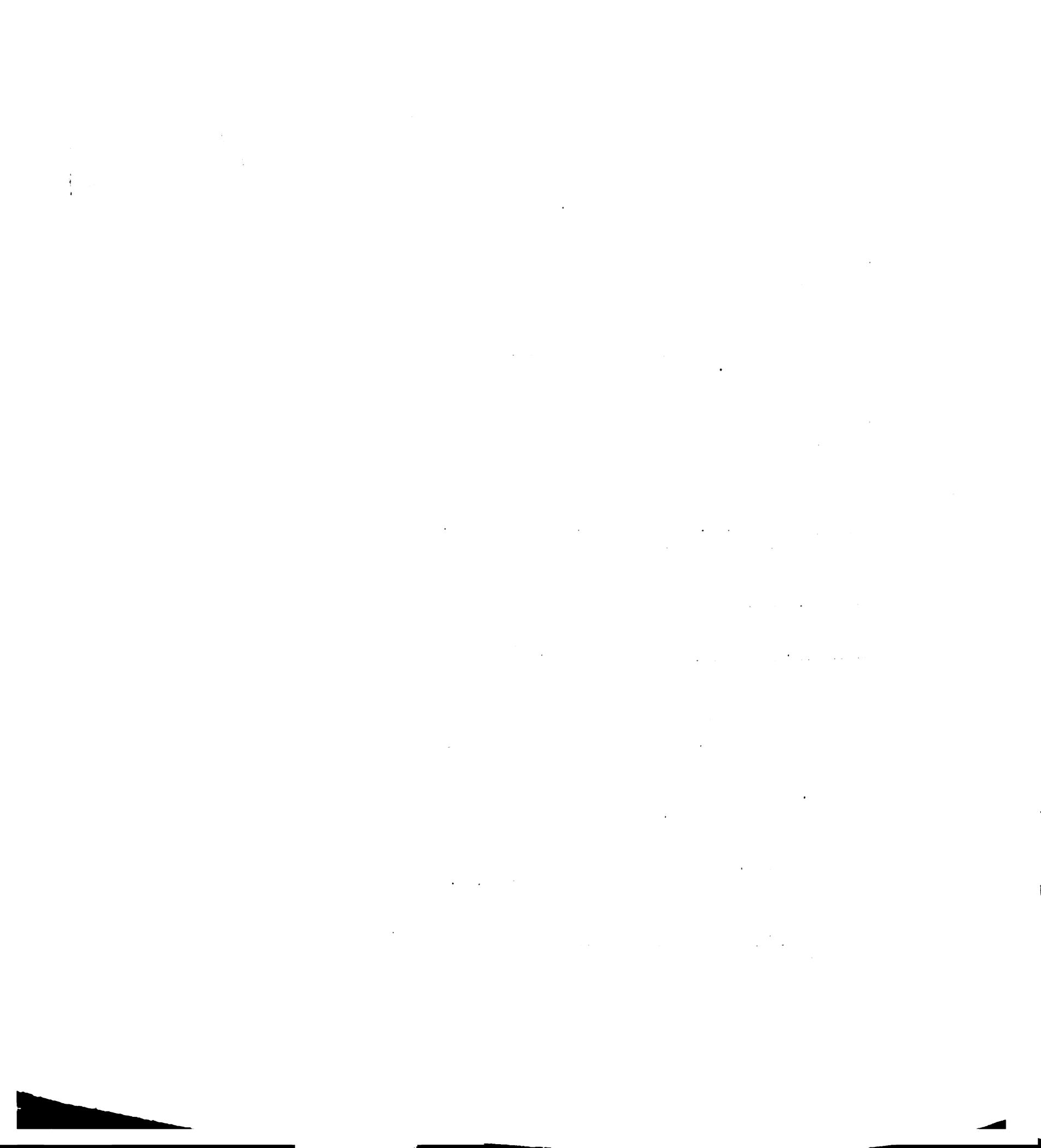
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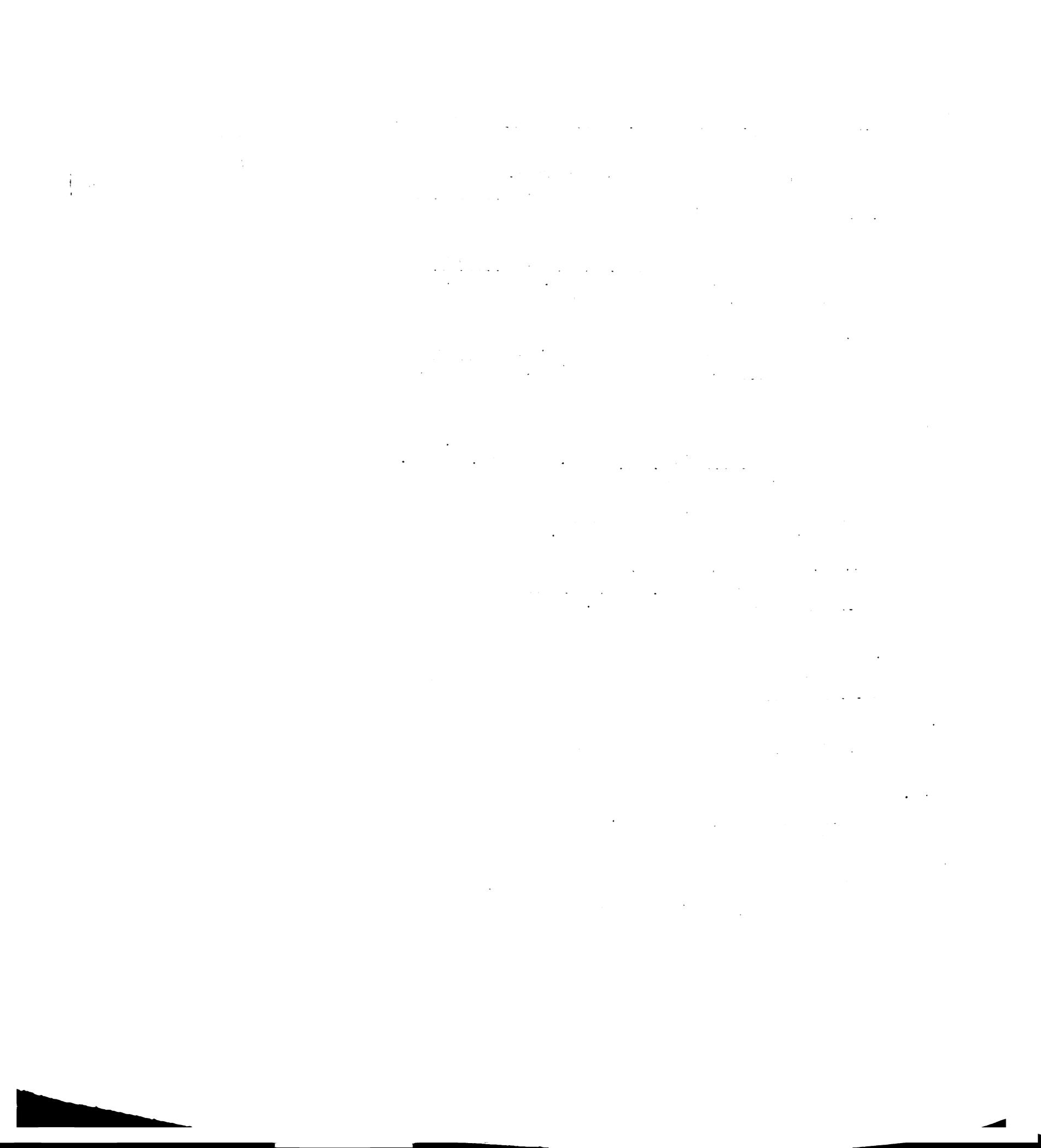
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APPENDIX A

Consent to be a Research Subject

(City and County Hospital)

Consent to be a Research Subject

Psychiatric nursing is one of the most demanding areas of nursing. Burnout and jobhopping frequently occur in nursing. Most studies have focused on individuals who have left nursing, rather than on how nurses who stay adjust to their roles.

A nurse and a medical anthropology student, Kathryn Kavanagh, is interested in how nurses who continue to work adjust in the psychiatric setting. Of particular interest are the ways that these nurses have blended nursing and psychiatry together in a nursing role, nurses' beliefs about mental health and mental illness, and how practicing psychiatric nurses fit the private and professional parts of their lives together.

If you agree to participate in this study, these topics will be discussed during two or more individual interviews. These discussions can take place in any agreed upon location.

Participation in the study may present some inconvenience for you. As a result of these discussions there is a possibility of some loss of privacy. To protect against this, Ms Kavanagh will separate all names and responses and will keep names coded and the code locked. When writing the research results, all identities and the setting will be disguised. Your confidentiality will be protected in all possible ways.

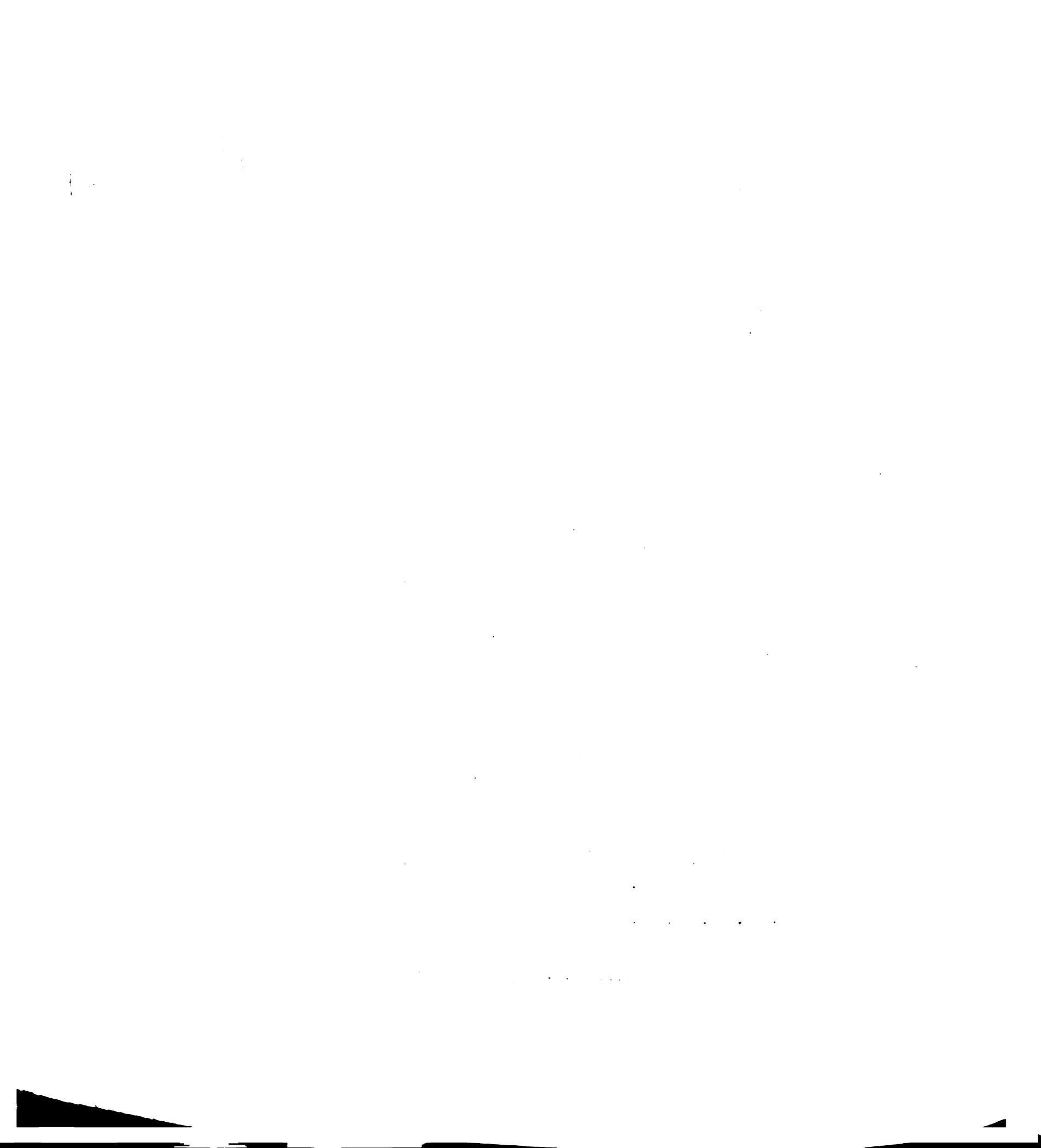
Although you may not experience significant personal benefit from participating in the study, the interviews will contribute toward understanding nursing as it is experienced by practicing psychiatric nurses. Focusing on how psychiatry and nursing work together, the study will also contribute information relevant to patient care and outcome.

You will receive a copy of this form to keep. You have the right to refuse to participate or to withdraw from the research at any time. Kathryn Kavanagh can be reached at 391-0881.

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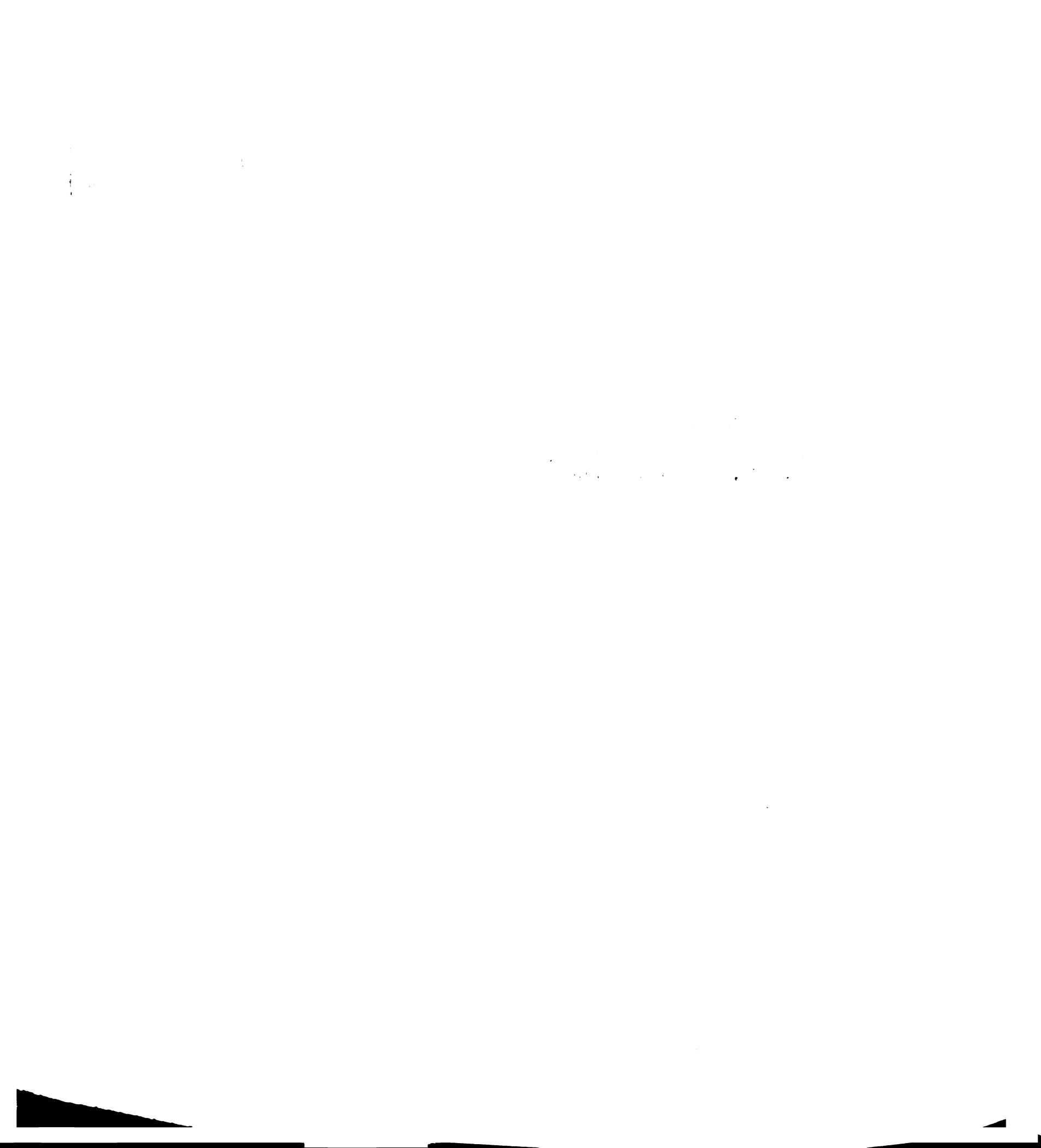
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APPENDIX B

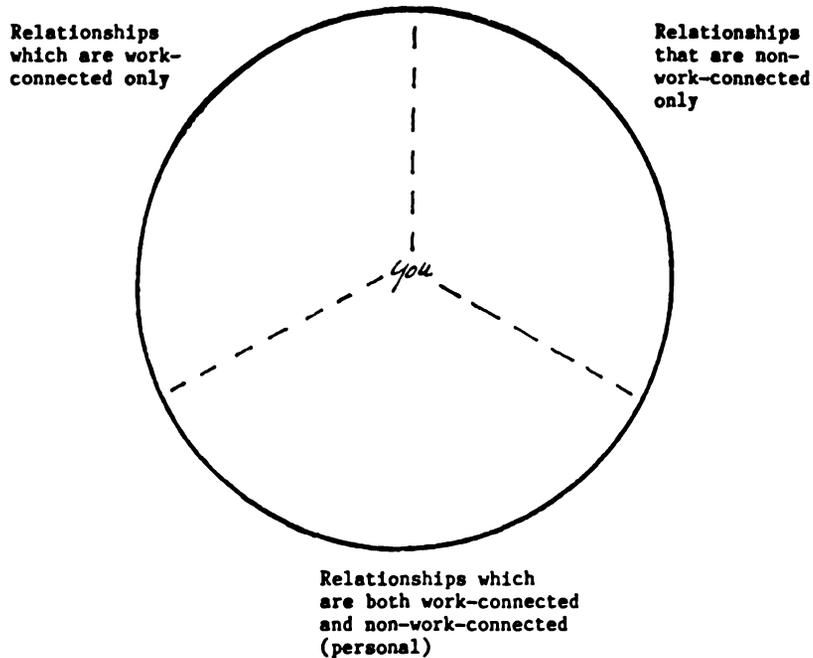
Social Network Analysis Questions,
Map, Grid, and Support Scale



QUESTIONS FOR NETWORK INTERVIEW

1. List those persons who are most important to you.
Any number of persons can be included, of any age, or in any location. Include those persons you consider most significant in your life at the present time, or about whom you feel most strongly, whether or not you like them or feel that you have "good" or friendly relationships with them.
2. Place each individual on the map.
You are in the center. Place those individuals who are most important to you on the map. Place those to whom you feel closest nearest to you, and others farther away to represent your emotional closeness to or distance from each individual.

Move the segment lines to make the sections the appropriate sizes.



3. Which of the persons who are important to you know each other?
 Place a "W" in the boxes of those persons who know each other well.
 Place a "K" in the boxes of those persons who know each other, but not well.
 Place an "S" in the boxes of those persons who know each other only slightly.
 Leave blank the boxes of those persons who do not know each other.

	1	2	3	4 etc. (Names from Question 1)
(Names from Question 1) 1				
2				
3				
4				
etc.				

4. Describe each person on your map.
 How did you meet this individual?
 Describe the type of relationship (eg., friend, nurse on same unit, son, etc.), the individual's marital status, age, employment status, whether an RN or not (if an RN, what type of educational program and current subdiscipline), age, sex, years of education, residence, ethnic background, religious orientation, children.
 Describe what you usually do together, the length and profile of the relationship (i.e., has your relationship always been like you describe it now?)
5. Is or has been each relationship associated with your job?
 If yes, in what way?
6. What kinds of things do you actually do together?
7. How do you feel about the relationship that you have with each individual?
 What emotional dimensions characterize the relationship?
8. What kind(s) of role(s) do you see each of you filling for the other?

9. Does he or she generally make your life easier (better) or harder (worse)?
How?

Mark your response for each person along the continuum next to his or her name.

- + 3 Very supportive
- + 2 Supportive
- + 1 Probably supportive
- 0 Neutral
- 1 Probably non-supportive
- 2 Non-supportive
- 3 Very non-supportive

<u>List of names</u>	+3	+2	+1	0	-1	-2	-3
_____	+3	+2	+1	0	-1	-2	-3
_____	+3	+2	+1	0	-1	-2	-3

etc.

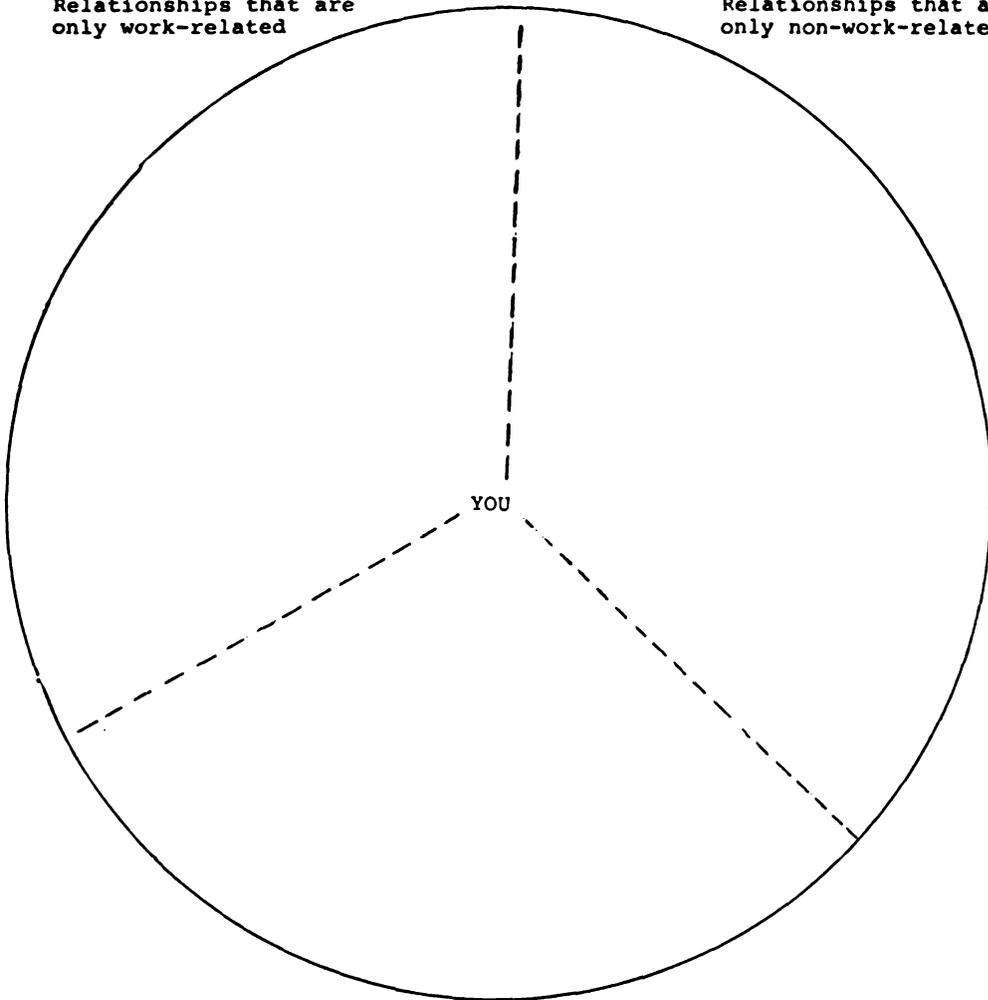
10. Looking at the circle as you filled it in with the names of people who are important to you now, in general, how similar or different is it to how you would have filled it in a year ago?
Before that?
11. How would you change the content of the circle if you felt free to make it any way you wanted it to be?
12. Which persons on your list see life most closely to the way you do?
13. Which persons have ideas about nursing, psychiatric nursing, mental health and mental illness that are most similar to yours?
14. Looking at the circle the way that you divided the relationships into the three sections, which section has the greatest overall impact on your life? Which has the least?

Mark "1" for the most important and "3" for the least.

- _____ Work-related relationships
- _____ Non-work-related relationships
- _____ Combined work-related and non-work-related relationships.

Relationships that are
only work-related

Relationships that are
only non-work-related



Relationships that are both work-related
and non-work-related.

APPENDIX C

Conceptions of Mental Illness Questionnaire

Conceptions of Mental Illness

Instructions

You are being asked to participate in a study of mental health problems. Your participation will supply valuable information about the ways that psychiatric nurses, *also LPTs & Therapists* actually conceptualize mental illness and mental health.

On the following pages you will find a number of statements about health problems. I want to know how much you agree or disagree with each of the statements. To the right of each statement you will find a rating scale:

Disagree						Agree
1	2	3	4	5	6	7
<input type="checkbox"/>						

The points along the scale (1, 2, 3, ... 7) can be interpreted as follows:

1. Completely disagree
2. Mostly disagree
3. Disagree more than agree
4. Neutral
5. Agree more than disagree
6. Mostly agree
7. Completely agree

The use of the scale can be illustrated with the following statement:

"Smoking causes lung cancer."

If you agreed completely with the statements, you would place a mark in column 7. If you agree slightly with the statement, you would place a mark in column 5. If you mostly disagreed with the statement, you would place a mark in column 2. In this manner you can indicate the extent to which you agree or disagree with each of the statements on the following pages.

Like everyone else, you will probably feel that you do not know the answer to some of the statements. When this occurs, please make the best guess that you can.

Please make your marks completely within a box on the scale, not midway between numbered boxes. Also please make sure that you make a mark for each statement. Leave none of the statements blank and make only one mark for each. You should not spend more than a few seconds marking any statement. If it is difficult for you to make up your mind, make the best guess and go on to the next one.

Thank you very much for participating in this study.

Conceptions of Mental Illness

	Disagree							Agree						
	1	2	3	4	5	6	7	1	2	3	4	5	6	7
1. The mentally ill pay little attention to their personal appearance.														
2. People who keep themselves occupied with pleasant thoughts seldom become mentally ill.														
3. Few people who enter mental hospitals ever remain permanently discharged.														
4. Older people have fewer emotional problems than younger people.														
5. People cannot maintain good mental health without the support of strong persons in their environment.														
6. Will power alone will not cure mental disorders.														
7. Women have more emotional problems than men do.														
8. X-rays of the head will not tell whether a person is likely to become insane.														
9. Emotional problems do little damage to the individual.														
10. Psychiatric nurses try to teach mental patients to hold in their strong emotions.														
11. Mental illness can usually be helped by a vacation or change of scene.														
12. Disappointments affect children as much as they do adults.														
13. The main job for the psychiatric nurse is to recommend activities and other ways for the mental patient to occupy his mind.														
14. The insane laugh more than others do.														
15. Psychiatric nurses try to show the mental patient where his/her ideas are incorrect.														
16. Mental disorder is not a hopeless condition.														

Conceptions of Mental Illness

	Disagree							Agree						
	1	2	3	4	5	6	7	1	2	3	4	5	6	7
17. Mental health is one of the most important national problems.														
18. Mental disorder is usually brought on by physical causes.														
19. It is easier for women to get over emotional problems than it is for men.														
20. A change of climate seldom helps an emotional disorder.														
21. The best way to mental health is by avoiding morbid thoughts.														
22. There is not much that can be done for a person who develops a severe mental disorder.														
23. Mental disorder is one of the most damaging illnesses that a person can have.														
24. Children sometimes have mental breakdowns as severe as those of adults.														
25. Nervous breakdowns seldom have a physical origin.														
26. Most of the people in mental hospitals can communicate with other people.														
27. Mental health is largely a matter of trying hard to control the emotions.														
28. If a person concentrates on happy memories, he will not be bothered by unpleasant things in the present.														
29. The mentally ill have not received enough guidance from the important people in their lives.														
30. Women are as emotionally healthy as men.														
31. The seriousness of the mental health problem in this country has been exaggerated.														

Conceptions of Mental Illness

	Disagree			Agree			
	1	2	3	4	5	6	7
32. Helping the mentally ill person with his financial and social problems often improves his condition.							
33. Mental patients usually make a good adjustment in society when they are released.							
34. The good psychiatrist is like a father to his patients.							
35. Early adulthood is more of a danger period for mental illness than later years.							
36. Almost any disease that attacks the nervous system is likely to bring on insanity.							
37. You can tell a person who is mentally ill from his appearance.							
38. Mental illness is usually associated with life stresses.							
39. Women are more likely to develop mental disorders than men.							
40. Most mental disturbances in adults can be traced to emotional experiences in childhood.							
41. People who are uncomfortable with their sexuality are more likely to develop mental disorders than other people.							
42. A person can avoid worry by keeping busy.							
43. A poor diet can contribute to mental disturbance.							
44. Emotionally upset or unstable persons are often found in important positions.							
45. Good emotional habits can be taught to children in school as easily as spelling can.							
46. The eyes of the insane are different from others'.							

Conceptions of Mental Illness

	Disagree							Agree						
	1	2	3	4	5	6	7	1	2	3	4	5	6	7
47. When a person is recovering from a mental illness, it is helpful to discuss his/her treatment with him/her.														
48. People who go from doctor to doctor with many complaints know that there is nothing really wrong with them.														
49. A person cannot rid himself of unpleasant thoughts by trying to avoid or forget them.														
50. The main job of the psychiatric nurse is to explain to the patient the origin of his troubles.														
51. Most suicides occur because of feelings of rejection.														
52. People who are likely to develop a mental disturbance are likely to pay little attention to their personal appearance.														
53. Most of the time there is no way to predict whether or not a patient's mental disorder is curable.														
54. If people could learn to avoid stress and relax they would be less likely to develop mental illnesses.														
55. Books on "peace of mind" prevent many people from developing mental disturbances.														
56. Mental illness is really a disease and psychiatric nurses should treat it as such.														
57. Physical exhaustion does not lead to psychological breakdown.														
58. The adult who needs a great deal of affection is likely to have had little affection in childhood.														
59. Physical rest is part of psychiatric treatment.														
60. Most of the people who seek psychiatric help need the treatment.														

Opinions about Mental Illness

	Disagree							Agree						
	1	2	3	4	5	6	7	1	2	3	4	5	6	7
61. Nervous breakdowns usually result from working too hard.														
62. Mental illness is an illness like any other.														
63. Most patients in mental hospitals are not dangerous.														
64. Although patients discharged from mental hospitals may seem all right, they should not be encouraged to marry and have children.														
65. If parents expressed more concern for their children, there would be less mental illness.														
66. It is easy to recognize someone who once had a serious mental illness.														
67. People who are mentally ill let their emotions control them; other people can think things out.														
68. People who were once patients in mental hospitals are no more dangerous than the average citizen.														
69. When a person has a problem, it is best not to dwell on it, but to keep busy with more pleasant things.														
70. Although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of everyday life.														
71. There is something about mental patients that makes it easy to tell them from other people.														
72. Even though patients in mental hospitals behave in bizarre ways, it is wrong to make fun of them.														
73. Most mental patients are willing to work.														
74. The small children of mental patients should not be allowed to spend much time with their mentally ill parent.														

Opinions about Mental Illness

	Disagree			Agree			
	1	2	3	4	5	6	7
75. People who are successful in their work seldom become mentally ill.							
76. People would not become mentally ill if they felt better about themselves.							
77. Patients in mental hospitals are in many ways like children.							
78. More tax money should be spent in the care and treatment of people with severe mental illness.							
79. A heart patient has just one thing wrong with him, while a mentally ill person is completely different from other patients.							
80. Mental patients come from homes where the parents took little interest in their children.							
81. People with mental illness should not be segregated from people with physical illness.							
82. Anyone who tries hard to better himself deserves the respect of others.							
83. If our hospitals had enough well trained doctors, nurses, and techs, many of the patients would get well enough to stay out of the hospital.							
84. A woman would be foolish to marry a man who has had a severe mental illness, even though he seems fully recovered.							
85. If the children of mentally ill parents were raised by "normal" parents, they would probably not become mentally ill.							
86. People who have been patients in a mental hospital will never be their old selves again.							
87. Many mental patients are capable of skilled labor, even though in some ways they are very disturbed mentally.							

Opinions about Mental Illness

	Disagree							Agree
	1	2	3	4	5	6	7	
88. Anyone who is in a hospital for a mental illness should not be allowed to vote.								
89. The mental illness of many people is caused by the separation or divorce of their parents during childhood.								
90. The best way to handle patients in mental hospitals is to keep them behind locked doors.								
91. To become a patient in a mental hospital is to become a failure in life.								
92. The patients in mental hospitals should be allowed more privacy.								
93. If a patient in a mental hospital attacks someone, he should be punished so he doesn't do it again.								
94. If the children of "normal" parents were raised by mentally ill parents they would probably become mentally ill.								
95. Every psychiatric unit should have controlled security and guards.								
96. The law should allow an individual to divorce his/her spouse as soon as he/she is confined and/or treated for a severe mental illness.								
97. People who are unable to work because of mental illness should receive money for living expenses.								
98. Mental illness is usually caused by some physiological condition.								
99. Regardless of how you look at it, patients with severe mental illness are no longer really human.								
100. Most men and women who were once patients in a mental hospital could be trusted as baby sitters.								
101. Most patients in mental hospitals don't care how they look.								

Opinions about Mental Illness

	Disagree							Agree
	1	2	3	4	5	6	7	
102. Professionals are more likely to become mentally ill than are the unemployed.								
103. Many people who have never been patients in a mental hospital are more mentally ill than many hospitalized mental patients.								
104. Although some mental patients seem all right, it is dangerous to forget for a moment that they are mentally ill.								
105. Sometimes mental illness is a punishment for bad deeds.								
106. Our mental hospitals should be organized in a way that makes the patient feel as much as possible like he is living at home.								
107. One of the main causes of mental illness is a lack of moral strength or will power.								
108. There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed.								
109. Many mental patients would remain in the hospital until they were well even if the doors were unlocked.								
110. The distinction between being "mentally ill" and being "normal" is not always clear.								

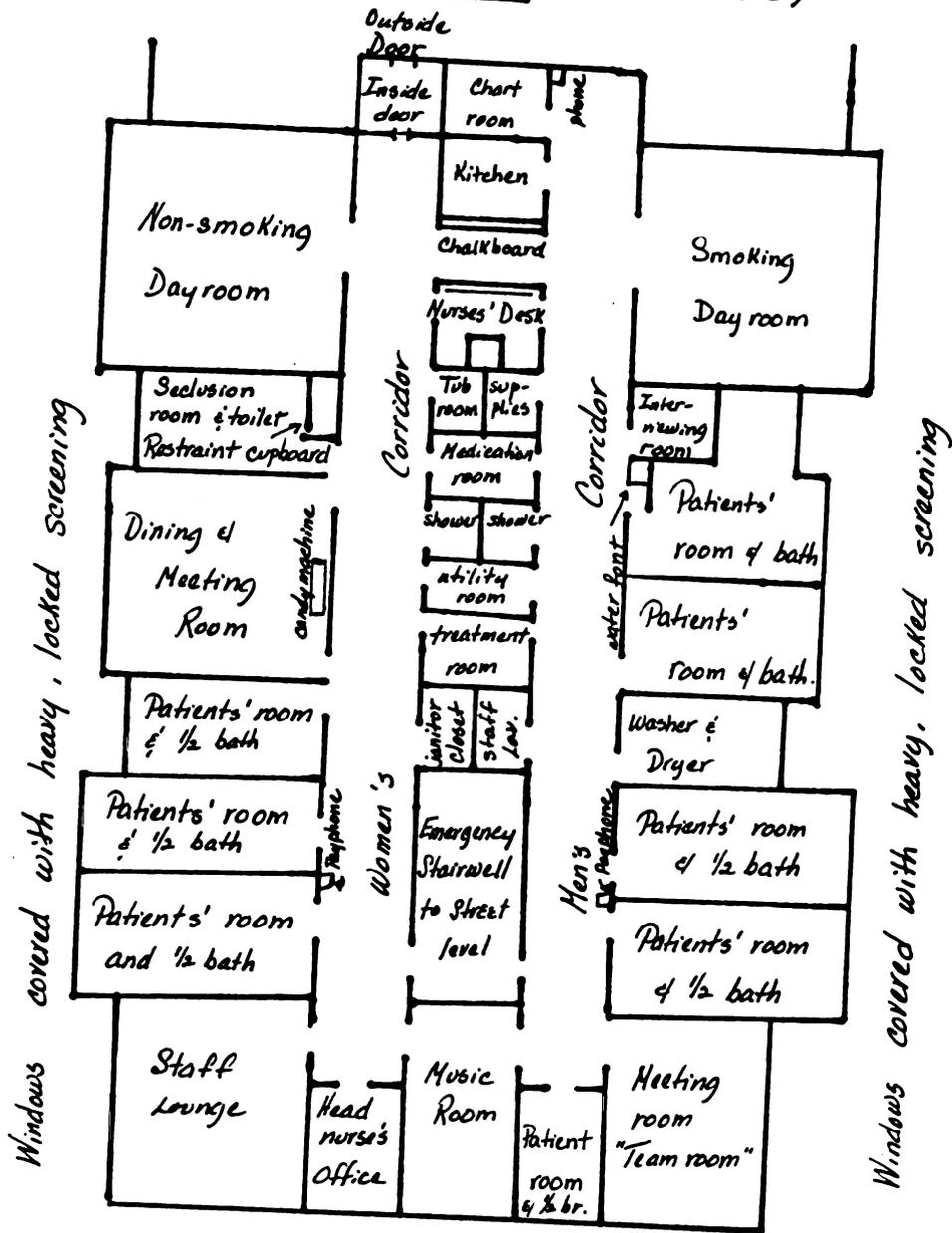
Now that you have completed the questionnaire, would you please check to make sure that you have rated your agreement or disagreement with every statement in the questionnaire, and that you made only one mark for each statement.

THANK YOU AGAIN FOR YOUR HELP IN THIS RESEARCH.

APPENDIX D

Unit Format: Maps of Unit and Day Rooms

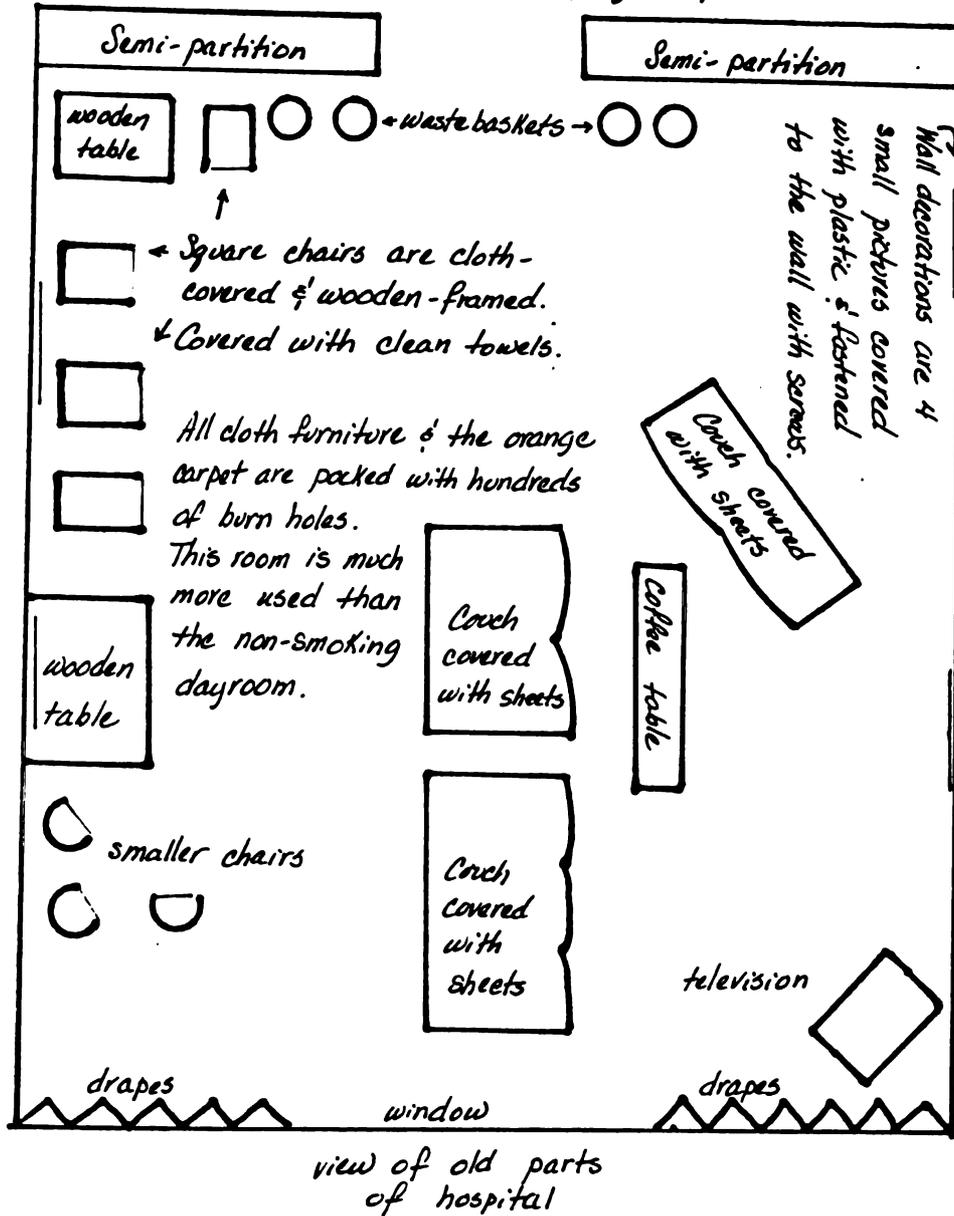
Ten East (not to scale)



Windows covered with heavy, locked screening
 Most patients' rooms have semi-partitions for privacy (2 or 3 pts. per room).

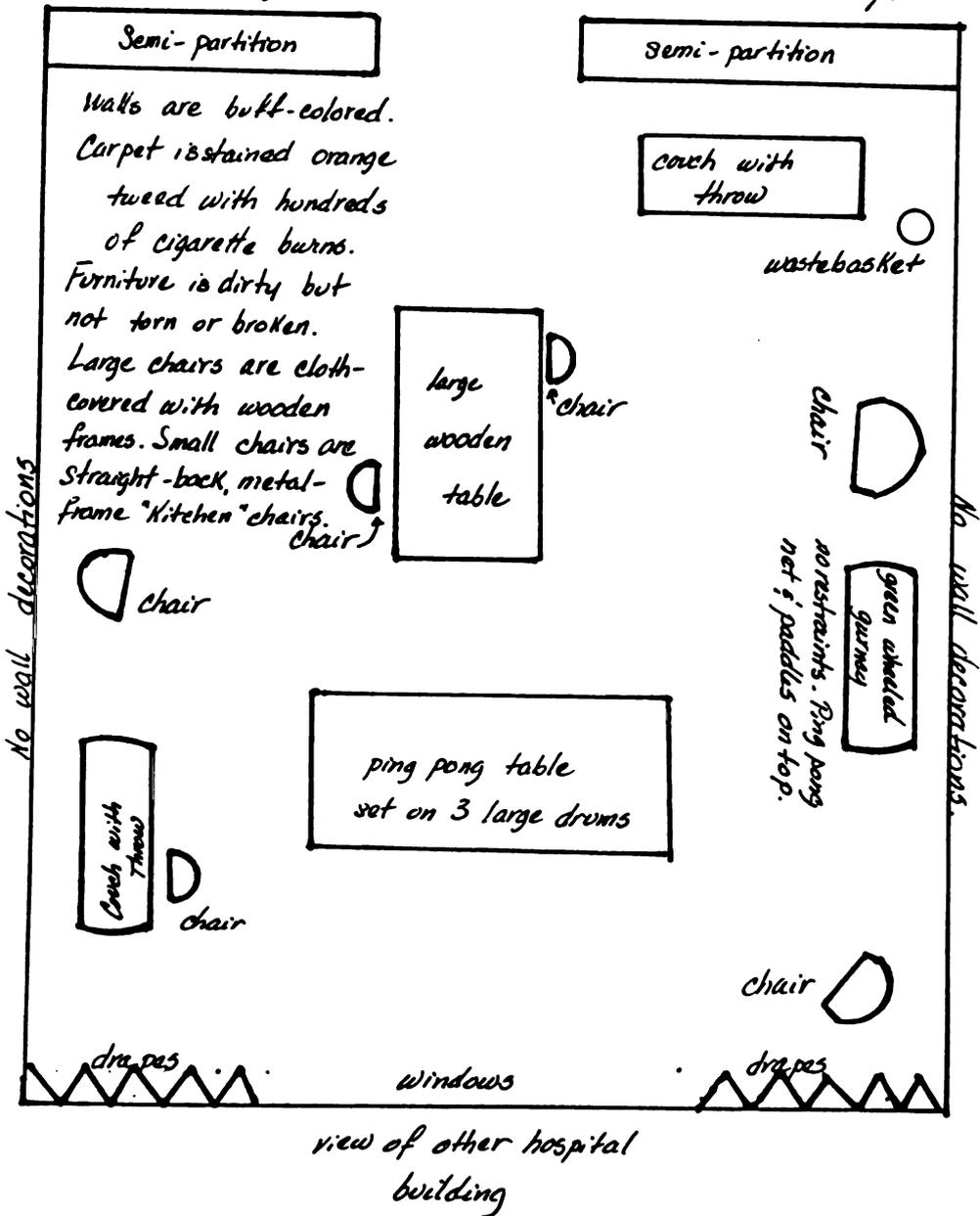
Smoking Dayroom

All furniture except the T.V. is frequently moved.



Non-Smoking Dayroom

Except for large tables, furniture is moved almost daily.



APPENDIX E

Organizational Charts for the Department of Psychiatry

Figure 1.

A. Organizational Chart for City and County's Department of Psychiatry

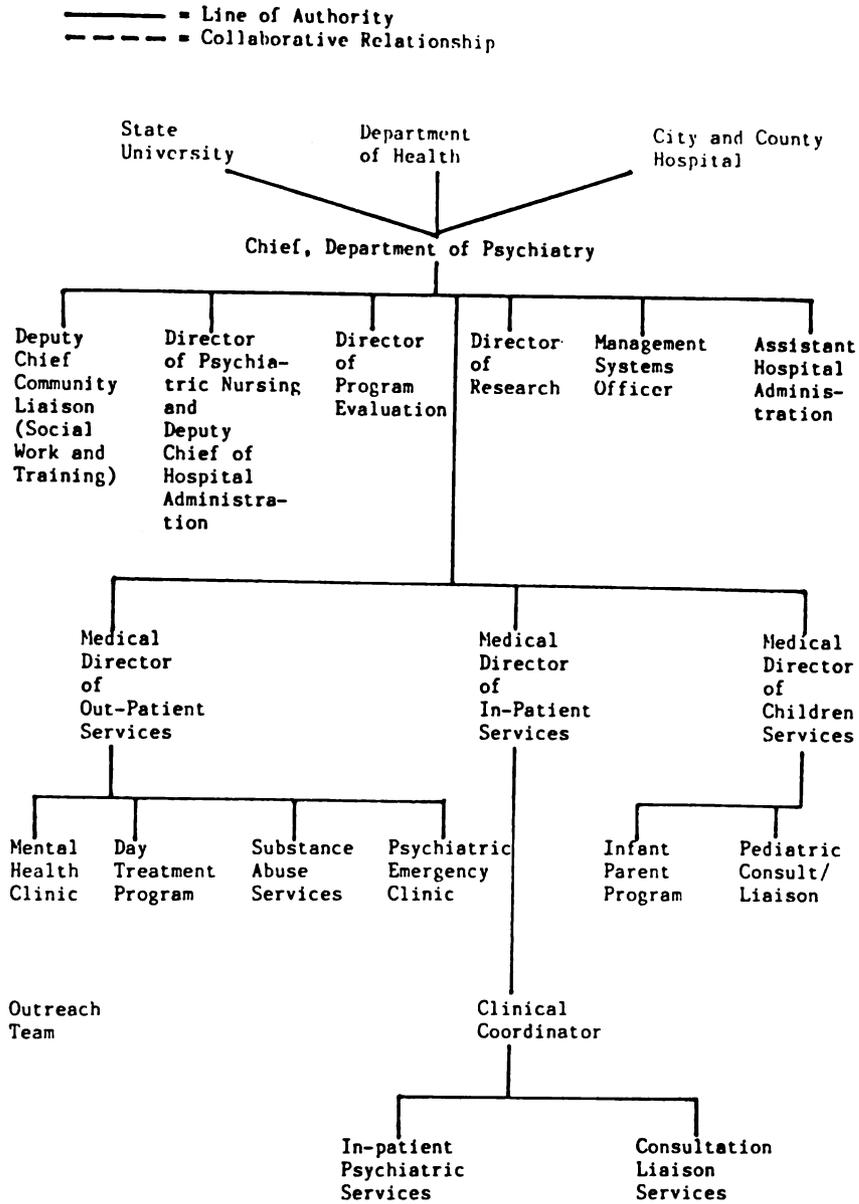
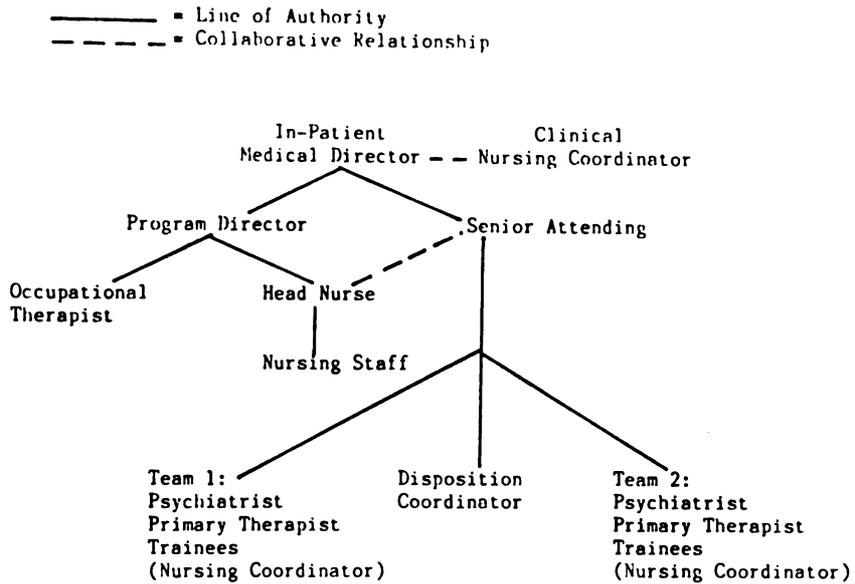


Figure 2.

B. Organizational Chart for Unit

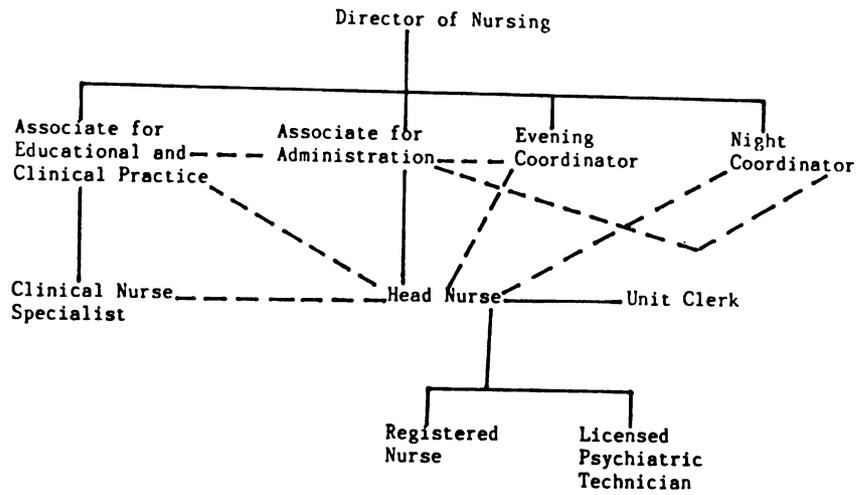


(One unit has a nursing coordinator to mediate between the therapy team and the nursing staff. On the other units, nurses are not represented within the team organization, although, rarely, a clinical nurse specialist may follow a patient.)

Figure 3.

C. Organizational Chart for Nursing Administration

————— = Line of Authority
----- = Collaborative Relationship



APPENDIX F

Demographic Characteristics of
Registered Nurses

Table 1

Ethnicity of RNs, by Age and Sex
n = 54

	<u>Sex</u>	20-29		30-39		40-49		<u>Present Age</u>		60-69		% Total	
		M	F	M	F	M	F	M	F	M	F	Males	Females
<u>Asian</u>		1		1	2		1					1.9	7.4 (9.3%)
<u>Black</u>				1	3		2		3			1.9	14.8 (16.7%)
<u>Anglo/White</u>		2	4	9	10	1	6		4		1	22.2	46.3 (68.5%)
<u>Hispanic</u>		1					2					1.9	3.7 (5.6%)
												100.1%	

Table 2

Present Marital Status of RNs, by Age and Sex
n = 49

	<u>Sex</u>	20-29		30-39		<u>Present Age</u>		60-69		% Totals		
		M	F	M	F	M	F	M	F	Males	Females	
<u>Married</u>		2		2	3			3		8.2	12.2 (20.4%)	
<u>Remarried</u>				1		1		1			6.1 (6.1%)	
<u>Divorced</u>				3	2	1	4	2		1	8.2	18.4 (26.6%)
<u>Widowed</u>						1		1			4.1 (4.1%)	
<u>Never Married</u>		1	5	5	6	4					12.2	30.6 (42.8%)

Totals

Married:	20.4%	Not Married:	26.6%
	6.1%		4.1%
	<u>26.5%</u>		<u>42.8%</u>
			<u>73.5%</u>

100

101

102

103

104

105

106

Table 3

Highest Level of Nursing Education of RNs, by Age and Sex
n = 48

	<u>Sex</u>	20-29		30-39		<u>Present Age</u> 40-49		50-59		60-69		% Totals Males/Females		
		M	F	M	F	M	F	M	F	M	F			
<u>2 Year</u>														
Associate Degree in Nursing (ADN)		1	1	4						1		10.4	4.2	(14.6%)
<u>3 Year</u>														
Diploma			1	1	2	4		5				2.1	25.	(27.1%)
<u>4 Year</u>														
Bachelor in Nursing Science (BSN)		1	3	5	6	4						12.5	27.1	(39.6%)
Master in Nursing (MSN)				4		1	3		1			2.1	16.7	(18.8%)
												<u>100.1%</u>		

Table 4

Additional (Non-nursing) Education of RNs, by Age and Sex
n= 48

	<u>Sex</u>	20-29		30-39		<u>Present Age</u> 40-49		50-59		60-69		% Totals Males/Females		
		M	F	M	F	M	F	M	F	M	F			
<u>Associate Degree (AD)</u>			1		2		1					4.2	4.2	(8.4%)
<u>Bachelor of Art (BA) or Bachelor of Science (BS)</u>			1		4	2	1		1			8.3	10.4	(18.7%)
<u>Master of Art (MA) or Master of Science (MS)</u>					1		1						12.6	(12.6%)
												<u>39.7%</u>		



Table 5

RNs currently working toward additional degrees, by Age and Sex
 n = 47

	<u>Sex</u>	<u>Present Age</u>										<u>Total %</u> Males/Females	
		20-29		30-39		40-49		50-59		60-69			
		M	F	M	F	M	F	M	F	M	F		
<u>Working on:</u>													
<u>BSN</u>				1								2.1%	(2.1%)
<u>MSN</u>		2										4.3%	(4.3%)
<u>Doctorate in</u>													
<u>Nursing</u>				1								2.1%	(2.1%)
<u>Other MA, MS</u>						1						2.1%	(2.1%)
<u>Other PhD</u>				1		1						4.3%	(4.3%)
												14.9%	

Table 6

Interest in Increased Education, by Age and Sex
 n = 41

	<u>Sex</u>	<u>Present Age</u>										<u>% Totals</u> Males/Females	
		20-29		30-39		40-49		50-59		60-69			
		M	F	M	F	M	F	M	F	M	F		
<u>Yes:</u>													
<u>Nursing</u>		1	2	4	2	1						12.2	12.2 (24.4%)
<u>Other</u>		1		1	2	1	5	2				7.3	22.0 (29.3%)
												53.7%	
<u>No:</u>		1		5	5	1	1	5	1			17.1	29.3 (46.4%)

Yes: 53.7%

No: 46.4%

100.1%

Table 7

Age at Entering Job Market as RN, by Present Age and Sex
 n = 37

	<u>Sex</u>	<u>Present Age</u>										<u>Total %</u> Males/Females	
		20-29		30-39		40-49		50-59		60-69			
		M	F	M	F	M	F	M	F	M	F		
<u>21-25</u>			3	2	7	6		4				5.4	54.1 (59.5%)
<u>26-30</u>		2		4	2	1		1				16.2	10.8 (27.0%)
<u>31-35</u>				1	1	2						2.7	8.1 (10.8%)
<u>36-40</u>													---
<u>41-45</u>													---
<u>46-50</u>										1		2.7	(2.7%)
													<u>100%</u>

Table 8

Year of Graduation and Entering Job Market, by Age and Sex
 n = 37

	<u>Sex</u>	<u>Present Age</u>										<u>% Totals</u> Males/Females	
		20-29		30-39		40-49		50-59		60-69			
		M	F	M	F	M	F	M	F	M	F		
<u>1950-54</u>								4				10.8	(10.8%)
<u>1955-59</u>								1				2.7	(2.7%)
<u>1960-64</u>						4						10.8	(10.8%)
<u>1965-69</u>					1	2				1		10.8	(10.8%)
<u>1970-74</u>				2	3	3						5.4	16.2 (21.6%)
<u>1975-79</u>			2	4	4							10.8	16.2 (27.0%)
<u>1980-84</u>		1	2	1	2							5.4	10.8 (16.2%)
													<u>99.9%</u>

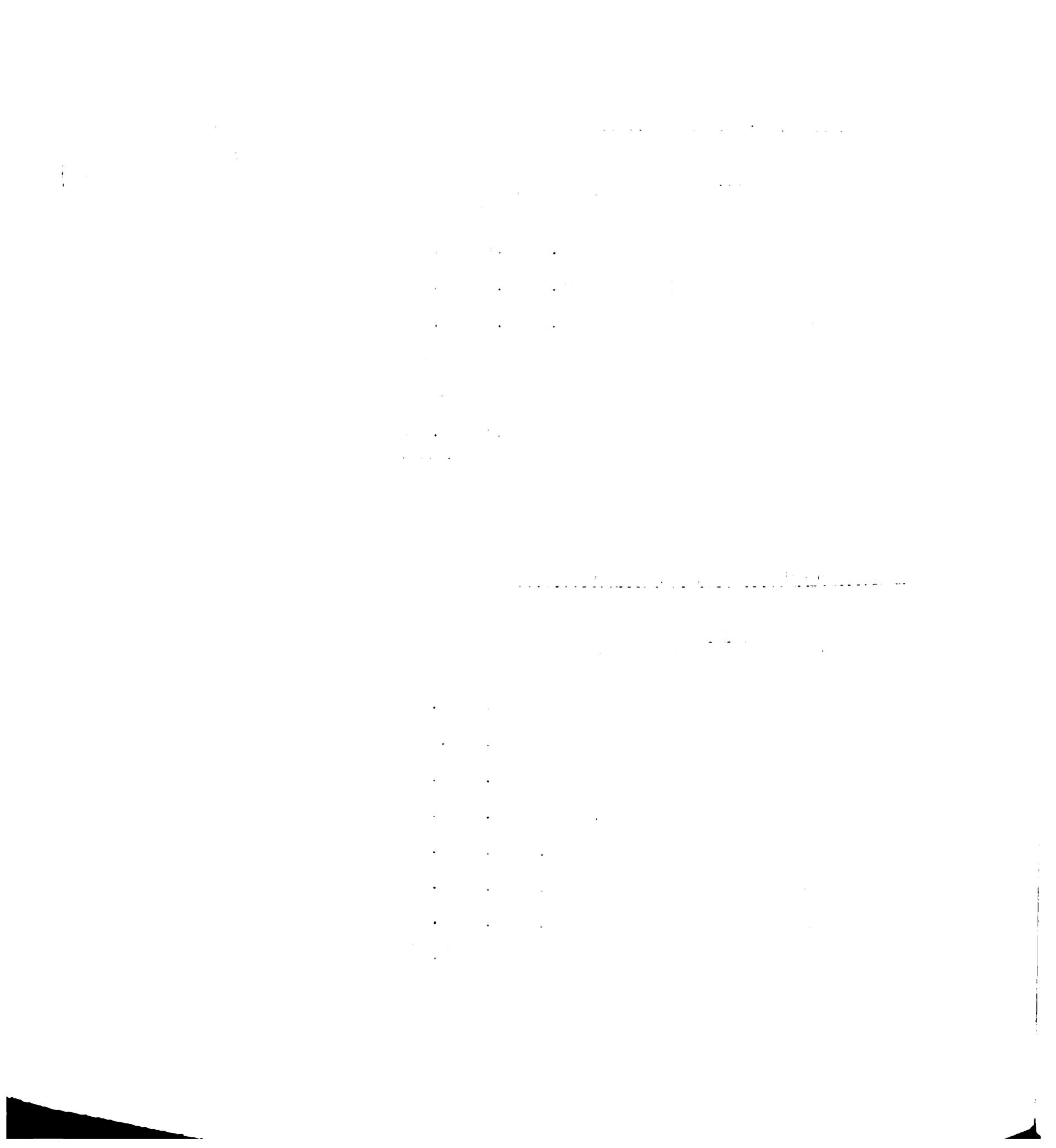


Table 9

Number of Nursing Jobs Held Previously, by Age and Sex

n = 38

Some RNs have been employed by the City and County system more than once. Previous employment episodes at City and County Hospital are treated as separate jobs. Work in the Psychiatric Emergency Clinic is treated as part of current job. Work in community mental health settings is treated as separate.

<u>Sex</u>	20-29		30-39		<u>Present Age</u> 40-49		50-59		60-69		<u>% Totals</u> Males/Females	
	M	F	M	F	M	F	M	F	M	F		
<u>Number of Positions</u>												
0		1		1							2.6	2.6 (5.3)
1				2				1			5.3	2.6 (7.9)
2				3	2	1		2			7.9	13.2 (21.1)
3		2		2	2	2		1		1	5.3	23.7 (26.3)
4				1	1	1		2			2.6	10.5 (13.2)
5												
6						1						2.6 (2.6)
7				1		1						5.3 (5.3)
8												
9				1		3						10.5 (10.5)
10												
11-15						1		1				5.3 (5.3)
16-20								1				2.6 (2.6)
												100.1%

n = 38

mean = 4.1 previous nursing jobs

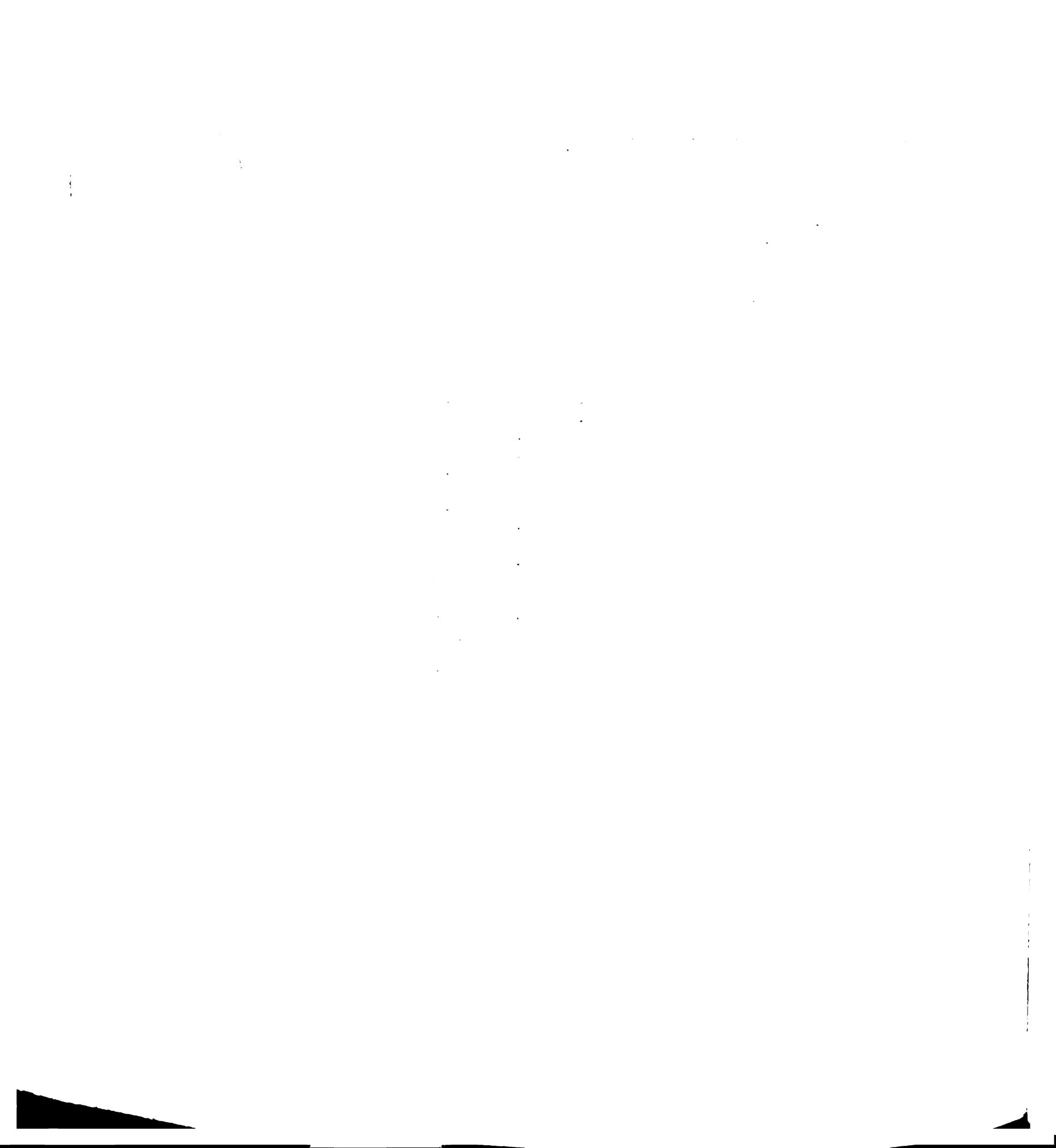


Table 10

Years Working in Current Civil Service Position, by Age and Sex
 n = 37

If previously employed at City and County, only the length of current employment episode is represented here. No one in the sample was previously employed at City and County for more than a few weeks.

	20-29		<u>Present Age</u>				50-59		60-69		% Totals	
	<u>Sex</u>	M F	M F	M F	M F	M F	M F	M F	Males/Females			
<u>Less than 1 yr</u>		2	4		1					10.8	8.1	(18.9)
<u>1 to 1.9 yr</u>			1	1	4					2.7	13.5	(16.2)
<u>2 to 3 yr</u>				3	3						16.2	(16.2)
<u>4 to 5 yr</u>		1	2	2	2		2		1	5.4	21.6	(27.0)
<u>6 to 10 yr</u>			1	1	1					2.7	5.4	(8.1)
<u>11 to 15 yr</u>					1		1				5.4	(5.4)
<u>16 to 20 yr</u>											-----	
<u>21 to 25 yr</u>							2				5.4	(5.4)
<u>26 to 30 yr</u>							1				2.7	(2.7)
												<u>99.9%</u>



Table 11

Working Full or Part Time, By Age, Sex, and Nursing Education
n = 49

	Sex		Present Age						% Totals Males/Females			
			20-29		30-39		40-49				50-59	
	M	F	M	F	M	F	M	F	M	F		
<u>Full Time</u>												
<u>2 yr ADN</u>	1	1	4						1	10.2	4.1	(14.3)
<u>3 yr Diploma</u>	1		1	2	4		5			2.0	24.5	(26.5)
<u>4 yr BSN</u>	1		5	2	2					12.2	10.2	(22.4)
<u>MSN</u>			3		1	3				2.0	12.2	(14.2)
												77.4%
<u>Part Time</u>												
<u>2 yr ADN</u>												---
<u>3 yr Diploma</u>					1						2.0	(2.0)
<u>4 yr BSN</u>	3	1	2		2					2.0	14.3	(16.3)
<u>MSN</u>			1				1				4.1	(4.1)
												22.4%
Full Time	77.4%											
Part Time	22.4%											
	<u>99.8%</u>											

Table 12

Percentages Working Full Time and Part Time, by Age, Sex, and Education
n = 49

<u>Education</u>	<u>Total</u>	<u>Full Time</u>	<u>Part Time</u>
<u>2 yr ADN</u>	7	100%	---
<u>3 yr Diploma</u>	14	92.9%	7%
<u>4 yr BSN</u>	19	57.9%	42.1%
<u>MSN</u>	9	77.8%	22.2%



APPENDIX G
Nursing Staff Schedules

Figure 1: A. Ten West Nursing Staff Schedule

<u>Hour</u>	<u>Monday</u>	<u>Tuesday</u>	<u>Wednesday</u>	<u>Thursday</u>	<u>Friday</u>
8:15- 8:45 AM	Team II Meeting		Team II Meeting		Team II Meeting
8:45- 9:15 AM	Team I Meeting		Team I Meeting	Team II Case Review	Team I Meeting
9:15- 9:30 AM	Unit Review		Unit Review		Unit Review
9:30- 9:45 AM	Level Meeting	Team II Meeting and	Level Meeting	Team I Meeting and	Level Meeting
9:45- 10:30 AM	Community Meeting	Case Review	Community Meeting	Case Review	Community Meeting
10:30- 11:15AM					Case and Journal Conference
11:15- 12 Noon		Team I Meeting and Case Review		Nursing Discussion Group	
12-2:30 PM					
2:30- 3:00- 4:00-		Staff Meeting	Nursing In-Service (1 hour)	Nursing Staff Meeting (45 min.)	
4:20 PM		Team I Meeting		Team II Meeting	
6:30- 7:00 PM			Nursing Rap Group		

and the extent to which they are able to meet their needs.

There are a number of reasons why this is the case.

First, the elderly are often

more dependent on

family members for support and care.

Second, the elderly are often

more likely to be living in

poor housing conditions.

Figure 2: B. Ten North Nursing Staff Schedule

Hour	Monday	Tuesday	Wednesday	Thursday	Friday
8:30-9:00 AM	Unit Review				Unit Review
9-10 AM	Team A Meeting	Team A Meeting	Team A Rounds and Case Review	Team A Meeting	Teams A and B Rounds
10-11 AM	Team B Meeting	Team B Meeting	Team B Rounds and Case Review		Community Meeting and Staff Rehash
11-12 AM	Community Meeting and Staff Rehash	Executive Committee Meeting			
12-1 PM		Patio Lunch			
1-2 PM					
2:30-3:00-4:00 PM		Staff Meeting	Nursing Staff Meeting (1 hour)	Inservice Training (1 hour)	
4-5 PM			Community Meeting and Staff Rehash	Team B Meeting	



Figure 3: C. Ten East Nursing Staff Schedule

Hour	Monday	Tuesday	Wednesday	Thursday	Friday
8:55 AM	Unit Review		Unit Review		Unit Review
9:15 AM	Community Meeting and Staff Discussion	Team II Meeting	Community Meeting and Staff Discussion	Nursing Meeting	Community Meeting and Staff Discussion
10 AM	Team II Meeting	Team I Meeting		Team II Case Review	Team I or II Meeting or Case Conference
11 AM	Team I Meeting				Team I or II Meeting or Case Conference
12 Noon					
1 PM			Probable Cause Hearings		Probable Cause Hearings
2 PM			Staff Meeting	Nursing Staff Meeting	
3 PM	Group Consultation (every other week)	Clinical Nursing Meeting			
4 PM			Team II Meeting	Team I Meeting	



APPENDIX H
Attitudinal Questionnaire Results

Table 1. Summary of responses of RNs, LPTs, and therapists to questionnaire statements which generated statistically significant differences between group mean variance and within group variance.

Response Numbers:

- Completely Disagree.....1
- Mostly Disagree.....2
- Disagree more than Agree.....3
- Neutral.....4
- Agree more than Disagree.....5
- Mostly Agree.....6
- Completely Agree.....7

<u>Statement</u>	<u>Response</u>	<u>n and % LPTs</u>		<u>n and % RNs</u>		<u>n and % Therapists</u>	
2	1	10	38.5	13	36.1	14	45.2
	2	2	7.7	9	25.0	9	29.0
	3	2	7.7	9	25.0	4	12.9
	4	5	19.2	1	2.8	0	
	5	3	11.5	3	8.3	2	6.5
	6	2	7.7	0		1	3.2
	7	2	7.7	1	2.8	1	3.2
Totals		26	100	36	100	31	100
Mean		3.12		2.33		2.16	
Variance		4.35		2.11		2.54	
F ratio (theoretically significant at 0.05)						3.11	
F ratio						3.73	
7	1	11	42.3	15	41.7	10	33.3
	2	3	11.5	8	22.2	9	30.0
	3	2	7.7	8	22.2	3	10.0
	4	4	15.4	4	11.1	5	16.7
	5	1	3.8	1	2.8	1	3.3
	6	2	7.7	0		2	6.6
	7	3	11.5	0		0	
Totals		26	99.9	36	100	30	99.9
Mean		2.96		2.11		2.47	
Variance		4.84		1.36		2.33	
F Ratio (theoretically significant at 0.05)						3.11	
F ratio						8.83	

Table 1, continued

<u>Statement</u>	<u>Response</u>	<u>n and % LPTs</u>		<u>n and % RNs</u>		<u>n and % Therapists</u>	
13	1	7	28.0	16	44.4	8	26.7
	2	3	12.0	8	22.2	11	36.7
	3	3	12.0	4	11.1	8	26.7
	4	3	12.0	4	11.1	1	3.3
	5	4	16.0	4	11.1	1	3.3
	6	1	4.0	0		0	
	7	4	16.0	0		1	3.3
Totals		25	100	36	99.9	30	100
Mean		3.52		2.22		2.33	
Variance		4.84		2.01		1.75	
F Ratio (theoretically significant at 0.05)						3.11	
F Ratio						6.80	
20	1	4	15.4	2	5.6	0	
	2	2	7.7	3	8.3	3	9.7
	3	5	19.2	4	11.1	1	3.2
	4	5	19.2	6	16.7	5	16.1
	5	3	11.5	4	11.1	8	25.8
	6	3	11.5	7	19.4	10	32.3
	7	4	15.4	10	27.8	4	12.9
Totals		26	99.9	36	100	31	100
Mean		4.00		4.88		5.06	
Variance		4.00		3.64		2.06	
F Ratio (theoretically significant at 0.05)						3.11	
F Ratio						4.27	
27	1	9	34.6	20	55.6	14	45.2
	2	5	19.2	9	25.0	10	32.3
	3	2	7.7	3	8.3	5	16.1
	4	3	11.5	0		1	3.2
	5	2	7.7	1	2.8	1	3.2
	6	3	11.5	2	5.6	0	
	7	2	7.7	1	2.8	0	
Totals		26	99.9	36	100.1	31	100
Mean		3.03		1.97		1.87	
Variance		4.44		2.54		1.05	
F Ratio (theoretically significant at 0.05)						3.11	
F Ratio						5.52	

Table 1, continued

<u>Statement</u>	<u>Response</u>	<u>n and % LPTs</u>		<u>n and % RNs</u>		<u>n and % Therapists</u>	
34	1	9	34.6	11	30.6	10	32.3
	2	1	3.8	15	41.7	12	38.8
	3	4	15.4	4	11.1	2	6.5
	4	6	23.1	2	5.6	5	16.1
	5	2	7.7	3	8.3	2	6.5
	6	2	7.7	1	2.8	0	
	7	2	7.7	0		0	
Totals		26	100	36	100.1	31	100.2
Mean		3.19		2.27		2.25	
Variance		4.00		1.81		1.60	
F Ratio (theoretically significant at 0.05)						3.11	
F Ratio						4.46	
42	1	4	15.4	10	27.8	8	25.8
	2	3	11.5	7	19.4	10	32.3
	3	5	19.2	4	11.1	2	6.5
	4	1	3.8	4	11.1	1	3.2
	5	5	19.2	8	22.2	9	29.0
	6	4	15.4	2	5.6	1	3.2
	7	4	15.4	1	2.8	0	
Totals		26	99.9	36	100	31	100
Mean		4.07		3.08		2.87	
Variance		4.39		3.34		2.92	
F Ratio (theoretically significant at 0.05)						3.11	
F Ratio						4.10	
45	1	3	11.5	7	19.4	5	16.1
	2	2	7.7	8	22.2	8	25.8
	3	2	7.7	5	13.9	11	35.5
	4	4	15.4	3	8.3	2	6.5
	5	6	23.1	5	13.9	4	12.9
	6	3	11.5	1	2.8	0	
	7	6	23.1	7	19.4	1	3.2
Totals		26	100	36	99.9	31	100
Mean		4.57		3.61		2.87	
Variance		4.01		4.76		2.05	
F Ration (theoretically significant at 0.05)						3.11	
F Ratio						7.29	



Table 1, continued

<u>Statement</u>	<u>Response</u>	<u>n and % LPTs</u>		<u>n and % RNs</u>		<u>n and % Therapists</u>	
46	1	10	38.5	23	63.9	15	48.4
	2	4	15.4	4	11.1	7	22.6
	3	0		4	11.1	5	16.1
	4	4	15.4	2	5.6	1	3.2
	5	4	15.4	1	2.8	2	6.5
	6	1	3.8	2	5.6	0	
	7	3	11.5	0		1	3.2
Totals		26	100	36	100.1	31	100
Mean		3.11		1.88		2.09	
Variance		4.83		2.16		2.22	
F Ratio (theoretically significant at 0.05)						3.11	
F Ratio						5.87	
52	1	3	11.5	7	19.4	3	9.7
	2	0		5	13.9	8	25.8
	3	4	15.4	6	16.7	5	16.1
	4	5	19.2	5	13.9	1	3.2
	5	6	23.1	10	27.8	13	41.9
	6	4	15.4	3	8.3	1	3.2
	7	4	15.4	0		0	
Totals		26	100	36	100	31	99.9
Mean		4.50		3.41		3.51	
Variance		3.30		2.82		2.46	
F Ratio (theoretically significant at 0.05)						3.11	
F Ratio						4.71	
54	1	0		1	2.9	1	3.2
	2	1	3.8	3	8.6	2	6.5
	3	2	7.7	6	17.1	9	29.0
	4	2	7.7	2	5.7	5	16.1
	5	10	38.5	11	31.4	11	35.5
	6	3	11.5	6	17.1	1	3.2
	7	8	30.8	6	17.1	2	6.5
Totals		26	100	35	99.9	31	100
Mean		5.38		4.74		4.09	
Variance		2.01		2.84		1.96	
F Ratio (theoretically significant at 0.05)						3.11	
F Ratio						9.84	

Table 1, continued

<u>Statement</u>	<u>Response</u>	<u>n and % LPTs</u>		<u>n and % RNs</u>		<u>n and % Therapists</u>	
55	1	5	19.2	7	20.0	7	22.6
	2	6	23.1	9	25.7	12	38.7
	3	5	19.2	4	11.4	10	32.3
	4	5	19.2	9	25.7	1	3.2
	5	1	3.8	4	11.4	1	3.2
	6	3	11.5	1	2.9	0	
	7	1	3.8	1	2.9	0	
	Totals		26	99.8	35	100	31
	Mean		3.15		3.02		2.25
	Variance		3.10		2.56		0.93
	F Ratio (theoretically significant at 0.05)					3.11	
	F Ratio					4.22	
58	1	1	3.8	2	5.6	4	12.9
	2	1	3.8	4	11.1	5	16.1
	3	2	7.7	9	25.0	3	9.7
	4	2	7.7	3	8.3	5	16.1
	5	7	26.9	10	27.8	8	25.8
	6	5	19.2	6	16.7	6	19.4
	7	8	30.8	2	5.6	0	
	Totals		26	99.9	36	100.1	31
	Mean		5.30		4.13		3.83
	Variance		2.78		2.69		3.01
	F Ratio (theoretically significant at 0.05)					3.11	
	F Ratio					8.29	
59	1	0		0		1	3.2
	2	1	3.8	1	2.8	1	3.2
	3	0		4	11.1	1	3.2
	4	1	3.8	1	2.8	6	19.4
	5	8	30.8	8	22.2	10	32.3
	6	3	11.5	7	19.4	7	22.6
	7	13	50.0	15	41.7	5	16.1
	Totals		26	99.9	36	100	31
	Mean		5.96		5.69		5.06
	Variance		1.64		2.16		2.06
	F Ratio (theoretically significant at 0.05)					3.11	
	F Ratio					6.69	

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Table 1, continued

<u>Statement</u>	<u>Response</u>	<u>n and % LPTs</u>		<u>n and % RNs</u>		<u>n and % Therapists</u>		
60	1	1	3.8	0		0		
	2	1	3.8	0		0		
	3	0		0		2	6.5	
	4	2	7.7	3	8.3	0		
	5	4	15.4	10	27.8	11	35.5	
	6	6	23.1	12	33.3	15	48.4	
	7	12	46.2	11	30.6	3	9.7	
	Totals		26	100	36	100	31	100.1
	Mean			5.80		5.86		5.54
	Variance			2.56		0.92		0.86
F Ratio (theoretically significant at 0.05)						3.11		
F Ratio						3.34		
61	1	4	16.0	10	27.8	3	9.7	
	2	4	16.0	8	22.2	11	35.5	
	3	3	12.0	10	27.8	9	29.0	
	4	6	24.0	3	8.3	3	9.7	
	5	4	16.0	4	11.1	3	9.7	
	6	3	12.0	1	2.8	2	6.5	
	7	1	4.0	0		0		
	Totals		25	100	36	100	31	100.1
	Mean			3.60		2.61		2.93
	Variance			3.17		2.02		1.86
F Ratio (theoretically significant at 0.05)						3.11		
F Ratio						5.02		
62	1	3	11.5	3	8.3	3	9.7	
	2	0		6	16.7	8	25.8	
	3	2	7.7	3	8.3	5	16.1	
	4	2	7.7	3	8.3	3	9.7	
	5	4	15.4	6	16.7	2	6.5	
	6	4	15.4	4	11.1	3	9.7	
	7	11	42.3	11	30.6	7	22.6	
	Totals		26	100	36	100	31	100.1
	Mean			5.30		4.63		3.96
	Variance			4.14		4.58		4.70
F Ratio (theoretically significant at 0.05)						3.11		
F Ratio						3.74		

Item	1998	1999
1. Total Assets	1,234,567	1,345,678
2. Total Liabilities	567,890	678,901
3. Total Equity	666,677	666,777
4. Total Revenue	123,456	134,567
5. Total Expenses	89,012	90,123
6. Total Profit	34,444	44,444
7. Total Dividends	12,345	13,456
8. Total Retained Earnings	22,100	31,000
9. Total Assets (Revised)	1,234,567	1,345,678
10. Total Liabilities (Revised)	567,890	678,901
11. Total Equity (Revised)	666,677	666,777
12. Total Revenue (Revised)	123,456	134,567
13. Total Expenses (Revised)	89,012	90,123
14. Total Profit (Revised)	34,444	44,444
15. Total Dividends (Revised)	12,345	13,456
16. Total Retained Earnings (Revised)	22,100	31,000

Table 1, continued

<u>Statement</u>	<u>Response</u>	<u>n and % LPTs</u>		<u>n and % RNs</u>		<u>n and % Therapists</u>	
67	1	4	16.0	9	25.0	11	35.5
	2	6	24.0	3	8.3	10	32.3
	3	3	12.0	9	25.0	5	16.1
	4	2	8.0	2	5.6	1	3.2
	5	4	16.0	9	25.0	4	12.9
	6	1	4.0	3	8.3	0	
	7	5	20.0	1	2.8	0	
Totals		25	100	36	100	31	100
Mean		3.76		3.33		2.25	
Variance		4.77		3.31		1.80	
F Ratio (theoretically significant at 0.05)						3.11	
F Ratio						6.68	
77	1	3	12.0	5	13.9	2	6.5
	2	2	8.0	4	11.1	6	19.4
	3	1	4.0	6	16.7	7	22.6
	4	3	12.0	5	13.9	1	3.2
	5	6	24.0	12	33.3	11	35.5
	6	5	20.0	3	8.3	4	12.9
	7	5	20.0	1	2.8	0	
Totals		25	100	36	100	31	100.1
Mean		4.68		3.77		3.80	
Variance		3.98		2.81		2.49	
F Ratio (theoretically significant at 0.05)						3.11	
F Ratio						3.30	
84	1	7	28.0	3	8.3	7	22.6
	2	4	16.0	7	19.4	9	29.0
	3	2	8.0	8	22.2	7	22.6
	4	4	16.0	5	13.9	4	12.9
	5	2	8.0	8	22.2	4	12.9
	6	3	12.0	5	13.9	0	
	7	3	12.0	0		0	
Totals		25	100	36	99.9	31	100
Mean		3.44		3.63		2.64	
Variance		4.76		2.47		1.77	
F Ratio (theoretically significant at 0.05)						3.11	
F Ratio						3.91	

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Table 1, continued

<u>Statement</u>	<u>Responses</u>	<u>n and % LPTs</u>		<u>n and % RNs</u>		<u>n and % Therapists</u>	
85	1	8	32.0	3	8.3	7	22.6
	2	4	16.0	7	19.4	8	25.8
	3	1	4.0	13	36.1	10	32.3
	4	10	40.0	6	16.7	5	16.1
	5	0		5	13.9	1	3.2
	6	1	4.0	2	5.6	0	
	7	1	4.0	0		0	
	Totals	25	100	36	100	31	100
	Mean		2.88		3.25		2.51
	Variance		2.94		1.74		1.26
	F Ratio (theoretically significant at 0.05)					3.11	
	F Ratio					3.16	
97	1	2	8.0	2	5.6	0	
	2	1	4.0	1	2.8	1	3.2
	3	1	4.0	1	2.8	0	
	4	2	8.0	6	16.7	1	3.2
	5	6	24.0	6	16.7	3	9.7
	6	5	20.0	8	22.2	13	41.9
	7	8	32.0	12	33.3	13	41.9
	Totals	25	100	36	100.1	31	99.9
	Mean		5.24		5.36		6.12
	Variance		3.44		2.92		1.18
	F Ratio (theoretically significant at 0.05)					3.11	
	F Ratio					5.13	
104	1	4	16.0	7	19.4	5	16.1
	2	1	4.0	8	22.2	5	16.1
	3	4	16.0	12	33.3	12	38.7
	4	3	12.0	3	8.3	3	9.7
	5	7	28.0	4	11.1	5	16.1
	6	2	8.0	2	5.6	1	3.2
	7	4	16.0	0		0	
	Totals	25	100	36	99.9	31	99.9
	Mean		4.20		2.86		3.03
	Variance		3.92		2.07		1.90
	F Ratio (theoretically significant at 0.05)					3.11	
	F Ratio					8.15	



Table 1, continued

<u>Statement</u>	<u>Response</u>	<u>n and % LPTs</u>		<u>n and % RNs</u>		<u>n and % Therapists</u>	
107	1	9	36.0	21	58.3	20	64.5
	2	4	16.0	6	16.7	7	22.6
	3	3	12.0	3	8.3	2	6.5
	4	5	20.0	2	5.6	0	
	5	2	8.0	2	5.6	2	6.5
	6	0		1	2.8	0	
	7	2	8.0	1	2.8	0	
	Total		25	100	36	100.1	31
Mean			2.80		2.02		1.61
Variance			3.50		2.60		1.18
F Ratio (theoretically significant at 0.05)						3.11	
F Ratio						5.56	
110	1	4	16.0	1	2.8	1	3.2
	2	0		0		1	3.2
	3	3	12.0	1	2.8	4	12.9
	4	3	12.0	2	5.6	0	
	5	3	12.0	6	16.7	9	29.0
	6	2	8.0	8	22.2	6	19.4
	7	10	40.0	18	50.0	10	32.3
	Totals		25	100	36	100.1	31
Mean			4.88		6.00		5.35
Variance			5.03		1.89		2.77
F Ratio (theoretically significant at 0.05)						3.11	
F Ratio						5.04	



Table 2. Two-tailed Student's t Test (for unpaired samples with degrees of freedom corrected for inequality of variances) applied to questionnaire responses of RNs and LPTs.

<u>Statement</u>	<u>Mean LPTs - Mean RNs</u>	<u>DF</u>	<u>Critical Value</u>	<u>T Value</u>
2	0.79	43	2.0211	1.7292
7	0.85	35	2.0301	1.9349
13	1.30	38	2.0301	2.7583*
20	-0.88	54	2.0086	-1.7275
27	1.06	45	2.0141	2.2180*
34	0.92	42	2.0211	2.1289*
42	0.99	51	2.0086	1.9462
45	0.96	58	2.0086	1.7403
46	1.23	41	2.0211	2.5960*
52	1.09	53	2.0086	2.3969*
54	0.64	60	2.0003	1.5418
55	0.13	52	2.0086	0.2956
58	1.17	55	2.0086	2.7077*
59	0.27	59	2.0086	0.7406
60	-0.06	38	2.0301	-0.1809
61	0.99	45	2.0141	2.3694*
62	0.67	57	2.0086	1.2215
67	0.43	47	2.0141	0.8217
72	0.14	41	2.0211	0.5047
77	0.91	47	2.0141	1.8954
84	-0.19	42	2.0211	-0.3888
85	-0.37	44	2.0211	-0.9356
97	-0.12	50	2.0086	-0.2561
104	1.34	42	2.0211	3.0100*
107	0.78	48	2.0141	1.7101
110	-1.12	37	2.0301	-2.3737*

* Significant above the 95% confidence level.

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the success of any business and for the protection of the interests of all parties involved.

2. The second part of the document outlines the various methods and techniques used to collect and analyze data. It describes the different types of data that can be collected and the various ways in which this data can be processed and analyzed to extract meaningful information.

3. The third part of the document discusses the importance of data security and the various measures that can be taken to protect sensitive information. It emphasizes that data security is a critical component of any data management strategy and that organizations must take appropriate steps to ensure that their data is protected from unauthorized access and disclosure.

4. The fourth part of the document discusses the importance of data privacy and the various measures that can be taken to ensure that personal information is handled in a responsible and ethical manner. It emphasizes that data privacy is a key concern for consumers and that organizations must take appropriate steps to ensure that their data handling practices are transparent and accountable.

5. The fifth part of the document discusses the importance of data governance and the various measures that can be taken to ensure that data is managed in a consistent and effective manner. It emphasizes that data governance is a critical component of any data management strategy and that organizations must take appropriate steps to ensure that their data is managed in a way that is consistent with their business objectives and the needs of their stakeholders.

Table 3. Two-tailed Student's t Test (for unpaired samples with degrees of freedom corrected for inequality of variances) applied to questionnaire responses of RNs and Therapists.

<u>Statement</u>	<u>Mean RNs - Mean Therapists</u>	<u>DF</u>	<u>Critical Value</u>	<u>T Value</u>
2	0.17	63	2.0003	0.4497
7	-0.36	55	2.0086	-1.0686
13	-0.11	65	2.0003	-0.3186
20	-0.18	65	2.0003	-0.4242
27	0.10	61	2.0003	0.2955
34	0.02	66	2.0003	0.0614
42	0.21	66	2.0003	0.4760
45	0.74	62	2.0003	1.5887
46	-0.21	65	2.0003	-0.5707
52	-0.10	66	2.0003	-0.2468
54	0.65	65	2.0003	1.6660
55	0.77	58	2.0086	2.2951*
58	0.30	64	2.0003	0.7159
59	0.63	65	2.0003	1.7419
60	0.32	66	2.0003	1.3618
61	-0.32	66	2.0003	-0.9221
62	0.67	65	2.0003	1.2509
67	1.08	65	2.0003	2.6866*
72	0.34	54	2.0086	1.2879
77	-0.03	66	2.0003	-0.0739
84	0.99	66	2.0003	2.7166*
85	0.74	66	2.0003	2.4145*
97	-0.76	61	2.0003	-2.1008*
104	-0.17	66	2.0003	-0.4843
107	0.41	63	2.0003	1.1824
110	0.65	60	2.0003	1.7240

* Significant above the 95% confidence level.

Table 4. Two-tailed Student's t Test (for unpaired samples with degrees of freedom corrected for inequality of variances) applied to questionnaire responses of LPTs and Therapists.

<u>Statement</u>	<u>Mean LPTs - Mean Therapists</u>	<u>DF</u>	<u>Critical Value</u>	<u>T Value</u>
2	0.96	47	2.0141	1.9329
7	0.49	45	2.0141	0.9605
13	1.19	38	2.0301	2.4288*
20	-1.06	45	2.0141	-2.2816*
27	1.16	35	2.0301	2.6592*
34	0.94	41	2.0211	2.1152*
42	1.20	49	2.0141	2.3392*
45	1.70	45	2.0141	3.6598*
46	1.02	44	2.0211	2.0402*
52	0.99	51	2.0086	2.1687*
54	1.29	55	2.0086	3.3839*
55	0.90	38	2.0301	2.3993*
58	1.47	55	2.0086	3.1858*
59	0.90	56	2.0086	2.4321*
60	0.26	39	2.0301	0.7510
61	0.67	45	2.0141	1.5653
62	1.34	56	2.0086	2.3478*
67	1.51	39	2.0301	3.1200*
72	0.48	53	2.0086	1.4069
77	0.88	46	2.0141	1.8098
84	0.80	38	2.0301	1.6586
85	0.37	40	2.0211	0.9534
97	-0.88	37	2.0301	-2.1728*
104	1.17	42	2.0211	2.5535*
107	1.19	37	2.0301	2.9205*
110	-0.47	44	2.0211	-0.8832

* Significant above the 95% confidence level.

APPENDIX I
Social Network Analysis

Table 1. Average number of significant relationships by highest educational degree accomplished

	ADN n = 4	Diploma n = 6	BA/BSN n = 18	MA/MSN n = 7
Work related*	1.6	1.6	.9	1.1
Non-Work related	8.4	7.8	8.1	8.4
Combined*	1.4	1.0	2.1	2.6
Total	13.0	13.3	11.0	11.9

* Less than 50% of these significant relationships are associated with current jobs at City and County.

Table 2. Average number of significant relationships by sex

	Male n = 7	Female n = 28
Work related	2.3	1.4*
Non-Work Related	7.5	8.9
Combined*	1.7	1.9
Total	11.5	12.2

* Less than 50% of these significant relationships are associated with current jobs at City and County.

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Table 3. Average number of significant relationships by age

Age in years	Work Related Relationships*	Non-Work Related Relationships	Combined Relationships*	Total
25-29 (n = 5)	1.3	9.8	2.5	13.5
30-34 (n = 9)	1.5	8.1	1.5	11.1
35-39 (n = 6)	2.2	6.5	1.5	10.2
40-44 (n = 6)	0.7	11.7	4.0	16.3
45-49 (n = 4)	2.3	4.8	0.8	7.8
50-54 (n = 3)	0.7	7.0	0.7	8.3
55-59 (n = 1)	2.0	27.0	3.0	32
60-64 (n = 1)	4.0	11.0	0	15

* Less than 50% of these relationships are associated with current jobs at City and County.

Table 4. Average number of significant relationships by ethnicity

Ethnic Category	Work Related Relationships	Non-Work Related Relationships	Combined Relationships	Total
Anglo White n = 25	1.6*	8.3	1.5*	11.4
Black n = 6	1.2	10.7	3.2*	15.0
Asian Pacific n = 2	3.0	7.5	1.5*	12.0
Hispanic n = 2	0.5*	12.0	3.0*	15.5

* Less than 50% of these relationships are associated with current jobs at City and County.

Table 5. Average number of significant relationships by marital status.

	Work Related Relationships*	Non-Work Related Relationships	Combined Relationships*	Total
Never Married n = 15	1.4	8.5	1.9	11.8
Married n = 8	2.6	5.4	1.6	9.5
Divorced n = 10	1.0	9.0	2.0	12.1
Widowed n = 2	1.0	21.5	1.5	24.0

* Less than 50% of these relationships are associated with current jobs at City and County.

Table 6. Average number of significant relationships by full time and part time employment status at City and County.

	Work Related Relationships*	Non-Work Related Relationships	Combined Relationships*	Total
Full Time n = 23	2.0	8.3	1.9	12.2
Part Time n = 2 half time plus 10 per diem	0.7	9.9	1.9	12.5

* Less than 50% of these relationships are associated with current jobs at City and County.



Table 7. Average number of significant relationships by shift assignment. (Some per diem nurses are assigned a variety of shifts. These numbers represent the shifts most often worked.)

	Work Related Relationships*	Non-Work Related Relationships	Combined Relationships*	Total
Day Shift n = 21	2.1	8.9	2.1	13.1
Evening Shift n = 8	1.0	8.3	1.2	10.5
Night Shift n = 6	0.5	8.5	1.8	10.8

* Less than 50% represent relationships associated with current jobs at City and County.

Table 8. Average number of significant relationships by unit assignment.

Unit	Work-related Relationships*	Non-Work Related Relationships	Combined Relationships*	Total
North n = 12	1.6	10.2	1.9	13.7
East n = 12	2.2	6.8	1.9	10.9
West n = 11	1	9	1.8	11.8



Table 9. Average number of significant relationships by time employed at City and County.

	Work Related Relationships*	Non-Work Related Relationships	Combined Relationships*	Total
Years at City and County				
0 - 1 Year n = 11	0.5	9.0	1.6	11.0
2 - 3 Years n = 6	1.3	8.8	1.3	11.5
4 - 5 Years n = 10	1.3	9.9	1.9	13.1
6 - 9 Years n = 3	0.6	7.7	3.3	11.6
10 or More Years n = 5	1.2	5.8	1.0	8.0

* Less than 50% of these relationships are associated with current jobs at City and County.

Table 10. Density of significant relationships by nurses' highest educational degree.

Educational Degree	% dyads who know each other well	% dyads who know each other, but not well	% dyads who know each other only slightly	% dyads who do not know each other
ADN n = 4 (range)	18.3% (10.4%-26.7%)	17.6%	14.9%	49.2% (32.5%-67.9%)
Diploma n = 6 (range)	36.5% (8.9%-71.4)	18.6%	7.2%	37.8% (0-66.7%)
BA/BSN n = 18 (range)	21.3% (1.8%-50.4%)	10.9%	12.6%	55.1% (0-91.2%)
MA/MSN n = 7 (range)	24.7% (12.9%-36.7%)	9.2%	7.4%	58.8% (37.7%-74.5%)

Table 11. Density of significant relationships by sex of nurses.

	% dyads who know each other well	% dyads who know each other, but not well	% dyads who know each other only slightly	% dyads who do not know each other
Males n = 7 (range)	16.8% (9.5%-28.6%)	18.9%	19.6%	44.7% (0-67.9%)
Females n = 28 (range)	26.6% (1.8%-71.4%)	10.1%	8.3%	55.1% (0-91.2%)



Table 12. Density of significant relationships by nurses' ethnicity.

Ethnic category	% dyads who know each other well	% dyads who know each other, but not well	% dyads who know each other only slightly	% dyads who do not know each other
Anglo White n = 25 (range)	25.5% (1.8%-71.4%)	13.4%	12.6%	48.6% (0-83.3%)
Black n = 6 (range)	24.5% (14.4%-46%)	10.2%	10.4%	54.9% (20%-72.4%)
Asian Pacific n = 2 (range)	14.9% (8.9%-20.9%)	19%	1.9%	64.3% (60.3%-68.2%)
Hispanic n = 2 (range)	27.4 (4.4%-50.4%)	4.3%	0	68.3% (45.4%-91.2%)

Table 13. Density of significant relationships by nurses' marital status.

Marital Status	% dyads who know each other well	% dyads who know each other, but not well	% dyads who know each other only slightly	% dyads who do not know each other
Never married n = 15 (range)	20% (6.4%-41.2%)	12.2%	13.3%	54.5% (34.6%-83.3%)
Married n = 8 (range)	30.3% (10.4%-47.3%)	13.5%	12.7%	43.5% (13.3%-68.2%)
Divorced n = 10 (range)	23% (1.8%-71.4%)	12.7%	7.9%	56.4% (0-91.2%)
Widowed n = 2	48.2%	19.1%	0	32.7%



Table 14. Density of significant relationships by time in geographic area.

	% Dyads who know each other well	% Dyads who know each other, but no well	% Dyads who know each other only slightly	% Dyads who do not know each other
Years in area				
0-5 n = 13 (range)	24.9% (1.8%-46.7%)	10.1%	9.2%	55.9% (13.3%-91.2%)
6-10 n = 10 (range)	20.9% (6.4%-26.7%)	10.4%	15.5%	54% (32.5%-73.7%)
11-15 n = 3 (range)	20.6% (19%-22.4%)	12.5%	4.3%	62.6% (48.6%-72.4%)
16 to always n = 9 (range)	30.5% (8.9%-71.4%)	19.3%	9.6%	41% (0-74.5%)

Table 15. Density of significant relationships of foreign-born and native nurses.

	% Dyads who know each other well	% Dyads who know each other, but not well	% Dyads who know each other only slightly	% Dyads who do not know each other
Foreign-born n = 4 (range)	14.2% (4.4%-22.4%)	11.9%	.9%	73% (60.3%-91.2%)
Native n = 6 (range)	38.6% (17.6%-71.4%)	25.1%	13.1%	24.2% (0-71.4%)



Table 16. Density of significant relationships by nurses' shift assignments. (Per diem nurses are not always assigned to the same shifts. These figures represent those shifts to which they are most often assigned.)

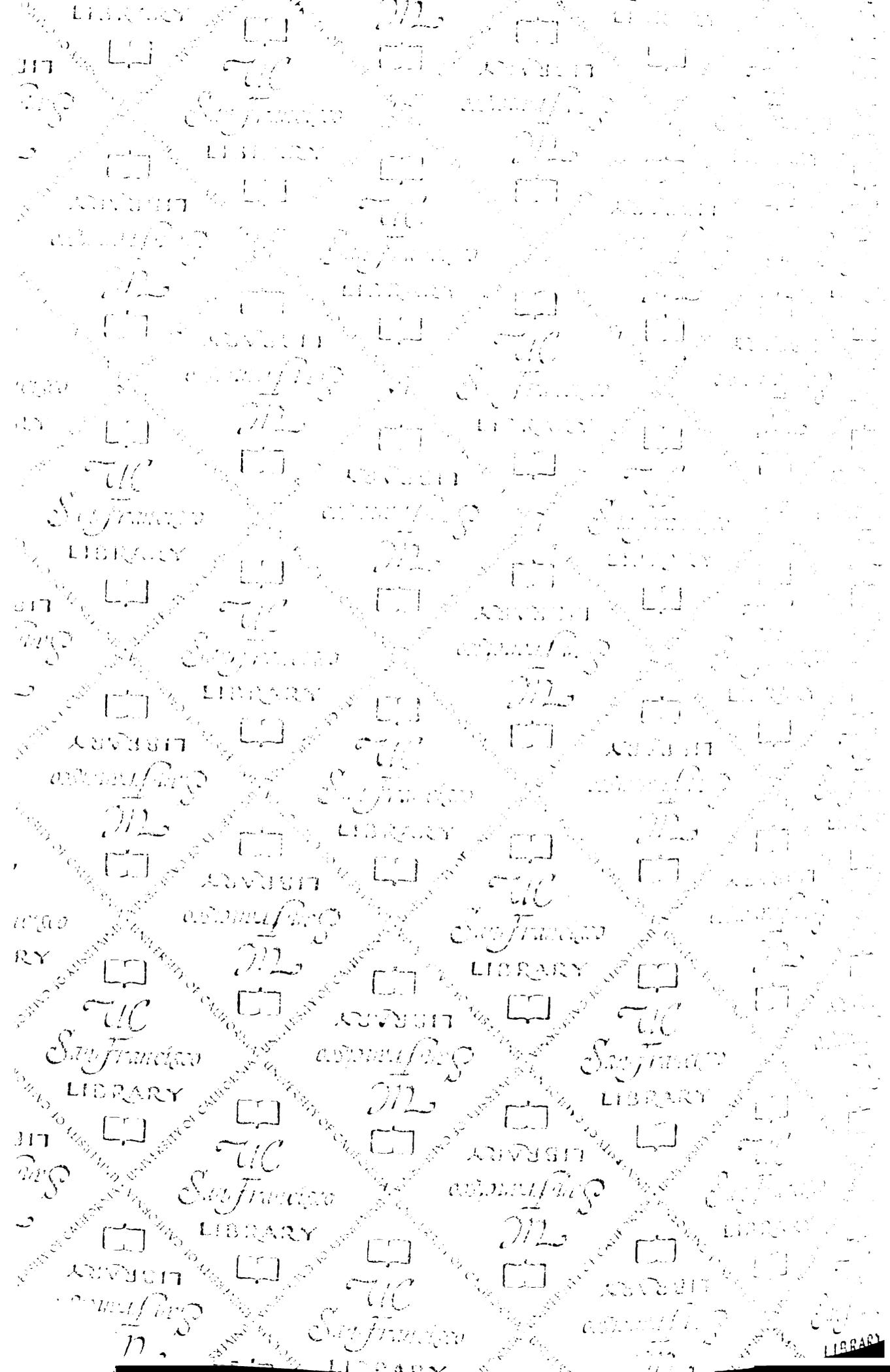
Shift	% Dyads who know each other well	% Dyads who know each other, but not well	% Dyads who know each other only slightly	% Dyads who do not know each other
Days n = 21 (range)	25.1% (1.8%-47.3%)	13.6%	12.6%	48.7% (0-91.2%)
Evenings n = 8 (range)	16.6 (6.4%-26.7%)	12.8%	14.3%	56.3% (42.9%-73.7%)
Nights n = 6 (range)	34.8% (16.7%-71.4%)	9%	.3%	56% (0-83.3%)



Table 17. Density of significant relationships by nurses' ages.

Ages of nurses in years	% Dyads who know each other well	% Dyads who know each other, but not well	% Dyads who know each other only slightly	% Dyads who do not know each other
25-29 n = 5 (range)	22.1% (1.8%-41.2%)	9.9%	10.8%	57.2% (34.6%-74.5%)
30-34 n = 9 (range)	29% (17.6%-47.3%)	13%	12.2%	45.8% (0-68.2%)
35-39 n = 6 (range)	14.8% (9.5%-21.4%)	12.9%	12.1%	60.2% (32.5%-83.3%)
40-44 n = 6 (range)	19.8% (4.4%-50.4%)	7.6%	11.6%	61.2% (35.6%-91.2%)
45-49 n = 4 (range)	29.8% (8.9%-46.7%)	16.4%	7.2%	46.8% (13.3%-66.7%)
50-54 n = 3 (range)	34.7% (13.6%-71.4%)	17.5%	6.6%	41.2% (0-74.5%)
55-59 n = 1	40%	12.5%	12.5%	35%
60-64 n = 1	26.7%	18.1%	7.6%	47.6%

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