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A study of some factors impeding the effectiveness of student-patient relationships in a psychiatric hospital.

Archambault, Muriel L.

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Boston University
A STUDY OF SOME FACTORS IMPEDING THE EFFECTIVENESS OF STUDENT-PATIENT RELATIONSHIPS IN A PSYCHIATRIC HOSPITAL

by

Muriel L. Archambault

A field study submitted in partial fulfillment of the requirements for the Degree of Master of Science

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First Reader:  Miss Minifred Gibson

Second Reader:  Miss Helen Thumm
Acknowledgment

The writer wishes to thank the nine senior students of Boston University School of Nursing who helped make this study possible.

M. L. A.
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CHAPTER I

INTRODUCTION

Today, in some of our better schools of nursing, the student in a psychiatric nursing experience is given a unique opportunity to learn more about the dynamics of human behavior than ever before. Interacting in a human laboratory, which she and her colleagues form in the seminar, the student can experience significant interpersonal relationships. The student becomes more aware of her feelings and emotions as she relates with the members of her peer group. Through the various interactions which take place in such a seminar, the student of human behavior becomes more and more cognizant of why she reacts in a certain way, as well as what particular effects her response or behavior may have on others. If the student of nursing is to be therapeutic in her relationships with the mentally-ill patient, she must have some understanding of her own emotions and their effects in the nurse-patient relationship. Only in this way can she adequately function in the ward milieu.

STATEMENT OF PROBLEM

It is the writer's supposition that the student of nursing will relate more effectively with the mentally-ill
patient than the student who has not experienced this learning process. The study of one's own behavior is essential to effective nurse-patient relationships. However, the student of nursing who has this form of orientation is not always given the opportunity in the hospital setting to utilize what self-understanding she may possess. The ward assignments and routines may be such that they impede, rather than promote, effective nurse-patient relationships. In this study, therefore, the investigator wishes to identify some of the factors which senior students in a basic collegiate nursing program state impede them in utilizing their understanding of human behavior in their relationships with the mentally-ill patient in a dynamically oriented experience.

JUSTIFICATION

If nursing education is to move forward, the various prescribed learning activities designed for the individual student's growth and development should be continuously evaluated and re-evaluated. The writer's interest in the investigation is not so much in the effectiveness of the particular approach used in the clinical area explored, as in what happens to the student who is involved in this kind of learning experience when she is on the ward. What is the reality factor in each interpersonal situation experienced
by the individual student? What interpretation does the student give to the incidents experienced?

SCOPE AND LIMITATIONS

The study has definite limitations. The size of the sample is small. Only nine students were included, and only 25 anecdotes were analyzed. The fact that the students included certain incidents and not others indicates that there was some subjectivity in the selection and writing of the anecdotes. The observer believes that the nine senior students experienced some stress, since they were confronted with the problem of adjusting to a very different clinical situation than they had experienced up to this time. However, to what degree the students were under stress is not part of the exploration. Another limitation to the study is the writer's lack of knowledge as to the intensity or depth of the amount of self-understanding each student possessed.

DEFINITION OF TERMS

1. Ward milieu - As the term "ward milieu" appears in the context of the study, the investigator is referring to the social setting of the ward where varied interpersonal relationships take place between patients and personnel.
2. Self-understanding - For our particular purpose, it means insight into one's own motivations, needs, interests, aspirations, prejudices, weaknesses, and strengths. It implies acceptance of one's self and the fact that growth never ceases but continues throughout one's life.

OVERVIEW OF METHODOLOGY

The investigator gathered the data for the study in the form of anecdotes with the collaboration of nine senior basic collegiate nursing students. The students were asked to describe briefly on four-by-six cards actual incidents in which they felt impeded in utilizing their understanding of human behavior in their relationships with the psychiatric patient in the ward environment. The anecdotes were to be written as the incidents were experienced by the individual students. The anecdotes were analyzed to isolate the impeding factors.

SUMMARY OF PRESENTATION

Chapter II deals with the theoretical framework which the writer used as background for the study. Chapter III explains in detail the methodology used to do the study. The presentation and analysis of data appear in Chapter IV. The summary, conclusion, and recommendations are in Chapter V.
CHAPTER II

THEORETICAL FRAMEWORK

The emotional interchange between people is motivated by a need to express oneself, to reduce inner tensions, and to obtain a response from the other person. This response is important since it leads to gratification or frustration.\(^1\)

This important concept holds true with all interpersonal relationships one encounters in life, be it a child-parent relationship, a teacher-student relationship, or a nurse-patient relationship. Students in the field of human behavior need to understand the influence of emotional and social forces on the individual. Too, they need to understand how these forces may help them live more effectively as human beings. Given the opportunity to explore her feelings in group interaction, where the atmosphere is permissive and non-punitive, the student in a psychiatric nursing experience is helped to recognize the various reactions which her behavior and attitudes arouse in others. If the role of the psychiatric nurse is ever to change from that of custodian to nurse therapist, it is imperative for the nurse to know

and understand some of her feelings and attitudes toward the mentally ill.

The nurse's awareness of the patient's needs and the nurse's increased conviction of her own adequacy in meeting these needs, will be reflected in her relationships with patients.¹

Didactic teaching of human relationships has little or no meaning to the student unless she is given the opportunity to explore her own particular behavior patterns and her use of these patterns relating to people. The writer does not believe that courses alone achieve a basic change of attitudes among the students.

The attitudes which we develop in childhood, whether they pertain to racial and religious prejudice or economic and social status, are not modified solely by an educational process.²

The person's feelings remain the same until he himself changes them. The student of nursing must be given the opportunity to explore and examine her own feelings so that she can begin to understand how some of her ideas and prejudices developed. In general, it is a rare student of nursing who is aware of

¹. Ibid. P. 10.

her own feelings of adequacy or inadequacy in working with patients. It is in this very area that students of nursing have an urgent need for specific preparation in human relations.

In a nurse-patient relationship, the student may treat the psychiatric patient as essentially a rational person. For example, withdrawal or unresponsiveness by the patient may be met with indifference or counter-withdrawal by the nurse. The mentally-ill person's attempt to relate to the student nurse may arouse anxiety, fear, or hostility. These emotions then demand defensive attitudes and responses on the part of the nurse. The student who becomes overwhelmed by the patient's expressions of emotion may be unable to understand and cope with her own feelings that are aroused. As a result, the student's inability to deal constructively with these feelings hinders or prevents the development of a therapeutic relationship with the patient.

We know that the behavior of the patient has meaning; that his behavior affects the behavior of those who care for him; and the behavior of those who care for him affects the patient. However, mere knowledge of this does not help the individual student to become more adequate in communicating.

with the psychiatric patient. Ideally, the student receives assistance and support in the clinical situation. The clinical instructor and/or the head nurse would provide the opportunity on the wards to discuss her feelings, thoughts, or actions that puzzle her regarding her relationships with the psychiatric patient. Developing any kind of understanding and awareness of a patient's feelings, as well as one's own feelings, is no easy task. It is acquired gradually. It depends on the opportunity that the student has to analyze with competent instructors her interactions with patients.

However, the above utopia can hardly materialize if the student's ward assignments are such that she receives little experience in working directly with the mentally-ill patient. Proximity to patients does not insure the establishment of meaningful relationships between the student and the patient.

REVIEW OF THE LITERATURE

Although dynamically oriented psychiatric nursing experiences for student nurses are gaining impetus in the field, there have been no studies done in this particular area so far as the investigator knows. Hargreaves in 1952, was the first psychiatric nurse to implement and develop a

teaching tool which can be used to help give the student this type of orientation to psychiatric nursing. Though much emphasis is beginning to appear in the various nursing journals and publications regarding specific preparation in human relations for students, little or no opportunity exists in many of the schools of nursing for this kind of learning to take place.

Within recent years, the importance of creating a "therapeutic community" in the hospital has been greatly 1 emphasized. Hyde and Greenblatt, York, and Brown have reported studies made in mental hospitals which confirm the importance of the human environment; that is, the attitudes of personnel, the relationships between staff and patients in influencing ward behavior and ultimate recovery of the mentally ill. In the book, The Mental Hospital, Stanton and 2 Schwartz call attention to the influence of interpersonal relationships in working with the psychiatric patient.

Therefore, the personality of the nurse has much to do with the recovery of the patients in her care. She has 24

hours a day in which to influence the patients. Whatever a nurse is doing with the patient—bathing him, feeding him, or playing games with him—she is maintaining some type of relationship with him. Schwartz and Schockly repeatedly emphasize the importance of the therapeutic role of the nurse in the mental hospital. The authors wrote:

One cannot order feelings and attitudes to be had by a nurse toward a patient... Rather a general approach that encourages an inquiring and curious attitude and the exploration of different ways of relating to patients will provide the conditions under which the nurse can be most therapeutic.¹

CHAPTER III

METHODOLOGY

The writing of anecdotes by nine senior students of a basic collegiate nursing school during a twelve-week psychiatric nursing experience was the method used to collect the data for the study. The anecdote seemed to be a plausible methodological tool to employ, as the student was to give a descriptive account of the incidents which she felt impeded her in utilizing her understanding of human behavior in relating to patients.

1 Hamalainen says that Randall was the first to name the anecdotal record and described it as:

"A record of some significant item of conduct, a record of an episode in the life of a student; any narrative of events in which the student takes such a part as to reveal something which may be significant about his personality.

In this field study, the anecdote was regarded by the investigator as a simple narration of incidents in which students experienced impeding factors in their contacts with the psychiatric patient.

The psychiatric hospital in which the study was done is a 120-bed institution for the acutely ill in the Boston area. It is maintained by the Commonwealth of Massachusetts and the Department of Psychiatry of the Harvard Medical School for purposes of diagnosis, treatment, teaching, and research. The hospital's general philosophy is that patients have great potentialities within themselves for improvement if they are placed in a favorable environment. By and large, this environment consists of personnel-patient relationships founded on understanding, recognition of the rights of the individual, and an appreciation of the need for people to relate to each other.

The nine senior students were selected from a basic collegiate nursing program and had completed courses in sociology, psychology, and child growth and development. The first two were in a college of liberal arts. The students' clinical experiences have been medical, surgical, maternity, and pediatric nursing. Unlike the preceding learning experiences factual content is not stressed in this particular psychiatric nursing experience, but rather the process in which the students are involved.

The students' psychiatric nursing experience took place between December 5, 1955, and February 26, 1956. For the first week, students are not assigned to any particular ward.
Instead they may visit at will any or all parts of the hospital. At the beginning of the second week, the students select the ward in which they wish to work for the remaining eleven weeks. Allowing the student to select her own ward not only lessens the adjustment problem to a new situation, but allows the student to say in which unit she would be most comfortable. Of the nine students, three selected the Female Acute Ward; three, the Male Acute Ward; two, the Female Convalescent Ward; and one, the Male Convalescent Ward. All nine students, with the exception of one, remained on the same ward for the entire twelve weeks. The student who requested the change went from the Female Acute Ward to the Female Convalescent Ward in the eighth week because she was "unhappy" in the situation. The reasons for her unhappiness were not identified.

The writer met informally with the nine students during the first week of their experience in order to present and explain the area of investigation for the proposed study. The object in meeting with the students was to ascertain their willingness and support in implementing the field study. The students were informed at this time that no set number of anecdotes would be expected from any one of them, but that the writer hoped each student would be able to write and submit a few during the twelve weeks. It was the writer's
feeling that a more meaningful anecdote would be produced if the students involved were left to their own interest and motivation in the clinical situation.

The students were asked to describe briefly on four-by-six cards the exact incident or situation in which they felt impeded from utilizing their understanding of human behavior. The writer explained to the students that the impeding factors involved could come either from within the individual or outside the individual. In giving the above explanation, the writer was intimating to the students that perhaps they would experience situations where they might not feel comfortable or at ease in relating to a particular patient, and that in this instance the impeding factor would be from within the student herself. The writer's reason for not being explicit in the above explanation was to help the student identify the impeding factor more naturally.

The suggestion was made that the incidents as experienced be written as soon as it was feasible to do so. The writer informed the students that she would personally collect the anecdotes from them in the clinical area. Enthusiasm and interest were displayed by several of the students, so that the investigator had the general feeling that the group had accepted the proposed plan and that they were willing to participate in the field study as described. The
investigator saw the students in the ward situation periodically. The objective was to try to motivate the students to produce anecdotes, as well as to assist the students in writing them if necessary.
CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

A total of 25 anecdotes were submitted during the twelve-week experience. The number of anecdotes written by the nine students varied from five to zero. (See Table I.) From the investigator's observation of the individual students on the various wards, it was noted that the student who seemed to adjust more readily and who seemed more content in the clinical situation was better able to participate in helping to collect the data. The two students who did not submit any anecdotes repeatedly informed the writer that they would do so. The end of the twelfth week appeared, however, and no anecdotes were submitted by either one.

Table I

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The anecdotes were reviewed by the investigator to isolate the factors which the students felt hindered them in their relationships with the mentally-ill patients. Two groups of factors were identified: (1) Intrinsic, or factors within the student; and (2) extrinsic, or external factors. In the analysis of the 25 anecdotes, the investigator found that the length of time that the student had spent in the clinical situation did not seem to be a determining factor in the writing of the anecdotes. For example, one student cited an incident which occurred in the third week, and another in the fourth week in which she identified intrinsic factors which interfered in the student-patient relationship. Moreover, the anecdotes that were written in the eleventh and twelfth week by two other students described incidents that identified extrinsic factors only.

Too, it is significant that of the 25 anecdotes submitted, twenty-one identified extrinsic factors, and only four identified intrinsic factors. An explanation for the above phenomena may be that the students involved found the extrinsic factors more easy to identify than the intrinsic factors. It is usually more comfortable for the individual to look at the effects of outside forces in any nurse-patient relationship than it is to look at himself and explain the possible effects his personality may have in the situation. Or it may
be that the student lacked the understanding of her role in the varied nurse-patient relationships which she experienced.

The extrinsic factors which were identified can be divided into six groups:

1. Interruptions by other patients
2. Administrative functions
3. Administration of treatments and medications
4. Carrying out non-professional tasks
5. Patient's withdrawal
6. Miscellaneous

Excerpts from the anecdotes are given for each group, followed by a general interpretation of the data:

1. Interruptions by other patients

a. "Frequently while talking to a patient, another patient would come to us and unknowingly interrupt train of discussion."

b. "Patient was telling me about his background, his stay in the hospital, and his hopes for the future, when another patient joined us."

c. "I was talking to patient B.K. when another patient came up to me to ask who the visitor was."

d. "Patient needed more assistance, but another patient intervened to ask me to open her locker."

e. "Patient talked freely for about fifteen minutes, when another patient who was also on the ward became excited and then patient stopped talking."
f. "While listening to patient M.C. discuss her feelings regarding insulin treatment she was to receive, another patient came up to me to seek help in the use of the washing machine."

General Interpretation - Incidents a, b, and c seem to indicate that the students in this study feel more adequate in a one-to-one relationship with the mentally-ill patient. The anecdotes demonstrate that at times, some students are unable to enlarge a one-to-one relationship to include others in the interaction. It is by communicating to others that the patient will improve.

As indicated in the anecdotes c, d, and f, if the student is the only person on duty, it is expected that she will be approached from time to time for various things. Being interrupted to open a patient's locker or to demonstrate the use of the washer to another does not necessarily hinder the nurse-patient relationship that has been established. It indicates that the student's understanding of effective nurse-patient relationships is not too clear.

2. Administrative functions

a. "As we were beginning to establish some form of relationship, the phone rang and I was forced to excuse myself to answer it."

b. "Patient was expressing her feelings that no one understood her and the shame she felt for having to return to her native country, when the supervisor appeared for the ward report."

c. "In the middle of patient's discussion, I was called away to speak to another patient's visitor."

d. "Patient seemed relaxed and eager to talk, but I was called to the phone."

**General Interpretation** - The above incidents imply that the student is given some administrative experience in the psychiatric hospital. This is especially true when the student is on the 3-11 duty. The answering of the phone, the writing of the ward report, and attending to visitors are some of the functions of the person in charge of any hospital unit or ward. The more experienced nurse carries out these accepted administrative procedures and does not consider them detrimental to patient relationships. In reality, no nurse can remain with any one patient for any length of time and ignore the other patients who are on the ward. Whatever self-understanding the nurse possesses, helps her to understand better the need of a patient for more individualized attention.

3. Administration of treatments and medications

a. "Patient and I were discussing what he could do with the opportunities offered him in the rehabilitation program when I was called away to give a medication."
b. "We had arrived at a point when patient was communicating his fears of me even though we have established a friendly relationship, when I was called to the office to give a medication."

c. "Just when the patient was beginning to tell me about his illness, a student nurse came to relieve me so I could return to the ward to give medications."

d. "As we progressed in our conversation, so did the time, and I had to leave to give other medications."

3. "I was with B.K. once more after being interrupted for a second time, when the head nurse asked me to relieve the student who was specialing two bed patients."

**General Interpretation** - In this clinical setting, it appears as if more emphasis is placed on task-centered activities than on patient-centered activities. For example, one student is usually assigned to do all the treatments and give the medications prescribed for all the patients on the ward. This particular procedure is better known as the "functional method" of assignment. It seems as if more meaningful relationships would evolve for both the patient and student if the "case method" of assignment were used. In the latter method, the student is responsible for the total care and treatment of the patient. The student would concern herself with the patient as a whole person.
4. Carrying out non-professional tasks

a. "While doing a puzzle with a very withdrawn patient who was at last beginning to talk and even display a little humor, I was directed by the head nurse to clean a corner of the ward which was full of odds and ends."

b. "I was with Mr. McP. who is quite seclusive and who had come in television room for the first time, when I was approached to do an errand."

c. "I was talking to Mr. B., but as we were sitting near the main entrance of the ward, I was frequently interrupted to unlock door for visitors."

General Interpretation - Analysis of these anecdotes indicates that awareness of the role of the student of nursing in the clinical situation is incomplete. If the head nurse had been cognizant of the student's role in the nurse-patient relationship in incidents a and b, the student would not have been interrupted as she was in both instances. As for incident c, a more experienced person would not have placed herself in such a vulnerable spot on a visiting day if the person intended to have a meaningful talk with a patient. Here again, the simple task of unlocking the door might have been assigned to an ancillary worker. The above three incidents point out that the performance of non-professional tasks by students seem to persist to some degree, even though much thought and effort have been given in the
attempt to eliminate such practices in the education of students of nursing.

5. Patient's withdrawal

a. "When I informed the patient that I would rather play a game than sit on the couch and hold hands with him as he requested, the patient walked away."

b. "Looking at the television screen, patient saw a couple embracing and commented, 'They're bad; that's terrible.' I answered patient by asking, 'Is sex immoral?' At this the patient got up from couch and walked away."

General Interpretation - In both of these incidents it appears as if the patient was the impeding factor in the student-patient relationship, for it was the patient who walked away from the student. It is conceivable, however, that had the student's response been different, the patient might have remained in both situations. For example, in incident a, the student might have had subconsciously similar feelings toward the patient and felt uncomfortable in the situation, thereby responding as she did. In the second incident, a different reaction from the patient might have occurred if the student had allowed the patient to explain what she meant by the comment, "They're bad; that's terrible." A non-directive approach might have been more productive.
6. Miscellaneous

a. "Just about the time patient was saying how depressed he felt about his transfer from the convalescent ward to the acute ward, the head nurse informed me that I could go to ward rounds."

General Interpretation - The analysis of the anecdote indicates that the student's special conferences or meetings are not always pre-planned. If the student is informed of the various learning activities available in advance, she is better prepared to plan her work accordingly.

Four intrinsic factors were identified by the students. Excerpts from the anecdotes are given, followed by a general interpretation of the data:

1. Inner feelings of loneliness

"I felt alone; I tried to change the subject, but I was not successful so I simply stopped the conversation."

General Interpretation - In the analysis of the anecdote, it was noted that the student described her reaction as "defensive". The student herself experienced grief because of her separation from a loved one on the previous day and was unable to cope with the patient's questions regarding her personal relationships.
2. Conflict in what to tell patient

"I felt a conflict between what I wanted to tell the patient and what I felt the doctor wanted her to know."

**General Interpretation** - One interpretation of the incident experienced may be that the student had some unresolved feelings regarding insulin therapy herself and felt ill at ease in the situation because of this.

3. Ambivalence

"I didn't know whether or not to include the patient in the ping pong game or not."

**General Interpretation** - The student had mixed feelings as to whether or not to include the patient in the game. The negative feelings apparently surpassed the positive feelings, for the student made no apparent overture to invite the patient. Why the student experienced these feelings is not apparent.

4. Not feeling wanted

"The patient refused to tell me anything further, so I ended the conversation with the remark that I would like to be her friend when she was ready to accept me."

**General Interpretation** - In this instance the student did well to recognize that the patient felt threatened and for this reason the student did not force her friendship on the
patient. Instead, the student leaves but informs the patient that she is willing to wait until the patient is ready to accept her as a friend.
SUMMARY, CONCLUSION, AND RECOMMENDATIONS

The study was made with the collaboration of nine senior basic collegiate nursing students in a dynamically oriented psychiatric nursing experience of twelve weeks, to identify some of the factors which they felt impeded them in utilizing their understanding of human behavior in their relationships with the mentally-ill patient. The writing of anecdotes was the form used to collect the data. The students were asked to describe briefly on four-by-six cards the actual incidents in which they felt impeded in utilizing their understanding of human behavior. An analysis of the anecdotes was made to isolate the impeding factors.

The data, as they appear in Chapter IV, reveal that the impeding factors in student-patient relationships may be either intrinsic or extrinsic in nature. Of the 25 anecdotes submitted by the nine senior students, it is significant that there are 21 identified extrinsic factors and only four intrinsic factors. A plausible explanation may be that the students involved in the study found the extrinsic factors more easy to identify than the intrinsic factors. It is usually more comfortable for the individual to look at the effects of external forces in any nurse-patient relationship than it is to look at
herself for the possible effects her personality may have in the relationship. Another reason may be that the individual student lacked understanding of her role in the varied nurse-patient relationships, so that she was not able to identify intrinsic factors that might have been present.

The extrinsic factors identified can be grouped into six sub-areas. They are:

1. Interruption by other patients
2. Administrative functions
3. Administration of treatments and medication
4. Carrying out non-professional tasks
5. Patient's withdrawal
6. Miscellaneous

The four intrinsic factors identified are unique in themselves. They are:

1. Feelings of loneliness
2. Conflict in what to tell the patient
3. Ambivalence
4. Not feeling wanted

In the analysis of the data, the investigator found that the length of time the student spent in the clinical situation did not seem to be a determining factor in the writing of the anecdotes.
The study points out that students of nursing feel more adequate in a one-to-one relationship with the mentally ill. The anecdotes demonstrate that at times, some students are unable to enlarge from a one-to-one relationship to include others in the interaction. Yet the patient will improve when he learns to communicate some of his ideas and feelings and can relate comfortably to other people. The study also indicates that the student's understanding of effective nurse-patient relationships is not too clear. The interpretation of the anecdotes reveals that the student does not seem to comprehend that satisfying minute-to-minute relationships which nurses or others establish with the psychiatric patient in any situation may be therapeutic.

The study reveals the following:

1. That the largest number of anecdotes related to incidents in which other patients interrupted the patient-nurse relationship;

2. That students in a psychiatric nursing experience are given some administrative functions to perform;

3. That the students' learning experiences on the wards are task-centered rather than patient-centered; and

4. That the allocation of non-professional functions by the nursing administration to the student of nursing indicates a misconception of the student's role in the clinical situation.
RECOMMENDATIONS

As a result of this study, the following recommendations are made:

1. That the student of nursing be recognized as a learner in the clinical area. The educational experience of the student in nursing might be enriched if:
   (a) Student's ward assignments were patient-centered rather than task-centered.
   (b) The case-study method of assignment were utilized in preference to the functional method of assignment.
   (c) Non-professional functions were allocated to ancillary workers rather than students.
   (d) There were improved guidance of the learning activities of the student.

2. That students of nursing need the opportunity to explore their feelings and attitudes early in the program and have continuity of same throughout their educational experience.

PROPOSALS FOR FUTURE STUDIES

1. That a study be made of the various learning activities available to the student of nursing in the psychiatric hospital.
2. That a study be made to explore and evaluate methodologies for teaching the understanding of human behavior in all clinical experiences.

3. That a study be conducted to evaluate the effectiveness of relationships with patients formed by students of nursing in the psychiatric nursing clinical situation.

4. That a study be done to define what is meant by psychological nursing care.

5. That a comparative study be conducted in psychiatric nursing of the learning outcomes of the one-to-one nurse-patient relationships with the one-to-group patient relationships.
APPENDIX A

ANECDOTES WHICH IDENTIFY INTRINSIC FACTORS
IN STUDENT-PATIENT RELATIONSHIPS

Anecdote 1

"I find it rather easy to talk to patients but today when a patient began to tell me of her unfortunate love experiences and asked me questions of my love life, I became defensive, for my fiance had left the day before and I felt alone. I tried to change the subject but I was not successful so I simply stopped the conversation."

Anecdote 2

"A patient who was very upset approached me to say that her doctor told her she was to start insulin treatments in the near future. Patient questioned me to great length about the treatment, such as, what would happen to her; how would she feel; et cetera. Since my knowledge of this treatment is somewhat limited, as well as not knowing what or how much her doctor wished her to know since he had obviously explained nothing to her, I felt I could not answer patient satisfactorily. I directed patient to ask her doctor and I also offered to find more information for her. I felt a conflict between what I wanted to tell patient and what I felt the doctor wanted her to know."

Anecdote 3

"One patient came up to me while I was picking things up about the piano. After a little while we played some ping pong and patient talked rather freely during the game. Soon, later, Nickie, another patient, walked down the end of the hall, stopped and looked at us. I spoke to patient and she answered me and then patient returned to her room. I didn't know whether to stop playing long enough to include her in the activity or what."
Anecdote 4

"My patient seemed depressed in the afternoon so I suggested that she lie down in open seclusion for a while until she felt better. I went in with her and tried to draw her into telling me what was bothering her. Patient told me that she didn't trust anyone, including me, and that she had no friends, nor did she want them. Patient refused to tell me anything further, so I ended the conversation with the remark that I would like to be her friend when she was ready to accept me. I left her alone hoping that she would think about it and perhaps come to the realization that everyone hasn't rejected her as she now feels."
APPENDIX B

ANECDOTES WHICH IDENTIFY EXTRINSIC FACTORS
IN STUDENT-PATIENT RELATIONSHIPS

Anecdote 1

"The most frequent interruption in talking to patients was that of the authority; in this case, the head nurse. In one instance, while doing a puzzle with a very withdrawn patient who was at last beginning to talk and even display a little humor, I was called away by the head nurse to clean a corner of the ward which was full of odds and ends. This interrupted the entire pattern of conversation."

Anecdote 2

"Frequently while talking to a patient, another patient would come to us and unknowingly interrupt train of discussion. This always happened it seemed at a crucial moment and the situation could never be recaptured effectively."

Anecdote 3

"I had medications on this particular day. Between medications I became involved in talking to one of the male patients. As we progressed in our conversation so did the time, and I had to leave to give other medications. This was disturbing to both patient and myself."

Anecdote 4

"I was talking to Mr. B. but as we were sitting near the main entrance of the ward, I was frequently interrupted to unlock door for visitors who wanted to leave the ward. As a result, my contact with the patient was broken and it had to be started all over."
Anecdote 5

"I was sitting in the television room with Mr. McF. who is quite seclusive and had come in the T.V. room for the first time, when I was approached by one of the attendants to go on an errand for the head nurse."

Anecdote 6

"As the patient attempted to express to me her feelings that no one understood her and the shame she felt for having to return to her native country, I was interrupted by the supervisor for the evening ward report."

Anecdote 7

"While at Occupational Therapy with some of the patients this evening, one of the male patients started to talk to me. Since we are from the same town, we had material to discuss. Just when patient was beginning to tell me about his illness, a student nurse came up to relieve me so that I could return to the ward to give medications. I felt disturbed in leaving the patient and I think the patient felt this too."

Anecdote 8

"When working alone on 3-11:30, it is necessary to constantly check the patients whether they are on the ward or in their room. Many patients when upset remain in their room. This night, one of the patients was upset because she was to be sent to her home in Japan. Her definite plans for flight were not made, however, and the uncertainty of the situation was upsetting her. As I checked in on her, patient requested that I sit and talk with her. This I did, but in the middle of the patient's discussion, I was called away to speak to a visitor who wanted to report that his relative was depressed upon returning to the hospital. I was forced to leave the patient just when she was beginning to "unload" her feelings to me."
Anecdote 9

"The patient and I were talking out on the ward. Patient was re-telling some of his family background. He went on to tell how he was feeling at present and his hope for inclusion in the rehabilitation program. We were discussing what he could possibly do with the opportunities offered him in the above program when I was called away to give a medication."

Anecdote 10

"The patient and I were in the office; patient was telling me about his background, his stay in the hospital, and his hopes for the future. This was the first time we had talked on other than a social basis. Another patient walked in to join us and we lost the thread of conversation."

Anecdote 11

"The patient and I were talking in the locker room about his general insecurity with people and his fears of them. We had arrived at the point where he was communicating his fears of me, even though we have established a friendly relationship, (patient fears I am going to think something bad of him) when I was called to the office to give a medication."

Anecdote 12

"While giving out the morning medications, my patient started to talk about her fears re shock treatments and how her family thought this was the best hospital for her to be in. Patient seemed relaxed and eager to talk, but I was called to the phone, after which I had to finish distributing the medications. Later, when I returned to talk with the patient, she was waiting for visitors and neither of us were much in a mood to discuss anything."
Anecdote 13

"I was talking to patient B.K. when another patient came up to me and asked me who the visitor was that had just come in. Having been interrupted, B.K. went to lie down on couch and closed her eyes."

Anecdote 14

"I started to talk with a group of patients after breakfast who were sitting on their bed. One of the patients was saying how depressed he felt about being transferred from the convalescent ward to the acute ward. Just about this time the head nurse came up to us and informed me that I could go to "Ward Rounds". As it was time to go, I bid farewell to the patients and left."

Anecdote 15

"I was with B.K. once more after being interrupted for a second time, when the head nurse asked me to relieve the student who was specializing two bed patients that morning."

Anecdote 16

"One night my patient was upset; she was crying. Patient told me that the "voices" informed her "she couldn't walk." Patient was lying on her bed and believed that she would never be able to get off the bed by herself. After twenty minutes of reassurance and support, I told patient that she could walk if she really wanted to. When I helped her get on her feet, patient was relieved to find that the "voices" were wrong. Patient needed more assistance, but another patient intervened to ask me to open her locker. As I was the only one with the key, I had to leave the patient. When I returned to patient, she was asleep in her bed."
Anecdote 17

"I had sat down with my patient in the back lounge. Patient is a proud, warm, yet distant woman. I had spent many brief moments with this patient where I had tried to show an interest in her welfare. As we were beginning to establish some form of relationship, the phone rang and I was forced to excuse myself to answer it. The call was to inquire the whereabouts of Dr. X. No sooner did I return to the patient than the phone rang once more and I left the patient to answer it again."

Anecdote 18

"One of the patients approached me to tell me of her fear of death. Since I have had this same fear myself, I urged patient to talk about it. She talked freely for about fifteen minutes when another patient who was also on the ward became excited and then patient stopped talking. I felt a "block" between us. Patient said that she didn't want to talk any more right then and our conversation stopped."

Anecdote 19

"While listening to patient M.C. discuss her feelings re insulin treatment she was to receive, another patient came up to me to seek help in the use of the washing machine. Being the only one on duty, I had to leave M.C. at a point when she wanted me to listen. Having shown patient how to use the washer, I started to go to M.C. when two other incidents developed which detained me from returning to patient. When I was finally able to get to M.C., patient's comment was, 'You're too busy to talk to me.'"

Anecdote 20

"Patient B.K. was upset because her doctor told her that she could go home on Monday if she wanted to and patient felt that she was not ready to go yet, as "she was dead inside." Looking up at the television screen, patient saw a couple in
an embrace and commented, "They're bad; that's terrible." At this point, I answered patient by saying, "Is sex immoral?" At this remark, patient got up from couch and walked away.

Anecdote 21

"I was sitting in the television room writing my notes for a sociogram when I noticed Mr. F. sitting alone at one of the tables. I went over to him to ask if he would play checkers with me. Patient informed me that he didn't know how to play checkers. I told patient that I could teach him how to play, but he didn't want to learn. When I asked patient if there was another game he would like to play, patient answered that he wanted to sit on the couch and hold hands with me. I informed patient that I would rather play a game with him and patient at this point walked away."
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