Twelve common concerns expressed by male convalescent psychiatric patients in weekly group discussions.

Viens, Josephine Elizabeth
Boston University

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TWELVE COMMON CONCERNS EXPRESSED BY
MALE CONVALESCENT PSYCHIATRIC PATIENTS
IN WEEKLY GROUP DISCUSSIONS

BY

Jdsephine Elizabeth Viens
(Bachelor of Science in Nursing, Boston University, 1958)

A field study submitted in partial fulfillment of the requirements for the Degree of Master of Science in the School of Nursing Boston University June, 1963

First Reader: Liby E. Waymouth

Second Reader: Frances K. Clark
ACKNOWLEDGMENT

The writer is greatly indebted to her advisor and reader, Miss Lilyan T. Weymouth, whose guidance and encouragement aided immeasurably in the completion of this study; and to Miss Frances K. Clyde, her reader, whose assistance and support contributed to the completion of the study.

The writer's colleagues and the patients of the Foxborough State Hospital have also provided much support and assistance in the development of the study.

This study was supported (in part) by a training grant, U.S.P.H.S. 2M50I8 (C9) from the National Institute of Mental Health, U.S. Public Health Service.
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CHAPTER I
INTRODUCTION

In today's competitive and stressful world, health has been difficult to sustain for many; almost impossible for some. However, the outlook has brightened for the ever-increasing number of persons whose emotional problems require the specialized services of a psychiatric hospital.

One contemporary trend in hospitalization has been the encouragement of the voluntary form of commitment. Another trend has been the effort to return the patient to the community as soon as possible. The hospitalization period itself has included plans for a quality of care that will contribute significantly to the patient's therapeutic progress.

Schwartz and Shockley,¹ Hyde,² Greenblatt, York, and Brown³ in this country, and Maxwell Jones⁴ in England have con-


tributed important socio-psychiatric studies which proved the worth of a therapeutic hospital climate. These studies investigated personnel-patient relationships as a means of influencing behavior and the outcome of illness.

Psychiatric nursing in the past followed structured patterns or procedures which required little intellectual exercise and emotional understanding on the part of the nurse. She functioned within this limited framework without seeking the underlying reasons for her course of action, much less the reactions of the patient. Although the nurse was aware of her responsibilities, she was seldom encouraged to demonstrate initiative or the capacity to think or act beyond the accepted operational pattern.

However, in the last decade psychiatric nursing theory and practice have moved into a period of marked and radical change, even though the basic purpose has remained the same for those working close to the patient; namely, to provide the best care possible and to bring about recovery.

Now, a dynamically-oriented treatment program, and a shorter period of hospitalization can be the expectation of the majority of patients. New concepts concerning the dynamics of behavior in health and illness have contributed to knowledge and new methods have been utilized for studying behavior. One direct result of these new concepts and methods has been the expansion of areas in psychiatric nursing that require exploration.
Even in the past patients were regarded as people with loves and hates. They reacted to the same stresses and strains as the personnel caring for them, but in more bizarre and exaggerated ways, and with greater degrees of intensity. Although personnel responded intuitively to patients' needs without understanding the underlying motivation, an increased knowledge of the dynamics of behavior provided them with the key to influencing attitudes, and in turn made patients more accessible to treatment.

Public psychiatric hospitals are often seriously under-staffed with professional personnel even though the patient population remains consistently high. Moreover, the majority of newer patients admitted do recover and return to the community despite this handicap to intensive therapeutic care.

Staff physicians frequently carry responsibility for two hundred or more patients, and few physicians on the average psychiatric hospital staff are qualified psychiatrists. The relatively few professional nurses available are employed in an administrative or supervisory capacity for the most part, which indicates that nursing care is predominantly in the hands of semi-professional and non-professional personnel.

Brown pointed out the increasing tendency of pro-

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Brown, op. cit., p. 11.
professional personnel to consider the unlimited latent possibilities that exist for helping patients through competently handled interpersonal relations and group processes. This consideration included a recognition of the inherent influence upon patients of everyone who came in contact with them, including the influence of patients upon one another.

Since enough psychiatrists will not be available in the foreseeable future to furnish individual or even group treatment for all patients in public hospitals, this recent acknowledgment that roles having therapeutic value may be taken by other members of the staff and by patients can scarcely be overestimated as a promise of greatly enlarged and improved patient care.

The group discussion process was seen as one means of providing therapeutic communication between patients and personnel in regard to ward life. Individual requests, criticisms, and comments tend to be regarded with less seriousness than those expressed by a majority of patients. The concerted opinions of patients in group discussion should in turn point out aspects of common concern which might be used to influence change or modification of existing conditions toward a more therapeutic ward climate. Group effort would also tend to stimulate a sense of participation in the improvement of the hospital community. This particular study was concerned with one such group discussion process and its outcomes.
Statement of the Problem

Through the method of weekly group discussions with male convalescent patients in a public psychiatric hospital, would it be possible to identify some significant areas of common concern associated with convalescence, as perceived and expressed by the patients?

Justification of Problem

A program was initiated by hospital administration to extend the advantages of group experience to an increasing number of patients, despite the limited number of trained psychotherapists on the medical staff. Group leaders were recruited chiefly from the nursing service and were supervised and counselled by a staff physician.

A nurse leader was selected to conduct weekly group discussions with male patients from two convalescent wards of the admissions treatment center. This nurse initially saw the use of group work as a means of becoming better acquainted with the problems of these particular patients, and of obtaining first hand knowledge of the things which were a source of concern to them.

As the sessions progressed it became evident that participants welcomed the opportunity to communicate in a non-restrictive atmosphere. They demonstrated considerable ability in presenting topics for discussion which concerned
them as a group living together in a ward community.

There was evidence from the recordings that areas of concern tended to recur, even though members changed frequently. This change occurred when recovered members left the hospital and new arrivals on the convalescent wards were invited to join the group.

Group discussions came to be seen as a means of providing a satisfactory face-to-face outlet for an increasing number of patients, with nurse expectations and patient expectations given a voice in outcomes.

Observations of the group discussions stimulated the leader's interest in identifying some of the areas of concern which were regularly repeated by convalescent patients. It was felt that a study of this nature would provide some guidelines for other nurses, who might desire to utilize the method of group discussion in working with patients.

Scope

Eighteen weekly group discussions were conducted with male patients selected by availability from two convalescent wards of a public psychiatric hospital. The meetings extended over a period of five months in 1962.

Analyses were made of the concerns recognized by the nurse leader as similar or identical subjects introduced by a frequently changing patient group.

A conclusion was drawn, recommendations were made and
proposals for further study were presented upon the basis of the findings.

**Limitations**

Patients were designated as convalescent through the medium of being transferred to two open convalescent wards by a staff physician.

Recordings and observations were made of eighteen weekly group discussions with convalescent male patients selected by availability.

Recordings and observations were written by the nurse leader, using the method of memory recall within one hour following each group discussion period.

Data were confined to a representative group of convalescent male patients. It did not include opinions from all convalescent patients residing in the building or admitted to it.

Frequent changing of ward population to the acute ward or to the community was considered to be a limiting factor in group continuity.

**Preview of Methodology**

The recordings of eighteen group discussions were examined to determine meaningful topics of concern expressed by male convalescent patients.

Each recording was scrutinized separately; material
of a meaningful nature was transposed to a master sheet which indicated the number of times a topic was introduced and the overall number of patients who expressed opinions concerning it.

Order of importance was established by the number of sessions in which group members repeatedly expressed concern about a particular aspect of ward life; a second criterion was reiteration of a concern by ten or more patients.

The results were considered under four nursing care categories for purposes of discussion of the findings.

**Sequence of Presentation**

Chapter I included an overview of the subject to be explored.

Chapter II included a review of the literature relating to this study and a statement of the hypothesis.

Chapter III was concerned with a more detailed account of the methodology used in terms of the selection of the sample, the setting for the study, the tools used, and the procurement of the data.

Chapter IV presented the discussion of the data.

Chapter V presented the summary, conclusion and recommendations which resulted from this study.
CHAPTER II
THEORETICAL FRAMEWORK OF THE STUDY

Review of Literature

The survey of the literature was concerned with three general areas: (1) recent contributions of social psychiatric studies with the resulting effect upon psychiatric nursing practice, (2) the newer psychiatric nursing concepts as they applied to the establishment and maintenance of a therapeutic hospital climate, and (3) the use of the group discussion method as a therapeutic tool by the psychiatric nurse to foster satisfactory patient-personnel relationships.

Nahm ¹ mentioned the far-reaching impact of the social science field--clinical and social psychology, social anthropology, and sociology--on nursing, on medicine, and on the allied professional disciplines. The Russell Sage Foundation, she pointed out, has supported a number of research projects in psychiatric institutions which investigated the use of the social environment of a ward or an entire hospital for therapeutic purposes; on an understanding of the hospital social

system; the position and functioning of nurses and other personnel in this system. Nahm further emphasized that psychiatric nursing research studies also have been focusing upon the inter-personal relationships of any two persons—nurse-patient, nurse-nurse, and patient-patient; interpersonal relationships in a particular group; or interpersonal relationships among groups.

There is emphasis on the nurse as a participant-observer who makes inferences from observations and interviews. She observes not only patients' behavior but her own. She uses her relationships with the patients to foster emotional growth and deliberately responds in such a way as to prevent the patient from experiencing the rejection he has learned to expect. Through her role as participant-observer she is evolving hypotheses about the nurse-patient relationship which can be tested through further and perhaps more well-defined research.²

Jones³ cited the nurse-patient relationship as the biggest single problem facing the nurse. If left undefined, her role could be invested with whatever anti-social or personal feelings the patient or group of patients might wish to project.

Jones interpreted the nurse's role under three general


headings—authoritarian, social, and therapeutic. The authoritarian or disciplinary role followed the trend of the community structure, with emphasis upon the need for a positive pattern of intervention clearly understood by both staff and patients—active interference in extreme situations, but determined by circumstances in less severe instances; an acknowledgment that any patient-community needs a positive discipline to control its more antisocial elements. In carrying out her authoritarian role the nurse would be responding to a community need.

The social role required flexibility and initiative in interpreting the social needs of the patient groups, to provide them with a feeling of security and of being understood. Jones warned the nurse that she must constantly guard against satisfying her own needs rather than those of the patients.

The treatment role was seen as one in which the nurse interpreted or transmitted the unit culture to the patient, and the more she had accepted this culture, the more readily and competently she could fulfil her role.

Jones emphasized that the aim was to achieve a communal responsibility in regard to all unit problems, whether related to patients or staff. This distribution of responsibility tended to increase the tensions of the staff, but eventually led to a far more realistic attitude toward
the treatment program. 4

Greenblatt, York, and Brown 5 pointed out changes that have occurred in the psychiatric nurse's role within the last decade. Reduction of disturbed patient behavior and elimination of punitive measures led to a movement away from rigid routines. The nurse became an active participant in the thinking and planning of ward activities, with the goal of making the ward a pleasant place in which to live. She began to think of herself as responsible for patient interaction, group activities and ward morale. She became a vital part of the treatment team; informal group discussions increased her therapeutic potential and her closeness to patients.

The above investigators saw the nurse as being released from the unhappy role of taskmaster, with three dynamic and fairly distinctive functions having emerged. She became: (1) the captain of the ward team, with the all-important morale of the ward in her hands; (2) a teacher of ward personnel and patients; and (3) increasingly, a group leader. With this triad of functions she conducted both formal and informal meetings with ward staff, or with staff

4 Ibid., p. 159.

and patients, where the discussion revolved around problems of living and working together, around problems of improving the physical and social environment.  

Deibel insisted that a democratic hospital atmosphere which fostered respect for patients and promoted emotional growth also promoted a sense of responsibility for solving their problems following discharge from the hospital. Patients should be allowed to voice opinions about the hospital, encouraged to participate in group discussions, and invited to share in establishing ward policies and rules.

If modern psychiatric nursing accepts the premise that the need for prestige and self-respect is fundamental, than this should be reflected in the nursing care given to psychiatric patients.

However, Bloomberg warned of the responsibility inherent in psychiatric hospital function--protection of the family and the community from aggressive behavior, and protection of the patient himself. Bloomberg felt that we should ask ourselves: "Is freedom good for patients, for all patients, for all patients, for all patients, for all patients?

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6 Ibid., p. 170.


8 Ibid., p. 329.

for this particular patient?" He also felt that the setting of limits was important for the purpose of letting the patients know they were protected from their own impulses. Even in the grossly ill patient there was a portion of the ego which acknowledged illness and needed someone to lock the door and say in effect "This far you may go and no farther."\textsuperscript{10}

Stubblebine\textsuperscript{11} wrote of the psychotherapeutic help for patients that can come from any source, not necessarily from doctors, professional or non-professional staff—it often came from another patient. This was borne out by the knowledge that many patients have recovered in mental hospitals with minimal contact with the professional staff. He considered the therapeutic community to be one which recognized the truth of this and tried to use it to therapeutic advantage. In such communities patients would be encouraged to regard themselves as being potentially helpful to some of their fellow patients, although not obliged to do so. Patients would be encouraged to appraise for themselves the potential value of relationships with other persons in the group. The commonality of purpose which bound the group together would be essential for a therapeutic climate.

\textsuperscript{10}Ibid., p. 11.

In commenting on the forces that created or built a therapeutic climate, and those which could be destructive, Stevens\textsuperscript{12} felt that the personnel regularly working on the nursing unit influenced the ward atmosphere to a large degree. Job satisfaction; awareness of emotional needs and the dynamics of behavior; attention to safety factors and physical comfort measures; and effective communication contributed to the positive elements of a therapeutic setting. On the other hand, personnel tensions or anxieties; diminished job satisfaction because of inconsistent personnel policies; ineffective communication; supervisory or administrative practices that threatened ego structure and diminished status; and poorly defined work roles were considered to be destructive forces working in opposition to the achievement of a therapeutic ward climate.

Will\textsuperscript{13} referred to administration as a method of working with people, and to psychiatric nursing administration as committed to the concept of the importance of interpersonal relationships. The patient's mode of participation with the hospital staff was seen not only as a reflection of


the life experiences which led him to seek hospitalization but also as part of the total social field in which he lived at present. This included the formal and informal social structure on the ward, the general institutional context which ordered or forbade certain activities within the hospital, the attitudes and relationships that existed among staff members, and the community situation from which the patient came and to which he would return.

Will posed a number of questions which need to be considered as the role of the nurse undergoes change:

How can we work with the people who are now staffing our mental hospitals in such a way that they can move toward more effective therapeutic functioning with patients? What experiences are necessary for nursing personnel in the job situation if they are to provide therapeutic experiences for patients?

What do these people, who have a lifetime of experience in living with others, bring to the hospital situation that is potentially useful to our patients?

How can we mobilize this potential into awareness and skill in interpersonal relationships? 14

Will believed that one approach to the solution of these problems was the study and manipulation of the administrative process that exists within a psychiatric nursing service, with the goal to increase effective participation on part of the nursing staff with ultimate improvement of patient care.

14 Ibid., p. 238.
In working with problems always present in the administrative process she formulated two tentative hypotheses.

The first hypothesis was:

The pattern of nursing administration will determine the participation of staff and patients within that particular setting. For example, in a setting in which rigid limits are set for staff, they will in turn set rigid limits for patients. If the nursing administration is not clear on its role in the setting, the nursing staff will have difficulty in becoming clear on their role with patients and the patient concept of the nurse will be confused.

The second hypothesis grew out of, or was an extension of, the first:

The types of experiences which patients have during their hospitalization are directly related to, or are the same as, those of the staff. For example, if the staff can express themselves freely with patients and each other, the patients' communication will be facilitated, i.e., the need for patients to "talk crazy" is greatly reduced on a ward where the staff is able to communicate freely with patients and each other. Another example can be seen in decision making. If staff can make their own decisions, or at least participate freely in them, gradual increase in patients' own decisions can be observed.¹⁵

Will visualized several important administrative areas emerging from these hypotheses. An operational philosophy which included the exploration of "what it means to be mentally ill" from the standpoint of both nurse and

¹⁵Ibid., p. 240.
patient was the first area. The social field, or total situation, in which the administrative process took place was her second area. This area would include the physical environment, and development of a program encouraging maximum patient-staff participation and socialization. The third area was the method of operation which would reflect the type of relationship that existed at any level of the administrative process. The fourth area was the lines of communication, which were considered very important because of the powerful effect upon the entire nursing process, as communication is in all life experiences. 16

Will concluded by saying that this type of nursing administration would not be without problems, but was one in which the problems could be dealt with openly and in a direct manner, and "one in which the burden of responsibility for patient care is shared by all participants, including the patient." 17

In speaking of group experience as a form of therapy for hospitalized psychiatric patients Frank and Powdermaker 18 commented that most human beings function in groups throughout

16 Ibid., pp. 240-245.
17 Ibid., p. 247.
their lives, and group relationships exerted a powerful influence in molding and fixing personalities. If harmonious and satisfying, the person functioned effectively in the group; if they were threatening, he was miserable and ineffective. Growing recognition of the importance of group influence, coupled with an increasing demand for psychotherapeutic help, has led to rapid development and acceptance of group methods of therapy.

Frank and Powdermaker contended that the therapist came to know the patients better, was surprised at their responsiveness, and could observe changes in their behavior. In turn group experience strengthened the patients' sense of individual worth. Therapeutic groups reminded patients that they could again be valued as individuals entitled to voice problems, complaints, and hopes, and to be listened to with respect. 19

In composing groups, certain "natural" groupings of hospital patients seemed to work to advantage, with the type of therapy modified to fit the needs of the particular group. The group might be the outlet for much complaining, the only place where patients would dare to voice dissatisfaction, but Frank and Powdermaker felt that this often aided group cohesiveness. The importance of striving for a working agree-

19 Ibid., p. 1371.
ment with patients was stressed, with aims and methods of the group clearly understood by patients and therapist.20

Bueker21 felt that doctors and nurses still represented "figures of guidance" to patients in group therapy, but in this role they were more supportive. Patients were the actual therapists, interacting to identify problems and gain insight into behavior. She emphasized that the group leader role demanded the skills which any leader must have in addition to the skills of a psychiatric nurse and a psychiatric therapist. The nurse guided conversation, facilitated expression of feelings, but recognized that progress and changes in attitude must come from the patients themselves.

Martinez22 referred to her experience as a psychiatric nurse in group therapy as "rewarding." The compatibility between the nurse's customary ward role and the symbolic mother role she would have as therapy leader were considered to be advantageous. The group setting created a special environment in which the patient had an opportunity to develop new and more appropriate behavior patterns. He could do this in a permissive and understanding atmosphere. For the nurse

20 Ibid., p. 1372.


actively involved in the group dynamics, the outcome may be
even more self-understanding than the patients gain.

Rosen\textsuperscript{23} insisted that the group approach has become a
valuable tool of administration, teaching, and ward management.
It provided a means for the study and control of milieu and
for facilitating communications from the various echelons of
the hospital.

Sommer\textsuperscript{24} quoted Greenblatt\textsuperscript{25} and his associates as
believing that the patient's relations with his social group
are the first to break down. Thus, the nurse's role in
therapy would include ability to help the patient integrate
into a group, and develop a sense of group membership and
identification. The first task of the nurse was seen to be
that of developing group feeling and identification within
the total ward situation; later on to help in developing the
capacity for self-expression with the group situation. Sommer
considered the final goal of the nurse to be the development
of the patient's capacity for self-expression within the frame-
work of society.

\textsuperscript{23}Irving Rosen, "Developing and Sustaining Group
Therapy Programs," \textit{Mental Hospitals}, X (December, 1959), p. 28.
\textsuperscript{24}Robert Sommer, "Working Effectively With Groups,"
\textsuperscript{25}Milton Greenblatt and others, \textit{From Custodial to
Therapeutic Care in Mental Hospitals}. (New York: Russell
Basis of Hypothesis

The assumption underlying this study was that the group discussion process could be utilized as one means of providing therapeutic communication between patients and personnel; an effective device for resolving problems which arose within the hospital community.

According to the literature reviewed therapeutic groups served to remind patients of their right to be listened to with respect, and tended to strengthen a sense of individual worth.

Statement of Hypothesis

The hypothesis was, therefore, that patients would be capable of identifying and discussing problems of common concern associated with convalescence.
CHAPTER III
METHODOLOGY

The Hospital – Locale and Aims

Two male convalescent wards of the admissions treatment center of a public psychiatric hospital served as the focal area in this study of eighteen weekly group discussions with patients.

The locale of the hospital was a suburban town of over 10,000 population, situated about eighteen to twenty-five miles away from the nearest city. There was no public transportation system or proximity to one, which made it difficult to reach the hospital except by automobile. People coming from the environs which used its specialized services were sometimes obliged to rely upon expensive taxi transportation.

The hospital had a patient population of about twelve hundred. Its overall function was to provide specialized facilities for the diagnosis and treatment of adult patients with all types of psychiatric disorders. The hospital received admissions from a district designated by the Massachusetts Department of Mental Health. This district extended over a radius of twenty miles to include portions of three counties; the services of the hospital, therefor, were extended to one
moderately large city, one smaller city, and twenty-nine surrounding towns.

The Admissions Treatment Center

The admissions treatment center of the hospital was a newly constructed building of modern design which provided accommodations for one hundred and sixty-two in-patients during the acute or convalescent phase of illness. Its chief aim was to focus intensive application of the various diagnostic and therapeutic services available towards alleviating symptoms and facilitating recovery as rapidly as possible. The admission rate for the fiscal year beginning July 1, 1961 and ending June 30, 1962 was 748 patients, and the mean average for the five months in which the study occurred was 61.1 patients.

This building contained three wards for male patients, and three wards for female patients. For each sex there was one closed admission ward with a capacity of twenty-three beds, and two open convalescent wards with an overall capacity of fifty-two beds. There was also a twelve-bed intensive care unit for men or women who had medical or surgical problems which required treatment during the period of hospitalization. In addition there was an out-patient department with facilities for psychological testing; operating room suites; X-ray and physiotherapy department; electro-shock therapy unit; occupational therapy and volunteer department; interfaith chapel for
religious services; medical library; patients' cafeteria; and numerous offices for members of the medical staff, psychological and social service departments, and the nursing service. The hospital switchboard and information desk, the offices of the Superintendent, Assistant Superintendent, and Clinical Director, the medical-stenographic and records department, the admissions suite, and the nursing supervisors' office were located on the ground floor of this building. It was the reception center for all patients and visitors coming to the hospital.

The Ward Setting

The two male convalescent wards extended across the entire third floor front of the building, with one ward at each end and community day-room quarters centered between the two. Each ward had accommodations for twenty-six patients: six single rooms, one four-bed room, and four four-bed dormitories. A bed, bedside table and chair, and a clothing locker with an individual combination-type lock was assigned to every patient coming to the ward. There was also a glassed-in nursing station; a utility room containing an electric hot-plate unit and equipment for ironing; a shower room containing two shower stalls and one bathtub; a linen closet; a washroom with four sinks and mirrors, two toilet stools and two urinals; and a utility closet for housekeeping equipment.

The wide communicating area between the two wards
served as a community sitting room, and there was also a large television room with book-lined shelves, a smaller card room, a visiting room, and a locked minor treatment room which contained the refrigerator used by both wards.

The entire area was light and well-ventilated, modern in design and decoration. The wards were attractively furnished, with the bright colors of the upholstered furniture, draperies, and bedspreads lending a homelike atmosphere. Numerous houseplants, books, magazines, games, and personal belongings of the occupants enhanced the impression of comfortable living conditions.

The personnel regularly assigned to these two wards consisted of three male licensed practical nurses, two charge attendants, and three attendants over a twenty-four hour period. They were under the supervision of three professional nurses over the same period of time. Ward personnel were responsible for the physical and psychological nursing needs of these convalescent patients; they were also responsible for ward housekeeping duties although the greater part of these latter chores were handled through patient work assignments. It was the responsibility of each patient to make his own bed, dry-mop the surrounding area, keep his locker and bed-side table in order, and take care of his personal belongings.

All meals were served in the cafeteria under the supervision of the dietary department. Food was prepared in
the kitchen at the main hospital and transported in heated food-truck containers to the service area of the cafeteria before each meal. The service area was equipped with steam tables, multiple toasters, urns, griddles, and refrigeration units.

The dining area accommodated about sixty persons, with seating arrangements for four at each table. Fiberglass plastic chairs in bright, cheerful colors blended with the floor-length traverse draperies which covered the glass walls of the sides of the room.

Each patient was transferred to a convalescent ward by order of his personal staff physician when, in the doctor's opinion, the patient gave indication that he could assume responsibility for living on an open ward and abiding by the rules and regulations which governed it. All ward members had grounds privileges during the daylight hours, but were expected to return to their respective wards at mealtime unless they had the physician's written permission to leave the hospital for a stated period of time. Such permission could be a town pass (usually three hours in the afternoon), an entire day with a specific destination, or a week-end visit with a relative or friend.

As a part of grounds privileges these patients could walk about the grounds; go to work assignments unaccompanied; keep appointments in the various departments; attend religious
services; visit the hospital canteen, the occupational and recreational therapy areas; and patronize a small restaurant and a dairy bar adjacent to the hospital grounds.

Selection and Description of Sample

Each group session was made up of approximately nine to thirteen members selected by availability, who met for one hour weekly under nurse leadership. Since members were drawn entirely from the two open convalescent wards of the admissions treatment center, the group turnover was consistently rapid. New members were added as current members left the hospital or returned to the closed admission ward. This policy was adopted to insure continuity of group experience for patients over an indefinite period of time, since the average length of stay for any one person was relatively brief. A total of fifty-eight patients were participants in the group at one time or another during the eighteen recorded sessions; only two of these attended all of the sessions.

The purpose of each meeting was defined by the nurse leader as an opportunity for members to introduce and explore problems of common concern through the method of open group discussion. It was pointed out that group thinking would sometimes influence attitudes and bring about change more effectively than individual effort. The chief aim was therapeutic in nature, an attempt to create an atmosphere in which members would be able to ventilate feelings and discuss
problems without fear of retaliation. Leadership was permissive and non-directive.

Meetings were held in the ward visiting room, and were of the "formal" or planned-meeting type of group. The seating arrangement was kept as informal as possible by placing chairs in a circle and encouraging members to take the initiative in introducing topics for discussion. As members were not in favor of note taking during group sessions the leader assumed the roles of recorder and observer, using the method of recall from memory within one hour of group adjournment. On the following week the recording was read back to the group as a means of acquainting new participants with what had been discussed at the previous session. It also provided assurance for all members that individual anonymity would be preserved. Members were in agreement that topics of common concern could be discussed elsewhere if individuals were not identified with any particular statement. They had no objection to being quoted as a group.

**Procurement of Data**

Eighteen group discussions were recorded by the nurse leader over a five-month period of time. In an attempt to identify some meaningful topics of concern perceived and expressed by male convalescent patients, each recording was scrutinized separately. The concerns voiced by members were transposed to a master sheet. The chart indicated the number
of times a topic was introduced, and the overall number of patients who expressed opinions concerning it. Order of importance for selecting an area of concern was established by the number of sessions in which group members repeatedly expressed concern about a particular aspect of ward life; a second criterion was reiteration of a concern by ten or more patients. The data were then discussed in terms of four broad categories having to do with nursing care needs; areas of concern associated with (1) Hospital Orientation, (2) Personal Comfort, (3) Therapy, and (4) Preparation for Discharge.

**Summary**

The data were gathered in eighteen group sessions with male convalescent patients over a five-month period as described in the foregoing section.

All recordings and observations were compiled from memory recall within one hour following group adjournment.

Twelve concerns were found to be consistently expressed by a changing group. Such concerns were expressed with different degrees of intensity at different phases of the study.
CHAPTER IV
PRESENTATION AND DISCUSSION OF DATA

Analysis of the recorded data revealed that a frequently changing patient group tended to introduce similar or identical subjects as areas of common concern. Twelve concerns associated with hospitalization emerged; ranging from a high distribution of eight sessions with nineteen members contributing, to a low of four sessions with eleven members involved. A further examination of these member contributions suggested a pattern of nursing care needs which could be divided into four categories, those associated with (1) Hospital Orientation, (2) Personal Comfort, (3) Therapy, and (4) Preparation for Discharge.

**Hospital Orientation**

The category of hospital orientation was sub-divided into four sections, identified by the groups as areas of concern: current hospital commitment status, grounds privilege rules not clearly defined, rules and regulations not clearly defined, and Veterans' Administration versus state hospital advantages for patients.

**Current Hospital Commitment Status.** Discussion of this topic was introduced at seven group sessions with a total of thirteen
<table>
<thead>
<tr>
<th>Nursing Care Categories</th>
<th>Sub-categories of Expressed Concerns</th>
<th>Total No. of sessions in which topic was introduced</th>
<th>Total No. of patients expressing concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Hospital Orientation</td>
<td>a. Current hospital commitment status</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>b. Grounds privilege rules not clearly defined</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>c. Rules and regulations not clearly defined</td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>d. V.A. versus State Hospital advantages</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>II. Personal Comfort</td>
<td>a. Personnel attitude to patients making coffee on wards</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>b. Personnel too rigid about ward regulations</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>c. Personnel--selected T.V. programs</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>d. Dietary dissatisfactions</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>III. Therapy</td>
<td>a. Method of treatment</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>b. Scarcity of staff physicians</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>IV. Preparation for discharge</td>
<td>a. Job security</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>b. Family economic security</td>
<td>4</td>
<td>11</td>
</tr>
</tbody>
</table>
members expressing concerns having to do with commitment status. Eight members were concerned with clarifying the various types of commitment used to hold patients in the hospital, and the length of stay involved in each; two members wanted information about the amount of control the hospital would have upon patients returning to community life; three men expressed resentment that a "court order" was necessary for a period of further observation, since they had broken no laws.

Data from the seven discussion periods indicated that these thirteen men had received information pertinent to individual status from the physician assigned to each one of them. This data would lend weight to the indication that group discussion was used to get reassurance about the validity of the information obtained from another source.

**Grounds Privilege Rules Not Clearly Defined.** At six group sessions a total of fourteen members expressed the concern that grounds privilege rules and boundaries were not clearly defined. Four members expressed a need for a written directive spelling out exact boundaries; three members indicated that a list of "restricted areas" would be adequate; seven members insisted that these regulations should be tailored to fit the needs of the individual, with the physician setting whatever limitations might be indicated in each instance. The entire group expressed resentment that all patients were required to return to the wards before dark.
Rules and Regulations Not Clearly Defined. An inadequate clarity of rules and regulations was expressed in five group sessions with a total of eighteen members contributing evidence. Seven members requested clarification of rules associated with the hours of rising and retiring, the use of the showers, and use of shaving equipment; four members indicated that regulations which applied to driver's license, valuables, and money were not clearly stated; three members were concerned about the procedure for obtaining a week-end pass; and four members requested clarification of rules for obtaining a town pass for personal shopping and the handling of business affairs which required immediate attention.

Since these last two sub-categories were closely associated, the distinction between them was made entirely from group contributions. In the first instance seven out of fourteen patients wanted written directives for all patients, while the other half of the group wanted regulations adapted to individual needs. In the second instance seven patients were concerned with in-patient, hospital-oriented needs, while eleven patients expressed concerns associated with out-patient, or community orientation.

Veterans Administration Versus State Hospital Advantages for Patients. At five group sessions a total of seventeen patients expressed a preference for treatment in a veterans hospital. Eight of these men had been hospitalized in a veterans psychiat-
### TABLE 2
CONCERNS ASSOCIATED WITH THE NURSING CARE CATEGORY OF HOSPITAL ORIENTATION

<table>
<thead>
<tr>
<th>Concerns Expressed under each Sub-category</th>
<th>Number of patients voicing each concern</th>
<th>Total number of patients expressing concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Current hospital commitment status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Clarification of types of commitment available and length of hospital stay involved in each</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>2. Amount of hospital control upon patients returning to community life</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3. Resentment of court order as part of observation status</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>B. Grounds privilege rules not clearly defined</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Need for written directive of exact boundaries</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>2. Need for list of &quot;restricted areas&quot; only</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3. Need for individual limits set by physicians</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>4. Resentment of &quot;before dark&quot; curfew</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>C. Rules and regulations not clearly defined</td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>1. Clarification of rules for rising, retiring, use of showers, and shaving equipment</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>2. Clarification of rules concerning valuables, money, and driver's license</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>3. Clarification of rules for obtaining a week-end pass</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4. Clarification of rules for obtaining a town pass</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>
TABLE 2 Continued

<table>
<thead>
<tr>
<th>Concerns Expressed under each Sub-category</th>
<th>Number of patients voicing each concern</th>
<th>Total number of patients expressing concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>D. VA versus State hospital advantages for patients</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>1. VA had superior programs and facilities which got patients home sooner</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>2. VA rehabilitation programs provided vocational training</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>3. VA personnel-patient ratios afforded more opportunity for individual therapy</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>4. VA hospitalization eliminated family transportation problems</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

ric hospital at least once in the past, and four had currently made application for transfer to the Veterans Administration and were waiting for confirmation of acceptance.

Six of the ex-patients from Veterans Administration expressed the concern that with the superior programs and facilities provided at VA hospitals, patients were returned home sooner than from State hospitals. These patients opined that VA hospitals had a much larger staff available to fewer patients; more direct contact with physicians; more clearly defined policies; and much more available assistance in meeting their interests in regard to work and recreation. The four
members awaiting transfer expressed a particular need for the vocational training afforded through well-developed VA rehabilitation programs; five members felt that the increased numbers of professional personnel in VA hospitals would provide more opportunity for individual therapy; and two members were concerned about family proximity to the VA agency which would eliminate transportation difficulties.

Since all of these men were veterans they felt entitled to the benefits afforded to ex-servicemen through the VA agencies—lowered cost of hospitalization, aid to family, rehabilitation training with prospects for greater economic security following discharge, and more satisfaction of physical needs.

Eight members were in a position to make an experimental comparison of the two systems, and of these, six were in the group who expressed concern that VA patients returned home sooner than state hospital patients. The four men awaiting transfer to VA had been hospitalized at least once in a state hospital prior to the current admission. Two of the five patients who expressed need for individual therapy were ex-patients from VA indicating that twelve patients evidenced some degree of chronicity, a factor which would contribute to their concern about the long-range advantages associated with the Veterans Administration. The predominant theme was a need for the emotional support and security which the Veterans Administration represented to them.
Personal Comfort

The areas of concern identified with personal comfort were sub-categorized in the following manner: Personnel attitude to patients making coffee on the wards; personnel too rigid about ward regulations; personnel-selected television programs; and dietary dissatisfactions.

Personnel Attitude to Patients making Coffee on the Wards. The topic was presented for discussion at eight group sessions with a total of nineteen patients expressing concern. Five men were concerned about establishing a consistent arrangement for heating water for morning coffee, since a two-hour waiting period occurred between the hour of rising and breakfast; eight men wanted clarification of time limits for the use of ward equipment for coffee-making in the evening; three men expressed concern that patients were expected to drink coffee in the ward utility room and the personnel drank coffee in the ward television room; three men wanted refrigerator, hot plate, and seating arrangements provided in a "ward coffee room."

Since order of importance was established by the number of sessions in which group members expressed concern, as well as the total number of patients contributing to a particular concern, ward coffee-making emerged as the chief concern expressed by convalescent male patients. Socializing needs appeared to be dominant in this group. It was also
<table>
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<tr>
<th>Concerns Expressed under each Sub-category</th>
<th>Number of patients voicing each concern</th>
<th>Total number of patients expressing concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Personnel attitude to patients making coffee on wards</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>1. Need for a consistent arrangement for making a.m. coffee</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2. Need for consistent time limits for making p.m. coffee</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>3. Need for fair personnel-patient areas for coffee drinking</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4. Need for &quot;ward coffee room&quot; for patients</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>B. Personnel too rigid about ward regulations</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>1. Regulations applying to morning hours</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>2. Regulations applying to evening hours</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>C. Personnel-selected television programs</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>1. Need for TV programs to be patient-selected</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2. Need for personnel intervention only when patients disagree</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>D. Dietary dissatisfactions</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>1. Dissatisfaction with cold food at breakfast</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2. Monotony of hospital menu</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>3. Starchy diet with rapid weight gain</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>
important to note that the majority of patients, namely fifteen, who expressed this concern had a background of alcoholism as a primary or secondary factor contributing to current admission; which would suggest the satisfaction of oral needs as a further basis of concern.

Personnel too Rigid about Ward Regulations. The concern that personnel were too rigid about ward regulations was voiced at six group sessions with a total of twenty patients presenting examples of rigid application. Ten men expressed concern about regulations which applied to the morning hours; (a) hour of rising enforced at six o'clock in the morning when shaving was not permitted before six forty-five a.m.; (b) shaving facilities available for four patients at a time, and shaving period ending promptly at seven-thirty a.m. with razors collected and locked up; (c) breakfast at eight o'clock; (d) no allowance made for patients with early morning off-ward work assignments.

Ten men expressed concern about rigidity of ward regulations which applied to the evening hours; (a) no shaving time allowed; (b) shower rooms frequently locked early; (c) members of one ward not encouraged to visit on another ward; (d) members not permitted to listen to eleven o'clock television news broadcasts.

The examination of these concerns indicated that ward regulations needed to be reviewed and revised to meet ward
living situations more appropriately.

Personnel-Selected Television Programs. At five group sessions a total of ten patients requested clarification of the rules pertinent to the selection of ward television programs. Five men insisted that selection of television programs should be within the province of the patient group assembled in the room; five men agreed that personnel intervention should occur only when patient-group agreement could not be attained. All ten members indicated that the ward personnel selected evening programs without consulting the wishes of patients assembled in the television room.

Animosity about TV programs is a part of any family structure situation; it would indicate need for discussion among the personnel about their role toward TV programs.

Dietary Dissatisfactions. Food service was the subject of discussion at four group sessions with a total of fifteen members presenting points of concern. Five group members voiced dissatisfaction with the breakfast menu--cold toast and cold fried eggs served in a cafeteria equipped with multiple toasters, a grille and steam tables; four members objected to the monotony of the menu; and six members were concerned about the predominance of starchy foods in the diet with resultant gain in weight.

Recorded data pointed to the fact that thirteen of these men had also expressed some of the concerns pertaining
to coffee-making on the wards.

Concern about food would tend to reinforce the previous statement made regarding the tendency of this particular group to use satisfaction of oral needs as a means of providing emotional security.

Certain meat-extender dishes—spaghetti, macaroni, cheese, noodles—were part of the standard master menu in all state hospitals, which would support the contention of added starch in the hospital diet. However, the nutritional value of the master menu was established and planned according to standards recommended by the Food and Nutrition Board of the National Research Council. A more realistic appraisal of increase in weight should include an assessment of the number of between-meal snacks consumed by the majority of convalescent patients at a nearby restaurant and dairy bar.

**Therapy**

Two areas of concern were identified under the category of therapy; method of treatment, and scarcity of staff physicians.

**Method of Treatment.** Treatment measures were a topic for discussion at five group sessions with a total of ten members expressing concern. Six members were concerned because several medications were prescribed for them, daily dosage was disturbingly high, probably duration of treatment was not indi-
## TABLE 4
CONCERNS ASSOCIATED WITH THE NURSING CARE CATEGORY OF THERAPY

<table>
<thead>
<tr>
<th>Concerns Expressed under each Sub-category</th>
<th>Number of patients voicing each concern</th>
<th>Total number of patients expressing concern</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Method of treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Concern because medication was prescribed</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>2. Concern because medication was not prescribed</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>B. Scarcity of staff physicians</strong></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>1. Physician-patient ratios limited amount of time for individual therapy</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2. System of patient-physician assignment</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3. Inability to establish patient-physician relationship</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

cated, and unpleasant side effects were not always given immediate attention; four members were concerned because medication was not prescribed for them. Receiving medication denoted illness, with dosage and duration used as the yardstick for measuring degree of intensity of illness by the patients expressing concern; on the other hand, failure to receive medication was interpreted by patients as lack of
interest, or the withholding of vital support in a setting where the giving of medication represented concern.

The Scarcity of Staff Physicians. A shortage of physicians was the topic of discussion at five group sessions with a total of ten members contributing comments. Five members expressed the concern that current physician-patient ratios limited the amount of time available for individual psychotherapy; three men were dissatisfied with the system of assigning patients to physicians; and two members expressed inability to establish a relationship with their physician.

Shortages and frequent turnover of staff physicians was a reality factor which contributed to arousing uneasiness in patients and feelings of rejection. The two patients who expressed inability to establish a doctor-patient relationship had experienced re-assignment upon the departure of the physician assigned to them at the time of admission. They demonstrated a fear of re-investment of emotional dependence, and of rejection.

Preparation for Discharge

The category of Preparation for Discharge incorporated two concerns: job security, and family economic security.

Job Security. A need for steady occupation was mentioned as a matter of concern at seven group sessions with a total of thirteen members making contributions. Four members expressed
TABLE 5
CONCERNS ASSOCIATED WITH THE NURSING CARE CATEGORY OF PREPARATION FOR DISCHARGE

<table>
<thead>
<tr>
<th>Concerns Expressed under each Sub-category</th>
<th>Number of patients voicing each concern</th>
<th>Total number of patients expressing concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Job security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Change of occupation due to loss of driver's license</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>2. Ability to meet job requirements</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3. Loss of job with need for new occupation</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>B. Family economic security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Loss of income during hospitalization</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>2. Ability to resume role of provider</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3. Family ties broken--need to support children</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

Concerning the loss of their driver's license which forced a change of occupation; three members were concerned about their ability to meet the requirements of their former jobs; and six members who were without jobs expressed a need for help in finding occupation after discharge.

These men had lost confidence in their ability to
retain a job; or to obtain another one which would satisfy
the need to be self-supporting.

Family Economic Security. Ability to support a family was
presented for discussion at four group sessions with a total
of eleven members expressing concerns. Five members worried
about loss of income and accumulating debts during the period
of hospitalization; three members voiced unease of family
acceptance, and ability to resume the role of provider; and
three members indicated that although family ties had been
broken, they had minor children to support.

In the patient's absence some family member had
stepped into the role of paternal provider and might be
reluctant to relinquish this position, unless considerable
assurance of ability to carry family responsibility was forth-
coming. This would in turn establish a cycle of resentment
and ill-feeling unless, and until, the patient found that he
could use job skills with efficiency, and thus bolster his
sense of self-worth in his own eyes and those of his family.
CHAPTER V
SUMMARY, CONCLUSION, AND RECOMMENDATIONS

Summary and Conclusion

The group discussion method under nurse leadership was studied with selected male patients from two convalescent wards in a State Hospital. The basic assumption was that group discussions could be used as one means of providing therapeutic communication between patients and personnel. The area of concentration was an identification of some meaningful problems of common concern associated with convalescence, as perceived and expressed by patients.

A review of the literature included recent socio-psychiatric studies; the newer psychiatric nursing concepts as they applied to creating a therapeutic hospital climate; and the use of the group discussion method as a means of fostering satisfactory patient-personnel relationships. A majority of the research studies emphasized the changing role of the nurse, in which she was seen increasingly as a group leader. Her goals could be summarized as follows: (1) to foster group spirit and identification within the ward situation; (2) to encourage capacity for communication within the group; and (3) to reinforce the patient's capacity for self expression as a member of society.¹

Weekly group discussions under nurse leadership were held with a changing group of male patients from two convalescent wards of a public psychiatric hospital. A total of fifty-eight patients were group participants at one time or another during the five months in which the study was conducted. Individual sessions averaged from nine to thirteen members.

Recordings of eighteen group sessions were made by the nurse leader using the method of recall from memory within one hour of group adjournment. Each recording was scrutinized separately, and the concerns expressed by members were entered on a master chart. Criteria for selecting an area of concern were:

1. The number of sessions in which group members repeatedly expressed concern about a particular aspect of ward life.

2. Reiteration of a concern by ten or more patients.

The resulting data were analyzed in relation to four categories having to do with nursing care needs. Twelve concerns were found to be consistently perceived and expressed by male convalescent patients.

The findings of the study were:

1. There was a lack of consistent practice in orienting patients to the various phases of hospital life. Some of the routine procedures and regulations aroused concern because they
were partially clarified, when more knowledge
would have provided reassurance.

2. The psychological preparation of patients about
to be transferred to the convalescent wards was
not emphasized sufficiently; therefore, some of
the concern about rules and regulations reflected
a fear of being unable to adjust to the con-
valescent role.

3. The comfort and socializing needs of convales-
cent patients were sometimes unrecognized for
the sake of a structured ward environment.

4. There was indication of a need for a re-appraisal
of hospital rules and regulations as they
specifically applied to the convalescent wards,
as compared with the hospital as a whole.

5. Frequent turnover and shortages of staff physi-
cians aroused anxiety in patients, indicating a
need for some tangible outlet for pent-up feel-
ings about rejection.

6. There was a need for opportunity to express
ambivalent feelings about returning to community
life; the doubts, fears, and hopes that became
pressing as the convalescent phase of illness
progressed.
Conclusion:

Use of the group discussion process as an effective psychotherapeutic nursing measure was supported by this study; a flexible device for increasing satisfactory interpersonal communication.

Recommendations

1. The process of hospital orientation should begin at the time of admission. It should be considered a nursing care responsibility since the concerns experienced by patients are predominantly under the direct responsibility of nursing personnel.

2. Nursing personnel should assume more responsibility for the psychological preparation of patients who are to be transferred from the structured confinement of the admission ward to the semi-structured freedom of the convalescent wards.

3. The group discussion process should be developed as a means of continuing the orientation process; an opportunity for nursing personnel to transmit the hospital culture and policies, and for patients to express feelings about the hospital and share in formulating reasonable ward regulations.

4. The socializing needs of convalescent patients
should be recognized, and allowance made for the satisfaction of these needs within the framework of a few broad, well-clarified ward regulations.

5. A periodic reappraisal of regulations should be a policy of nursing administration to modify certain conditions which are a source of annoyance, or to aid in the formulation of new regulations wherever indicated.

6. Extension of the group discussion process to include increasing numbers of nursing personnel should be considered. Group experience would tend to heighten interpersonal skills with patients, to influence democratic attitudes, and to contribute to job satisfaction in providing a comfortable hospital environment.

7. Realistic dietary dissatisfactions should be recognized and an attempt made to serve food at the temperatures consistent with palatability.

8. Nursing personnel should provide opportunities for patients to discuss the problems they will encounter on return to the community.

9. The primary consideration of nursing administration should be the maintenance of nursing care programs which provide reassurance and support regarding the patient's treatment regimes; con-
fidence in the belief that the hospital staff is interested in his recovery and general welfare.

Further areas for study might include:

1. The use of the group discussion process to identify common problems associated with the acute, or the chronic, phase of illness.

2. The effects of readjustment to the relative freedom of a convalescent ward as compared to the more structured climate of the acute service.

3. The psychological effect upon patients who are returned to the acute service from the convalescent area.
BIBLIOGRAPHY
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Books


Periodicals and Journals


Unpublished Material
