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A comparison of interpersonal relationships between patients and authoritarian and non-authoritarian aides in a psychiatric hospital.

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A COMPARISON OF INTERPERSONAL RELATIONSHIPS
BETWEEN PATIENTS AND AUTHORITARIAN AND NON-AUTHORITARIAN
AIDES IN A PSYCHIATRIC HOSPITAL

A thesis
Submitted by
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First Reader: Winifred M. Gibson
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CHAPTER I

INTRODUCTION

If one accepts the fact that other human beings are paramount in influencing the direction and development of the human potential, the psychiatric hospital can be seen as serving as an extension for interpersonal relationships. The type of interpersonal relationships which may ensue is dependent on the characteristic mode of reaction which the staff has developed as their individual pattern for these interpersonal relationships. One possible type of reaction which can be utilized has been called "authoritarian." Because the psychiatric aides compose numerically the greatest portion of a psychiatric hospital's staff, the interplay of relationships between patients and aides becomes important as a factor which can hinder, modify, or perpetuate a patient's inadequate handling of his relationships.

Statement of the Problem

This study will attempt to investigate the types of interpersonal contacts psychiatric patients have with aides who are authoritarian to varying degrees.

Sub-Problems

1. To determine the nature of the relationship between patients and aides who are authoritarian to varying degrees.

2. To compare the nature of the relationships in order to ascertain differences, if any, in the type of interactions between patients and these aides.
Justification

Because of the increasing emphasis on person to person relationships in psychiatric hospitals, it is becoming apparent that more needs to be known about the kinds of personalities that the patient will meet during his stay as a patient. How well he does will depend on the relationships which can be established between him and the aide. Even though authoritarianism has been tacitly recognized and reacted to subjectively, it has remained an area which has been largely neglected in mental hospitals.

Inferences which may be drawn from the findings may be helpful in determining qualifications for selection and placement of aides in the psychiatric hospital.

Scope and Limitations

This study is confined to the three female units of the reception building of a large psychiatric hospital in the Boston area. Six aides, stationed on these three units, were observed over a period of a month during which ten one-half hour observations for each was done.

It is recognized that the sample of aides is limited in number and that the period of observations is a relatively short one. There is no way of evaluating the effect the presence of the observer had on the interpersonal relationships of the patient and the aide.

Because care was taken to have these observations take place at representative and consistent periods, the variable of treatment programs taking place at different times on these three units could not be controlled. Because of the time limitations only aides who were scheduled for the day shift were tested and selected.
Definition of Terms

Within the framework of this study the following terms mean:

Authoritarianism - characterized by a striving for submission and domination so that simultaneously there is a behavioral readiness to dominate and derogate those considered to be powerless and to submit and conform to those considered to be powerful. A rigid stereotyped way of thinking which leaves little or no room for ambiguity is utilized.

Personality - a more or less enduring organization of forces within the individual. These persisting forces of personality help to determine response in various situations, and it is thus largely to them that consistency of behavior - whether verbal or physical - is attributable.

Overview of Methodology

A battery which tests three different attitude areas was given to the fourteen aides on the day shift. Six aides were selected on the basis of their scores on the authoritarian scale. Two with the highest scores were considered to be high authoritarian, two with the middle scores were the average authoritarian, and two with the lowest scores were the low authoritarian. To offset any possible bias, the scores were tabulated by some one other than the writer so that the observations could be made without the knowledge of the specific scores for the aides participating.

in the study.

The aides were then observed in their relationships with patients. Ten one-half hour observations were done on each aide. A modified form of the Interaction Tally Sheet was utilized as the observational tool. Details about the Attitude Battery and Interaction Tally Sheet will be found in Chapter III.

Summary of Presentation

Chapter II will include a review of the literature and the theoretical framework underlying this study. Chapter III will include a detailed description of the tools utilized. Chapter IV will present the evaluation and analysis of the data which were gathered. Chapter V will present the summary and conclusions reached from the data. The recommendations for further study will also be found in this Chapter.
CHAPTER II

REVIEW OF LITERATURE

As far as could be determined there is no available literature which takes into consideration the kind of interpersonal relationships which evolve between authoritarian personnel and psychiatric patients.

There is literature available which offers conceptualizations about authoritarianism. These concentrate more on the anti-democratic trends (equated with authoritarianism) within individuals and focus attention on the meaning of these trends in terms of broad sociological questions, e.g., prejudice and ideological backgrounds predisposing to the various totalitarianisms.

Fromm has done the first important work in this area. He posits that man in the throes of an individualistic society with concomitant freedoms and choices has found himself in a position where he has feelings of aloneness and a loss of ties with sources which once afforded feelings of security and belongingness. In man's efforts to escape from this feeling of aloneness and powerlessness, he maneuvers in such a way that there will be opportunity for submitting to new forces of authority or for conformity to accepted patterns. The concept of authoritarianism is equated with sado-masochistic characteristics. Fromm describes the person with the sado-masochistic characteristics as one who admires authority and tends to submit to it but at the same time he wants to be an authority

and have others submit to him.

"It seems that this tendency to make oneself the absolute master over another person is the opposite of masochistic tendencies, and it is puzzling that these tendencies should be so closely knit together. No doubt with regard to its practical consequences the wish to be dependent or to suffer is the opposite of the wish to dominate and to make others suffer. .... I suggest calling the aim which is at the basis of both sadism and masochism; symbiosis. Symbiosis in this psychological sense means the union of one individual self with another individual self. In one case I dissolve myself in an outside power; I lose myself. In the other case I enlarge myself by making another being part of myself and thereby I gain the strength I lack as an independent self. It is always the inability to stand the aloneness of one's individual self that leads to the drive to enter into a symbiotic relationship with some one else." 2

Fromm concludes that:

"For the authoritarian character there exist, so to speak, two sexes: the powerful ones and the powerless ones. His love, admiration and readiness for submission are automatically aroused by power, whether of a person or an institution, and powerless people automatically arouse his contempt." 3

Careful consideration must be given to these characteristics in terms of interpersonal relationships if one wishes to think of patients as being pretty powerless in the usual sense of the word.

The most comprehensive literature is the California study done by Adorno et al. 4 This study focuses on discrimination in terms of the "authoritarian type of man." The study was concerned with personality components favoring the acceptance of an ideology which is anti-democratic and prejudicial in nature. Various techniques, questionnaires, interviews,

2. Ibid., p. 158
3. Ibid., p. 159
and projective techniques, were utilized to assemble a mass of data concern-
the opinions, attitudes, and values of a great many people. From this was
developed a scale which, among other things, measures the degree of authori-
tarianism present in individuals. An authoritarian syndrome is tentatively
identified.

"Social adjustment is brought about by obedience and subordina-
tion. Ambivalence is all pervasive, being evidenced mainly by the
simultaneity of blind belief in authority and readiness to attack
those who are weak and socially acceptable as 'victims'.......there
is an emphasis on 'in-group' and 'out-group'." 5

The study contains much dynamic interpretation which in essence agrees
with Fromm's concepts.

The work of Adorno and his collaborators aroused interest in this area
and subsequent research has been done around various aspects of the findings.
All of the studies seem to accept the concept of authoritarianism with its
concomitant characteristic modes of reaction and behavior patterns.

Garcia 6 questioned whether the authoritarian personality structure was
related to psychoanalytical interpretation or whether there were other fac-
tors which could also produce this. The conclusion was reached that sub-
cultural variations in terms of situational factors could also produce the
authoritarian type of person. This can be an important factor to consider
in terms of a hospital situation with its authoritarian type of social
structure.

The next two studies can be considered in terms of the psychiatric
aides who have had little or no status in the mental hospital. Adelson 7

5. Ibid., pp. 759-762
   Journal of Abnormal and Social Psychology, (October, 1953)
   pp. 477-485.
undertook to find out if a minority group which often is subject to prejudice could also in turn be prejudiced. Intensive interviews were carried out with a minority group (Jewish college men). The findings confirmed the results of the California study. The conclusion was reached that authoritarianism is a variable which underlies a variety of attitudes.

Brown undertook to question if rigidity is an enduring pervasive aspect of authoritarianism or whether it is dependent on something else. His conclusions were that the rigidity is dependent on situational factors which contain an ego-involving atmosphere so that there is anxiety about personal failure and achievement.

All of these studies serve to validate the concept that there are certain personality components which can be termed authoritarian and which predispose to certain ways of thinking and feeling. Once a person thinks and feels there is the possibility that he will convert this to behavioral patterns. Once this happens it is possible to observe and record this. For Bales the action or interaction is equated as being the overt behavior of the person in a situation. In addition to speech, interaction includes facial expressions, bodily attitudes and emotional signs. The observer tries to put himself into the shoes of the other person in reacting to each act of the act and to apply the frame of reference he feels the other to have. There is a system of acts which he conceives as proceeding from a beginning to an end.


Philosophy

In recent years there has emerged a growing recognition that the psychiatric patient's relationships with the personnel within the psychiatric hospital has much to do with his behavior during hospitalization and his subsequent handling of his emotional problems. That this has been a recent development is rather surprising if one considers that the one seemingly most important influence on the developing human being revolves around his contacts with others. From these contacts, beginning at birth and progressing onward into increasingly more complex and more demanding relationships evolves the multitude of personalities which are met in day to day living. This socializing process, which influences the development of the individual, can evolve in such a way that the human potential for growth can either develop fully or become stunted and/or impaired in some way. The psychiatric patient can be taken as a point of departure wherein the human potential is disturbed and the person cannot interact with his fellow human beings in socially acceptable ways. When this happens, the person becomes a patient who now is placed in a special environment. This environment is an extension of the community which will either perpetuate the stunting or impairment of his capacity for socialization or will provide opportunities for developing new capacities for sound interaction.
"Patients come to hospitals primarily because of their inability to get along with people in their community or at work. Whatever the basic personality or thought disturbance it is usually the social manifestations which cause admission to the mental hospital." 10

Greenblatt et al. emphasize this point also when they say:

"Although psychiatrists used standards of social adjustment, they did not use specific phrase ..... had they been familiar with the body of conceptualization that sociologists had built around the term "social adjustment" and that now is being built around more dynamic terms "social efficiency" and "interpersonal competence", it is possible that the social environment of the hospital - consisting both of persons and physical resources - might have been envisaged earlier as a facility to be used therapeutically ..... recognition has been slowly growing of how therapeutically important is that other part of the social environment, namely, the persons who comprise it."

What happens to the patient in his new environment will depend a great deal on the type of people he encounters while he is in residence on one ward or another in the hospital. Every person who comes into contact with the patient has a potential role to play which can either be a positive or negative factor in the patient's illness. That these contacts will vary in importance to the patients is recognized. There will always be some contacts made with various personnel which will be of greater or lesser importance in the patient's hospital life. Some of these contacts will be initiated by the patient and others will be initiated by the personnel.


The contacts initiated by the patient will be dependent on the kind and depth of his psychopathology while those initiated by the personnel will be dependent on their personalities and usual patterns of relationships with people. R. Boyd, T. Baker and M. Greenblatt, in an analysis of patient interaction found that there was a general correlation of patients' social behavior on the ward with clinical improvement. An increase in patient's socializing ability was accompanied by a return from psychotic behavior to more "normal" social behavior. Their most important conclusion was that the quality of patient interaction was directly related to the affective atmosphere of the ward. They felt that it was necessary to consider most carefully how good ward morale could be achieved.

As soon as one begins to think of a mental hospital not only as a physical unit for purposes of housing patients but also as a unit which contains people who have interpersonal contacts with each other, the question of what is involved in the interpersonal process is evident. If one considers patients and personnel as forming a group on any one given unit in a hospital, the socializing process inherent in any group comes to the fore. It becomes a two way process wherein the behavior of the patients affects the behavior of the personnel and the behavior of the personnel affects the behavior of the patients. Not only is it imperative to be aware of how the patient feels about the personnel and how they behave toward them but it is also imperative to recognize how the personnel feel about patients and how they behave towards them.

The patient's relationships with others around him will be determined to a certain extent by the psychopathological symptoms which he is utilizing as his means of adaptation to the world around him. The personnel's relationships will be determined by the complex and diverse forms of meeting their original needs which have been modified in the process of coping with the social and personal demands placed on them from childhood onward. That there will be a multiplicity of these complicated personal reactions is recognized but by the time chronological maturity is reached, these personal reactions have evolved into relatively permanent configurations of reactions to people and social situations. The personnel will react to patients on the basis of these configurations which they utilize in their relationships with all people.

While it is recognized that personality is rather nebulous in many ways and that the person reacts as a whole to any situation, nevertheless various attempts have been made to more or less isolate certain habitual patterns of reactions within the individual. One of these patterns has been termed authoritarian in character. The authoritarian personality is of particular interest in a mental hospital because of the new emphasis being placed on person to person relationships.

One of the peculiar characteristics of all hospitals is an emphasis on authority. Whether this authority is perceived in more or less concrete terms such as the emphasis on "going through channels" or the reaction is on a very personal basis wherein one feels a certain way about authority or authoritarianism, does not alter the fact that authority plays a very important part in the hospital environment. A certain kind and amount of authority is necessary for the proper functioning of any institution.
Things have to be done and, in order for them to get done, different people assume different roles with various functions within the hospital. Miller\textsuperscript{13} conceives of this kind of authority as having certain characteristics. There is a directive component to it. By virtue of occupying a given position in a patterned role relationship, one individual is empowered to direct actions of others and others are obligated to accept that direction. There is also a functional differential. Occupants of two role positions perform a different aspect of the total task. Fromm\textsuperscript{14} has called this kind of authority a "rational authority." There is also another kind which he terms an "inhibiting or irrational authority."

If irrational or inhibiting authority is incorporated as an individual pattern of reactions in interpersonal relationships, it becomes an extremely important aspect of ward life. It will influence the patient in his behavior because the person with authoritarian components will have certain ways of relating to him.

The concept of individualizing treatment for the creation of a therapeutic environment for patients is dependent on the adaptability of the personnel on any given ward. The authoritarian personality, because of the constellation of characteristics typifying his reactions, may very well have difficulty with this. Horkheimer\textsuperscript{15} has listed traits of the

\begin{itemize}
\end{itemize}
authoritarian personality. The more important ones in terms of social situations are listed below:

"1. The authoritarian personality adheres rigidly to conventional values, at the expense of any autonomous moral decision.
2. He thinks in terms of black and white. White is the in-group, black the out-group. Anything different is violently rejected.
3. He hates whatever is weak, calling it a burden or a 'misfit.'
4. He is violently opposed to self-examination, never questions his own motives, but always blames others or external, physical, or 'natural' circumstances for any mishap.
5. He thinks in stereotypes ..... the individual appears as a mere specimen of its kind.
6. He thinks in hierarchial terms - 'people at the top, at the bottom and so forth.'
7. He tends to reject the subjective, the imaginative, the tender-minded individual.
8. He is generally more interested in means than in ends. To him things are more important than humans. He regards human beings mainly as tools or as obstacles - as things.
9. He is more interested in 'what he gets out of people' than in true affection. He is 'manipulative'.
10. He attributes an exaggerated importance to the ideas of purity, neatness, cleanliness, and such characteristics."

While it is true that no one person exhibits all these traits in all situations, nevertheless there is a potential and a readiness for such behavior on the part of the authoritarian person. More often than not these traits will be called into play as interactions occur between the various patients and the authoritarian person in the ward situation. That this can negate either all or part of a possible therapeutic situation for some patients where a selectively permissive atmosphere is required, can readily be seen. The patient benefits in proportion to the degree where a setting is created which meets a wide range of his needs. The authoritarian person will be unable to create this sort of interpersonal setting
because his own needs are not being met. When this happens, difficulties can be created for the patient but at the same time the authoritarian person is also having his own difficulties with the same situation.

Up to this point the personnel of a mental hospital have been mentioned in a general way. A variety of different functions are necessary in caring for patients. The psychiatrist because of his leadership position in a mental hospital has been the person most frequently considered when therapy is mentioned. Today, because of the increasing emphasis on person to person relationships, thought is being given to the other people also involved in the patient's ward environment. One body of personnel, who have been for the most part either taken for granted or ignored in terms of their possible contribution to a therapeutic setting, have been the psychiatric aides. Their importance is becoming more and more recognized. Greenblatt, York and Brown16 point out:

"The inclusion of attendants in treatment programs is a sine qua non in any project for improved ward care of patients. Not only because quantitatively the essential manpower in mental hospitals resides in their ranks but also because the attendant is the proximal individual with whom the patient interacts. In his actions he embodies the tone of the institution, either watchdog, cold, distant and threatening; or relaxed, friendly, and interested. It is largely the attendant-patient relationship that determines the amount and type of disturbed behavior of patients, the level of fear, the degree of arbitrary authoritarianism and the point at which seclusion becomes the answer. The attendant can make or break the patient. He can arrange the situation so that the patient whom he fears or against whom he harbors deep antagonisms will eventually land in seclusion - and by the physician's order."

Since the current emphasis in mental hospitals is on interpersonal relationships, it seems necessary to determine what sort of responses are

16. Greenblatt et al., op. cit., p. 64
elicited from patients in constant contact with psychiatric aides who are authoritarian in varying degrees. That there are a multitude of other personality traits which also affect the interpersonal relationships between people is recognized. However, as in other corporate endeavors, the emphasis in administrative planning in mental hospitals has been geared primarily toward the functions which have to be performed and how to best obtain the greatest efficiency of operation of these functions. This has led to hierarchial situations with rather rigid lines of demarcation, which in turn have tended to emphasize the authoritarian potentials within the individual. This writer feels that this must be examined as the next step in the progression of mental hospitals from custodial institutions to therapeutic communities.

**Basic Assumptions**

1. That authoritarianism is a measurable definable phenomenon.

2. That the personality of the psychiatric aide influences patients' behavior and responses.

**Hypothesis**

The greater the degree of authoritarian characteristics governing the aide's reactions, the less person to person humanistic interaction there is; the lesser the degree of authoritarian characteristics there are, the more person to person humanistic interaction there is.
CHAPTER III

DESCRIPTION OF THE SETTING

This study was carried out in the reception building of a large state mental hospital. The reception building is a three storied building which contains three male and three female units. All the units are physically alike. There is a large day hall with a corridor leading from it to the sleeping units. The sleeping units are either two bed rooms or beds grouped within two alcoves. The patients eat, in rotation, in a central dining room located on the second floor.

Each of the three units has a patient capacity of thirty to thirty-five patients. The patient population consisted of newly admitted patients and those patients who were now participating in various treatment programs. These units are the intensive therapy units of the hospital. The first floor unit differs from the other two in that it is an unlocked ward and patients are allowed to come and go as they desire. This is being done on an experimental basis and is considered to be the "calculated risk" ward. The second and third floor units are locked wards and patients have to be let in and out.

Because the reception building contained the highest percentage of patients who were able to relate in a verbal way to those around them, it was felt that this would provide the best opportunity for observations which would have more observable bases. It is recognized that non-verbal behavior is many times more meaningful in interpersonal relationships than more objective behavior. However, because of the writer's inexperience in
the more subtle observational methods which rely on sensing and interpreting complex unspoken symbolic responses, it was felt that more verifiable data could be obtained by the selection of patients on these units. The female units were chosen because it was felt that a female observer would be less conspicuous on a female unit than on a male unit.

Methodology

The Custodial Mental Inventory Scale was utilized for purposes of selecting the psychiatric aides who would participate in the study. The sixteen aides who were on the day shift were contacted on an individual basis and explanations were given as to the purpose of this investigation. Questions were encouraged and each aide was assured that it was her privilege to participate or not as she wished. A great deal of defensive behavior was exhibited by some of the aides. A few were worried about who would have access to the data. One was concerned about the writer's motivation in doing such a study. Another expressed annoyance at being bothered by too many "investigators." One aide refused to participate at all. It was decided not to press the issue with her. The others were reassured as much as possible and fourteen aides in all took the battery of tests.

This battery is a modified form of the scale devised by Adorno et al. in their California study which identifies the authoritarian or antidemocratic personality. Because that scale was devised for use with the

1. An unpublished scale which has been developed by Dr. Daniel J. Levinson, Boston Psychopathic Hospital.

general public, Dr. Daniel J. Levinson, in his current work at a small research hospital, devised a modified form of the original scale which would be more applicable in hospital settings.

The battery contains fifty-four statements which cover three attitude areas. Thirty questions are concerned with the Custodial Mental Inventory ideology (CMI) and center around how a person feels about mental illness. Twelve questions center on authoritarianism (F scale). These questions indicate the degree of authoritarianism present in the respondent. Eight items center on Traditional family ideology (TFI scale) and indicate how traditional a respondent is in terms of family situations. Four items are also included which serve as "buffer" items. The respondents are asked to indicate whether they agree or disagree with the statements and to what degree they do. Code numbers are used to indicate the degree of feeling about an item. These are listed below:

+1: I agree a little
+2: I agree pretty much
+3: I agree very much
-1: I disagree a little
-2: I disagree pretty much
-3: I disagree very much

In scoring, items were considered to be either "high" or "low" items. High items were ones which expressed the point of view indicated by the scale title. On the F scale, the following statement would be a high item:

The best teacher or boss is the one who tells us just exactly what is to be done and how to go about it.

Agreement with these items is given a high score and disagreement a low score. "Low" items were ones which expressed a point of view opposite to that indicated by the scale title. On the CMI scale, the following statement would be a low item:

3. One of the co-authors of the Authoritarian Personality.
When a patient is discharged from a hospital he can be expected to carry out his responsibilities as a citizen. Agreement with these items is given a low score, disagreement a high score. Responses to the "high" items were converted into scores as follows:

-3 = 1 point  +3 = 7 points
-2 = 2 points  +2 = 6 points
-1 = 3 points  +1 = 5 points

Omissions = 4 points

Responses to the "low" items were converted into the following scores:

-3 = 7 points  +3 = 1 point
-2 = 6 points  +2 = 2 points
-1 = 5 points  +1 = 3 points

Omissions = 4 points

The aide's total score was added up on the F scale and then divided by the number twelve (the number of statements pertaining to the F scale). This number is then multiplied by ten because of the convenience of working with whole numbers. The possible range of scores on the scale was ten to seventy with forty as the mid point. The scores were tabulated by someone other than the writer so as to forestall any possible bias on the observer's part.

Six aides out of the fourteen who took the battery, were selected on the basis of their scores on the F. scale. Two aides with low scores were considered to be low authoritarian. Two aides with middle scores were considered to be average authoritarian and two aides with the highest scores were considered to be high authoritarian. The scores were as follows: High - 53; High - 48; Average - 31; Average - 31; Low - 26; and low - 15. These scores presented some problems. There was an eleven point difference between the low score of fifteen and the next low score of twenty-six, while there was only a five point difference between the next two scores of thirty-one. In addition the highest scores of fifty-three
and forty-eight were much below that of the possible highest score of seventy. These results were discussed with Dr. Levinson. It was his experience that the scores in this particular section of the country ranged closer to sixty than to seventy so that the high scores were typical. There was also a range of scores so that it was permissible to consider these aides in the manner indicated.

Each one of the six aides was asked if she would participate in this part of the study. Explanations were given as to the role of the observer and questions were again encouraged. Twenty-five hours in a five day period was spent in this type of preparation and in practicing how to use the observational tool.

These six aides were then observed for ten one-half hour periods over a month's time. The half hour periods of observation occurred at the same time but very often on different days. If one aide was observed from eight to eight thirty in the morning, the others were also observed for this period. It was impossible to observe each aide on the same day as the others because of days off duty, vacation, holiday and class time. The particular hours of observation (8-8:30, 8:30-9; 9-9:30; 9:30-10; 10-10:30; 10:30-11; 11-11:30 and 1-1:30; 1:40-2:10; 2:15-2:45) were chosen because they were the hours during which the aides were available and on the wards.

A modified form of the Interaction Tally Sheet was the observational tool utilized.

This tool was specifically designed for the recording of the interactions of individuals. At the same time differentiations could be made between procedural and personal interactions. In addition, who initiated the interaction and what feeling tones prevailed during the interaction could also be tallied. These areas, initiation of interaction, differentiation into type of interaction, and feeling tone surrounding the interaction were seen as being central in ascertaining the kind of relationships made between patients and aides. The modification of this tool occurred chiefly in the area of initiation of interaction. Arrows are used to indicate the flow of interaction. The tool was utilized also for half hour periods instead of the suggested limit of fifteen minutes. The type of information sought in this study made this modification feasible.

A sample copy of the Interaction Tally Sheet is found on the following page. A few examples are shown to illustrate the manner in which the interaction between patients and aides was recorded. The meaning of the coding is also given.
### Figure 1. Interaction Tally Sheet

<table>
<thead>
<tr>
<th>Time</th>
<th>9-9:30</th>
<th>1-1:30</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pt.</strong></td>
<td></td>
<td>Patient</td>
</tr>
<tr>
<td><strong>A.</strong></td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td><strong>Pt.G.</strong></td>
<td>↓</td>
<td>Aide</td>
</tr>
<tr>
<td><strong>Procedural</strong></td>
<td></td>
<td><strong>Verbal Categories</strong></td>
</tr>
<tr>
<td>1. Seek I.</td>
<td></td>
<td>Seeking Information</td>
</tr>
<tr>
<td>2. Rec. I.</td>
<td></td>
<td>Receiving Information</td>
</tr>
<tr>
<td>3. Give I.</td>
<td></td>
<td>Give Information</td>
</tr>
<tr>
<td>4. Proc. Shower</td>
<td></td>
<td>Performing Nursing Procedure</td>
</tr>
<tr>
<td>5. Misc.</td>
<td></td>
<td>Performing miscellaneous tasks (lighting cigarettes)</td>
</tr>
<tr>
<td><strong>Personal</strong></td>
<td></td>
<td><strong>Greetings</strong></td>
</tr>
<tr>
<td>A. Greet.</td>
<td></td>
<td>Joking</td>
</tr>
<tr>
<td>B. Joke</td>
<td></td>
<td>Discussion of hospital events*</td>
</tr>
<tr>
<td>Cc + Hosp.</td>
<td></td>
<td>Discussion of outside events*</td>
</tr>
<tr>
<td>Dd + Out</td>
<td></td>
<td>Discussion of feelings and problems*</td>
</tr>
<tr>
<td>Ee + Feel</td>
<td></td>
<td>Discussion of social, occupational, recreational skills^</td>
</tr>
<tr>
<td>Ff + I &amp; S</td>
<td></td>
<td>Passive or Spectator participation in Activities</td>
</tr>
<tr>
<td>P.P.</td>
<td></td>
<td>Active Participation in Activities</td>
</tr>
<tr>
<td>A.P.</td>
<td></td>
<td><strong>Conv.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>X F</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Conversation with Activities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>X = Conversation about Activity</td>
</tr>
<tr>
<td>Activity</td>
<td>Scrabble</td>
<td><strong>Type of Activity</strong></td>
</tr>
<tr>
<td>Affect</td>
<td></td>
<td>* = Degree of conversation:</td>
</tr>
<tr>
<td>+</td>
<td></td>
<td>Capital letters = long</td>
</tr>
<tr>
<td>-</td>
<td></td>
<td>Small letters = short, casual</td>
</tr>
<tr>
<td>±</td>
<td></td>
<td>+ = Aide discussed own feelings and opinions.</td>
</tr>
<tr>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ to -</td>
<td></td>
<td>Warm and friendly</td>
</tr>
<tr>
<td>+ to ±</td>
<td></td>
<td>Neutral and business-like</td>
</tr>
<tr>
<td>+ to 0</td>
<td></td>
<td>Negative and hostile</td>
</tr>
<tr>
<td>- to +</td>
<td></td>
<td>Ambivalent</td>
</tr>
<tr>
<td>- to 0</td>
<td></td>
<td>Combination</td>
</tr>
<tr>
<td>- to ±</td>
<td></td>
<td>of</td>
</tr>
<tr>
<td>0 to +</td>
<td></td>
<td>four</td>
</tr>
<tr>
<td>0 to -</td>
<td></td>
<td>affective</td>
</tr>
<tr>
<td>0 to 0</td>
<td></td>
<td>Responses</td>
</tr>
<tr>
<td>0 to ±</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 to 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 to 0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The first example indicates that the following took place: The aide contacted the patient in order to shower her. During the course of the showering a discussion took place about an event outside of the hospital and how this patient felt about this. The aide remained neutral and business like during the interaction.

The second example indicates the following: The patient contacted the aide because she wanted to play scrabble. The aide played scrabble with the patient and conversation took place about the game and about other recreational topics. The aide was warm and friendly during this interaction.

It is to be remembered that during the course of a half hour period of observation, one or a great many interactions are possible between the patients and the aides. As many interactions as occurred are scored for the half hour interval.
CHAPTER IV

PRESENTATION OF THE DATA

The broad plan for analyzing the data was carried out in the following manner. The first procedure was to tabulate the total number of contacts between patients and aides who were authoritarian in varying degrees. These were then differentiated into the number of patient initiated and aide initiated interactions. This was followed by a breakdown into the kinds of interactions the patient and the aide initiated. Interaction profiles were then constructed to show graphically the over-all pattern of patient and aide interactions. Throughout this analysis the feeling tone generated during the interaction was observed and recorded.

Table 1 shows the kind and total aide initiated contacts.

These data are analyzed on the following pages.

Table 1. Type and Total Aide Initiated Interactions

<table>
<thead>
<tr>
<th>Aide</th>
<th>Procedural</th>
<th>Personal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>23</td>
<td>21</td>
<td>44</td>
</tr>
<tr>
<td>High</td>
<td>23</td>
<td>12</td>
<td>35</td>
</tr>
<tr>
<td>Average</td>
<td>38</td>
<td>16</td>
<td>54</td>
</tr>
<tr>
<td>Average</td>
<td>29</td>
<td>12</td>
<td>41</td>
</tr>
<tr>
<td>Low</td>
<td>29</td>
<td>13</td>
<td>42</td>
</tr>
<tr>
<td>Low</td>
<td>32</td>
<td>14</td>
<td>46</td>
</tr>
</tbody>
</table>

**High Authoritarian Aide 1**

The procedural interactions involved thirteen activities such as showering patients, combing hair, and helping patients make their own beds. There were only two conversations carried on during the course of the
activities. There were ten verbal interactions which centered around checking whether patients had received their medications and reminders about various appointments. The affect was neutral during fifteen of the interactions and warm and friendly during eight.

The personal interactions involved seven conversations about the patients' feelings and events inside and outside the hospital. The two hospital conversations concerned patient's responsibilities in terms of cleanliness about the ward. One occurred when the aide reprimanded a patient for leaving soiled clothing about and the other concerned reprimanding a patient for leaving a "messy" kitchen. The aide asked patients to play scrabble on two occasions. The remaining twelve interactions were of a short and casual nature. The affect was neutral in nine instances, warm friendly in eleven, and hostile in two.

**High Authoritarian Aide 2**

Fourteen procedural activities such as showering, dressing patients, and passing medications were carried out. Four conversations accompanied these activities. Nine interactions were verbal ones and centered on the aide reminding patients about various rules of the ward. The affect was neutral seventeen times and warm and friendly five times. Hostility was shown once when a patient could not make up her mind about going to the hairdresser.

Six personal interactions consisted of active participation in scrabble games with patients. There was little conversation with these. Four interactions were short remarks in passing. Two were conversations. One was about a patient's impending discharge and one occurred when a patient felt physically ill. The affect was neutral six times and friendly
six times. One of these was quite reassuring in nature and took place with the physically ill patient.

**Average Authoritarian Aide 1**

The procedural interactions involved nineteen activities such as escorting, showering, and dressing patients. Eight of these were accompanied by a great deal of conversation. There were nineteen verbal interactions consisting, for the most part, of checking on patients. The affect was neutral eighteen times, friendly nineteen times, and hostile once when a patient was slow in showering.

Nine personal interactions were conversational in nature. Four were short greetings to patients. Active participation in playing cards and going for walks occurred on three occasions. The affect was neutral seven times, friendly eight times and hostile once in an interaction with a patient who was acting out her feelings.

**Average Authoritarian Aide 2**

Thirteen procedural activities such as escorting patients and gathering them together for various activities were carried out. Six of these were accompanied by conversations. The sixteen verbal interactions consisted of checking on functional things. The affect was neutral in nineteen instances, friendly in nine instances and hostile once toward a patient who persisted in ripping off her clothes.

Five of the personal interactions consisted of active participation in playing cards, going for walks, and playing scrabble. Six interactions were long conversations about patients' feelings during which this aide contributed many personal comments regarding herself. One interaction was a short casual greeting. The affect was friendly on ten occasions, neutral
on one occasion, and hostile once when a patient procrastinated in preparing for a walk.

Low Authoritarian Aide 1.

Twenty-two procedural interactions took the form of activities. These included escorting patients, feeding and dressing them. Six conversations were carried on during these activities. The seven verbal interactions consisted of functional inquiries. The affective atmosphere was neutral during nineteen interactions, friendly during six, and hostile during four. These last interactions were with a young patient who constantly acted out and who also teased a great deal.

Four personal interactions were spent in active participation in card playing and in dancing. Active interchange of conversation went on during these times. Six interactions were in the form of long conversations. Three were of a short casual nature. The affect was friendly on nine occasions, neutral on three occasions and became hostile once during the course of a game of whist.

Low Authoritarian Aide 2

Seventeen interactions concerned procedural activities with twelve conversations being carried on during the course of these activities. There were fifteen verbal interactions for the purpose of finding out where patients had put things, when their next appointments were, etc. Affect during these interactions was neutral nineteen times and friendly thirteen times.

Twelve long conversations with patients expressing how they felt about things were carried out in the personal interactions. One such conversation was a long and involved one where a patient was crying and the
aide comforted her. There were only two casual remarks. Affectively, the feeling tone was warm and friendly on twelve occasions and neutral twice.

**Evaluation of Aide Initiated Interactions**

In conjunction with the preceeding material, Interaction Profiles were compiled in Figures 2 and 3, which appear on the following page. The first of these profiles shows that approximately fifty per cent of the interactions of each aide took the form of procedural activities. It would seem that the degree of authoritarianism present has little to do with whether an aide carried out the procedural requirements of her job. There are differences, however, in verbal communication while carrying out these activities. The more authoritarian the aide the less conversation there seemed to be. The lowest authoritarian aide had twelve conversations with patients while carrying out the seventeen activities, whereas the highest authoritarian aide only had two conversations while carrying out the thirteen activities. The remaining aides were on a continuum. Conversation tends to create a more personal interaction and apparently the higher the degree of authoritarianism, the less personal attributes there were to the procedures.

The verbal procedural category showed that the two average authoritarian aides had the most verbal interactions with patients while the two low and two high aides had the least. The data in this area were non contributory.

The second of these profiles shows that the least authoritarian aide had the greatest number of prolonged face to face contacts with patients. Twelve of the fourteen interactions were prolonged conversations. The other aides varied in this. The next lowest authoritarian aide had six
Figure 2.
Hide Initiated Procedural Interaction Profile

Figure 3.
Hide Initiated Personal Interaction Profile

* Score on Authoritarian Scale
† No Active Participation
out of thirteen. The two average authoritarian aides had six out of twelve and nine out of sixteen. The two high authoritarian aides had two out of twelve and seven out of twenty-one. It would seem that the less authoritarian components present, the more inclination there is to react to patients on a more personal basis.

In regards to participation of aides in recreational and occupational activities a differentiation needs to be made. These activities can serve two purposes in terms of interpersonal relationships. One is that the activity serves as a basis for mutual participation and for mutual enjoyment. The other is that the activity is utilized to create a barrier to interpersonal relationships. In other words, the activity itself can be used as a shield against too close a contact. The least authoritarian aide had no active participation in activities. The next low authoritarian aide had five such interactions. These were of a varying nature; singing, dancing, going for walks, and playing cards. The two average authoritarian aides had five and three such interactions. These, too, were of a varied nature. The two high authoritarian aides presented an interesting pattern to their participations. The second highest authoritarian aide had six such interactions and the highest had two. These activities consisted of playing scrabble. In the case of both of these aides the games seemed to be entered into grimly, were played without any easy comradliness and were quite business-like.

The short casual interactions also present a contrast. The low and average authoritarian aides had the least number of such contacts while the high authoritarian aides had the most. It would seem that the low and average authoritarian aides have interpersonal contacts with patients on
a face to face basis either in prolonged conversations or in friendly participation in various activities. The highest authoritarian aides seem to have more short casual interpersonal contacts and the activities seem to be utilized as a means of protection against involvement in interpersonal relationships.

These data were next evaluated for the kinds of contacts patients initiated. These interactions were ones in which the patient moved toward the aide. The type and total number of patient initiated interactions are shown in Table 2.

**Table 2. Type and Total Number of Patient Initiated Interactions**

<table>
<thead>
<tr>
<th>Aide</th>
<th>Procedural</th>
<th>Personal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>31</td>
<td>15</td>
<td>46</td>
</tr>
<tr>
<td>High</td>
<td>13</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Average</td>
<td>35</td>
<td>24</td>
<td>59</td>
</tr>
<tr>
<td>Average</td>
<td>20</td>
<td>14</td>
<td>34</td>
</tr>
<tr>
<td>Low</td>
<td>35</td>
<td>6</td>
<td>41</td>
</tr>
<tr>
<td>Low</td>
<td>23</td>
<td>22</td>
<td>45</td>
</tr>
</tbody>
</table>

**High Authoritarian Aide 1**

Patients requested this aide to carry out twenty procedural activities. Typical requests resulted in lighting cigarettes, opening doors, and obtaining various necessities for patients, e.g. toilet tissue, soap, and clothing. Eleven interactions were verbal in nature and consisted of questions as to time and when lunch was, etc. The aide responded in a friendly manner eight times and in a neutral manner twenty-three times.

Patients initiated seven conversations of a personal nature. They
also passed casual remarks and greetings eight times. The affective response was friendly on ten occasions and neutral on five occasions.

**High Authoritarian Aide 2**

Patients sought this aide out eight times for lighting cigarettes and letting them in and out. The five remaining interactions were verbal in nature and were questions as to time. The aide responded in a neutral manner eleven times and was friendly twice.

There were only two personal contacts on the patients' part. One took the form of a greeting and the other occurred when the patient discussed her psychiatrist with this aide. The affective response was friendly in both instances.

**Average Authoritarian Aide 1**

Patients sought this aide out thirteen times for various procedural activities. Twenty-two interactions were verbal ones and involved seeking information about various aspects of ward life. The aide responded in a neutral manner twenty-eight times, in a friendly manner three times, and in a hostile manner four times. These last responses were directed toward the same patient who has been mentioned before.

Patients approached this aide eleven times to converse about various personal matters. They had twelve short contacts on a casual basis. One patient approached her to go for a walk. The affective response was friendly in twelve instances, neutral in ten, and hostile in two. These last two were in response to teasing and derogatory remarks on the part of one patient.

**Average Authoritarian Aide 2**

This aide was approached ten times for various procedural activities
such as lighting cigarettes, opening doors, and combing hair. There were ten verbal interactions which centered around the question of time and various questions about ward policies. The affective response was neutral fourteen times and friendly six times.

Personal conversations were carried on with this aide eight times. There were four short casual contacts directed to her. Twice she was asked to participate in activities. The affective response was friendly on nine occasions and neutral on five occasions.

Low Authoritarian Aide 1

This aide was approached twenty times for various procedural activities. There were also fifteen verbal interactions. The affective response was neutral twenty-seven times, friendly six times, and hostile twice. These last responses were directed to a patient who persisted in teasing those around her.

Patients approached this aide three times to converse with her about personal matters. They also had three short casual contacts with her. The affective response was neutral on three occasions, friendly on two occasions, and hostile once. This occurred in response to derogatory remarks passed by the previously mentioned patient who now focused her attention on this aide.

Low Authoritarian Aide 2

Patients approached this aide thirteen times to carry out miscellaneous activities for them. They also approached her on a verbal basis ten times to answer various questions pertaining to ward life. The affective response was neutral seventeen times and friendly six times.

She was approached sixteen times to converse about various personal
matters. There were also six casual remarks directed to her. The affective response was neutral six times and warm and friendly sixteen times. This aide was reassuring and quite motherly, e.g. putting her arms around the patient to comfort her during three of the friendly responses.

**Evaluation of Patient Initiated Interactions**

In conjunction with the preceding material, Interaction Profiles were also compiled and are shown in Figures 4 and 5 which appear on the following page.

The procedural profile shows that approximately fifty per cent of the moves which patients make toward the aides are for the purpose of having the aide do something for them. All the aides were the recipients of such requests although to varying degrees. The second lowest and the highest authoritarian aides were approached the most times. One average and the lowest authoritarian aides were approached an equal number of times. The second highest and the other average authoritarian aides were approached the least number of times. It would seem that in the procedural categories patients interact with aides in pretty much the same fashion regardless of the degree of authoritarianism. The lowest authoritarian aide and one average authoritarian aide responded with the most conversation during these activities. It would seem that regardless of who initiates the interaction, the highest authoritarian aides do not converse with patients as much while carrying out the various procedural activities.

The personal interaction profiles show that the least authoritarian aide was the one who was overwhelmingly sought out by the patients for personal conversations. Although one of the average authoritarian aides had more personal interactions quantitatively speaking, qualitatively,
**Figure 4.**

**Patient Initiated Procedure Interaction Profile**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Verbal</th>
<th>Activity</th>
<th>Verbal</th>
<th>Activity</th>
<th>Verbal</th>
<th>Activity</th>
<th>Verbal</th>
<th>Activity</th>
<th>Verbal</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="chart1.png" alt="Chart" /></td>
<td><img src="chart2.png" alt="Chart" /></td>
<td><img src="chart3.png" alt="Chart" /></td>
<td><img src="chart4.png" alt="Chart" /></td>
<td><img src="chart5.png" alt="Chart" /></td>
<td><img src="chart6.png" alt="Chart" /></td>
<td><img src="chart7.png" alt="Chart" /></td>
<td><img src="chart8.png" alt="Chart" /></td>
<td><img src="chart9.png" alt="Chart" /></td>
<td><img src="chart10.png" alt="Chart" /></td>
</tr>
</tbody>
</table>

- High Rate
- Average Rate
- Low Rate

**Figure 5.**

**Patient Initiated Personal Interaction Profile**

<table>
<thead>
<tr>
<th>Remarks</th>
<th>Activity</th>
<th>Remarks</th>
<th>Activity</th>
<th>Remarks</th>
<th>Activity</th>
<th>Remarks</th>
<th>Activity</th>
<th>Remarks</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="chart11.png" alt="Chart" /></td>
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<td><img src="chart14.png" alt="Chart" /></td>
<td><img src="chart15.png" alt="Chart" /></td>
<td><img src="chart16.png" alt="Chart" /></td>
<td><img src="chart17.png" alt="Chart" /></td>
<td><img src="chart18.png" alt="Chart" /></td>
<td><img src="chart19.png" alt="Chart" /></td>
<td><img src="chart20.png" alt="Chart" /></td>
</tr>
</tbody>
</table>

- High Rate
- Average Rate
- Low Rate

* No active participation
more than half of these were on a short casual basis. The second highest authoritarian aide was the least sought of all the aides. This was a consistent pattern throughout all the various interactions. With the exception of the fact that the lowest authoritarian aide was by far the preferred person for the more personal interactions, the overall pattern of patient initiated interactions showed little consistency in the selection of aides. The patients did not seek aides for participation in activities very frequently. Only two of the aides were approached and this only on three occasions. This would seem to indicate that participation in activities is something which is more aide initiated than patient initiated.

The overall affective responses of aides towards patients and the type of interaction is presented below in Table 3.

Table 3. Affective Responses of Aides and Types of Interaction

<table>
<thead>
<tr>
<th>Aide</th>
<th>Procedural</th>
<th>Personal</th>
<th>+</th>
<th>+</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>55</td>
<td>36</td>
<td>14</td>
<td>47</td>
<td>0</td>
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<tr>
<td>Low</td>
<td>64</td>
<td>19</td>
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<tr>
<td>Average</td>
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<td>40</td>
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<td>Average</td>
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<td>High</td>
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<tr>
<td>High</td>
<td>54</td>
<td>36</td>
<td>51</td>
<td>38</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 3 shows that for the most part neutral responses accompanied procedural interactions and either warm and friendly or a few hostile responses accompanied the personal interactions. The lowest authoritarian and one average authoritarian aides were the two exceptions. Their affective responses seemed to depend on the patient with whom they were
interacting rather than on the type of interaction taking place as seems
to be the case with the other aides.

Because the lowest authoritarian aide and the highest authoritarian
aide had almost exactly the same number of interactions with patients a
qualitative analysis was done. The active participation in activities is
not shown because they constituted such a small number of interactions.
Table 4 shows the comparison of procedural and personal interactions of
these two aides.

| Table 4. Comparison of Highest and Lowest Authoritarian Aides' Interactions |
|------------------|----------------|--------|----------------|----------------|--------|
| Procedural        | Conversation   | Personal| Conversation   | Remarks        |
| Low              | 52             | 20     | 37             | 29             | 8      |
| High             | 54             | 9      | 35             | 14             | 21     |

These figures show that the least and most authoritarian aides had almost
the same number of procedural contacts with patients. The lowest authori-
tarian aide, however, conversed with the patients twenty times as com-
pared to the highest authoritarian aide's nine conversations. Conversa-
tions during activities tend to personalize the interaction. The lowest
authoritarian aide personalized her procedural interactions more than
twice the number of times that the high authoritarian aide did. The
personal interactions of both aides were also numerically almost the same.
In the analysis of the types of these interactions, it will be noted that
the lowest authoritarian aide had twenty-nine prolonged conversations
while the highest authoritarian aide had fourteen. Conversely, the
highest authoritarian aide had twenty-one short casual interactions while the lowest authoritarian aide had only eight of these. Because this is a small sample, little can be said in the way of generalizations. However, there are indications that the lowest authoritarian aide had more humanistic interactions with patients and that the highest authoritarian aide had less humanistic interactions with patients.
CHAPTER V

SUMMARY

In order to compare the types of interactions which patients have with aides who are authoritarian in varying degrees, it was necessary to observe these aides in their interactions.

The observational data showed that approximately fifty per cent of the aide's interactions were of a procedural nature. This included the interactions which the aide initiated and also the interactions which the patients initiated. There were indications that these interactions were carried out both on a more or less personalized basis. As the degree of authoritarianism increased, conversation accompanying the procedural interactions decreased. It would seem that there were tendencies to de-personalize the procedural interactions on the part of the more authoritarian aides.

The verbal procedural interactions were non-contributory in nature. The two average authoritarian aides had the most of these interactions but no differentiations could be made in comparisons with the high and low authoritarian aides.

A comparison of the procedural interaction profiles showed that there was a definite pattern to the profiles. The profile of each aide showed that the interactions were of a reciprocal nature. If the aide initiated more interactions of a procedural nature and less verbal interactions, the patients' interactions also followed this pattern. If the aide initiated an equal number of procedural and verbal interactions, the patients seemed to reciprocate by moving toward the aide in the same fashion.
Active participation in activities seemed to serve a dual purpose. The low and average authoritarian aides seemed to enter into activities for the purpose of socializing with the patients. The high authoritarian aides seemed to enter into activities for the purpose of becoming involved in the activity itself. There is some question here whether activities with patients were used as protective devices against interpersonal relationships by the high authoritarian aides.

The personal interactions indicated that the low and average authoritarian aides had more long personal conversations with patients and that the high authoritarian aides had more short casual communications. The low and average authoritarian aides tended toward more face to face contacts with patients than the high authoritarian aides did.

In differentiating between the degree of authoritarianism present and the types of interactions there were with patients, very few definite statements can be made on the basis of this study. While it is true that different interaction profiles resulted from the observations, none of these is consistent for the two high authoritarian aides as compared to the two average and two low authoritarian aides. The only definitely different patterns of interactions which were consistent throughout the study were those of the highest and the lowest authoritarian aides. This sample is small and only a few tentative statements can be made. The lowest authoritarian aide consistently had more conversations with patients in procedural interactions than did the highest authoritarian aide. The lowest authoritarian aide personalized the procedural interactions whereas the highest authoritarian aide did this to a lesser degree. The lowest authoritarian aide also initiated more prolonged personal interactions.
The patients responded by seeking her to talk to her about the more personally oriented things involving them. The low authoritarian aide had more short verbal communications. This seemed to indicate that the low authoritarian aide's interactions with patients were on a more personalized level and the high authoritarian aide's interactions were maintained on a more impersonal level.

Conclusions

In terms of the data which had been analyzed, it was tentatively recognized that authoritarianism does play a part in the types of interpersonal relationships carried on between patients and aides. What definite part it plays, however, remains a question.

The reciprocal nature of the interactional process was shown throughout the data. Patients seemed to sense the type of relationship the aide was going to maintain with them and they, in turn, responded by also maintaining the same sort of pattern in their relationships with the aide. If this proves to be true, then the implications in terms of helping the patient regain a more adequate pattern of interpersonal relationships, become obvious.

Recommendations

It is recommended that:

1. Further studies be carried out around the question of authoritarianism and interpersonal relationships with such factors as age and sub-cultural variations being held constant.

2. That studies be made to determine the correlation between the types of interpersonal relationships the aide has with patients and the status which the aide has in the hospital hierarchy.
3. That further studies be made about the various other components in the aide's personality which may have an effect on interpersonal relationships.

4. That studies be made to determine which kind of psychiatric patient responds favorably and which kind responds unfavorably to authoritarian components in the personnel.
BIBLIOGRAPHY

Books


Articles and Periodicals


APPENDIX A

CUSTODIAL MENTAL INVENTORY SCALE

Please answer each statement below with your personal opinion. There are many different points of view represented. You may find yourself agreeing strongly with some statements, disagreeing as strongly with others.

Mark each statement in the left margin according to how much you agree or disagree with it. Please mark every one. Write in +1, +2, +3; or -1, -2, -3; depending on how you feel in each case.

+1: I AGREE A LITTLE
+2: I AGREE PRETTY MUCH
+3: I AGREE VERY MUCH

-1: I DISAGREE A LITTLE
-2: I DISAGREE PRETTY MUCH
-3: I DISAGREE VERY MUCH

1. Only persons with considerable psychiatric training should be allowed to form close relationships with patients.
2. Patients benefit as much from a warm personal relationship with an attendant or nurse as they do from specific treatment methods.
3. It is best to prevent the more disturbed patients from mixing with those who are less sick.
4. What the youth needs most is strict discipline, rugged determination, and the will to work and fight for family and country.
5. As soon as a person shows signs of mental disturbance he should be hospitalized.
6. Nowadays when so many different kinds of people mix together so much a person has to protect himself especially carefully against catching an infection or disease from them.
7. Mental illness is an illness like any other.
8. Sex crimes, such as rape and attacks on children, deserve more than mere imprisonment; such criminals ought to be publicly whipped, or worse.
9. Close association with mentally ill people is liable to make even a normal person break down.
10. People can be divided into two distinct classes: the weak and the strong.
11. We can make some improvements, but by and large the conditions of mental hospital wards are about as good as they can be considering the type of disturbed patient living there.

12. If people would talk less and work more, everybody would be better off.

13. We all have quirks very similar to those of the mentally ill.

14. The best teacher or boss is the one who tells us just exactly what is to be done and how to go about it.

15. We should be sympathetic with mental patients, but we cannot expect to understand their odd behavior.

16. No sane, normal, decent person could ever think of hurting a close friend or relation.

17. One of the main causes in mental illness is lack of moral strength.

18. When a patient is discharged from a hospital, he can be expected to carry out his responsibilities as a citizen.

19. Abnormal people are ruled by their emotions; normal people by their reason.

20. When a person has a problem or worry, it is best for him not to think about it, but to keep busy with more cheerful things.

21. A mental patient is in no position to make decisions about even everyday living problems.

22. If children are told much about sex, they are likely to go too far in experimenting with it.

23. Patients are often kept in the hospital long after they are well enough to get along in the community.

24. Women who want to remove the word "obey" from the marriage service don't understand what it means to be a wife.

25. There is something about mentally ill people that makes it easy to tell them from normal people.
+1: I AGREE A LITTLE
+2: I AGREE PRETTY MUCH
+3: I AGREE VERY MUCH
-1: I DISAGREE A LITTLE
-2: I DISAGREE PRETTY MUCH
-3: I DISAGREE VERY MUCH

26. A child should never be allowed to talk back to his parents, or else he will lose respect for them.

27. Few, if any, patients are capable of real friendliness.

28. A man should not be expected to have respect for a woman if they have sexual relations before they are married.

29. Male and female patients should have opportunity for social activities together each day.

30. It is somehow unnatural to place women in positions of authority over men.

31. There is hardly a mental patient who isn't liable to attack you unless you take extreme precautions.

32. A woman whose children are at all messy or rowdy has failed in her duties as a mother.

33. Patients who fail to recover have only themselves to blame; in most cases they have just not tried hard enough.

34. There is hardly anything lower than a person who does not feel a great love, gratitude, and respect for his parents.

35. The improvement of many patients is greatly hindered by the loss of freedom resulting from hospitalization.

36. The facts on crime and sexual immorality show that we will have to crack down harder on young people if we are going to save our moral standards.

37. "Once a schizophrenic, always a schizophrenic".

38. Patients need the same kind of control and discipline as an untrained child.

39. With few exceptions most patients haven't the ability to tell right from wrong.

40. In experimenting with new methods of ward treatment, hospitals must consider, first and foremost, the safety of patients and personnel.
41. Young people sometimes get rebellious ideas, but as they grow up they ought to get over them and settle down.

42. Persons who have been discharged from a mental hospital after successful treatment are often more stable than many others in the community.

43. The mental hospital should insist that all patients keep themselves clean in dress, manners, and speech.

44. Science has its place, but there are many important things that must always be beyond human understanding.

45. As a general rule it is best that patients stop seeing each other after they leave the hospital.

46. Once a person is headed toward mental illness, there is not much that anyone can do to prevent it.

47. Mentally ill people are as intelligent, on the average, as "normal people."

48. Most of our social problems would be solved if we could somehow get rid of the immoral, crooked and feeble-minded people.

49. Anyone who has been a mental hospital patient should keep this fact a secret even from his friends.

50. What mental hospital patients need above all else is rest, quiet and good food.

51. In most cases it is all right for people who have been mentally ill to marry and have children.

52. More than anything else it is good hard work that makes life worthwhile.

53. Mental hospital doctors should spend less time letting patients air their problems and more time telling them what to do.

54. Once a person has been mentally ill he needs more supervision and advice from his family than would otherwise be necessary.