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A SAMPLING STUDY USING AN
OPINIONAIRE TO PROMOTE GROUP DISCUSSION
AMONG WORKERS IN THE FIELD OF ORTHOPSYCHIATRY

by
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A Thesis
Presented To
The Faculty Of The School Of Nursing
Boston University

In Partial Fulfillment Of The Requirements
For The Degree Of Master Of Science
1955

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CHAPTER I

THE PROBLEM AND ITS SCOPE

Introduction

In order to work effectively with disturbed children one must have a realistic understanding of the meaning of the therapeutic environment so necessary for their treatment, and a degree of self understanding in order to implement this knowledge. Each novice in the field of orthopsychiatry is faced with formulating an interpretation of the therapeutic environment, and with recognizing the basis of individual reactions to this environment.

It seems especially pertinent for all workers in this field to be aware of the importance of considering the feelings of everyone concerned in establishing this therapeutic environment. The focal point is, of course, the particular child and his needs. Of almost equal importance are the reactions of the entire staff to each other, and to this particular child and his actions. The staff needs to be aware of the importance of their own feelings in order to contribute more effectively to this environment. This implies that novices in the field need to acquire some degree of self insight.

This problem of understanding the meaning of the therapeutic environment has been faced by many eminent workers in

the field of orthopsychiatry. By helping the novices recognize some of their own emotional reactions to the behavior of the disturbed children, one should be able to help orient them to be more comfortable in this situation, and to recognize how one as an individual can best function in it.

Statement of the Problem

As first conceived, this study was to see if a test or questionnaire could be devised whereby one could didactically teach the meaning of the therapeutic environment and how one could function more adequately in this setting. If answers could be learned, this could be grasped in a short period of time. The group discussions following the first administration of the test tended to invalidate this plan of study. Field work with disturbed children under the guidance of experienced teachers further proved the fallacy of the original intent.

The main purpose of this study is to determine if students could be helped to become aware of their own attitudes and feelings toward the overtly expressed and oftentimes infantile behavior of the patients, and to realize how their feelings influence their interpersonal relationships with these children.

This involved three minor problems: 1. To ascertain if the therapeutic environment is a major part of the treatment

of disturbed children: 2. To determine if there is agreement among the workers in the field of orthopsychiatry as to the meaning of the therapeutic environment, and: 3. To see if an opinionaire could be devised to use as a tool to help the students become aware of situations that might be emotionally tinged for them, and through group discussion help them to express these feelings.

Delimitations

This study was limited to three small groups of staff members or students in the field of child psychiatry located in or near Boston, Massachusetts. This was a sampling only, as the participants consisted of five staff members and three students from agency X; the instructor and five students from Boston University Class NU-766, Nursing in Child Psychiatry; and the instructor and three students from the Gaebler Children's Unit of the Metropolitan State Hospital. These three basic nursing students were from three different hospitals in this geographic area, and were affiliating for a one week's experience in the field of child psychiatry. It would have been more desirable to have worked with the students affiliating in the hospital for a six weeks' experience, but because of the small number of students receiving this opportunity and the time limit before this experience would begin, this was not possible.

The objective of the opinionnaire changed after its first administration. Through experience there was also a change in the investigator; therefore, exact comparisons cannot be drawn.

Justification of the Study.

The importance of the environmental factors in the treatment of disturbed children have been recognized by many of the workers in this field. The writings of Bettelheim,¹ Redl,² Greenberg,³ and Sutton,⁴ emphasize the importance of the feelings and attitudes of the entire staff concerned with these disturbed children. Muller⁵ writes, "The personality of the nurse has much to do with the recovery of the patients in her care." Szurek⁶ found that free group discussion of mutual problems by the staff may affect attitudes of the staff and "One can isolate for particular attention the relief of the anxiety of the entire staff". Although many writers have

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1. Bettelheim, Bruno, Love Is Not Enough, p.7
 2. Redl, Fritz, and David Wineman, Children Who Hate, p.32
 3. Greenberg, Harold, Child Psychiatry and the Community, pp.127-128
 4. Sutton, Helen, "Some Nursing Aspects of a Children's Psychiatric Ward." The American Journal of Orthopsychiatry, 17:675, 1941
 5. Muller, Theresa, The Nature and Direction of Psychiatric Nursing, p.121
 6. Szurek, A. S., "Dynamics of Staff Interaction in Hospital Psychiatric Treatment." American Journal of Orthopsychiatry, 17:663, 1947

emphasized the importance of attitudes on the part of the staff working with these patients, nothing specific was found that had been used to help orientate newcomers to this field. Since this appears to be an expanding clinical specialty, such investigation seems indicated at this time.

Definition of Terms Used

Therapeutic Environment. The "therapeutic environment" as used in this study, was not concerned with the physical setting, but rather with the attitudes or the emotional climate that was produced by the interactions between the patients, the staff and the students.

Disturbed Children. The term "disturbed children" as used in this study refers to those children who have been adjudged by the psychiatrist or by the court, to be in need of psychiatric treatment or guidance.

Method

The first step in the study was to examine the literature in the field of orthopsychiatry for the past twenty years in order to gain a broader understanding of this field and to try to identify the problem areas.

The second step was to gain experience in working with disturbed children under experienced supervision. This aided in the development of an opinionnaire designed to recall or to present situations that might encourage free expressions of

attitudes and feelings. These situational questions were devised with a series of responses that were suggested from the literature or from actual experiences.

The third step was the construction of the opinionaire. Any device that arouses feelings must be handled in such a way as to encourage the free expression of these feelings rather than to suppress them.

The fourth step was to test it out with two more experienced groups to appraise its effectiveness in promoting freedom to express feelings and to consider its safety. It was administered to two groups. First it was given to the instructor and five students from Boston University Class NU-766 Nursing in Child Psychiatry. The second group consisted of five staff members and three students from agency X.

The fifth step was to administer it to the three-year nursing students from the Gaebler Children's Unit of the Metropolitan State Hospital.

The sixth step was the analysis of data from the three groups in order to determine whether or not the purposes were achieved. Conclusions and recommendations are drawn from the data, with full cognizance of the limitations from such a small sampling of subjects.

CHAPTER II

HISTORICAL REVIEW

One of the first big problems confronting every novice working with disturbed children is this lack of understanding of the meaning of the therapeutic environment. Many people feel that the therapeutic environment is synonymous with a permissive environment, one in which the child is allowed to do anything he wishes to do provided he does not physically harm himself; that literally this is the goal of the treatment environment. Many inexperienced workers feel that the child is helped the most by allowing him to do anything he wishes to do.

When the investigator first planned to start working with disturbed children it was believed that this therapeutic environment meant allowing the child to do anything that would not interfere with his physical safety or with the safety of any other child. It was felt that some of the behavior of the patients might be personally disturbing, but that this behavior must be tolerated for the well being of the child. Nurses have long been taught that it was the patient's welfare that was important. The importance of how nurses as individuals might feel was not clearly recognized.

We still suffer from our stereotype of the nurse as the bedside figure, or the operating room automation trained to a hair to carry out the current

surgeon's ceremonial. It has been exceedingly difficult for us to see the nurse as a source of action in herself. Indeed, when she does appear in this form, she constitutes a somewhat threatening figure, especially in the eyes of that insecure creature of a year - the junior interne.¹

The nurse's individual needs and personal satisfactions were divorced from her professional tasks. She was thoroughly indoctrinated to the theory of being a nurse while on duty and an individual only on off duty time. It is a well accepted fact that such a division of personality does not lead to a well integrated and emotionally satisfying way of life.

Even by omitting the important factor of meeting the needs of the staff caring for the disturbed child, this initial interpretation of the therapeutic environment does not meet the needs of the children. These disturbed children have the ability to grasp almost instantly how the adult really feels about his behavior regardless of what the adult actually says or does. The ambivalence of the workers frequently adds to the confusion and fears of the child. Here is an adult who permits specific behavior; may even encourage it, but who feels that this behavior is disgusting or bad and so the child becomes more disturbed.

1. Cameron, D. Ewen, General Psychotherapy, p.270

Again and again in our work we have found that what counted was not so much the hard facts as the feelings and attitudes that went with them...Permissiveness in itself may be useless or even harmful if it is more academic than felt.²

Many of the children are badly frightened by their desires or drives and wish reassurance through the wise setting of limits. The adult who feels that all behavior must be accepted or tolerated has no awareness of this need for protection from his own impulses that the child actually wishes. If he encourages the child to continue his behavior until he is completely disorganized and out of control, he is obviously not helping the child with his ego development or his adjustment to reality.

This problem of the therapeutic environment for disturbed children has long been one to be faced by the workers in the field of orthopsychiatry.

Our first naive expectations about the role of affection and permissiveness soon gave ground to our later more specific instrumentology of influence and interference techniques.³

Even trained therapists have become involved in this problem.

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2. Bettelheim, Bruno, Love Is Not Enough, p.7
 3. Redl, Fritz, and David Wineman, Children Who Hate, p.32

Some persons have the impression that in play therapy the therapist should permit the child to do anything he wishes in the playroom, even to the point of breaking windows and "attacking" the therapist. This is a misconception that needs correction, because good therapy does not permit this type of acting out. As a matter of fact, the therapist who permits a child to carry on wild, unrestrained behavior of this sort will soon have a very anxious, frightened child on his hands, if the child is still willing to return to him. Children require limitations and help in controlling and channeling their impulses. When a child's impulses are permitted a too free expression and full license, the youngster becomes panicky and angry, for the child's ego is not yet strong enough to evaluate such license, or to cope with the strength of his impulses without help from an adult. Without that help there is a threatening overwhelming of the ego by the unconscious drives, which is the cause of the panic. The panic arouses anger against the adult who does not help, but hurts, by not protecting the child who then refuses to return to the therapist. A child's personality can only develop properly with the aid of wise therapeutic limitations and help in directing these unconscious drives into socially acceptable channels.⁴

The fact that each new therapist still faces this problem with children was brought out in a field staff conference attended by two new workers in this field. One of the doctors was discussing a situation that occurred when he was playing with a disturbed child. The child filled a pitcher with water from the bathroom sink and, in the course of his play, started pouring it on the floor. The doctor's first reaction was, "How far do I let this kid go?" He stated

4. Greenberg, Harold, Child Psychiatry and the Community, pp.127-128

that he wouldn't allow his own children to do this at home. If he allowed the water to be poured on the floor, someone would have to mop it up, and the someone would be himself. He then wondered if the child needed to do this, Would allowing him to do it today make him more anxious to pour water anywhere and at any time? He finally decided the issue came down to, "How far am I willing to go along with this child?"

Another factor that adds to this problem is that one's decision about whether or not to limit or to approve specific behavior must be made rapidly. When a child senses the adult's ambivalent emotions about his behavior, he again becomes more anxious. He desires to continue with his activity but is hesitant about it because of the adult's indecision. There is one reassuring statement that can help all newcomers to this field. This is to become convinced of the fact that an error of judgment on their part will not be especially traumatic to the child. Even workers in the field over a long period of time are prone to make errors because of the complexity of human behavior.

Later on, in giving composite pictures of how the emotional problems of children may be handled we shall try to present what we consider to be an adequate handling of a specific problem situation. In doing so, we do not mean to imply that we are always a match for our tasks, because unfortunately we make mistakes. It seemed pointless, however, to burden the reader with an enumeration of our

failures, and if we concentrate on presenting a more positive picture in this book, it must not be taken to mean that we never make errors. Nevertheless, when we make them, we try to learn what we can from them and set them to good use.⁵

In the beginning of this discussion, meeting the emotional needs of the staff was purposely omitted. In discussing the therapeutic environment for the disturbed child it can be seen that these staff needs cannot be disregarded. The way the adult feels about the child and his actions is the most important factor in this environment.

The nurses control the living situation and create the atmosphere of the ward. Their contacts with the children and the environment which they provide must be therapeutic or much of the value of hospitalization is lost, and may be quite traumatic.⁶

In order for the workers to contribute to this environment, it is necessary to cultivate an awareness of their personal feelings about the child's behavior and also an understanding of the reasons for these feelings. Some situations tend to be threatening to security and thus interfere with the acceptance of the primitive needs that the children overtly display.

It would be unrealistic to think that any person can be free of conflict about all, or almost all of those infantile (instinctual) activities that are heavily tabooed in our society. Some adults

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5. Bettelheim, Bruno, Love Is Not Enough, p.15
 6. Sutton, Helen, "Some Nursing Aspects of a Children's Psychiatric Ward." The American Journal of Orthopsychiatry, 17:675, 1941.

may be able to take messiness or dirtiness in children without a qualm, but may find it quite another story (despite their theoretical knowledge) when it comes to children's masturbation. Others may be free of inner conflicts about obscenity and exhibitionism in children, but may be full of conflicts about such expressions of orality as wolfish eating or thumbsucking, or about physical aggression, and so on. The best we can hope for is that the adult himself will recognize which areas of behavior he is still not at peace about, and that on the basis of such insight he will try to stay away from the children when they are doing things that unsettle him. When the children are thus occupied, he should leave them to be handled by a person who is not apt to be disturbed by this type of behavior.⁷

The self understanding that is a requisite for dealing with these disturbed children is not acquired easily nor rapidly. One must have the courage to recognize, identify, and to admit that one does have feelings, both negative and positive, towards some of the behavior displayed by these children. Then with patient effort on the part of the worker, and understanding support from the remainder of the staff, one can try to recognize the cause of the disturbance. The investigator was acutely distressed over the management by the parents of some of the situations with these disturbed children. This negative reaction to a parent spread to a general antagonism toward all of the parents. Gradually, over a period of weeks, it was possible to identify this with feelings regarding her own childhood. After this

7. Bettelheim, Bruno Love Is Not Enough, p.11

experience the parents were recognized as individuals with strong points as well as with limitations, and it was possible to react more realistically to each situation.

The people who can adjust to the child's world, who can not only work, but live with children are those who have preserved some infantile traits: a certain amount of passivity, which makes possible their admirable patience; some remnants of the belief in magic, which accounts for the lack of over-anxiousness; slight anal fixations of a certain order, which facilitate the acceptance of the primary processes continually on display before them; some casualness about destruction, which remotely resembles the child's destructive tendencies. These infantile traits in the type of adult to whom I refer do not dominate their personalities or interfere with their sense of reality, their responsibility, or their efficiency in their life with children.

Good childhood or bad, happy or unhappy, if for some reason the adult can allow himself to live with the sufferings of his childhood and reach a degree of reconciliation with them as a part of his development; if he is able to "refeel" or relive the same emotions he had as a small child on this or another occasion; if he has managed to work through his early experiences (not necessarily in analysis) and come to find it natural in retrospect and remoteness that he did once have infantile needs; if he considers those needs of the past as much a part of himself as his history is a part of himself; if in the course of growing up, and perhaps with the aid of his sense of humor, he has gained some perspective toward those needs ---then he can begin to take for granted the child's primitive behavior. Then he will not feel seduced and endangered by being confronted with manifestations of the primary processes. Then he can permit himself guardedly to live in the strange fantasy world of children and, by ways

of sublimation, to be their guide and enjoy their growth.⁸

How do individuals actually function in this therapeutic environment? The first requisite is to have a practical understanding of the meaning of this environment. If this means an environment where one encourages and supports acting out of behavior when indicated, with a judicious use of supportive limitations to redirect the child's drives toward more socially accepted behavior on the basis of the needs of each particular child and adult, it provides the framework for realistic treatment for the child.

Then in order to function wisely in such an environment, one must know the needs and behavior of each child. Is this child who is overly aggressive and who needs firm and sympathetic limiting as soon as his behavior threatens to overwhelm him? Is this a child who is starting to express his aggressions through overt actions and does he need encouragement and support for expressing this behavior? Or is this a child who is still unable to express any aggression without becoming tense, frightened and markedly guilty at the first appearance of any feeling of aggression?

Returning to the situation involving the new therapist and water play with a particular child, one finds that the

8. Olden, Christine, "On Adult Empathy with Children." The Psychoanalytic Study of the Child, Vol. VIII, pp.124-125

needs of the child must be known before one can function adequately in the situation. A child fearful of expressing his feelings overtly might be allowed to trickle the water on the floor, while a little later on he might be allowed to splash the water around or throw it on the floor in the bathroom. Later he might need to deluge the floor, or climb into the sink and thoroughly soak himself. After he has worked through some of his intense feelings, he can be helped to confine his water play to controlled pouring or splashing in the sink.

This same range of individual needs at different levels of behavior can be demonstrated in any other activity. At first a child may be unable to sit at the table for juice or meals and instead, anxiously race around the room or furtively watch the rest of the group. Soon he may take his food and aggressively or aimlessly spill and smear it over the room. Then he will reach the place where he can be encouraged to join the group for part of the meal. He may spill his food and smear it around the table, eating small amounts of it with his fingers. He may grab food from other plates or from the serving dishes. And finally, with understanding support, he may reach the place where he can join the group for the entire meal and eat or not as he wishes. Here, again, the adult must know the child's needs and his

progress in order to place limits that are therapeutically wise and acceptable to the child.

The children accept the varying standards of behavior fairly easily. One child will be prevented from throwing things around the room or spilling articles from the table while another child is allowed to sweep the table clean of tinker toys or crayons. The child can be encouraged to express aggression by remarking, "I know how you feel. It's all right to do that sometimes," or by reassurance such as, "We can pick them up again. It's all right to do that sometimes." Limits are frequently accepted by the child when the adult kindly and firmly, but quickly responds with, "You don't need to do that," or, "That's not to throw, but the ball is."

Sometimes the needs of the children conflict. One little girl who had submissively given up everything to a slightly older brother, one day had progressed to the point where she could defend herself by attempting to keep a toy she was using from a little boy. She feebly threw a small block which struck the boy on the throat. The blow was slight, but this particular youngster was born with a throat defect which had required frequent and lengthy hospitalization and much painful surgery. He was particularly vulnerable to any threat toward his face or throat. His terrified over-reaction frightened the aggressor and

both children required a great deal of comforting and reassurance.

Sometimes the feelings of the adults in the situation interfere with adequately meeting the needs of the children.

When affects of children are expressed with undisguised urgency, any adult dealing with the child will inevitably be challenged by these manifestations in terms of his own life history.⁹

One child who therapeutically needed to be prevented from unacceptable behavior, was encouraged and supported by an inexperienced worker, in throwing furniture around the room and out of the window. She later said, "I enjoyed seeing him throw the furniture around." Frequently one tends to be overly permissive from a sense of repressed needs, insecurity, or feelings of inadequacy about coping with the situation. Sometimes one does so because of not wishing to appear to be rigid. New workers in the field are particularly hesitant about interfering with the children's activities because of their own feelings of incompetence. They are not sure that a child needs to sweep blocks and crayons onto the floor. If they prevent him from doing so and he needs this freedom, they might be criticized for their rigidity or laziness. Until they gain a more ade-

9. Blos, Peter The Adolescent Personality, p.500

quate awareness of the needs of the children and a sense of personal security in the therapeutic environment, they rightly tend to be less discriminating in the setting of limits.

One of the most important issues for helping newcomers to this field then, is to help them become more comfortable in this environment themselves. They may then become more sensitive to the child and his needs. Psychiatric nursing has long recognized the importance of the attitudes and feelings of the staff as a factor influencing either for or against patient recovery. Free group discussion is one of the ways staff attitudes have been brought to the awareness of the members. Sometimes this discussion has helped the members accept themselves and their feelings on a more realistic level.

Within the limits of more or less unalterable (by these discussions) personality traits of individual nurses, such group discussions offer a greater prospect that the patient's problems, symptoms, or impulses will meet with a uniformity of attitudes from all of the staff....In all of this, one can isolate for particular attention the factor of the relief of the anxiety of the entire staff. Open expression in group discussion by the psychiatrist of the more or less common but suppressed or repressed reactions of the staff to the child's symptoms - about which the staff frequently has some shame, disgust, guilt, or even fascination - certainly tends to reduce tensions. Perhaps it may also increase

somewhat their tolerance for themselves and hence for the patients.¹⁰

In order to be a contributing factor in this complex therapeutic environment then, it is found that one needs to understand the meaning of the environment, to understand the needs of the children, and to have enough self-awareness to allow for adequate functioning in this treatment setting.

10. Szurek, S. A. "Dynamics of Staff Interaction in Hospital Psychiatric Treatment of Children." The American Journal of Orthopsychiatry. 17:663 October, 1947.

CHAPTER III

DISCUSSION OF THE OPINIONAIRE

Group One

An opinioinaire was formulated in an attempt to help the investigator learn some of the ways that workers in the field of orthopsychiatry react to disturbed children. The prepared opinioinaire was administered to the six members of the class NU-766 Nursing in Child Psychiatry. Forty minutes of the class time were used for this purpose. At first the group had seemed eager and enthusiastic but, as they were completing the opinioinaire, it was noted that several members were skipping over questions. One member several times wrote in her own answers.

The investigator was totally unprepared for their reactions and sat in stunned silence as the group responded to the question, "What did you think about the opinioinaire?" One commented, "I felt all penned in." Another said, "I'm mad and I want a chance to fight back." Other comments were, "It's loaded," "I wanted to write in my own answers," "You've got us right in your hands." The entire group seemed hostile and very rejecting. They agreed as the class was finished that, "You can't have these papers back until we discuss them and we've had a chance to get back at you." The class session ended with the group unanimously agreeing

that they wanted to spend the next class session discussing the opinionaire. The investigator left the group remarking, "Well, I don't know whether I can come back next week or not." By tacit consent the topic of the opinionaire was avoided until the next seminar session.

The next class began with the group again uniting to attack the investigator. The group expressed their dislike of the opinionaire and the necessity of selecting answers with which they did not always agree. There really was no choice. Some questions had a socially acceptable answer which they stated that they were compelled to accept whether they agreed with it or not. Each member wished the opinionaire changed to provide a blank space so that they could write in their own choice of answers. The investigator was called rigid, autocratic, moralistic, idealistic and was accused of trying "to make everyone think as she did". Two members of the group vociferously and with hostility kept forcing her to assume the role of leader. At this point the investigator was feeling so rejected by the group and so surprised at their continued aggressions that there was no further desire on her part to continue the discussion. There was the wish to become again a member of the group, or else to get out physically. However, since there was no alternative offered, she, very inadequately, directed the group's attention to the first question. The discussion on the

first six questions was confined to the questions and the answers suggested, with the investigator still trying to gain readmission to the group. When the discussion of question seven began, the group discussed the way they reacted to aggression. They expressed their feelings about it when it was directed toward themselves, and how these feelings sometimes changed when the aggression was directed toward someone else. At this point the investigator interrupted with, "I think we are forgetting that the disturbed child sometimes is using this biting or striking out, as his attempt to establish a positive relationship with others much as a small toddler might." Two members of the group who had been quite vocal rejected this suggestion at first. Finally one said, "You know, she's right", but they had disagreed because they felt she was implying, "You have forgotten, but I haven't."

At this time the investigator stopped trying to force her way back into the group and accepted being an outsider. The discussion on this question continued when one member volunteered her feelings of conflict over her handling of a biting episode between her own children aged twenty months and six months. From this point there evolved quite a lengthy discussion of sibling rivalry. All members contributed to this discussion and even accepted the investigator's comments. At the close of this class the group asked to con-

tinue the discussion at the next meeting. The opinionaires were voluntarily returned. At this time the objective of the opinionaire began to change. The investigator had hoped to have an objective test to help students gain an understanding of the therapeutic environment; now she became aware of feeling the subjectivity of the opinionaire was its greatest value. The conviction that maybe there were no right or wrong answers emerged.

This discussion was continued at the next class session. Interest was expressed in the chart showing the grouping of the solutions as selected by the members. Their attention again was centered on the questions. When question twelve, which concerned vulgar and obscene language, was discussed, one member volunteered that children quickly sense how one feels about this. From field experience the member had found that after being exposed to this obscene and vulgar language by the group of older girls for a short period of time, some members of this patient group, who had previously joined in the use of this language, checked it by saying, "Don't talk like that, Miss X doesn't like it." The member had made no verbal expression of these feelings to anyone in this patient group.

Because of the time element involved, the group decided to discuss specific questions in which they were interested and to abandon the attempt to try to discuss each one. Ques-

tions twenty-eight to and including thirty-six were discussed with the exception of thirty-three. Questions twenty-nine and thirty, dealing with the use of toys, again brought forth much discussion. The conversation centered on rivalry and loss and how individuals reacted to those situations. The desire to be the "good" mother or nurse was argued. These emotions, they felt, influenced their behavior.

At the conclusion of this class the group expressed the feeling that this had been a learning experience for them. They also felt that they no longer had any of their formerly expressed hostile feelings about the opinionnaire, if it were revised to include a space where one could write in one's own response.

Group Two

The investigator, through experience in handling this opinionnaire, changed her attitude and her objective for its use. Because of her desire to control more of the variables in the study, she felt that it must be given the second time in its original form. Due to this misconception, the opinionnaire was not revised to include the blank space as requested by the first group.

The second group to respond to the opinionnaire was at Agency X, a school for disturbed pre-school children. This

group of seven included four nursery school teachers with two or more years of experience in working with disturbed children. One was a therapist who had had many years experience with such children. The remaining three were students. Two were nursery school trainees, one with nearly two years' experience at the center, while the other had been there less than a month. The other student was a nurse on a master's program from another university.

The opinionnaire had been discussed with several of the teachers. They had expressed an interest in it. Near the close of one of the regular student-teacher meetings, the subject of the opinionnaire was mentioned. They all expressed a willingness to answer and then to discuss it. The opinionnaires were distributed, but due to the lack of time, they were not all completed during this meeting. Some were returned at the end of the afternoon. One student disagreed on many points and wrote beside the introduction on her paper, "Statement of the problem. What is it then? Good and Skates Methods of Research, a very good reference." Since the next week was spring vacation, most of the papers were not returned until after the holiday. One was not returned.

The first discussion period started with the investigator stating the problem of her thesis, and attempting to clarify the use of the opinionnaire as a tool. She expressed the

feeling that discussion without any device to stimulate it was usually limited and non-productive; that by bringing up generalized and non-specific situations you could sometimes recall specific incidents to the various members' attention. It was merely in group discussions of these experiences that one hoped to profit from the use of this opinionaire.

Some members expressed the feeling that there might be dangers inherent in this, if the feelings involved were too deeply seated. Others felt that there would be safety in numbers because the member would not expose too acute feelings in the group setting. Another wondered "if expression of feelings would be enough to accomplish". One expressed the feeling that, "To expose feelings in **ganeral** helps one to focalize and to relate feelings to specific feelings".

The group expressed dissatisfaction with the introduction to the opinionaire and made suggestions for a change in wording. They also expressed the need for the opportunity to write in their own choice of responses when they were not satisfied with any of the suggested answers. They suggested rewording all questions to read, "I would:". One objected to the use of the word "annoying" in question thirty-six because " 'annoying' implies that all are annoying". All of these suggestions were utilized in revising the opinionaire.

They concluded with expressions of this device: "a catalyst", "the vagueness of the questions removes the authority

figure". One remarked, "I feel better now. It no longer seems so authoritarian". The group decided to spend the next teacher's meeting reviewing specific questions and suggested answers.

The second meeting started with attention being directed toward the opinionaire. The revised tool was presented to the group. When question ten, which dealt with soiling or wetting, was mentioned, much time was spent on discourse concerning rewards. Were they material rewards only, or did rewards also include positive praise? The group decided that praise and encouragement were also rewards. They expressed their feelings about the use of bribes.

Most of the group felt that question eleven, which dealt with destruction, posed three problems. First, one of material damage and of repair; second, and probably the most important problem, the child's feelings about his behavior; and third, the reaction of the staff to this child and to his behavior.

Question twenty, destruction of toys, was discussed briefly. After the discussion, some felt that perhaps "C" might have been the most adequate choice, although none of them had selected it. The remainder of the hour was spent on question twenty-one, which concerned the adult reversing a decision. Many examples were discussed. One commented that changing the decision might mean that the adult would,

"lose face if you do". Another wondered why one would change his opinion. Was it changed because "we felt that our previous decision was wrong, or was it because the child was crying"?

At the close of this conference one teacher said, "This has been very interesting. We could spend the rest of our meetings this year discussing these questions."

Group Three

When the investigator walked into the library to meet the basic affiliating nursing students participating in this study for the first time, the instructor was remarking, "Remember what I told you about this study this morning. You will have to give of yourselves."

The three students were seated around a table. They appeared to be a little tense and very quiet. This was the first day of their week's affiliation in child psychiatry.

The investigator explained that she was also a student. She hoped that this week's hourly discussion periods would be a learning experience for all. The students expressed a willingness to participate in the study. The use of the tape recorder was discussed. None of the group had seen one, nor had they heard their recorded voices. Each student announced her name, the name of her School of Nursing, and her status in the training program. Three different Schools of Nursing were represented. Two of the girls had had their pediatric

experience, while one had not. Two were in the second year of a three-year program; the third was in her senior year.

The revised opinionaire was discussed with the students with special emphasis placed on the fact that there were no right or wrong answers. The way they felt themselves about the situation would be the right answer for them. They were also asked to try to answer the last question in terms of what they felt this therapeutic environment should include. Each student, and their instructor, was given an opinionaire to answer. The students appeared surprised and the investigator felt a little relieved, when they realized that the instructor was participating in the study with them.

The only comment made during the writing of the test came when the instructor was answering question number three. She looked up and remarked, "You're a sly one." At the time this was not investigated further because this might have interrupted the students. However, it was soon realized this was an error, and it was mentioned later. The instructor completed the opinionaire first.

Since there were ten minutes remaining, an attempt was made to rectify the earlier omission. The question, "Why did you feel that I was being sly?" was directed to the instructor. Her answer was, "This is like state boards. They gave five or six choices and all of them could be right. You had to choose the best one. This was just like that."

The group quickly discussed question one with some participation from each member. Most of the discussion centered on why limits were necessary and therapeutic to the child, and why adults liked some limits in their own lives.

The meeting ended with the investigator saying, "I'll see you tomorrow at nine." The students agreed and left.

The second meeting with the students was tape recorded. The discussion was started by one of the students who asked, "Did you look at our papers?" This was answered in the affirmative. They were then asked, "What did you think of the opinionnaire?" One felt that the questions were ambivalent, that they would be answered on the basis of your past experiences, how your instructors had taught you and how you felt. One felt that it was frustrating not to have right or wrong answers. The leader stated again that the purpose of the opinionnaire was to find out how one felt about these situations.

One student expressed the opinion that she did better work when she was comfortable with the head nurses, other staff members and patients. The leader asked, "Then how one feels about situations affects one's environment?" The students all responded to this. One thought, "Everybody does better work with patients when she is comfortable herself." One "felt happier in friendly surroundings". Another expressed, "liking the freedom to choose where she would spend

her last six weeks so that she could go where she would be most comfortable".

One student brought up an incident in which the children had taken advantage of the nurse. When the nurse expressed how she felt, she thought that the children tended to "egg you on". One discussed handling an incident with one of the older boys who was swearing. She had remarked that he couldn't do that. His reply had been, "What can you do about it?" She had walked away and left him. Another student told of one of the younger boys who had "bothered me quite a bit" by moving his hands around on her leg. She had asked him to fold his hands on his lap if he wanted to hear the rest of the story. She felt capable of handling this situation because of the possibility of its occurrence having been discussed with her beforehand. She also felt that she would not be so distressed now if it happened again because she had been able to manage this incident. A second student volunteered that she had experienced the very same thing. She felt that she would have been more upset if the child had attempted this a second time. The third student had had a physical struggle with one of the teenaged girls who had wrestled with the nurse to try to gain control of her keys.

The discussion turned to the fact that some of these experiences might have been attempts on the part of the

patients to test out the new students. They all agreed this might be so. One stated that they tested out new situations and new people all the time.

The leader asked how they felt about the children who were mentally disturbed but not physically ill. Each student responded. One was "bothered very much". One stated, "Your heart goes out to them a little more." The third felt that some of them look so normal you wouldn't think that there was anything wrong with them. The fourth felt "the children look so hurt -- their eyes. If you look at their eyes, they look as if someone were beating them over the back. They never look happy. They may smile, but their eyes are never happy." The first student added that she "felt so sorry for some of these boys who just sit along the side of the room all day". She wished that one could do something for them. What could be done for these children was discussed by the group.

Some of the students felt it was not good to group the children by ages alone. They did not feel that the personality disorders, neurotics and psychotics should be in the same group. The possible advantages and disadvantages of these kinds of groupings were discussed. This led into a discussion of the concept of team nursing and good staff interpersonal relations.

The students expressed the sense of feeling free. They

felt more able to express themselves than they had before. One said, "If you have something on your mind and you can't talk about it, you coop it up inside and then you go back to your room and talk about it." A second added, "The gripe session." Another comment was, "I've never talked so much before in a class." The third said, "I know back at the hospital I just sit there and take everything in and you don't dare say boo." The first added that she could never think of anything to say, anyway.

One of the students mentioned that nurses change as soon as they graduate. They all felt that the bridge between student nurses and graduates was too great.

They expressed the fact that they felt comfortable here. One said, "The way I see it, back at our school you know, we're not supposed to raise a rumpus. You're going to make that noise because you're mad at someone. Down here you don't feel that tension, I don't think." However, they did not feel that this sense of freedom carried over into their work. One said, "I don't think it makes that much difference in your work. I don't know, I feel I act the same way."

They were asked if working with these children was interesting to them. One replied, "I enjoy it very much." One expressed that she was afraid before she came. She had not known what to expect. She said, "When you get on the wards you still have some fear, but you lose most of it."

Two mentioned that the public expressed such a dislike for the field of psychiatry. One of them felt it was more interesting to see a patient get better from a mental illness than from a physical one.

As the discussion seemed to be lagging, the final part of the hour the group's attention was directed toward question two; the meaning of hospitalization to a child. One expressed some puzzlement about this question. They all felt that to the child it would probably be hospitalization was a punishment for his badness, or it might be as a separation from his parents. They then discussed visiting hours on any pediatric ward and agreed that the children really needed to be allowed to see their parents.

The third group meeting was tape recorded, but due to lack of attention on the part of the investigator, the recordings were inaudible. The students had been very vocal and the loss of this taped material was deplored. The summary of this meeting was written the day following the conference. One of the students was absent. The instructor was at a meeting. The two students present participated actively in the discussion. They both seemed eager to talk. They had been on the adolescent girls' ward for the first time. This had apparently been an unpleasant experience for both, but much more so for one of the girls.

When they entered the ward the patients had all gathered

around them. Their comments had been directed to each other, but were all concerning the two students. They had said, "Here's another bunch of dumb students. One of them has on a torn uniform. What are you bothering us for?" The first student said, "My uniform is torn here on the sleeve, but I'm in my last year of training and my uniforms are wearing out." They had continued to remain seated while the patients talked. When they were asked how it made them feel to be called dumb students, the first student felt that it hadn't bothered her at all. She had just considered the source. The second student did not reply but sat tensely in her chair. She was clasping and unclasping her hands. This discussion was encouraged by asking if they thought the patients might be expressing something more than they were actually saying. After a short silence the first student wondered if the patients could be jealous. She thought the girls were so near their age they might feel envious. The second student agreed that they were very near our age and here they were locked up. When they were asked if they felt that these patients might really be asking them for something, for some help, they both answered in the negative. They didn't think the patients wanted any help. The second student felt that these girls had just been trying to be annoying.

This student, with a great deal of feeling, told of an incident that happened to her. The girls were gathered

around her. One had said, "Your hair is just like a man's. You look like a man." Another added, "How do we know? Maybe she is a man." A smaller patient had then come up to her and asked her to read to her. She kept bringing books over but had not paid any attention to the stories. The student had read until she was hoarse and then she had stood up and walked out. In response to, "Where did you go?" she replied, "Just out in the hall." She had walked around for awhile and when she went back, the bigger girls were gone. When she was asked if she thought the little girl might have wanted to help her, or to keep her close to her, the student didn't think this could be possible. She was sure "the patient had just wanted to annoy her". This student hated to have the girls know that they had been able to run her out. She was asked why she felt that they might know this since she could have left the ward for many reasons. This appeared to be somewhat reassuring to the student as she seemed more relaxed. Her hands were quiet on the table. She remarked the patients had made her so nervous that she just had to get out. She felt that she was nervous anyway. Then she discussed being hospitalized for stomach ulcers prior to entering training.

They were asked if they thought these adolescent girls seemed to be happy. They both stated that they weren't happy, but that they didn't seem to want to change. They felt the girls were much worse than the boys. "They were so

rude and so vulgar. They kept using those nasty four lettered words. Even the babies use those words, and they all looked so tough."

One believed the women patients in the general hospitals were harder to take care of than the men. "Women are so demanding and always telling you how to take care of them. They didn't realize that the nurses knew what to do." One student had loved ward A-3, (the male ward). She felt it was wonderful. The men were so nice. She planned to ask to spend her last six weeks there. The other student agreed, "The boys here are nice. The big boys try to help the little ones. They are polite, while the girls order the nurses around like slaves." Both students agreed the big girls were not nice to the littler ones. They seemed to push them around.

In response to, "Why do you suppose the girls behave like this?" they answered that they assumed the girls wanted to be tough. One wondered if their home environment could have been bad. She thought maybe their mother worked and that they didn't get enough supervision at home. The other thought these girls might have belonged to a tough gang. She wondered if some of the gangs outside were worse than those in the institution. She also wondered if their parents had been strict enough with them. Her own parents had been very strict with her. She felt that her father had had funny

ideas. He kept strict watch over her. The other girl's parents had not done this. She realized now, however, that her parents had been taking care of her. The first student recalled that her parents weren't strict. She had had to keep certain hours but she had really loved high school.

They expressed the feeling that they had really talked a lot today and they both had wanted to talk.

As the hour drew to a close one said that she felt like she'd like to go to the big girls' ward again to see what would happen. The second student thought she could go back now but that she'd rather be with the boys. They were going to go down to the boys' ward until three, when they were going to the patients' dance where they would be with all the children.

Both students expressed feeling that one week's experience was enough to let them see the functioning of the staff in child psychiatry. One student was enjoying this experience and thought that she might put it down as her second choice for her final six weeks. The second student did not like it and did not feel that a longer experience in the field would change her opinion about it.

The group of three students came into the meeting promptly at nine. The instructor was out attempting to locate an adolescent girl who had escaped. A lengthy discussion was started by the students describing this escape.

They had arrived at the yard immediately following this episode. They heard some patients calling, "Run, Annie! Run!" Others were urging the nurses to go and find her. Some of the patients were angered by Annie's behavior and wondered if they would lose their yard privileges because of it. The students seemed very interested but were not frightened. They discussed the responsibility that nursing service had but did not feel that anyone would be blamed for this escape.

The student who was missing the previous day was welcomed back. She had had a cold but stated she felt fine today.

The conversation turned to the dance that was held the previous day. One of the patients had approached the two students and asked, "Any of you dumb students know how to jitterbug?" The students did not think this bothered them. They felt that the patients had not enjoyed the dance. The attendant playing the records had remarked, "This is a waste of time." The girls had refused to dance and the boys and girls had tended to sit separately, although a few had "coupled off". They wondered why this had happened because both the boys and girls had dressed and "spruced up" for this occasion. One student said, "The patient who told me I looked like a man yesterday, came up to me at the dance and had her hair all slicked back from her face. She asked, 'Isn't my

hair a mess?' I tried to fix it like yours." The student's answer was, "I thought you didn't like my hair." The student was asked if she thought this might be a compliment to her. She did not think so. To carry this further she was asked, "What people that you know do you tend to pattern yourself after?" After a short pause two of the students answered, "After the people you like."

The discussion then centered around question three, concerning discipline of disturbed children. Two of the students again repeated they enjoyed working with the younger girls or boys. The girls were so vulgar and rude and "they throw those four lettered words around all of the time". They all believed that the girls knew what they were doing. In response to the question, "Then you think that they chose to act in this manner?" one answered, "I'm sure they do." She felt that they were asking for "a good beating and that is just what they need". A second student agreed with her.

They recalled the case study held in staff. It concerned one of these adolescent girls and her problems. From quite a detailed discussion of this, the girls agreed that environment might have some influence on the patient's behavior, but they did not feel that it was entirely responsible. They felt "the patients still can make a choice".

Leaving question three at this point we skipped to questions sixteen and seventeen, concerning oral and injected

medication, and discussed them together. They had all answered, "Find out why the child doesn't want to take the oral medication." All of them had answered the next one by allowing the child to decide whether he would let the nurse give him the injection or have it given by force. One had checked as a second answer, "Find out why he doesn't want to take it." They felt their reason for this was "an injection is more important than a pill". This was discussed more fully and it was agreed that this was not necessarily true. One remarked that, "They might be more successful in forcing a child to take an injection than a pill." The rest agreed with this.

One student asked to discuss question twenty-one, whether or not the adult should reverse a decision once it was given. She thought that you should never change your mind after you had given a child an answer. "If you do change your mind you lose your dignity and the patient's respect. They keep trying to see if they can make you change it again and it gets to be a test." Another student felt that you might change it sometimes because "you might have been wrong". Some time was spent on this topic but the group held to a divided opinion.

When talking about question thirty-five, concerning the most difficult part of the care of the disturbed child, one of the students had chosen meal time as the most difficult

part of the patient care. She said, "Meal times always bother me. I don't like them in the general hospital." This was the student who had had ulcers. To the query, "Have you wondered why you don't like meal times?" she answered, "No, I just don't like them." One student remarked about the unpleasantness of the children's general messiness and their smearing. One patient was mentioned as trying to upset everything so one person has to hold both his arms while the second person feeds him. They also discussed the children who grab food from the other patients' plates.

At the close of the meeting one student said, "It has surely helped to be able to talk about some of these things. We don't have to keep thinking about them."

The final meeting with these students started with a discussion of the change in the behavior of the adolescent girls. The students were conscious of the fact that the girls had been different, that they were very nice and polite. One thought it might be because the students were no longer new. The change had occurred when they had gone to the girls' ward immediately following the conference meeting held the day before. They were asked if they felt any different themselves about going on the girls' side. One said briefly, "I did." The second said, "I felt different. I really felt more comfortable." The third student remarked, "They just didn't bother me too much." They all assumed that if they

stayed longer the patients would get used to them and one thought "the girls would grow on you after awhile". They commented on the fact that the girls weren't swearing now. They were asked why they thought the girls had done this previously. The students felt the adolescents wanted to show that they were tough and bad.

The discussion centered around why the children were hospitalized. Some were bad, or behavior problems, while some were ill. The students did not feel that they could tell why any of the children were there and no one had told them why,

Question twenty-seven, concerning the difficulty of the care of the disturbed child, became the next topic of conversation. One student believed the only difference between the care of the normal child and the disturbed one was that the disturbed children tended to destroy more things. "This destruction was not necessary." One student said, "I can't see it (destruction). It bothers me." Another student felt it could be prevented if you would talk to them. She thought that you could say something to stop it. The third felt it might be beneficial sometimes to help the children get it out of their systems. One student thought that she would accept more from these children than she could from normal ones. She felt this to be true because "there is a lot behind their behavior". The discussion was centered on

how one would feel if one had to spend all of the time with these children, as their parents had. One student believed she would have been inclined to whip them more. Another student was sure that she would yell at them all of the time. They came to the conclusion that the patients had been treated like this. One said, "I think it's evident in their behavior here because they do it, and where else would they learn it?"

The group was sure there would be a definite carry-over from the experience in child psychiatry to pediatrics. The two students who had had their pediatric affiliation thought it would have been more valuable to have had their psychiatric affiliation first.

One student mentioned that this was the last day of this experience. Two of the students would have been willing to return. The third student did not wish to do so. She said, "I couldn't take it for six weeks." She felt that she was doing nothing. "The children, especially the withdrawn ones, don't even respond at all. Sometimes they don't notice you, and sometimes they turn their heads away or cover them up as if you are annoying them." She would have felt better if the patients had responded a little. One student said, "Those that don't respond just don't respond at all." When asked if they thought the children were aware of their presence, one answered, "Oh, probably they are. We've

learned through the book that they are supposed to be aware of you."

They were aware of liking some of the children better than others. They stressed liking the nice, polite, good children. The discussion centered on the little boy who had annoyed two of the students by running his hands over their legs. He had repeated his behavior again this morning. One of the students had been quite distressed by this. She said, "Well, I don't want to talk with him any more. This morning when he started over, I just gave him one look and he had it. I really got mad. I'd rather not say anything. I'd already spoken to him enough, I thought." She concluded that if she had had to say anything more it wouldn't have bothered him, but, "It would have bothered me. To think I had to keep telling him when I knew very well that he understands well enough."

One of the students believed she was getting a better relationship with some of the patients. The patients were beginning to know her and this took time. One of the students thought this was natural. "It's like these meetings. The first two days I was here, I listened but I didn't talk too much." Another replied, "I think they are better now." The third said, "We know you a little better. We've sized you up, you know." They felt maybe this was why they were getting a better relationship with the patients. They had

been sized up by them,

The students were very interested in one patient who was very concerned with "weird people". They had all attempted to satisfy his concept of weird people without success. He told them, "When people are frightened they cry. They cry an awful lot. When they aren't afraid they run away." He had been unable to give them any of his own feelings about weird and they felt frustrated and relieved when he changed the topic. They had tried to reassure him by saying that they would not be afraid of weird people themselves.

Summary of these Discussion Groups

The discussions with each group followed decidedly different trends. In group one, the investigator was in a peer group that had existed for more than a six months' period. The response from this group was spontaneous, aggressive and forceful. All of the members were vocal and most of them were eager to respond. They received and apparently needed, very little direction or stimulation to talk. They were eager to express their feelings of frustration and of hostility that the opinionaire had engendered. After an uninhibited vocal expression of these feelings, they proceeded to discuss the opinionaire and freely related many questions to personal situations and expressed both negative and positive attitudes about them. The topics discussed in

this fashion included: 1. Aggression-conflicts over handling of specific aggressive acts; 2. The intuition of patients and the accurate responding to adult attitudes that disturbed children sometimes display; 3. The group's feelings about obscene and vulgar language; 4. The desire to be the "good" nurse or mother; 5. Reactions to loss and how all of these attitudes influenced their specific reactions.

At the completion of six hours of non-directive discussion, group one unanimously expressed feeling that this had been a learning experience for them. Except for the desire to have a blank space included, they no longer felt that the opinionnaire was objectionable.

The situation in group two was different. In this second group the investigator was a student at the agency. The group members here were concerned with fostering student growth. They felt that the opinionnaire might be a valuable means to stimulate discussion and wished to improve its effectiveness. Most of their discussion therefore, centered around suggestions for improving the wording of the opinionnaire. They discussed the procedure to be used with the basic student nurse group. They wondered if a mere expression of feelings would be beneficial; and if there might be dangers inherent if the feelings discussed were too deep seated. At the close of the first meeting some members expressed "feeling better because the opinionnaire no longer seemed so authoritative".

Some of the questions were discussed briefly. Some of the topics mentioned were: 1. Rewards, and what they were, when should rewards be used, and when might they be considered as bribes; 2. Destruction, and what this means to the child and to the adult in the situation; 3. What it means when the adult reverses her decision.

The tendency for this group to select the same response indicates that through closely associating together for a period of more than two years, they have developed a common philosophy. In discussing some of the questions this common philosophy was expressed. It provided an opportunity for them to re-examine and to discuss this philosophy. At the close of this conference one teacher remarked, "We could spend the rest of our meetings this year discussing these questions."

In the third group, the basic nursing students were strangers and in addition to this, the investigator was placed in the role of teacher or group leader. This group also held the advantage of trying out the revised opinionnaire, with a free space to answer each question in their own words.

The basic nursing students followed an entirely different course in their group discussions. They appeared to be tense and apprehensive prior to answering the opinionnaire. After completing it, however, they seemed at ease and did not express any concern over the opinionnaire itself.

They needed more direction and stimulation to talk, especially during the first two group meetings. They tended to relate the questions discussed to their field experiences and many of the situations presented in the opinionnaire were discussed at the student's instigation without reference being made to their appearance in the opinionnaire itself. The discussion became notably more free and less restrained after the second meeting. Many of the situations they met in their field experience had produced anxiety and they spent a great deal of time discussing these episodes. They seemed to seek reassurance and support. When specific situations seemed to be causing a great deal of tension, further discussion was encouraged. Two of the students appeared to relax markedly after a lengthy discussion centered around the adolescent girls and their behavior. After the second session in which this problem was discussed, the "girls changed their behavior and were so good". The students felt that they themselves had changed their attitudes toward these patients, but did not feel that this could have affected the change in the girls' behavior. Instead, they felt it occurred because "the patients knew them better".

All three of the students expressed at different times, a punitive attitude toward these patients, especially toward the adolescent girls. This attitude had not been discerned in either of the other groups. This punitive attitude did

not appear to be changed by the group discussions. It was again forcefully expressed in the final meeting.

During two of the meetings, the students stated that it helped to be able to talk about the problems encountered and how they felt about them.

At the close of the final meeting in written response to, "Did our group discussions add to this experience, or were they unnecessary?" all three answered that they were "very profitable, were of great value, or were a great help to me". One felt they "Made me feel at ease in discussing my problems and it was funny to see that others had the same problems. They made me feel more comfortable and a part of the working team." Another said, "It gave us a chance to freely voice our opinion on things, which isn't often done in our home schools." The last student wrote, "You brought out possibilities of motives in the actions of the children... I tried to analyze the behavior of the children to try to find out what was behind it all."

During the course of these discussion meetings the students expressed their feelings about: 1. Overt sexual aggression from the patients; 2. The unpleasantness of the "testing situation"; 3. The disturbed child in contrast to the physically ill one, specifically toward the withdrawn child, the aggressive one, and the "good" one; 4. Fear of the mentally ill and society's attitudes about it; 5. Un-

pleasant personal comments made about the students; 6. Patients not wanting help and not wanting to behave "better" and the feelings aroused when they felt they were not able to help the patient; 7. Vulgar, rude and obscene language; 8. Women patients in general being harder to care for than men, and the adolescent girls being especially difficult; 9. About eating; 10. About destruction; 11. Punishment and discipline; 12. The change in students when they become graduate nurses; and, 13, This being a more free environment than that in their home schools.

In spite of the varying roles and the relationships of the investigator in the three groups, the opinionaire stimulated discussion in all of them. It appeared to encourage the discussion of situations that those working in the field of child psychiatry face. Individual feelings and attitudes were expressed during the group discussions.

Group one expressed feeling that this had been a valuable learning experience. One member of group two (and others expressed agreement) said, "We could spend the rest of our meetings this year discussing these questions." The students in group three wrote: "The group discussions were very profitable," "Were of great value to me," or, "Were a great help to me." These expressed opinions on the part of the members of these three groups indicate that this opinionaire stimulated discussion with the more experienced

workers and with the novices in the field of orthopsychiatry.

This may substantiate, in part, the statement made by one worker with many years experience in this field. She wrote, "There is no doubt in my mind, however, that in using your opinionnaire as a tool to bring out free discussion, any group less psychiatrically orientated than ours, is sure to give a good deal of expression to the ways in which the different members used to feel. We all believe you have something valuable and useful."

Discussion of the Written Responses to the Opinionnaires.

An examination of the responses to the opinionnaire reveals a marked clustering of responses. This occurred even though the first two groups were not given an opportunity to write in their own responses while the basic nursing students used the revised opinionnaire which provided this choice. All of the inexperienced students answering this revised opinionnaire used the blank space; one used it once, while the other two used it four times each. One of these students who wrote in four responses, in three instances also marked one of the other choices. The one experienced member of this group did not utilize the blank space.

On Question five, concerning regular hours for bedtime and mealtime, there was a marked split between the members'

responses in all three groups. The closest agreement was in group two where five members selected response "a". Two members each from the other two groups also selected this choice. Three members from each group selected response "e".

Another question that produced a division among the three groups was number twenty-two, which was concerned with crying. Eight members selected response "a", while nine chose "b". There was almost equal division among the members of groups one and two, but in group three the three inexperienced students selected "b".

Some of the questions indicated a difference in response from the basic nursing students in group three. In question two, dealing with the meaning of hospitalization to a child, three of the members in group three selected "b", while only one member from each of the other groups selected this response. Again in question six, discussing the routine of getting patients up and dressed, the three inexperienced students from group three chose "a"; one student in group two also selected "a". The more experienced member from group three selected response "b" along with every member of groups one and two. In question seven, dealing with aggression in patients, two students from group three and one from group two selected "b", while the more experienced member and one student from group three selected

response "c" along with every member from group one and all but one from group two. In question nine, dealing with eating, two inexperienced students from group three and two students from group two selected response "d". The other two members of group three selected response "b" along with most of the other two groups. In question eleven, concerning destruction, the three inexperienced members of group three and one student from each of the other two groups selected response "d". The more experienced member from group three joined with eleven others who selected response "a". Question seventeen, concerning an injection of medication, produced another split in the student group. Two of the inexperienced students in group three selected response "d" along with one member from group two and two members from group one. The other two members from group three joined seven others in selecting "b". In question eighteen, concerning sexual assault, two members from group three and two from group two selected "d" while the other two students from group three joined with twelve in the other two groups to select "a". In question twenty, concerning the destruction of a toy, the three inexperienced students in group three selected response "c". The more experienced member from group three joined with ten of the other members to select response "b". In question twenty-one, concerning the adult reversing her decision, two of the stu-

dents in group three selected two responses. Three members from group three selected response "a". One member from each of the other two groups selected this response. There were twelve from the other two groups selecting response "d" and three from group three also selected this response. In question twenty-three, concerning personal comments made by a patient, the three inexperienced students from group three selected response "b" along with one student from group two. The more experienced member from group three joined twelve others to select response "d". There was division in all three groups on question twenty-four. In this question, dealing with the disturbance of the adult working with these patients, two of the students from group three joined one student from group two in selecting response "c". The other two students from group three joined with ten others in selecting response "b". Two students from group one and three from group two selected response "d". In question twenty-five, concerning the lack of activities for patients, the more experienced member from group three selected response "a" along with eleven members from the other two groups. Two of the students from group three joined with a student from group two in choosing response "d". Two also wrote in their own response to this question. In question twenty-eight, dealing with the timing of activities, two in-

experienced students from group three joined with a student from group two in selecting "a". The other inexperienced student joined with a student each from groups one and two to select "b". The more experienced member from group three joined with eleven others to select response "c". In question twenty-nine, discussing the giving up of toys by a child, the three inexperienced students from group three joined with one student member each from groups one and two to select "d". In question thirty, dealing with conflict over toys, two of the inexperienced students from group three joined with a student in group two to select response "d". The other two members of group three joined with twelve others to select "a". In question thirty-one, concerning limits for patients, every member of groups one and two and the experienced member of group three selected "b". One student each from groups two and three selected response "a" and response "c". In question thirty-two, dealing with provocative behavior, the more experienced member from group three joined with twelve others to select "b". Two students from group three joined with one from group two to select responses "a" and "d". In question thirty-four, concerning the use of seclusion, two members of group three joined with nine from the other two groups to select "a". Three members from group three joined with one student from groups one and two to choose "b".

From examining the responses to the opinionaire it was noted that those members from groups one and two that tended to verbalize more freely also tended to select more isolated responses than did the less vocal members of the first two groups.

A Summary of the Written Responses to Question Thirty-seven.

The therapeutic environment seems to have a more varied interpretation between groups than within the groups. There is one main factor with which nearly everyone agreed. This factor was meeting the specific needs of the individual child. Each member of the group at agency X included this as a requirement. Half of the group from NU-766 mentioned this as a requisite. The instructor and one student from hospital X included this as a necessary factor. Eleven of the sixteen persons answering this question agreed on this criterion. Two members from agency X and from NU-766 included helping the child to grow or to progress. All of the group from agency X and three from NU-766 included the setting of valid limits for the child as another element necessary in this environment.

The therapeutic environment appeared to have a different meaning to each member of the Nursing in Child Psychiatry class. One member's entire criteria seemed to be self-centered. She felt this to be an environment in which "I feel the most comfortable....One in which I can allow both

the child and myself to be spontaneous". Students number four and five were solely concerned with meeting the needs of the child in this situation. The other three felt this environment must recognize the needs of both the staff members and the children.

The entire group at agency X again expressed quite similar viewpoints on the meaning of the therapeutic environment. Student number six did not answer the question. All the remainder, with the exception of number five, mentioned; 1. Meeting the needs of each individual child; and, 2. Freedom, within limitations, that each child needs. The attitudes of the staff were mentioned by all as being warm, accepting, or understanding. One added, "The adults like the child at all times, despite his behavior which they may frequently disapprove of." To each of these workers the environment appeared to be concerned with accepting the child as he is, and meeting his particular needs.

The basic students at hospital X on the first day of their week's affiliation, defined the therapeutic environment in physical terms. One mentioned the destructive tendencies of the children. Another stressed the activities available. Student number four included, "Small groups work and play together", and also, "Giving the big boys responsibility".

At the end of their week's experience student two wrote, "I still feel more or less the same." Again she stressed the destructive tendencies of the children and the physical facilities at the hospital. Student number three felt that this environment should be one where a child "is less apt to be influenced to do wrong things by older boys. Keep him with his own age group and give him the right discipline when needed". This seems to show some recognition of limits although these limits were expressed in a punitive sense. Here, student number four isolated, "Meeting the particular needs of each child". She also added, "Nurses working and playing with the children give them a good relationship." She apparently recognized and identified the child's need to form a good relationship with adults as a part of this environment.

The instructor at this hospital stressed the importance of the comfortable, relaxed atmosphere with limits set by those working with the children. She also included flexible rules to meet individual needs, love and understanding, and sufficient help to do all you would like to do to help these children, as important in the therapeutic environment. In her definition she included meeting the needs of the children and the staff involved with their care.

A second group of four students, upon the completion of their week's affiliation at hospital X, were asked to write

out the meaning of the therapeutic environment. This group of students did not answer the opinionaire, nor have any contact with the investigator. Two of these students wrote that they did not fully understand the question. Three of the four felt the environment should be bright, colorful, and cozy. One thought the personnel should be understanding and able to cope with the situations that arose. The other student believed it was "the environment in which the patient is placed in order that he may receive the best treatment for him personally".

Again this group of basic students seemed to be concentrating on the physical aspects of the environment and excluding the interpersonal aspects of the therapeutic environment.

CHAPTER IV

SUMMARY AND CONCLUSIONS

A questionnaire was designed to use as an objective test to help students develop a more adequate understanding of the therapeutic environment as it is utilized in the treatment of disturbed children.

After using this device with one group it became apparent that instead of being an objective questionnaire, the tool was a subjective opinionaire. It stimulated group discussion on situations that were experienced with disturbed children. It seemed the ability to stimulate discussion of these experiences was its greatest value.

This opinionaire was used with three different groups. The relationship of the investigator to these three groups seemed to influence the group discussions. In group one where the investigator was a member of the class, the discussion was active, direct and required very little leadership. The investigator was a student member of group two. The discussions here were concerned with improving the construction of the opinionaire. The third group placed the investigator as the instructor and required more guidance and encouragement to promote free discussion. It would be interesting to explore this more fully to see if the role of the investigator in the group continued to establish the

tone for the group discussions. The members from the three groups expressed the belief that these group discussions were profitable experiences for them.

One of the problems was to ascertain if the therapeutic environment was a major part of the treatment for disturbed children. Many of the eminent workers in the field of orthopsychiatry support this statement. From the material quoted in the historical review in chapter two, one can conclude that many experts in this field have reached this opinion, with emphasis on the importance of the attitudes and feelings on the part of all who work with disturbed children.

Another problem was to see if there was agreement among the workers in the field of child psychiatry as to the meaning of the therapeutic environment. From their written response to the last question in the opinionaire, most of the experienced workers agreed on two points: 1. Meeting the needs of the individual child; and, 2, Providing valid limits for the child. There was less agreement on two more points. Seven members felt the adult must have a warm, accepting, and understanding attitude toward these children. Four members felt it was important to meet the needs of the staff and of the children.

There was a marked agreement among the inexperienced student group. The students tended to confine their responses to the physical setting only. The physical environ-

ment was not mentioned by the more experienced groups.

The third minor problem was concerned with a means whereby students could become aware of situations that might be emotionally tinged for them, and through group discussion help them to express these feelings. The revised opinion-aire used with group three stimulated group discussion of situations that were experienced with disturbed children. The students in a directed group discussion were able to verbalize many feelings that were connected with their experience with these disturbed children.

The main purpose of this study was to determine if students could be helped to become aware of their own attitudes and feelings toward the overtly expressed, and oftentimes infantile behavior of disturbed children, and to realize how their feelings influence their interpersonal relationships with the children. The students, through group discussions, recognized that the patients were "testing them" and that this was an unpleasant experience. They also realized that they tended to "test out" new people and new situations. They became aware of the contrast in their own attitudes toward disturbed children and toward those children who were physically ill. They realized that they also had different attitudes toward these disturbed children; they liked the "good" children and the withdrawn patients better than they did the aggressive ones. Their feelings about the aggressive

behavior tended to vary with the specific situations and depended, sometimes, on whether the aggression was directed toward them or to another child. They expressed feelings of inadequacy when they felt unable to do something for these disturbed children and had a tendency to attribute their limitations to the patients by believing that the patients did not want help. These students were distressed by the vulgar, rude and obscene language, especially as it was used by the girls.

The students realized that they would rather work with the disturbed boys instead of the girls. They also felt this was true in general nursing in any hospital because men were easier to care for than women. The general destructiveness of the disturbed children was very upsetting to these students. This topic entered into the group discussions repeatedly. It was not mentioned by either of the more experienced groups.

The importance of accepting the child has been clearly recognized, but does this indicate that too much is expected from the young student? Is she expected to tolerate more than it has been possible for her to achieve because of her own limited life experiences?

The group discussions held with the students in group three indicates that they did become aware of some of their attitudes and feelings aroused by their experiences with dis-

turbed children. These group discussions further indicate that the students did not realize how their feeling and attitudes influence the interpersonal relationships with these children. Since the investigator required several months' experience working with trained experts to change pre-conceived ideas and attitudes, it was not to be expected that in one week's time these students could have marked changes in their attitudes or behavior.

The release of the students' anxiety in group discussions made it possible for them to tolerate more easily anxiety producing situations. After discussion of the problems concerned with the adolescent girls in two meetings, they felt capable of returning to the girls' ward. They noticed immediately the change in the behavior of the patients, but did not feel that their own change in attitudes could have affected this change. There was also a change in viewing the behavior of these children; from evaluating all of the situations on a moralistic basis, they were trying to understand this behavior.

Even in this short period of time, these students seemed to develop a habit of inquiry, and a desire to understand the behavior of these disturbed children which, if stimulated and encouraged, might be expected to continue to develop.

The discussions with these three small groups indicate that the opinionnaire was a useful device to stimulate dis-

cussion both with experienced workers in the field of orthopsychiatry, and with inexperienced students.

The written responses to the opinionaire revealed some interesting variations. In marking thirteen questions the student group selected twenty-six responses that had a punitive connotation. None of the experienced workers selected these responses.

The responses on question five regarding the hours for going to bed, getting up in the mornings, and for mealtimes provoked a marked division of responses.

It was interesting to note that on question sixteen and question seventeen, dealing with a specific area of nursing, the administration of oral or injected medication, there was a marked variation in response. Most of the members selected "find out why a child doesn't want to take an oral medication". When the medication was an injection, most of the members selected "allow the child to decide whether he will allow you to give him the medication, or have it administered by force".

Another question that produced a marked division of responses was number twenty-two concerning a child crying. This might indicate that certain situations allow for a more personal response.

The two more experienced groups demanded the opportunity to write in their own response to the opinionaire. When

this was provided for the students, it was only utilized nine times, and four times another response from the opinionaire was also selected.

It was found that those members of groups one and two who tended to verbalize more freely in the group discussions also tended to select responses that were isolated from the rest of the members' choice.

CHAPTER V

RECOMMENDATIONS

This sampling study using the opinionnaire indicates that it should be more fully explored.

1. This opinionnaire should not be used indiscriminately. The administrator should be aware of its potentialities. It should not be used unless arrangements can be made for group discussions.

2. The opinionnaire should be administered in a controlled study with nursing students. If this group could be divided into three sections, with one section used as a control, one section to have group discussions only, and the third section to answer the opinionnaire and have group discussions, the effectiveness of the opinionnaire could be ascertained.

3. In marking thirteen questions the student group selected twenty-six responses that had a punitive connotation. None of the experienced workers selected these responses. Is it to be expected that students without training in orthopsychiatry will respond in this way? Might this mean that inexperienced students require more defenses to work with disturbed children? If further investigation with larger groups would validate this, it might be considered as added justification for including orthopsychiatry field

experience in the nursing curriculum.

4. The varying relationship of the administrator of the opinionnaire needs to be more fully explored. There was a difference in the reactions of these three sampling groups: 1. Where the administrator was a member of one group; 2. Where she was a student in one group; and, 3, Where she was the instructor in the group. Was the difference in the group discussions influenced by the role of the administrator? Was this difference in attitude a response to the construction of the opinionnaire? Two groups did not have the opportunity to write in their own responses while the third did.

5. It was found in groups one and two that those workers who tended to verbalize more freely also tended to select responses that were isolated from the group's choice. If this could be demonstrated in more exploration with this tool, could the group tone be ascertained from the responses to the opinionnaire by the administrator prior to the group discussions?

5. The responses on question five regarding the hours for going to bed, getting up in the mornings, and for meal-time provoked a marked division of responses. This area should be investigated, not in an attempt to try to have people think alike, but rather to explore potential differences and how we could best utilize these differences to

improve patient care.

7. The questions dealing with the administration of an oral medication, and with injections, also revealed a marked variation in responses. Many members felt that injections were more important than oral medications. This area warrants more exploration.

8. In question twenty-two, dealing with a child crying, there was a marked variation in responses. Might this mean that some situations allow for a more personal handling?

9. The students revealed feeling inadequate when they were unable to do something for these disturbed children. Some exploration should be done to see if students can be helped to acquire the ability for watchful waiting. They need to realize that behavior cannot be changed immediately.

BIBLIOGRAPHY

Books

- Aichhorn, August, Wayward Youth, New York: The Noonday Press, 1955.
- Allen, Frederick, Psychotherapy With Children, New York: W. W. Norton and Co., 1942.
- Allport, Gordon, Becoming, New Haven: Yale University Press, 1955.
- Alpert, Augusta and S. Krown, "Treatment of a Child with Severe Ego Restriction in a Therapeutic Nursery", The Psychoanalytic Study of the Child, Vol. 8, pp. 333 - 354, New York: International Universities Press, Inc., 1953.
- Alpert, Augusta, "Observations on the Treatment of Emotionally Disturbed Children in a Therapeutic Center", Psychoanalytic Study of the Child, Vol. 9, pp. 334 - 343, New York: International Universities Press, Inc., 1954.
- Baruch, Dorothy, One Little Boy, New York: Julian Press, 1952.
- Bergler, Edmund, The Battle of the Conscience, Washington, D. C.: Washington Institute of Medicine, 1948.
- Bettelheim, Bruno, Love Is Not Enough, Glencoe, Illinois: The Free Press, 1950.
- Blake, Florence, The Child, His Parents and the Nurse, Philadelphia: J. B. Lippincott, 1954.
- Blos, Peter, The Adolescent Personality, New York: Appleton - Century Co., 1941.
- Bonaparte, Marie, A. Freud and E. Kris, Sigmund Freud's Letters to Wilhelm Fliess, New York: Basic Books, Inc., 1954.

- Bowlby, John, J. Robertson and D. Rosenbluth, "A Two-Year Old Goes to the Hospital", The Psychoanalytic Study of the Child, Vol. 7, pp. 82 - 94, New York: International Universities Press, Inc., 1952.
- Cameron, D. Ewen, General Psychotherapy, New York: Greene & Stratton, 1950.
- Deutsch, Albert, Our Rejected Children, Boston: Little Brown and Co., 1950.
- English, O. Spurgeon, and Gerald H. J. Pearson, Emotional Problems of Living, New York: W. W. Norton and Co., 1945.
- _____, Common Neuroses of Children and Adults, New York: W. W. Norton and Co., 1937.
- Freud, Anna, "Psychoanalysis and Education", The Psychoanalytic Study of the Child, Vol. 9, pp. 9 - 15, New York: International Universities Press, Inc., 1954.
- Greenberg, Harold, Child Psychiatry and the Community, New York; G. P. Putnam's Sons, 1952.
- Hartley, Ruth, L. Frank and R. Goldenson, Understanding Children's Play, New York: Columbia University Press, 1952.
- Horney, Karen, Self Analysis, New York: W. W. Norton and Co., 1942.
- Lawson, Lowery, and V. Sloane, Orthopsychiatry 1923-1948, Retrospect and Prospect, American Orthopsychiatric Association, 1948.
- Muller, Theresa, The Nature and Direction of Psychiatric Nursing, Philadelphia: J. B. Lippincott & Co., 1950.
- Olden, Christine, "On Adult Empathy with Children", The Psychoanalytic Study of the Child, Vol. 8, pp. III-126, New York: International Universities Press, Inc., 1953.
- Plant, James, The Envelope, New York: Commonwealth Fund, 1950.

Redl, Fritz, and David Wineman, Children Who Hate, Glencoe, Illinois: Free Press, 1952.

_____, Controls From Within, Glencoe, Illinois: Free Press, 1952.

Reik, Theodor, Listening With The Third Ear, New York: Farrar, Straus and Company, 1954.

_____, The Secret Self, New York: Farrar, Straus and Young, 1952.

Silverberg, Wm., Childhood Experience and Personal Destiny, New York: Springer Publishing Co., 1952.

Stanton, Alfred, and M. Schwartz, The Mental Hospital, New York: Basic Books, Inc., 1954.

Strecker, Edward, Their Mothers' Sons, Philadelphia, J. B. Lippincott & Co., 1946.

Wickes, Frances, The Inner World of Childhood, New York: D. Appleton - Century Co., 1927.

Magazines

Ackerly, Spafford, "The Clinic Team", American Journal of Orthopsychiatry, Vol. 17 (April, 1947), pp. 191-195.

Benjamin, Annie, and H. Weatherly, "Hospital Ward Treatment of Emotionally Disturbed Children", American Journal of Orthopsychiatry, Vol. 17 (October, 1947), pp. 665-674.

Bernard, Viola, A. Burton and J. Wallenstein, "Doris - An Experimental Study and Treatment Home for Adolescent Girls", American Journal of Orthopsychiatry, Vol. 19 (October, 1949), pp. 683-696.

Bettelheim, Bruno, and E. Sylvester, "Therapeutic Influence of the Group on the Individual", American Journal of Orthopsychiatry, Vol. 17 (October, 1947), pp. 684-692.

_____, "A Therapeutic Milieu", American Journal of Orthopsychiatry, Vol 18 (April, 1948), pp. 191-206.

_____, "Mental Health and Current Mores", American Journal of Orthopsychiatry, Vol. 22 (Jan., 1952), pp. 76-85.

- Betz, Barbara, "A Psychiatric Children's Ward", American Journal of Nursing, Vol. 45 (October, 1945), pp.817-821.
- Bornstein, Berta, "Emotional Barriers in the Understanding and Treatment of Young Children", American Journal of Orthopsychiatry, Vol. 18 (October, 1948), pp. 691-697.
- Bradley, Charles, "Indications for Residential Treatment of Children with Severe Neuropsychiatric Problems", American Journal of Orthopsychiatry, Vol. 19 (July, 1947), pp. 427-431.
- Bruch, Hilde, "Parent Education or the Illusion of Omnipotence", American Journal of Orthopsychiatry, Vol. 24 (October, 1954), pp. 723-731.
- Devereux, George, "The Social Structure of the Hospital as a Factor in Total Therapy", American Journal of Orthopsychiatry, Vol. 19 (July, 1949), pp. 492-499.
- Ridenour, Nina, "The Relation Between Clinical Experiences and Attitudes Toward Psychoanalysis", American Journal of Orthopsychiatry, Vol. 13 (January, 1943), pp. 33-40.
- Robinson, J. Franklin, A. Maxwell and K. Dominguez, "Resident Psychiatric Treatment of Children", American Journal of Orthopsychiatry, Vol. 17 (July, 1947), pp. 484-487.
- Ross, Helen, and E. Schour, "An Experiment in Interdisciplinary Education in Child Care", American Journal of Orthopsychiatry, Vol. 24 (July, 1954), pp.546-553.
- Sutton, Helen, "Some Nursing Aspects of a Children's Psychiatric Ward", American Journal of Orthopsychiatry, Vol. 17 (October, 1947), pp. 675-683.
- Szurek, S. A., "Dynamics of Staff Interaction in Hospital Psychiatric Treatment of Children", American Journal of Orthopsychiatry, Vol. 17 (October, 1947), pp.652-664.
- _____, "Problems of Staff Interaction with Spontaneous Group Formations on a Children's Psychiatric Ward", American Journal of Orthopsychiatry, Vol. 19 (October, 1949), pp. 599-611.

- Campbell, Wm., Form and Style in Thesis Writing, Boston: Houghton Mifflin Co., 1954.
- Freedman, Paul, The Principles of Scientific Research, Washington, D. C.: Public Affairs Press, 1950.
- Good, Carter, A. S. Barr and D. E. Scates, The Methodology of Educational Research, New York: Appleton - Century - Crafts, Inc., 1941.
- Manual of Style, Chicago: University of Chicago Press, 1952.
- Newsom, N. William, and G. E. Walk, Form and Standards for Thesis Writing, Scranton: International Textbook Co., 1953.
- Young, Pauline, Scientific Social Surveys and Research, New York: Prentice Hall, Inc., 1949.

A P P E N D I X

REVISED OPINIONAIRE
WITH
RESPONSES SELECTED BY THE THREE GROUPS

This is not a test for grades, ratings, or evaluations of any kind. It is merely an attempt to find how we feel about some of the situations we meet when we work with disturbed children.

Read the statement (s) first and then put a plus (+) sign in the parenthesis to the left of the answer(s) which you would be most comfortable in using. If none of the suggested solutions seems acceptable to you, write in your own choice under "e".

1. When we discuss a therapeutic setting for disturbed children I mean:
 - a. () A setting in which the child can do anything he wishes to do.
 - b. (2) A setting in which he can do anything that will not physically hurt himself or anyone else.
 - c. (1) A setting in which he is allowed to do anything within reason.
 - 82.3% d. (14) A setting which allows him to meet his needs both for freedom of expression and of limitations.
 - e. ()

2. We need to remember that being hospitalized does not mean the same thing to a child that it does to an adult. To the child this experience may mean:
 - a. (2) A new, strange, but pleasantly exciting experience.
 - b. (5) A separation from his parents and his home.
 - 82.3% c. (14) A punishment for his badness.

4. Cont'd. d. (2) A chance to get well.
e. (3)
3. We must realize that disturbed children:
a. (2) Are aware of what they are doing and through discipline must be taught to control themselves.
b. (2) Are not aware of what they are doing, but must be disciplined so that they won't make the same mistakes.
82.3% c. (14) Are there for their protection and guidance and we need to protect and encourage them.
d. () Are just children who have never been taught to mind or to respect the rights of others.
e. (4)
4. Should all of the children in the group be treated alike?
a. () Yes, otherwise it leads to jealousy and anger on the part of the other children.
b. () They should be treated alike to keep the adults from showing favoritism or being inconsistent.
c. (2) They should not be treated alike because they have to learn how to live in our society which doesn't treat people alike.
94.1% d. (16) They should not be treated alike because their needs are not all the same.
e. ()
5. The hours for going to bed, getting up in the morning, and for mealtimes:
52.9% a. (9) Should always be on a regular schedule because it provides security for these children.
b. (1) Should be changed frequently because this will provide variety in an otherwise monotonous schedule.
52.9% c. (9) Should be changed for special occasions and planned in advance with the children.
d. (2) Need not be on a regular schedule just as long as they are all included in the day's activities.
e. ()

6. If a child refuses to get up and get dressed in the morning I would:
- a. (4) Tell him it doesn't matter to us if he gets dressed or not, but that he can't eat or join in any activities until he does.
 - 82.3% b. (14) Give him plenty of time to get awake and offer to help him dress.
 - c. (1) Get him up immediately and dress him by force if it is necessary.
 - d. (1) Call him once, and if he doesn't get up, leave and let him go without food until he wants to get up.
 - e. ()
7. If a child is aggressive and striking or biting others I would:
- a. (1) Strike or bite him back so that he would learn that his behavior is painful to others.
 - 82.3% b. (3) Take him away from the group as punishment.
 - c. (14) Restrain him by picking him up or by holding him and reassure him that you won't let him hurt anyone.
 - d. (1) Spank him and tell him he will receive the same treatment if he tries this behavior again.
 - e. (1)
8. If a child is afraid to go to sleep at night, I would:
- a. (1) Tell him that there is nothing to be afraid of in the dark, turn out the lights and leave.
 - 88.2% b. (15) Try to find out why he is afraid, and reassure him that he will not be left alone.
 - c. (5) Tell him that he doesn't need to be afraid; that you will leave a light on.
 - d. () Appeal to his pride by pointing out that he is a big boy now, and only babies are afraid at night.
 - e. (1)
9. If a child refuses to eat but plays and smears his food all around, I would:
- a. (1) Punish him by taking his food away from him.

9. Cont'd. b. (12) Give him something to play with like
71.2% clay or finger-paint and point out the difference between food and objects that we play with.
- c. (1) Let the child alone but show that you are displeased with his behavior.
- d. (4) Place him in his chair, help him feed himself, or if it is necessary, spoonfeed him.
- e. (4)
10. If a child beyond the age of four consistently soils or wets himself and never goes to the toilet, I would:
- 88.2% a. (15) Try to find out from the child why he refuses to use the toilet.
- b. (1) Punish him so that he knows that we don't approve of his behavior.
- c. (1) Offer him rewards as an incentive to get him to use the toilet.
- d. (1) Humiliate and shame him before the rest of the group so that group pressure will cause him to conform.
- e. (3)
11. If the children are destructive and succeed in breaking a window, furniture, or toys, I would:
- 71.2% a. (12) Have the damage repaired immediately.
- b. (1) Insist that the group tell you who was responsible and punish the children who were responsible.
- c. (1) Punish the whole group by withdrawing some privilege from them.
- d. (5) Be tardy about having the repair made so that the children will be deprived of its use while it is being repaired.
- e. (1)
12. If a child persists in using vulgar or obscene language, I would:
- a. (1) Appeal to his better nature by telling him that good children don't use such language.
- b. (1) Use the time honored remedy of washing his mouth out with soap.
- 94.1% c. (16) Ignore his choice of words but continue to speak quietly and calmly.
- d. (1) Tell him that he can't shock you, that you know more vulgar words than he does.
- e. (1)

13. One cause of mental or emotional illness in children that is most generally accepted is:
- a. (1) Something that happened to the child before or during birth.
 - 100% b. (2) It is caused by poor heredity.
 - c. (17) It is caused by the interactions between the child and his environment.
 - d. (1) It is caused because the child is unwilling to learn to conform to reality.
 - e. ()
14. These disturbed children should:
- a. (1) Not be allowed visitors because their behavior is usually unpredictable.
 - b. (1) Not be allowed visitors because it is very upsetting to the child when the visitors leave.
 - c. (1) Be allowed visitors on Sundays and holidays.
 - 82.3% d. (14) Be allowed to see their parents any time.
 - e. (3)
15. We should expect disturbed children to:
- a. (2) Want to do what we feel is the right thing.
 - b. (1) Accept willingly and eagerly a therapeutic environment, including the adults in it.
 - c. (1) Form a quick and lasting relationship to the understanding adults who care for him.
 - 88.2% d. (15) Repeatedly test out his environment and the adults in it.
 - e. (1)
16. If you have to give a child an oral medication and he refuses it:
- a. (2) Try to reason with him, or bribe him to take it.
 - 82.3% b. (14) Find out why he doesn't want to take it.
 - c. () Tell him that he must take it because the doctor has ordered it, and if he won't take it, get someone to help you give it by force.
 - d. (2) Tell him that if he doesn't take it he is hurting himself, not you, and record it on the record that he refused his medicine.
 - e. (3)

17. If you have to give a child an injection of medicine and he won't willingly let you, I would:
- a. (2) Have plenty of help to restrain him and give him the injection.
 - 52.9% b. (9) Tell him you are sorry, but he must have it and allow him to choose if he will cooperate or be restrained to take it.
 - c. () Make no comment on his behavior but record it on his chart without trying further to give the medication.
 - 29.4% d. (5) Try to find out why he doesn't want to take it.
 - e. (4)
18. If a child attempts to assault you sexually in any manner I would:
- 82.3% a. (14) Tell him that you don't like his behavior and won't allow him to act like that.
 - b. (1) Tell him that he is bad and that he must learn to behave better before he can go home.
 - c. (1) Remove him from the group before they become infected by his bad habits.
 - d. (4) Say nothing to the child but report to the one in charge immediately.
 - e. ()
19. If a child is masturbating I would:
- a. (1) Help him to stop such activity by holding his hands or restraining him.
 - b. (1) Tell him that if he continues we will have the offending parts cut off.
 - 100% c. (17) Make no comment on his activity but try to divert his attention to some other activity.
 - d. (1) Inform him that good children don't do such things and that if he continues, no one will like him.
 - e. (2)
20. In this treatment setting for disturbed children, when I see a child trying to destroy a toy I would:
- a. (1) Watch him do it and say or do nothing.
 - 64.7% b. (11) Allow him to destroy an inexpensive toy if it is felt that he has a need to do so, but not allow this as a general rule.
 - c. (3) Take the toy away from him and tell him we are doing this because he hasn't learned how to use it.

20. Cont'd. d. (1) Allow him to destroy it and then to learn a lesson from it by not being given anything else to play with.
e. (2)
21. If I tell a child "No," he can't do something that he wishes to do I would:
29.4% a. (5) Never reverse my decision once it has been given.
b. (1) Reverse it if he cries long enough and makes a real serious fuss about it.
c. (1) Always allow him to do as he wishes if it isn't too important an issue.
82.3% d. (14) If it seems very important to the child and it is permissible, reverse your decision and allow him to do it without making an issue of it.
22. If a child is crying very hard I would:
47.1% a. (8) Comfort and reassure him immediately.
52.9% b. (9) Try to find out why he is crying.
c. (3) Offer him something to play with that he usually likes very much.
d. (3) Tell him that he doesn't need to cry, that you will help him and remain with him for awhile.
e. ()
23. If a child tells the adult with him, "I don't like you":
a. () You should ignore him and his comments.
b. (4) You could reply, "Well, we can't like everyone, can we?"
c. (2) Since children are usually truthful try to arrange for someone else to take care of him and stay out of his way as much as possible.
77.1% d. (13) Reassure him that it is all right for him to feel like that.
e. (2)
24. Any adult working with disturbed children is apt to become emotionally upset at times because:
71.2% a. (1) The worker is not emotionally mature.
b. (12) Some situations are particularly stressful because they recall the difficulties experienced in our own childhood.

24. Cont'd. c. (3) Childhood should be a happy carefree time and these children are obviously not happy and carefree.
- 29.4% d. (5) We are frequently not able to understand what these children are asking us for.
- e. (1)
25. These disturbed children frequently spend too much time lying on the floor, sitting, or just doing nothing because:
- 71.2% a. (12) We do not offer the child adequate help and encouragement to find something that he can do.
- b. (1) There isn't anything that they are capable of doing well.
- c. (1) We should not be expected to provide activities for these disturbed children.
- d. (3) It is too expensive to keep replacing the materials that they destroy so there is frequently nothing available for them to use.
- e. (4)
26. The adults responsible for the care of disturbed children should:
- a. (2) Always be ready to join in their games and activities "just like another child would".
- 71.2% b. (12) Be ready to join in an activity when her encouragement and guidance is indicated.
- c. (1) Should never join in the play activities or games with the children.
- d. (4) Should do as the children wish and join in their activities when invited to do so.
- e. (2)
27. Disturbed children are much harder to care for than are more normal children. The adults working with these children should:
- a. (1) See that they are clean, dressed and fed, but cannot be expected to help them enjoy their leisure time.
- 82.3% b. (14) Help the children enjoy their time by reading to them, singing with them, or encouraging them to play simple group games.
- c. (1) Realize that these children don't want to do anything and should leave them alone except when they need care.

27. Cont'd. d. (1) Realize that quiet children are happy ones and not interfere with the children unless they get too active or too loud.
e. (2)
28. If a child refuses to join in an activity such as finger painting, coloring or clay play when it is offered to him, but later after the materials are put away he wishes to do so, I would:
a. (3) Tell him that he has had his chance and now he will have to wait until the group wishes this activity again.
b. (3) Prepare the materials for him, but warn him that next time he will have to do this when the group does or go without.
71.2% c. (12) Fix the materials for him and allow him to enjoy using them without comment.
d. (1) Ignore his request and try to divert his attention to something that would be less bother.
e. (1)
29. If one child habitually gives up his toys to the other children whenever they wish to take them from him I would:
a. (1) Tell him what a nice boy he is to always be so willing to share his things with others.
b. (1) Help him pick out something else to play with.
67.7% c. (11) Help him learn to defend his own rights by encouraging him to keep his things if he isn't through using them.
29.4% d. (5) Offer the other child a toy he can use so that he doesn't need to take someone else's.
e. (1)
30. If two children both desire the same toy and are arguing, or both pulling at the same toy I would:
82.3% a. (14) Observe the scene without interfering to see if they could settle the difference for themselves.
b. (1) Immediately step in and settle the argument before they start to fight.
c. () Take the toy away and put it up until they can learn to share it peaceably.

30. Cont'd. d. (3) Allow the children to settle the conflict so that you are not drawn into taking sides for or against a child.
e. (2)
31. Disturbed children need help in controlling themselves. This involves the setting up of limits for them. We need to remember that:
82.3% a. (2) Children resent any limits placed on their behavior.
b. (14) They frequently are asking the adult to set limits on their behavior.
c. (2) They will dislike the person who sets the limits that they must meet.
d. (1) The more limits the child must conform to the more secure he will feel.
e. (2)
32. Occasionally the behavior of the disturbed child is very provoking to the adult. I would:
77.1% a. (3) Never let the child know this because he would continue his behavior all the more to annoy you.
b. (13) Let the child know that his behavior is annoying but that I didn't dislike him.
c. (1) Stop the child's behavior immediately and by force if necessary.
d. (3) Remove the child from the group and allow him to return when he could be good.
e. (2)
33. The parents of these disturbed children:
88.2% a. (1) Need much sympathy for the misfortune that they have experienced in having an abnormal child.
b. (1) Need to be constantly reassured that their child will recover.
c. (1) Need to be reassured that they could not have been the cause of their child's illness.
d. (15) Need to be seen regularly by some member of the clinic or hospital team.
e. (2)
34. Seclusion of a disturbed child in a room especially designed for this use should be done only:
64.7% a. (11) When it is necessary to remove him from the group for his own protection.
29.4% b. (5) To remove a child from the group when he becomes overly aggressive.

34. Cont'd. c. (2) When a child willfully disobeys a reasonable request that he could conform to.
d. (1) To confine him until he will agree to conform to hospital rules and regulations.
e. (2)
35. The part of the care of the disturbed child that I dislike most is
a. () Getting them up in the morning.
b. (1) Mealtime.
c. (1) Keeping them occupied during the day.
d. (1) When they are fighting and quarreling.
e. () Bath time.
f. (2) Bedtime.
g. (2)
36. Please rank the following behavior in order as it is most disturbing to you, by placing (1) in the space before the behavior that bothers you most; (2) in front of the next most disturbing behavior, and so on.
A. () Thumb sucking.
b. () Head banging.
c. () Masturbation.
d. () Swearing or vulgar language.
e. () Soiling or wetting.
f. () Smearing.
g. () Attacking others.
h. () Sex play.
i. ()
37. There is a great deal of confusion about the meaning of the therapeutic environment that is a very important factor in the treatment of disturbed children. Since you are working in this environment with these children, what does this environment mean to you? Please indicate what you feel this to include either by listing, or in a short paragraph below.

ORIGINAL OPINIONAIRE

This is not a test for grades, ratings, or evaluations of any kind. It is merely an attempt to find out what people working with disturbed children have learned to do in handling the problems that they have to meet.

Read the statement(s) first and then put a plus (+) sign in the parenthesis to the left of the one which best answers the problem. If you decide to change an answer, do so either by erasing or crossing out your original choice.

1. When we discuss a permissive setting for mentally or emotionally disturbed children we mean:
 - a. () A setting in which the child can do anything he wishes to do.
 - b. () A setting in which he can do anything that will not physically hurt himself or anyone else.
 - c. () A setting in which he is allowed to do anything within reason.
 - d. () A setting which allows him to meet his needs both for freedom of expression and of limitations.

2. We need to remember that being hospitalized does not mean the same thing to a child that it does to an adult. To the child this experience may mean:
 - a. () A new, strange, but pleasantly exciting experience.
 - b. () A chance to get away from his parents and his home.
 - c. () A punishment for his badness.
 - d. () A chance to get well.

3. We must realize that disturbed children:
- a. () Are aware of what they are doing and through discipline must be taught to control themselves.
 - b. () Are not aware of what they are doing, but must be disciplined so that they won't keep making the same mistakes.
 - c. () Are there for their protection and guidance and we need to protect and encourage them.
 - d. () Are just ornery children who have never been taught to mind or to respect the rights of others.
4. Should all of the children in the group be treated alike?
- a. () Yes, otherwise it leads to jealousy and anger on the part of the other children.
 - b. () They should be treated alike to keep the adults from showing favoritism or being inconsistent.
 - c. () They should not be treated alike because they have to learn how to live in our society and it doesn't treat people alike.
 - d. () They should not be treated alike because their needs are not all the same.
5. The hours for going to bed, getting up in the morning, and for mealtimes:
- a. () Should always be on a regular schedule because it provides security for these children.
 - b. () Should be changed frequently because this will provide variety in an otherwise monotonous schedule.
 - c. () Should be changed for special occasions and planned in advance with the children.
 - d. () Need not be on a regular schedule just as long as all activities that should be done are included in the day's activities.
6. If a child refuses to get up and get dressed in the morning we would:
- a. () Tell him it doesn't matter to us if he gets dressed or not, but that he can't eat or join in any activities until he does.
 - b. () Give him plenty of time to get awake and offer to help him dress.

- c. () Get him up immediately and dress him by force if it is necessary.
 - d. () Call him once, and if he doesn't get up, leave and let him go without food until he wants to get up.
7. If a child is aggressive and striking or biting others we would:
- a. () Strike or bite him back so that he would learn that his behavior is painful to others.
 - b. () Take him away from the group as punishment.
 - c. () Restrain him by picking him up or holding him and reassure him that you won't let him hurt anyone.
 - d. () Spank him and tell him he will receive the same treatment if he tries this behavior again.
8. If a child is afraid to go to sleep at night we should:
- a. () Tell him that there is nothing to be afraid of in the dark, turn out the lights and leave.
 - b. () Try to find out why he is afraid, and reassure him that he will not be left alone.
 - c. () Tell him that he doesn't need to be afraid; that you will leave a light on.
 - d. () Appeal to his pride by pointing out that he is big now and only babies are afraid at night.
9. If a child refuses to eat but plays and smears his food all around, we should:
- a. () Punish him by taking his food away from him.
 - b. () Give him something to play with like clay or finger paint and point out the difference between food and objects that we play with.
 - c. () Let the child alone but show that you are displeased with his behavior.
 - d. () Place him in his chair, help him feed himself if it is necessary, or spoon feed him.
10. If a child beyond the age of four consistently soils or wets himself and never goes to the toilet we would:
- a. () Try to find out from the child why he refuses to use the toilet.

- b. () Punish him so that he knows that we don't approve of his behavior.
 - c. () Offer him rewards as an incentive to get him to use the toilet.
 - d. () Humiliate and shame him before the rest of the group so that group pressure will cause him to conform.
11. If the children are destructive and succeed in breaking a window, furniture, or toys, you would:
- a. () Have the damage repaired immediately.
 - b. () Insist that they tell you who was responsible, if you don't know, and punish the children responsible.
 - c. () Punish the whole group by withdrawing some privilege from them.
 - d. () Be tardy about having the repair made so that the children will be deprived of its use while it is being repaired.
12. If a child persists in using vulgar or obscene language you would:
- a. () Appeal to his better nature by telling him that good children don't use such language.
 - b. () Use the time honored remedy of washing his mouth out with soap.
 - c. () Ignore his choice of words and continue to speak quietly and calmly.
 - d. () Tell him that he can't shock you, that you know more vulgar words than he does.
13. One cause of mental or emotional illness in children that is most generally accepted is:
- a. () Something that happened to the child before or during birth.
 - b. () It is caused by poor heredity.
 - c. () It is caused by the interactions between the child and his environment.
 - d. () It is caused because the child is unwilling to learn to conform to reality.
14. These disturbed children should:
- a. () Not be allowed visitors because their behavior is usually unpredictable.

- b. () Not be allowed visitors because it is very upsetting to the child when the visitors leave.
 - c. () Be allowed visitors on Sundays and holidays.
 - d. () Be allowed to see their parents at any time.
15. We should expect disturbed children:
- a. () To want to do what we feel is the right thing.
 - b. () To accept willingly and eagerly a therapeutic environment, including the adults in it.
 - c. () To form a quick and lasting relationship to the understanding adults who care for him.
 - d. () To repeatedly test out his environment and the adults in it.
16. If you have to give a child an oral medication and he refuses it:
- a. () Try to reason with him, or bribe him to take it.
 - b. () Find out why he doesn't want to take it.
 - c. () Tell him that he must take it because the doctor has ordered it and if he won't take it, get someone to help you give it by force.
 - d. () Tell him that if he doesn't take it he is hurting himself, not you, and record it on the record that he refused his medication.
17. If you have to give a child an injection of medicine and he won't willingly let you:
- a. () Have plenty of help to restrain him and give him the injection.
 - b. () Tell him you are sorry, he must have it and allow him to choose if he will cooperate or be restrained to take it.
 - c. () Make no comment on his behavior but record it on his chart without trying further to give the medication.
 - d. () Try to find out why he does not want to take it.
18. If a child attempts to assault you sexually in any manner we would:
- a. () Tell him that you don't like his behavior and won't allow him to act like that.
 - b. () Tell him that he is bad and that he must learn to behave better before he can go home.

- c. () Remove him from the group before they become infected by his bad habits.
 - d. () Say nothing to the child but report it to the one in charge, or to the doctor immediately.
19. If a child is masturbating we should:
- a. () Help him to stop such activity by holding his hands or restraining him.
 - b. () Tell him that if he continues we will have the offending parts cut off.
 - c. () Make no comment on his activity but try to divert his attention to some other activity.
 - d. () Inform him that good children do not do such things and that if he continues, no one will like him.
20. In this treatment setting for disturbed children, when I see a child trying to destroy a toy I would:
- a. () Watch him do it and say or do nothing.
 - b. () Allow him to destroy an inexpensive toy if it is felt that he has a need to do so, but not allow this as a general rule.
 - c. () Take the toy away from him and tell him we are doing this because he has not learned how to use it.
 - d. () Allow him to destroy it and then to learn a lesson from it by not being allowed anything else to play with.
21. If you tell a child "No", he can't do something that he wishes to do you should:
- a. () Never reverse your decision once it has been given.
 - b. () Reverse it if he cries long enough and makes a real serious fuss about it.
 - c. () Always allow him to do what he wishes to do if it is not too important an issue.
 - d. () If it seems very important to the child and it is permissible, reverse your decision and allow him to do it without making an issue about it.
22. If a child is crying very hard you should:
- a. () Comfort and reassure him immediately.

- b. () Try to find out why he is crying.
 - c. () Offer him something to play with that he usually likes very much.
 - d. () Tell him that he does not need to cry, that you will help him and remain with him for awhile.
23. If a child tells the adult with him, "I don't like you":
- a. () You should ignore him and his comments.
 - b. () You could reply, "Well, I don't like you either."
 - c. () Since children are usually truthful try to arrange for someone else to take care of him and stay out of his way as much as possible.
 - d. () Reassure him that it is all right for him to feel like that and that it doesn't bother you.
24. Any adult working with disturbed children is apt to become emotionally upset at times because:
- a. () The worker is not emotionally mature.
 - b. () Some situations are particularly stressful because they recall the difficulties experienced in our childhood.
 - c. () Childhood should be a happy, carefree time and these children are obviously not happy and carefree.
 - d. () We are not always able to understand what these children are asking for.
25. These disturbed children frequently spend too much time lying on the floor, sitting, or just doing nothing because:
- a. () We do not offer the child sufficient help and encouragement to find something that he can do.
 - b. () There isn't anything that they are capable of doing well.
 - c. () We should not be expected to provide activities for these disturbed children.
 - d. () It is too expensive to keep replacing the materials that they destroy so there is frequently nothing available for them to use.

26. The adults responsible for the care of disturbed children should:
- a. () Always be ready to join in their games and activities "just like another child would".
 - b. () Be ready to join in an activity when her encouragement or guidance is indicated.
 - c. () Should never join in the play activities or games with the children.
 - d. () Should do as the children wish and join in their activities when invited to do so.
27. Disturbed children are much harder to care for than are more normal children. The adults working with these children should:
- a. () See that they are clean, dressed and fed, but cannot be expected to help them enjoy their leisure time.
 - b. () Help the children enjoy their time by reading to them, singing with them, or encouraging the playing of simple group games.
 - c. () Realize that these children do not want to do anything and should leave them alone except when they need care.
 - d. () Realize that a quiet child is a happy one and not interfere with the children unless they get too active or too loud.
28. If a child refuses to join in an activity such as finger painting, coloring or clay play when it is offered to him, but wishes to do so later after the materials are put away, I would:
- a. () Tell him that he has had his chance and now he will have to wait until the group wishes this activity again.
 - b. () Prepare the materials for him, but warn him that next time he will have to do this when the group does or go without.
 - c. () Fix the materials for him and allow him to enjoy using them without comment.
 - d. () Ignore his request and try to divert his attention toward doing something else that would be less bother.

29. If one child habitually gives up his toys to the other children whenever they wish to take them from him the adult would:
- a. () Tell him what a nice boy he is to always be so willing to share his things with others.
 - b. () Help him pick out something else to play with.
 - c. () Help him to learn to defend his own rights by encouraging him to keep his things if he isn't through with them, offering him physical support if necessary.
 - d. () Offer the other child a toy he can use so that he doesn't need to take someone else's.
30. If two children both desire the same toy and are arguing or both pulling at the toy, the adult would:
- a. () Observe the scene without interference to see if they can settle it for themselves.
 - b. () Immediately step in and settle the argument before they start to fight.
 - c. () Take the toy away and put it up until they can learn to share it peaceably.
 - d. () Allow the children to settle the conflict so that you are not drawn into taking sides for or against a child.
31. Disturbed children need help in controlling themselves. This involves the setting up of limits for them. We need to remember that:
- a. () Children resent any limits placed on their behavior.
 - b. () They frequently are asking the adult to set limits on their behavior.
 - c. () They will dislike the person who sets the limits that they must meet.
 - d. () The more limits the child must conform to the more secure he will feel.
32. Occasionally the behavior of the disturbed child is very provoking to the adult. The adult, however, should:
- a. () Never let the child know this because he would continue his behavior all the more to annoy her.
 - b. () Should let the child know that his behavior is annoying but that she doesn't dislike the child.

- c. () Stop the child's behavior immediately and by force if necessary.
 - d. () Remove the child from the group and allow him to return when he can be good.
33. The parents of these emotionally disturbed children:
- a. () Need much sympathy for the misfortune that they have experienced in having an abnormal child.
 - b. () Need to be constantly reassured that their child will recover.
 - c. () Need to be reassured that they could not have been the cause of their child's illness.
 - d. () Need to be seen regularly by the psychiatrist or someone else appointed to this task, by the person responsible for the child's care.
34. Seclusion of a disturbed child in a room especially designed for this use should be done only:
- a. () When it is necessary to remove him from the group for his own protection.
 - b. () To remove a child from the group when he becomes overly aggressive.
 - c. () When the child willfully disobeys a reasonable request that he could conform to.
 - d. () To confine him until he will agree to conform to hospital rules and regulations.
35. The most difficult part of the care of the disturbed child is:
- a. () Getting them up in the morning.
 - b. () Mealtimes.
 - c. () Keeping them occupied during the day.
 - d. () When they are fighting and quarreling.
 - e. () Bath time.
 - f. () Bedtime.
 - g. () Other _____.

36. Please rank the following behavior in order as it is most annoying to you, by placing (1) in the space before the behavior that bothers you most; (2) in front of the next most annoying behavior, and so on.
- a. () Thumb sucking.
 - b. () Head banging.
 - c. () Masturbation.
 - d. () Swearing or the use of vulgar language.
 - e. () Soiling or wetting.
 - f. () Smearing.
 - g. () Attacking others.
37. There is a great deal of confusion about the meaning of the permissive therapeutic environment that is a very important factor in the treatment of disturbed children. Since you are working in this environment, with these children, we would like to know what this environment means to you. Please indicate what you feel this to include, either by listing or in a short paragraph below.

WRITTEN RESPONSES TO QUESTION THIRTY-SEVEN

Group One.

Student #1

1. One in which the staff has as much respect for the personality differences of each other as they do for those of the children.
2. One in which a methodology is utilized to aid the staff in better understanding each other.
3. One in which the child's having to face his own destruction is minimized.
4. One in which the feelings of the parents are respected as much as those of the child.

Student #2

A permissive environment is one in which I feel the most comfortable. If I feel comfortable I can allow both child and myself to be spontaneous and only then do I feel I am communicating with the child. To me this is a very general term which needs defining every time you interact with the child.

A permissive environment is a dynamic one. It is never the same. What is permissive today may be authoritative tomorrow.

Student #3

This means allowing the child to act out his feelings without feeling they are bad. The adult must be able to understand her own feelings about this and be allowed to express them.

Student #4

The therapeutic environment is a situation in which the child is restricted only when he is going to physically injure himself, or others, and in which he is guided to meet a progressively more realistic situation as he adjusts first to a minimum of frustration and then to a more complex society.

Student #5

A therapeutic environment would be one in which a child's needs can be carried out as they are understood by the staff, with limits set in relation to hurting himself or others.

Student #6

1. Meeting the child's needs.
2. Progressing then to reasonable limits with which he can function in society without making an automaton out of him.
3. Knowing your own feelings and how you can best create a therapeutic environment through yourself.

Group Two.

Student #1

If a child has grown up without training or routines of any kind, I believe he should receive this as part of the therapeutic procedure.

On the other hand if a child has been surrounded by "Don'ts" and "Do's" and rules and regulations, I believe he should be allowed to wander and investigate as freely as the setting will permit, for a period at least.

If a child has never been able to express aggression, I would try to avoid situations in which his first attempts to express something of the kind had to be met with prohibition. A child who is constantly expressing aggression is probably anxious and should be reassured on a deeper level while he is limited in his behavior.

All kinds of behavior must be acceptable and accepted in the early stages of treatment, which, during later stages, must gradually be limited or eliminated.

In short the "permissive therapeutic environment" is used in different ways. The child's background must be understood if we are to provide a "therapeutic" situation.

Student #2

It should be a warm and non-punitive atmosphere which is tailored to the individual child and his needs. He should have an opportunity to make a relationship with a friendly adult, an opportunity to learn, to grow, and to regress if necessary. The environment should provide stability and security which would mean freedom within reasonable and flexible limits.

Student #3

A permissive therapeutic environment, as I know it for disturbed children of pre-school age, is an environment where they can play in a situation with understanding adults who do not treat them in the same way as their own parents have treated them at home; i.e., who do not place restrictions or allow complete license or punish them as their parents have done. Thus, for an overly aggressive child whose parents have been very inconsistent and have not given limits the child needs, this environment and the adults here place limits on the child's behavior which are much needed and reassuring to the child. For the child whose parents have been terribly controlling and inhibiting, the adults here permit the child more freedom to use materials, messily at times, to cry, etc. - insofar as the child is comfortable in expressing them.

Most important, the child is able to make a relationship with these adults who like the child at all times, despite his behavior, which they may frequently disapprove of.

I do not mean to suggest that one goes out of her way to do differently from what the parents have done; however, since the emotional disturbance is usually due to interaction between parent and child, the experience with an adult who responds less neurotically to some behavior of the child's, may help the child to express his anxiety, feel less naughty or bad, and like himself better.

Student #4

Permissive therapeutic environment means meeting the child's needs. His desires or impulses are not always indicative of his needs. Therefore, one needs to distinguish between what actions the child needs to perform and what ones he does not need to perform. This is being therapeutic. The child needs to be met and accepted on his own level (this may mean asocial behavior) and helped to grow, solve his problems, express his needs, and fulfill them in socially acceptable and healthy ways.

Thirdly, a permissive therapeutic setup means often

affording the child an opportunity to express his feelings overtly rather than verbally, that we may ascertain what it is that troubles him, what it is that he needs.

In short, permissiveness means freedom to express one's needs, and therapy means accepting this expression in order to help the child become well. The goal is good mental health, socially acceptable behavior, not license or freedom of expression per se. Therefore, permissiveness in therapy is two-fold, protecting the child from his own wishes, and allowing him to express his needs.

Student #5

Permissiveness does not mean laissez-faire. Realistic limits, or limits the child seems to be asking for, should be set. The therapeutic environment should be as permissive as possible because the problem of most of the children is a denial or repression of some original affect. It is only by encouraging the children to express and then recognize these feelings, that they can finally be helped to handle them realistically. Therefore, the therapeutic environment should not only be permissive, but encouraging and reassuring.

Student #6

This student did not answer the question.

Student #7

The permissive therapeutic environment to me would include a broad concept of environment, the attitude of the people in this environment, the degree of their security in working with the child. Interpretation of the child's needs and channeling activities to help meet these needs, giving support and confidence to the child rather than an authoritative atmosphere.

Limitations for the child's sake rather than for the convenience of the worker. The environment would be affected by goals, whether individual or group. Variety in materials and activity.

Group Three.

Student #1

1. A comfortable relaxed environment.
2. Limits set by those working with the children.
3. A flexible set of rules to meet individual needs.
4. Love and understanding.
5. Plenty of help to do all you would like to do to help these children.

Student #2

I believe the environment is sufficient and facilities adequate. The children, I have noticed, are quite destructive in general, seem to know what they are doing,

and have to be handled accordingly. Truthfully, I haven't been here long enough to judge.

Student #3

I think it is a pleasant environment although depressing at times. There are many things for the children to do. 1.hiking 2.baseball 3.checkers 4.cards 5.roller skating 6.books to read.

Student #4

I think a good therapeutic environment is where small groups work and play together. I liked the idea of bringing them from the big day hall to another room for play and games. Giving the big boys responsibility in the dining room helps them. I like the setup they have here.

Group Three - Responses After Their Week's Affiliation.

Student #2

Now that I've been here a week I still feel more or less the same as I have stated previously. I find the facilities here quite adequate and once some of the children realize they are not to destroy, I believe the situation will solve itself. This comes, I suppose, as the children progress from their sickness. Children are children and until they learn to appreciate, they will try to get away with things.

Student #3

To me it means that a child should be brought up in such an environment where he is less apt to be influenced to do wrong things by older boys. Keep him with his own age group and give him the right discipline when needed.

Student #4

- A. An environment where the children can be helped. Each child has his particular needs.
- B. Nurses working and playing with the children give them a good relationship - having newcomers or outside people interested in them helps; although sometimes it is hard for the new ones, especially if they do not understand the initial welcome, as we did in the beginning.

From a Second Student Group at the Gaebler Children's Unit of the Metropolitan State Hospital.

Student #1

The environment in which the patient is placed in order that he may receive the best treatment for him personally. Group therapy is an excellent therapeutic measure. However, I feel that there should be further separation of group as to age. I feel that more could be accomplished by this treatment. There could be a merging of both groups of ages at times, but I do not think they

should be together continuously.

Student #2

The therapeutic environment should be bright and cozy, with a feeling that the children are wanted. The personnel should be understanding toward the children and be able to cope with the different situations that happen on the wards.

Student #3

I do not fully understand the meaning of this question but will state that, concerning the therapeutic environment, I feel that it could be made a bit cozier, colorful and more like a home, or a friendly club house.

Student #4

Don't understand this question fully, but I know that the therapeutic environment could have more color and warmth to it. Most everybody likes color and warmth to any environment, whether it be in a mental institution or in an ordinary home or hospital.

Responses to Questions Asked at the Close of the Final Discussion Meeting Held with Group Three.

1. Do you feel that this week's experience was profitable to you? Why do you feel this way?

Student #2

Yes, I do. Now at least I can combine the actions of a well child and a sick child and interpret their feel-

ings a little more easily. I think I could handle a situation far better because I know, or have a rough idea what may be their problem. I believe I feel more comfortable.

Student #3

Yes, because it gave me a chance to see the different mentally ill children's actions and think of different ways in which one really wants to help them.

Student #4

Yes, I learned how to act in situations concerning children. You learn a lot about how or why adults act the way they do when you look at the behavior of the child.

2. If it were possible, would you like to spend more time in this service? Why?

Student #2

Yes, I would like to spend more time here even though a week gives you a very good sketch. I feel it takes about three days to get acquainted with the children and the routines, and in two days it isn't possible to let your true personality loose, or get to know the children that well.

Student #3

No, I wouldn't want to spend more time at this service,

because I don't feel as though I'm doing what I would really like to accomplish for these children.

Student #4

Yes, I enjoy working with children and was looking forward to coming here. I do admit it was somewhat different than I expected. This one week's experience has helped me iron out some of my ideas on how to handle rough and tumble kids. I'd like to come back to see if I could help them and those that are withdrawn.

3. Which group of children did you enjoy working with the most? Why?

Student #2

I enjoy the boys the best. To me they seem more cooperative, polite and willing to better themselves. I find their language not as vile as the girls', but this doesn't particularly bother me. They are more appreciative and seem to help themselves and others in the group more readily.

Student #3

I enjoyed working with the boys the most, because they seem to be easier to handle in that you can get them to do more things such as playing cards, making puzzles, and they usually enjoy conversing more than girls.

Student #4

Boys. There seemed to be a lot more activities that

they would participate in. I also felt more comfortable with them because I had spent more time with them the first two days.

4. Which group of children did you like working with the least? Why?

Student #2

We didn't work with the babies of the hospital so I really couldn't say. As I have stated above, I prefer the boys but I wouldn't mind working with the girls. I would treat them in no way different.

Student #3

I did not enjoy too much working with the girls because I found that they used vulgarity more than the boys and were very insulting. I thought they were much harder to become friendly with.

Student #4

The older girls - there didn't seem to be much we could do for them.

5. Did our group discussions add to this week's experience or were they unnecessary? How could we have made them more profitable for you?

Student #2

These group discussions were of great value in my estimation. They made me feel at ease in discussing my problems and it was funny to see that others had the

same problems. They made me feel more comfortable and a part of the working team.

Student #3

I found our group discussions very profitable because it gave us a chance to discuss our problems and see why we did right or wrong. It also gave us a chance to freely voice our opinions which isn't often done at our own home schools.

Student #4

These group discussions were a great help to me. You brought out possibilities of motives in the actions of the children that were new and revealing and very true. With these discussions in mind, I tried to analyze the behavior of the children, to try to find out what was behind it all.

REACTIONS OF ONE ADMINISTRATOR
WHO USED THE OPINIONAIRE

It was felt by some of the readers that there might be some interest in the use of this opinionaire by others working in the field of child psychiatry. The responses from the groups taking it does indicate that it stimulates discussion of personal feelings. Some have expressed the opinion that it may bring up repressed or unconscious feelings and because of this, it should not be used unless provisions for group discussions can be arranged.

The personality of the administrator of this opinionaire may need to be considered. One who has strong personal feelings about many of these situations herself, might find it more difficult to stimulate free group discussion. In order to prevent anyone from using this opinionaire without being aware of its possible consequences, it was suggested that the experience of one administrator of the opinionaire be included in this study.

The warning that field experience with disturbed children might activate unconscious material had been ignored. The admonition to come to the advisor or to ask for psychiatric guidance if this occurred was considered unnecessary. The participation in group discussions under the guidance of a trained psychiatrist was not considered to be a necessary

source of support for this field experience. The administrator feels that these conditions might have been considered as sort of a dare, and that she might have contributed to this situation to see if it could occur.

The first group to take the opinionnaire was the class, Nursing in Child Psychiatry. The administrator of the opinionnaire did not react as easily from this experience as the other members of the class did. Partly due to the unexpected reaction of this group, and probably partly due to the opinionnaire itself, she experienced a lengthy period of depression. The onset began at the time of giving the opinionnaire, but it became markedly more severe ten days later and lasted for a two week period. Everyone has experienced periods of depression, but never had the administrator been involved in such a severe or long lasting one. Before the depression became severe she wished to escape, to run away. When the more acute state developed she retreated to bed, facing the wall and avoiding as much contact with others as was possible in a dormitory setting with roommates. Attempts at condolence or invitations to join in social activities were irritably received and hostilely refused. She preferred to remain in bed longing for death and viewing the situation as completely hopeless. Suicide seemed the only logical solution during a three day period. Emotionally she knew that she could never emerge from this

state, but intellectually she clung to the fact that if you can wait just a little longer this episode will pass.

On the first day of this acute period, feeling that she could not contemplate suicide without freeing her advisor from responsibility, she called her to apologize for her rudeness and thinly veiled threat of suicide made on the previous day. At this time she did not consciously recognize the support that she received during this conversation. Although she clutched at the promise of help she felt that in reality, no one could be of any assistance. In retrospect the administrator felt that she was aware of a need for help and was unable to ask directly for it. This occurred during a weekend and holiday period so no regular appointment could be made. She was not consciously aware of the fact that her feelings about rejection had probably played an important role in this episode, but did know that if she directly asked for assistance and it was refused, it would be more than she could tolerate in her present condition. She continued to postpone overt action for an hour at a time, and five days later was no longer so concerned with self-destruction. She woodenly attended classes and rejoined her roommates for meals. All attempts to read or to study were abandoned. As far as she was concerned, these were two lost weeks and nothing constructive could come out of them. After two weeks this depression lightened and two days later she was able

to express the feeling that, "I've never been able to work well with depressed patients. I've always felt that they voluntarily descended into the depths and willingly remained there. The issues with which they were so concerned were so insignificant in reality that it was silly. This was a real learning experience and I'm sure that I will be able to understand and constructively help depressed patients from now on."

It was only later, after an apparently fruitless and non-productive interview with her advisor, that she was able to isolate more pertinent factors from this experience. She accepted the fact that her feelings of being rejected played a large part in stimulating this experience. These feelings about rejection were very strong and were connected with early childhood situations. She was aware of using over-conformity in earliest school and social life to prevent being rejected by the outside world since she felt that she had been at home. She was also aware that she did not try to conform at home but indulged in provocative behavior in the family constellation, thereby producing further instances of rejection. This strict conforming, to escape rejection from others, had inhibited personal spontaneity and had produced a rigid, automatic, and impersonal response to most situation.

Another factor isolated was the use of "controlled"

emotion. She had been surprised by the violence of her repeated aggressive attacks on one class member who frequently denied the existence of emotions and felt that intellectual reasoning and control was all that was needed in any interpersonal relationship. By using this personally objectional defense, she had successfully withdrawn from any meaningful relationships for many years and managed to enjoy surface ones without exposing herself to further trauma. Even though this method of reacting was unacceptable to the administrator, she did not voluntarily give it up. When faced with the reality that some relationships did have some meaning for her, she repudiated violently any such feelings. She was angry with herself for such betrayal of her security. She was angry with the others involved for the roles that they had played. Driven to the point of extremity where she was forced to accept these feelings as her own, she was unable to do so easily. She was extremely fearful and longed for the self-protection that she had lost.

She also became aware that she did not trust people. As long as she personally was not deeply involved, she enjoyed and trusted people, but as soon as she personally became concerned, trust was replaced by fear. This fear was engendered by a sense of impending trauma. Several weeks later she realized that she was trusting some individuals and actually enjoying this experience.

Another facet isolated had been previously noted. This involved a traumatic loss that had occurred several years ago. At this time she had renounced a previously strong feeling of trust and security in her belief in a benevolent diety. The awareness of this loss was intensified during these two weeks.

This method of gaining some self-insight is not an easy nor a pleasant one. Theodor Reik writes, "The most important and most valuable insights of psychoanalyses are found by self-analysis."¹ He later writes, "Nothing said to us, nothing we can learn from others, reaches so deep as that which we find in ourselves."² And again he writes, "Meeting oneself is rarely a pleasant experience even for the psychoanalyst."³ Without the continued support from the faculty advisor, this could have been a much more traumatic and unrewarding experience. Some of the outcomes have validated it as a learning situation. Some insights have emerged from this experience and the administrator is aware that more will probably occur in future re-evaluation of this incident.

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1. Reik, Theodor Listening with the Third Ear p.18
 2. Ibid p.19
 3. Ibid p.28

She feels much less controlled and more aware of her right to make decisions that are her own. She is aware of being more honest with herself, of being really aware of people, and actually enjoying them and perhaps understanding them. She feels that she is less rigid and automatic and more spontaneous and real. One roommate's comment seemed to express some of the administrator's feelings when she said, "Don't change again. I like you much better this way."