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Psychiatric home treatment center: Nurse satisfactions and dissatisfactions

PSYCHIATRIC HOME TREATMENT CENTER:

NURSE SATISFACTIONS AND DISSATISFACTIONS

BY

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CHAPTER I

INTRODUCTION

There is an increasing concern on the part of the American public with the problem of mental health. One evidence of their interest is demonstrated by the amount of money appropriated for the prevention and treatment of mental illness. In 1945, the average daily expenditure for each mental patient in the nation's hospitals was $1.06. In 1957, the figure rose to $3.65 per patient. The National Mental Health Act came into being in 1946 with its three pronged program of research in the field of mental diseases, training of personel, and assistance to the states in developing their mental health programs. In 1958, this program alone was allocated the sum of $24, 750,000. The same year a total of one billion dollars was appropriated for hospital care of the mentally ill.[1]

Further evidence of interest in the problems of mental health may be noted in the increasing concern various groups are displaying in this area. To supplement the services of paid workers, interested people in the community have formed groups to work with the patients within the hospitals. Not too long ago, hospitals for the mentally ill were shunned and regarded as a setting for violent and animal-like behavior.

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[1] "What Are The Facts About Mental Illness?". National Committee Against Mental Illness, Inc. Washington, D. C. 19, 1959.

Groups concerned with the welfare of mankind such as clergymen, lawyers and teachers are studying in the field of psychology and psychiatry in order to be of greater help to those whom they serve. Nursing educators have recently required a psychiatric nursing experience for all students for the first time. In analyzing its problems regarding absenteeism, industry has begun to recognize the emotional components inherent in work production and has begun to employ psychiatrists, sociologists, and psychologists to work on this problem. Dr. Fillmore Sanford has pointed out that, "We can, without being more than mildly insane, regard ourselves as having just passed through the era of economic man and as being on the threshold of the century of the psychological and socio-logical man."[2]

Because of this surge of public interest, the leaders in psychiatry now feel that it is possible to expand treatment facilities into the community. Traditionally, the care of the mentally ill, in the United States, has been confined to hospital facilities. Occasionally, hospital social workers have functioned as home visitors in offering support to patients discharged from the hospital and the families of these individuals but there have been few attempts to use community agencies to aid in this adjustment process. The emotionally ill person who did not need hospitalization has had few sources of treatment outside of the large mental hospitals. Leaders in the

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[2]Sanford, Fillmore, "Rising Tide of Mental Health". Public Health Reports 72:603, July 1957.

psychiatric field have recognized the need for the extension of services and have sought the community support necessary to establish new programs. With the awakened interest in the problem of mental health, community cooperation can be obtained more easily and the question arises as to what kind of services should be promoted.

One method of providing home visiting services to the patients discharged from the mental hospital is to utilize the services of the public health nurses in the community. These nurses are already working in the home and know many of the families of patients hospitalized because of mental illness. In two areas where this program has been initiated, the plan has been for the public health nurse to visit each discharged patient to help the families adjust to the patient's illness. Hopefully, this would reduce the patient's problems of adjustment and prevent his possible return to the hospital.[3]

Along with this effort to prevent the patient's readmission to the hospital has emerged a concomitant interest in avoiding hospitalization for the patient altogether. Centers are being established to offer treatment by a psychiatric team to persons who are still able to function in society with some therapeutic assistance. These are persons who are able to recognize the need for help and to seek it out; however, there is a large

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[3]Hanlan, Julian B., "Role of Mental Health Service in Local Health Department". Public Health Report 72:1093, December 1957.

group of patients who are unable to seek help. For this reason, the National Institute of Mental Health has established several research projects to determine the need for psychiatric home treatment in which a psychiatrist, a social worker, and a nurse go into the patient's home and offer him treatment. One such project is the scene of this study.

Statement of the Problem

This study attempts to determine the areas of satisfaction and dissatisfaction as seen by two nurses employed in a psychiatric home treatment center and as seen by the writer who is a psychiatric nurse with some public health background.

Justification

The movement to extend services to the mentally ill to include the establishment of day and night care centers, better care after discharge from the hospital and home care is of particular interest to the author. This interest naturally includes a concern in relation to the functions of the nurse in this new area.

An opportunity was afforded the author to spend some time observing the two nurses in a psychiatric home treatment program in a large metropolitan hospital. In addition to observing the nurses as they functioned, the author was able to participate in some of the agency activities. Initially, an attempt was made to gather data to describe the nurses' unique role. This was not done because there were few opportunities to observe nurse-patient contacts. In addition, since this is a new area of functioning for the psychiatric team, the team members had

not clarified their thinking enough to clearly define their ideas of the nurses' activities.

An attempt to gather data by means of a follow-up interview failed because of the patient's participation in other research. In the criteria established by the center for its own follow-up research, the patient was not to be seen for twelve months after termination of treatment; hence, the author could not disturb the plan by interviewing patients before this interval had elapsed.

An examination of the rather complete records of patient care did not seem to reveal any areas of nursing functions that could be meaningfully delineated. The author's limited observations did not seem to enlarge on this data.

However, the author's observations seemed to indicate that there were many obvious areas of satisfaction and dissatisfaction experienced by the nurses in this field. It was also felt that a study to define these areas could be meaningful to other nurses who might want to enter this new expanding field.

Scope

This study was concerned with one psychiatric home treatment center and the two nurses who worked in the agency. The author spent sixteen hours per week observing in this center over a period of three months. All the facilities of the agency were available to her for study. She participated in eighteen staff conferences, made three home visits to new patients, and two follow-up visits to patients whose treatment had been terminated for one year.

Limitations

This study was only concerned with the functioning of two nurses participating in one psychiatric home treatment agency; therefore, the observations may be unique to that agency.

The amount and scheduling of time spent in observation meant that all of the functions of the nurses and events in the agency were not observed.

The psychiatric home treatment project was also nearing its end and the number of patients being treated by the team was necessarily low at the time the observations were made.

The observer's personal conviction that the nurse has an important function in the home treatment of the mentally ill may have influenced her objectivity. One of the criteria utilized to define sources of satisfaction and dissatisfaction involved the use of the author's subjective judgment which further decreases the objectivity of the study.

Preview of Methodology

The author utilized participant observation as a tool and recorded fully all aspects of the nurses functioning in the agency where she observed. Records of staff meetings which the observer could not attend were read and meaningful comments extracted.

On the basis of the author's complete acceptance by the staff, it was felt that the incidents noted and the opinions expressed by the agency staff were freely given and were a reflection of honest thinking. The staff were most cooperative

and helpful; several offered their assistance in the areas of their research skills.

The recorded data were carefully studied to define areas of satisfaction and dissatisfaction and then tabulated according to the number of incidents relating to each area.

An interview with each nurse was conducted using an unstructured questionnaire to elicit her feelings concerned with these broad areas of satisfaction.

The observer's results were then combined with the nurses responses and shared with the two nurses and their nursing consultant in a joint interview. The nurses were asked if they agreed or disagreed with the defined areas of satisfaction and dissatisfaction and were encouraged to discuss their feelings about them.

Sequence of Presentation

Chapter I has included an overall view of the problem to be explored.

Chapter II will include a review of the literature relating to this problem and a statement of the hypothesis.

Chapter III will be concerned with a more detailed account of the methodology used in terms of the selection of the sample, of the tools used, and the procurement of the data.

Chapter IV will present the findings.

Chapter V will consist of the summary, conclusions and recommedations which resulted from this study.

CHAPTER II

REVIEW OF THE LITURATURE

Since the passage of the National Mental Health Act in 1946, there has been a rising tide of interest in the public health aspects of the problems of mental illness.[4] In 1953, Schwartz stated "the mental hospitals are increasingly accepting the responsibility for bridging the gap between hospital and community for the patients." She described the motivation for this movement as an attempt to prevent the patient's readmission to the hospital; it was hoped that the patient could be more quickly rehabilitated with more professional support.[5]

The recognition of the need for community psychiatric facilities for treatment probably originated in England and spread throughout the continent. Consequently, a study of European methods was made to determine the kind of service one should offer in this area.[6] Various teams composed of representatives of the disciplines involved in psychiatric care studied programs in the Netherlands, Belgium, Denmark and England. The team reports were utilized to extract meaningful principles of care and created further interest in establishing

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[4]Coleman, Jules, "Relations Between Mental Health and Public Health". Journal of the American Public Health Association 42:810, July 1956.

[5]Schwartz, Charlotte, "Rehabilitation of Mental Health Patients". Public Health Monograph 17:42, 1953.

[6]Lemkau, Paul, "Training Personnel for Mental Health Programs". Public Health Reports 72:609, July 1957.

community mental health facilities. Further impetus to establish such programs came from the World Health Organization Expert Committee on Mental Health. They stated that "a great deal of attention should be devoted to the development of extramural treatment facilities and other psychiatric facilities in the community."[7]

Ewalt[8] and Jules[9] further explored the need for establishing community facilities in the United States and proposed that public health methods and personnel should be utilized in providing this service. This concept was not new to nursing for in 1951, Dix stated that "modern psychiatric nursing is moving out from the public and private mental hospitals to the bedside of the patient. It is being taken into the home by the public health nurse and into the factory by the industrial nurse. It finds its way into the school room through the school nurse and is made available for all those who need such care and assistance through the services of the various clinics established for that purpose."[10]

Other professions soon began to recognize the fact that

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[7]Moross, H., "The Community Psychiatric Service". Mental Hygiene 6:397, April 1959.

[8]Ewalt, Jack, "A Case for the Community Survey". Public Health Report 72:620-623, July 1957.

[9]Jules, Henry, "Mental Health Education". Public Health Report 72:623, July 1957.

[10]Dix, A. A., "Modern Psychiatric Nursing". American Journal of Psychiatry 107:699, March 1951.

public health nurses have been involved in promoting mental health in their daily work and are in a position to enrich their contributions to the mental health of the families with whom they work.[11] It was felt also that the visiting nurse "is already accepted in the home, she understands the patient, his family and their problems and she knows how to work with related community services".[12] On the basis of this reasoning, health departments began to develop mental health programs utilizing mental health nursing consultants to assist the public health nurses with their nursing problems in this area. The aim of the program is to work with large groups in the broader aspects of mental health education. Mental health consultants provide consultation services to those doing individual patient care, but refrain from providing treatment for individual patients.[13]

In Georgia, an experiment was conducted which utilized the services of the public health nurses in the care of mentally ill patients discharged from the hospital. In reviewing this program, Ashford reports the nurses' contributions to the control of mental illness to be:

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[11] McLanahan, W. and Fleming, R., "The Visiting Nurse Adds Mental Health Service to Her Repertoire". Nursing Outlook 6:567, October 1958.

[12] French, Mary A., "The Visiting Nurse in a Psychiatric Program". Nursing Outlook 4:575, October 1956.

[13] Manlon, Julian C., "Role of the Mental Health Service in Local Health Department". Public Health Report 72: 1095, December 1957.

"1. Studying and frequently evaluating work in terms of mental illness.

2. Working closely with others concerned with the same problem.

3. Making optimum use of existing resources.

4. Guiding patients and families in taking intelligent action and supplying needed reassurance in dealing with mental illness.

5. Interpreting to the patients and their families.

6. Informing community leaders about needed facilities.

7. Supporting establishment of more programs for the prevention of mental illness."[14]

Nowhere in the literature could the author find a reference to psychiatric nurses participating in the home treatment of psychiatric patients except as a consultant to the visiting nurses. This would seem to indicate a new area of functioning for a psychiatric nurse and one which would be advisable to study in terms of its satisfactions and dissatisfactions.

A further review of the literature to investigate the availability of resource material related to satisfactions and dissatisfactions in nursing revealed many more studies. Nursing was a leader among the health professions in examining job satisfactions and dissatisfactions and justified its research by borrowing from industry the principle that "a contented staff is more efficient than one in which there is friction, dissatisfaction and constant turnover". In 1940, Nahm reported

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[14]Ashford, Mary, "Home Care of the Mentally Ill Patient". American Journal of Nursing 57:206, February 1957.

on her study which aimed "to measure the extent of nursing satisfactions and factors associated with it" and found that the most important factors differentiating satisfied nurses were:

"1. Interest in their work.

2. Good general adjustment.

3. Good relationships with superior officers.

4. Satisfactory family and social relationships.

5. Reasonable hours and remuneration.

6. Opportunity to advance and attain ambitions."[15]

Pickens and Tayback examined many areas of satisfaction among nurses on the assumption that satisfaction is "subjective in nature and is a relative condition affected by many variables".[16] They measured satisfaction in terms of salary, personnel policies, attitudes towards supervision and administration, opportunity for advancement, and area of work. Their findings indicated that relationships with co-workers were very important in terms of feelings of satisfactions in the nurses studied and that there was a higher level of satisfaction in those with more years of experience.

Frasher examined the attractiveness of nursing positions and the nurse's need for psychological satisfaction. He found demonstrated needs for recognition, security, approval and

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[15]Nahn, Helen, "Job Satisfaction in Nursing. American Journal of Nursing 40:1389.

[16]Pickens, M. E. and Tayback, M., "A Job Satisfaction Survey". Nursing Outlook 5:157, March 1957.

companionship, and competency. He further states that nurses sought "the privilege of doing work they want to do and for which they have been prepared to the best of their ability and as only they can do it."[17]

On the basis of these studies and their findings, the author felt that it would be well to examine the satisfactions and dissatisfactions experienced by the psychiatric nurse in a home treatment setting. The nurses studied were working in a new area without the obvious support of other nurses and with team members who held nebulous expectations of their performance. They were not sure if they could work successfully without the support of the ward structure; or if their efforts in patient care would be successful. According to the studies reviewed, these would be dissatisfying experiences.

Therefore, the hypothesis was that an examination of the areas of satisfactions and dissatisfactions of the two nurses in the Psychiatric Home Treatment Center would indicate more areas of dissatisfaction than satisfaction.

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[17] Frasher, Charles, "What Makes a Nursing Job Attractive". Nursing Outlook 9:509, September 1953.

CHAPTER III

METHODOLOGY

The data were gathered in one agency that was attempting to demonstrate the functioning of a psychiatric home care program. The center had been accepting and treating patients for eighteen months and was serving one district with a population of 80,000 residents.

The team consisted of two psychiatrists, two nurses, one social worker, one sociologist, one clinical psychologist and two secretaries. Their concern was with treating patients in need of psychiatric help who were referred to them by families, social agencies, clergymen and local doctors. The team was especially concerned with the possibility of maintaining the patient in the home and utilized hospitalization as only a last resort.

The usual plan of action was for the nurse to make the initial visit to a new patient to: (1) assess and appraise the present situation in terms of its emergency aspects; (2) relieve the anxieties of the family in relation to the patient's management and (3) explain the functions of the members of the center.[18] After this visit, the social worker and psychiatrist visited the home; all the information was then shared at a staff conference and possible plans of action explored. The evaluation period naturally varied in time according to the

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[18] As defined during a nursing conference at the agency, February, 1959.

extent of the family crisis. That is, if the problem was of long standing and had few acute aspects, the team might make several visits. If, on the other hand, there was an emergency in terms of a threat of suicide or a threat of bodily harm to the family, the team might all visit the same day and make immediate disposition.

Staff conferences were held twice weekly to discuss new patients and the progress of patients under continued treatment. At this time, all team members participated in planning the patient care and in discussing its research aspects. At intervals, consultants from various disciplines were invited to these meetings to assist in difficult areas.

The total number of patients seen during the entire project was ninety-three. Of these the nurses visited forty-two during the eighteen months the project accepted patients for treatment. While the observer was free to accompany the nurse on visits to new patients, the opportunities for this experience were limited to three. This was due to the fact that only eight new patients were admitted during the three months of abservation and the author's limited availability.

Tools

Since the author was well-accepted by the staff, she was able to function effectively as a participant observer in this agency. She was given a thorough orientation to all aspects of the agency's functioning and felt free to examine any area of the nurses' activities. She took copious notes at the staff

meetings in terms of the content of the meeting, the nature and number of the nurses' contributions and noted the non-verbal responses of the nurses. During the three home visits that she made with the nurses, she was introduced as a new nurse-member of the project. Although, she did not take notes during these patient contacts, she recorded her recall of the visit immediately following her return to the agency. Notes were also made of significant, informal discussions that took place during lunch and coffee hours. The author utilized the agency form for the two follow-up study visits which she made. These data were then analyzed in terms of four large areas; satisfactions and dissatisfactions relating to (1) the agency as a research project, (2) the patient care as practiced, (3) interpersonal areas and (4) intrapersonal areas. Under each of these areas, noted incidents indicating satisfactions and dissatisfactions were listed. These incidents consisted of the verbal and non-verbal responses by the agency members that the author had recorded.

Interview Guide

Two interview guides were structured by the author to facilitate a discussion of the problem with each nurse. The first was designed to provide a somewhat unstructured framework to allow the nurse freedom of expression when the author met with her individually. Some framework was provided in order to facilitate the use of the data obtained from the nurses. This structure consisted of the four large areas identified by the

author: that is each nurse was asked to describe her satisfactions and dissatisfactions in relation to the agency as a research project; in relation to the patient; and in relation to the interpersonal and intrapersonal areas of functioning. After the author had established a relationship with the nurses, appointments were made for the interviews; the fact that a relationship existed made the atmosphere of the interview relaxed and allowed the author to record the responses verbatim. These interviews lasted from one to one and one-half hours each.

The second interview guide was constructed after the data were analyzed in order to share with the participating nurses and the nursing consultant the compiled information and to secure their reactions to the data. This was done by indicating the large areas previously identified and the satisfactions and dissatisfactions occuring under each area. The above mentioned people were then asked if they agreed that this was a satisfaction or a dissatisfaction and urged to comment.

The source of the items was identified only when it was necessary to clarify their meaning. The author's data were also available during the interview to facilitate clarification if necessary; they were used only twice. At these times, incidents from the observations were read to the nurses to facilitate clarification.

All comments and indications of satisfaction and dissatisfaction were recorded by the author as they were stated by the nurses being interviewed.

Summary

The data were gathered in the one agency over a three months period as described in the previous section. Notes of staff meetings were recorded verbatim during the meeting. Notes of more casual discussions were recorded as soon as possible after the termination of the discussion. Visits made to patients were also described after the visit.

The individual interviews with the nurses were held three weeks after the observation period and the group conference was held one week after the individual interviews.

CHAPTER IV

FINDINGS

The data obtained from attendance at fourteen staff meetings at the psychiatric home treatment center and the notes of twenty-two unstructured meetings were analyzed to determine sources of satisfaction and dissatisfaction to the nurses in this agency. The two criteria used to define these sources were: (1) Did the nurses employed in the agency indicate in any way that this incident created feelings of satisfaction or dissatisfaction? and (2) Did the observer feel this would affect her own feelings of satisfaction or dissatisfaction if she were a nurse employed in this agency?

The observations utilized by the author to determine satisfactions or dissatisfactions consisted of both verbal and non-verbal responses. The verbal responses were analyzed not only in terms of the content, but for the tone of voice used, the frankness or cautiousness of the wording, the implied meanings, the placement of emphasis and the choice of words. For example, the treatment plan of a chronically ill patient was being developed in a staff meeting without too much interest being displayed. One nurse, who was interested, suggested that there was a chance of getting the patient to find employment. The response by a co-worker was, "The nurse could follow-up", but the tone of voice implied doubt as to whether it would be beneficial. The nurse then responded by asking, "Why are we interested in this patient?" This was interpreted as an indirect,

cautious way of asking for clarification and guidance as to how the other staff members thought the nurse could help the patient. Non-verbal responses such as the nurses' facial expressions, their sighs or groans, their exchange of glances, and their body posture were utilized by the author to interpret feelings of satisfaction and dissatisfaction. In most instances, the author was able to verify her interpretation by discussing the incidents later with the nurses in an informal way.

Author's Observations

Ten sources of satisfaction and dissatisfaction were identified in this manner; this appears in table one which includes the number of times these areas appeared in the data. It should be noted that the number of occurences is the only measure used to indicate signigicance; no attempt was made to measure the degree of satisfaction or dissatisfaction in each area. The number of areas of satisfaction was approximately half of the number of areas of dissatisfaction.

The data is more meaningful when it is rearranged according to categories as in table two.

A. Patient Care

In discussing the patient care with the agency nurses, they stated that they could visit the patient as often as it seemed desirable and could stay for two or three hours if the patient needed that much care. On the other hand, if the nurse felt that a scheduled visit would not be therapeutic at a particular time, she was free to cancel it. If it seemed desirable

TABLE 1

SOURCES OF SATISFACTION AND
DISSATISFACTION IDENTIFIED BY THE AUTHOR

Satisfactions	No.	Dissatisfactions	No.
1. Partial acceptance of nurse as team member....	10	1. Low expectations of nurse's potential.....	14
2. Increasing freedom to express difficulties....	6	2. Conflict between treatment goals and research goals.....	10
3. Obtaining and presenting information to staff	5	3. Partial acceptance of nurse as team member....	10
4. Participating in research project.....	3	4. Lack of definite goals in research design.....	9
5. Personnel policies..	3	5. Non-acceptability of being persistent in offering services to patient.....	7
6. Partial support of efforts by team members	3	6. Aloneness.....	5
7. Freedom to explore various approaches to patients.....	1	7. Partial utilization of nurse's reporting....	4
8. Unlimited time for visits.....	1	8. Lack of patient involvement.....	3
9. Long term investments in patients interested other team members.....	1	9. Unfamiliarity with research methods.....	1
10. Money available for services to patient.....	1	10. Difficulty in evaluating nurses' contributions.....	1
Total	34		64

TABLE 2

SATISFACTIONS AND DISSATISFACTIONS
FROM AUTHOR'S DATA ACCORDING TO CATEGORY

Category	Satisfaction	No.	Dissatisfaction	No.
Patient Care	Freedom to explore various approaches to patient.....	1	Conflict between treatment goals and research goals.....	10
	Long term investments in other patients interested other team members.....	1	Non-acceptability of being persistent in offering service to patient.	7
	Unlimited time for visits.....	1	Lack of patient involvement.....	3
Agency	Participating in research project.....	3	Looseness of research design.....	9
	Personnel policies...	3	Unfamiliarity with research methods.....	1
	More money than usual available.....	1		
Interpersonal	Obtaining and presenting information to staff.....	5	Low expectations of nurses' potential.....	14
	Partial acceptance of nurse as team member..	10	Partial acceptance of nurse as team member...	10
	Some support of nurses' efforts by team members.....	3	Partial utilization of nurses' reporting.....	4
Intrapersonal	Increasing freedom to express difficulties..	6	Aloneness.....	5
			Difficulty in evaluating nurses' contributions.....	1
Total		34		64

for her to accompany the patient to a hospital, clinic or to some social event, she could do so. Occasionally, the patients expressed little interest in seeing the nurse or any therapeutic person. In one case, the continued visiting by the nurse despite the patient's resistance evoked interest in other staff members. This seemed to be a rewarding experience for the nurse; traditionally, nurses have obtained a great proportion of their satisfaction in the area of patient care.

Concern for the patient also made it difficult for the nurses to accept staff decisions about terminating the treatment of a patient or not taking a patient for treatment when the latter did not fit into the research goals. For example, a housewife was referred to the agency; after the evaluation visit it was decided that, although the patient was mentally ill and had been for many years, her presenting problems were socio-economic in nature. These were alleviated by contacting other agencies and the case terminated. The reaction of the nurses was a query: "What is going to happen to the basic problem--the patient's illness?" The staff pointed out that since the patient was able to function in a limited way and was not in danger of hospitalization, she was not a good candidate for the research project. It was obvious that this decision was difficult for the nurses to accept.

Another principle that was difficult for the nurses to accept was that the patient should be willing to ask for help or at least show a willingness to accept treatment. She was

willing to continue demonstrating her availability over a long period of time; the other staff members were more quickly discouraged and indicated that the nurse was wasting her time. If a patient could not accept help, they felt he should be discharged from the agency; yet, the other staff members were willing to have the nurse visit him if the latter wanted 'something to do'.

The nurses were very willing to make an extended effort to establish a relationship for another reason: they indicated dissatisfaction with the lack of meaningful patient relationships. Although the initial visit to a newly referred patient was made by a nurse, her involvement in a continuing therapeutic relationship was infrequent. Since the initial visit was part of the evaluation of the situation, minimal satisfaction was derived in terms of a relationship. Of the ninety-three patients seen by the agency over an eighteen month period, only twenty of this number ever were visited more than once by the nurse. As one nurse stated, "I can struggle with all kinds of other problems if I can only have enough satisfying patient relationships".

B. Agency

The nurses derived feelings of satisfaction from the agencies policies that allowed them freedom to plan one's own time and attend professional meetings and were sufficiently flexible to allow for the individual nurse's needs. It was satisfying also to have money available for the provision of an

extra service to the patient. When the need was indicated, a private ambulance was used, taxi fares were paid, equipment and medication were purchased. Participating in a research project brought satisfaction when the agency was able to offer a needed service and when the staff was involved in describing and discussing their work with other professional groups. Contrastingly, the nurses found that the flexibility of the research design made it difficult to establish their goals and their functions. Although, the design was developed purposely to allow for change to emerge out of need, this flexibility resulted in a lack of structure that the nurses needed for guideposts. For example, the criteria for admission to the agency changed with the evolution of the project. It became difficult for the team to decide upon the eligibility of a particular patient for treatment. The nurse found it difficult to define her role since there was little exploration in the design concerning the possibilities for her functional development. The nurses felt unfamiliar with research methods; consequently they turned to the research person on the team concerning their contributions in this area.

C. Interpersonal

The largest number of incidents indicating satisfactions and dissatisfactions were identified in the interpersonal category. The team members seemed to expect little from the nurse in terms of therapeutic relationships and saw her as the person who would do 'real nursing such as getting the patient

to play games or go for a walk', who would supervise the patient taking medications or who would 'drop in and see why the patient did not keep his clinic appointment'. Although the reports of the nursing visits were read, they were rarely discussed or regarded to be sources of important material. Suggestions the nurses might make at staff meetings concerning patient care were rarely given the appreciative, thoughtful consideration accorded the suggestions made by other team members. Nevertheless, nurses were given an opportunity to report at staff conferences, and the value of some of their contributions was recognized. Their persistence in attempting to make suggestions gradually resulted in their being better accepted team members; an experience identified by the author to be satisfying.

There was also some further support given by the other team members, usually on an individual basis. For example, one nurse came into the agency office and reported to a co-worker that a rather inactive patient had been dressed for the nurse's visit. The co-worker replied: "This is progress; your visits are paying off".

D. Intrapersonal

There was an increasing freedom to express difficulties in the staff conferences. Throughout the observation period, the author noted that the questions on the part of the nurses became more and more explicit in their attempt to determine what the goals of patient care should be and what other team members saw as the nurses function. This was identified as a satisfying ex-

perience in the intrapersonal area, as it seemed to the author to indicate that the agency nurses felt sufficiently accepted to initiate this first step in resolving their felt difficulties.

The fact that the two nurses were working in a new area without many contacts with other nurses and without the usual close doctor-nurse relationship produced feelings of aloneness. This was expressed to the observer directly and indirectly by the agency nurses's eagerness to discuss all aspects of their work with the author and with their nurse supervisor. The content of the patient visits, the general progress of the patients, and the entire question of evaluation of the nurse's contribution in the agency were discussed frequently as a source of dissatisfaction.

Data From First Interviews

The areas of satisfaction and dissatisfaction reported by these two nurses are presented in table three. Their greatest source of satisfaction came from the area of patient care. Their greatest source of dissatisfaction came from the interpersonal area.

Data From Observations and Interviews

By tabulating the author's observations and the data obtained from the nurses through interviews as in table four, new areas of satisfaction and dissatisfaction were noted. One nurse found the population of the district served by the agency to be satisfying in terms of their verbalization skills and their

TABLE 3

SOURCES OF SATISFACTION AND
DISSATISFACTION REPORTED BY THE TWO NURSES

Category	Satisfaction	No.	Dissatisfaction	No.
Patient Care	Freedom to explore various nursing approaches.....	3	Lack of nurse-patient involvement in depth relationship.....	1
	Unlimited time for visits.....	2	Type of patient.....	1
	Changes of patient behavior.....	1	Assignment of patients...	1
	Long term investment in other patients interested other team members.....	1	Lack of contact with social agencies.....	1
	Increased understanding of patient as family member.....	1	Lack of clinical supervision.....	2
	Home more of reality situation.....	1	Conflict between treatment goals and research goals.....	1
	Population of district.....	1		
Agency	Participating in research project.....	1	Looseness of research design.....	2
	Validating performance by statistical means	1	Unfamiliarity with research methods.....	2
			Interchanging roles.....	3
Inter-personal	Obtaining and presenting information to staff.....	1	Individual team members did not always report on progress of patients.....	1
	Partial acceptance of nurse as team member..	2	Nurses reports not requested in detail.....	2
	Same support by other team members.....	1	Stereotyped concept of the nurses held by other team members.....	5
			Nurses' suggestions utilized indirectly.....	1

TABLE 3-continued

Category	Satisfaction	No.	Dissatisfaction	No.
Intra-personal	Working in a new area.....	2	Unfamiliarity with treating patient in emotionally charged atmosphere home.....	2
	Self-development.....	1	Home structures relationship in more formal way.....	1
	Arousing interest of other team members in nursing.....	1	No precedents for guidance.....	3
			Nurse has less control in home.....	1
			Few nurse contacts.....	2
			Difficulty in evaluating nurses contribution.....	1
			Lack of close doctor-nurse relationship.....	1
Total		20		34

TABLE 4

TOTAL SATISFACTIONS AND DISSATISFACTIONS
IDENTIFIED BY THE AUTHOR AND THE AGENCY NURSES

Category	Satisfactions	A*	A.N*	Dissatisfactions	A*	A.N*
Patient Care	Population of district.....		1	Goals of treatment in conflict with treatment goals.....	10	1
	Freedom to explore various approaches to patients.....	1	3	Non-acceptability of being persistent in offering service to patient.....	7	
	Unlimited time for visits.....	1	2	Lack of nurse-patient involvement in depth relationship.....	3	1
	Long term investments in patients interested other team members.....	1	1	Type of patient.....		1
	Change in behavior of patient..		1	Assignment of patient.....		1
	Better understanding of patient as family memberll...		1	Lack of clinical supervision.....		2
	Home more of a reality situation		1	Lack of contact with social agencies.....		1
Agency	Participating in research project	3	1	Looseness of research design.....	9	2
	Validating performance by statistical means..		1	Unfamiliarity with research methods.....	1	2
	Availability of funds for services to patients.....	1		Interchanging roles..		3
	Personnel policies.....	3				

*A.--Author

*A. N.--Agency Nurses

TABLE 4-continued

Category	Satisfactions	A.*	A.N.*	Dissatisfactions	A.*	A.N.*
Inter-personal	Obtaining and presenting information to staff....	5	1	Preconceived ideas of the other team members as to nurses role.....	14	5
	Partial acceptance of nurse as team member.....	10	2	Partial acceptance of nurse as team member.....	10	1
	Some support of efforts by other team members.....	3	1	Patrial utilization of nurses reporting..	4	2
	Increasing freedom to express difficulties.....	6		Individual team members did not always report on progress of patients.....		1
Intra-personal	Working in a new area.....		2	Unfamiliarity with treatment of patient in emotionally charged atmosphere of home.....		4
	Arousing interest of other team members in nursing..		1	Aloneness.....	5	5
	Self development...		1	Difficulty in evaluating nurses contribution.....	1	
				Lack of close doctor-nurse relationship...		1
Total		34	20		64	34

*A.--Author

*A. N.--Agency Nurses

homogenous background. The other nurse found them less verbal and thus a source of dissatisfaction. One nurse felt that the home was a more realistic situation than a hospital ward and that she understood the patient better in relation to his family. She found changes in patient behavior more satisfying since the nurse in the home had less control than she would have in a hospital situation and therefore any improvement the patient displayed meant more of an effort on his part. To illustrate this, the nurse cited as an example, a patient who proudly announced that the family was pleased he had taken a bath on his own volition; in a hospital ward, he might have been expected to take a bath routinely.

An additional area of dissatisfaction was also identified in the intrapersonal category. Both nurses felt that treating the patient in a home where the whole family was emotionally involved in a constant, continuing relationship was quite different than treating the patient in the hospital where the family has only intermittent contact with the patient. Their unfamiliarity with such home situations caused some feelings of dissatisfaction. One nurse also felt she missed the close doctor-nurse team relationship that is present in the ward situation.

Tables five and six indicate the areas of agreement and disagreement reached by the two nurses in the agency, the nursing consultant, and the observer.

TABLE 5

AREAS OF AGREEMENT AND DISAGREEMENT BETWEEN AUTHOR AND AGENCY NURSES IN DEFINING SOURCES OF SATISFACTION

Category	Source of Satisfaction	Agree	Disagree	Undecided
Patient Care	Population of district.....	3	1	
	Freedom to explore various approaches to patient care..	4		
	Unlimited time for visits...	4		
	Long-term investment in patients interested other team members.....	3	1	
	Change in patient behavior more satisfying in home.....	4		
	Better understanding of patient as a family member..	4		
	More of a reality situation.	4		
	*Improvement of patient is more basic as family is coping more in home.....	4		
	*There were fewer disciplinary conflicts in areas such as occupation therapy and physio-therapy.....	4		
Agency	Participating in research project.....	4		
	Validating nursing performance by statistical means...	4		
	Availability of funds for services to patient.....	4		
	Personnel policies.....	4		
	*Working closely with other disciplines besides medicine	3	1	

*Sources identified for the first time.

TABLE 5-continued

Category	Source of Satisfaction	Agree	Disagree	Undecided
Inter-personal	Obtaining and presenting information to the staff.....	3		1
	Acceptance on verbal level of team membership.....	1	2	1
	Partial support of efforts by other team members.....	4		
	Increasing freedom to express difficulties.....	4		
Intra-personal	Pioneering in new field of psychiatric nursing.....	4		
	Arousing interest of other team members in nursing areas.	3		1
	Development of own nursing skills.....	4		
	*Gradual acceptance of contributions of nurse.....	4		

*Sources identified for the first time.

TABLE 6

AREAS OF AGREEMENT AND DISAGREEMENT BETWEEN AUTHOR AND AGENCY NURSES IN DEFINING SOURCES OF DISSATISFACTION

Category	Source of Dissatisfaction	Agree	disagree	Undecided
Patient Care	Goals of treatment in conflict with research goals...	4		
	Non-acceptability of being persistent in offering service to patient.....	4		
	Type of patient.....	2	1	1
	Lack of nurse-patient involvement in depth relationship.....	4		
	Assignment of patients.....	4		
	Lack of clinical supervision	4		
	Lack of contact with social agencies.....	4		
Agency	Looseness of research design	4		
	Unfamiliarity with research methods.....	4		
	Interchanging roles of disciplines.....	4		
Interpersonal	Team members preconceived ideas of nurses' functions..	4		
	Low expectations of nurses' potential.....	4		
	Partial acceptance of nurse as team member.....	4		
	Partial utilization of nurses' reports.....	4		
	Not enough sharing of information.....	4		

TABLE 6-continued

Category	Source of Dissatisfaction	Agree	Disagree	Undecided
Intra-personal	Aloneness.....	4		
	Feelings of inadequacy in emotionally charged atmosphere of home.....	4		
	Difficulty in evaluating performance.....	4		
	Lack of close doctor-nurse relationship.....	4		

AREAS OF AGREEMENT AND DISAGREEMENT

A. Patient Care

The sources of satisfaction identified in this area included the freedom to explore various approaches to patient care, the freedom to visit the patient as often and as long as necessary, and the freedom to include simple forms of occupational therapy and physiotherapy in their care without fear of conflict with these disciplines. It was stated that the patient's improvement was more basic in a more realistic setting, the improvement more satisfying, and the patient better understood in the home.

The satisfactions arising from the fact that the patient's improvement was more basic, and the lack of disciplinary conflicts with occupational therapy and physiotherapy, were identified for the first time in this final conference. This seemed to indicate that the agency nurses had done some further exploration of the problem. The group agreed that these were sources of satisfaction.

One nurse felt that the characteristics of the population were not a source of satisfaction; she also was undecided whether her efforts to interest other team members in patients, through a long term investment in their care, was very rewarding.

The dissatisfactions in this area were related to the conflict between the goals of treatment and those of research, in the insufficient number of meaningful relationships with

patients and in the method of assigning patients. The nurses missed working directly with other social agencies for the patient's welfare. They also felt the need for more clinical supervision. The unwillingness of other team members to extend the agency services to patients who seemed unwilling or unable to seek the services was dissatisfying to the nurses.

B. Agency

Participating in a research project with its good personnel policies, provided satisfaction to the nurses. The agency was also able to supply funds for related services to patients in addition to the treatment offered in the agency. The use of a method of research that validated nursing performance was also satisfying.

One respondent did not agree that working closely with disciplines other than the medical profession was a source of satisfaction. The nurses' unfamiliarity with many research methods was a source of dissatisfaction. The looseness of the research design and the interchanging roles of the various disciplines made it difficult for the nurses to function as effectively as they had expected to perform in the agency.

C. Interpersonal

The group agreed upon only two sources of satisfaction in this category. These emanated from the partial support they received from their co-workers and the nurse's increasing ability to express their difficulties.

Both agency nurses disagreed with the author's finding that some satisfaction was experienced from the partial accept-

ance of the nurse as a team member. One nurse also disagreed with the finding that obtaining and presenting information to the staff was satisfying.

All of the respondents agreed that the stereotyped concepts of the nurse held by other team members and their low expectations of the nurse's potential performance interfered with her successful functioning. Her lack of status as a team member, the resulting minimal use of her reports and the disinclination of the other team members to share their information about a patient's progress were additional sources of dissatisfaction.

D. Intrapersonal

This area yielded three sources of satisfaction agreed upon by the group. They were: pioneering in a new field of psychiatric nursing, developing their own nursing skills and experiencing the gradual acceptance by the co-workers of nursing contributions. Another area, that of arousing interest in the nursing problems, was felt not to be a source of satisfaction by one nurse.

Feelings of aloneness were associated with sources of dissatisfaction, as were feelings of inadequacy in the emotionally charged atmosphere of the home. The lack of the close doctor-nurse relationship as experienced in most ward situations was dissatisfying. The other source of dissatisfaction was related to the felt difficulty in evaluating nursing performance.

The total number of sources of satisfactions numbered sixteen; the sources of dissatisfaction numbered seventeen.

CHAPTER V

SUMMARY, CONCLUSION AND RECOMMENDATIONS

Summary

This study was undertaken to determine the satisfactions and dissatisfactions as seen by two nurses employed in a psychiatric home treatment center and as seen by the writer who is a psychiatric nurse with some public health background. The author's hypothesis was that there would be more sources of dissatisfaction than satisfactions. The author utilized participant observation and interviews as tools to study this problem. The observation period extended over a three month period for approximately two hundred hours. The findings were categorized with three sources of satisfaction identified relating to patient care, three relating to the agency, three relating to the interpersonal area and one relating to the intrapersonal area. Three sources of dissatisfaction were identified in both the area of patient care and the interpersonal area; two sources were identified in the agency and intrapersonal categories.

Each nurse was interviewed to elicit her enumeration of satisfactions and dissatisfactions within these four categories. The greatest number of sources of satisfaction delineated in this manner fell in the category of patient care; seven were in this category compared to two in the agency category, three in the interpersonal area and three in the intrapersonal area. Sources of dissatisfaction were more evenly distributed; the categories concerned with patient care, interpersonal and in-

trapersonal areas each contained six sources while only three were identified as concerned with the agency.

In a joint interview with the two agency nurses and their nursing consultant, the sources of satisfaction and dissatisfaction were discussed to define areas of agreement. This interview developed sixteen sources of satisfaction and seventeen sources of dissatisfaction that the group agreed were a valid representation of these areas in this agency.

The largest number of sources of both satisfaction and dissatisfaction fell in the category of patient care. Three of these satisfactions were concerned with the nurses freedom to plan and carry out their concept of good nursing care; four of them were related to the satisfactions inherent in treating the patient in the home setting. Conversely, the dissatisfactions in the category of patient care were related to the lack of guideposts in carrying out nursing plans; the conflict in research and treatment goals, the conflict in philosophy regarding persistence in treatment and the lack of clinical supervision. Three sources of dissatisfaction were related to practices that limited their functioning; the method of assigning patients for nursing care did not always seem appropriate to the nurses special skills, the number of continuing nurse-patient relationships available was not sufficient, and the indirect contact with other social agencies was inadequate for their needs.

Both the satisfactions and dissatisfactions defined in the agency category were related to the research aspects of the center. The personnel policies, the experience of participating in research activities, using research methods, and the extra funds available for additional patient services were all satisfying elements. However, the looseness of the research design, the nurses lack of knowledge of the use of research methods and the flexible roles of the disciplines were research aspects that the nurse found dissatisfying.

Only two satisfactions were delineated in the interpersonal area as contrasted to five dissatisfactions. On the one hand, the occasional support of their co-workers was satisfying to the nurses; conversely, the co-workers' preconceived ideas of nursing functions and potentials resulted in the nurses participating in the project with less status than the other disciplines. However, the nurses were experiencing increasing freedom to express their difficulties which may be an indication that their status would improve.

Intrapersonal satisfactions were concerned with pride in being part of a pioneering effort, with developing their own nursing skills and with the gradual acceptance of their nursing contributions. Dissatisfactions centered around a feeling of aloneness, a feeling of inadequacy in the emotionally charged atmosphere of the home and difficulty associated with self-evaluation.

Conclusions

From the findings in this study, the following conclusions are drawn:

1. There is little numerical difference in the number of sources of satisfaction and dissatisfaction for the nurses in this agency. The hypothesis that there would be more sources of dissatisfaction was proven but the degree of difference does not seem to be of consequence.

2. A sufficient number of meaningful nurse-patient relationships is a major source of satisfaction to a nurse.

3. The concern a nurse experiences with a patient becomes a source of difficulty in carrying out goals of research which conflict with the welfare of the individual patient.

4. Although some freedom to plan and to carry out nursing care is satisfying to the nurse, some structure is needed for guidance.

5. There is a need for nurses to have the agency goals of treatment clearly defined.

6. Nurses need and seek adequate clinical supervision for the advancement of their professional performance and the renewal of their self-esteem.

7. Nurses need preparation in research skills.

8. Interpretation of psychiatric nursing skills to other disciplines is a continuing function of nurses in this field.

9. Nurses involved in a research project should participate in formulating its design.

10. Nurses have the ability to demonstrate their skills and to wait for recognition and acceptance of their contributions.

11. There is a need on the part of nurses to have continuing contact with other nurses when they are trying to define new functions for the purpose of nourishing their personal and professional identification.

Recommendations

While the findings are not new and dramatic, their very lack of uniqueness indicates that a nurse functioning in this area does not need to be concerned as much with developing new skills as with developing an awareness of the importance of the skills she possesses.

The following recommendations are made on the basis of the findings in this study in the hope that they will be useful in improving the satisfactions of nurses in similar situations.

1. Further study.

   a. Further study in other agencies would validate or refute this study.

   b. It would be profitable to determine the degree of satisfaction and dissatisfaction within the categories evolved by the author.

   c. An investigation of the concepts of nurses and nursing as defined by other disciplines in the agency would be of value in interpreting the nurses role.

   d. A joint attempt to study areas of nursing function and responsibilities by the various disciplines at the agency would be of value.

2. Nurses should be involved in the planning of research projects in which nurses are to participate.

3. Sufficient opportunities should be provided for satisfying nurse-patient relationships under an adequate plan of clinical supervision.

4. Nurses should have freedom in planning and carrying out nursing care, but there is a need for developing broad agency policies as guides. This could be accomplished in staff meetings with thorough discussion of such things as the goals, and function of the agency, the philosophy of patient care and the role of each discipline in providing this care.

5. The nurse entering a research project needs to carefully evaluate her feelings in relation to the conflict inherent in the goals of research and her concern for individual patients.

6. Individual nurses should be encouraged to develop an interest in research and the necessary skills to participate in it.

7. Opportunities should be provided for maximum communication between team members.

8. Provision for nursing contacts for consultant purposes should be included in the agency policies.

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APPENDICES

APPENDIX A

EDUCATIONAL BACKGROUND AND EXPERIENCE OF NURSES

Education	Nurse A	Nurse B
Basic	Diploma School	Diploma School
Advanced	Bachelor of Science	Master of Science
Experience		
Public Health Nursing	None	1 year
Psychiatric Nursing	5 years	25 years
Team Participation	Psychiatrist-Nurse	Psychiatrist-Nurse
Research	None	Collecting Statistics
Home Treatment Project	24 months	14 months

APPENDIX B

INTERVIEW GUIDE I

INTRODUCTION:

I am trying to define sources of satisfaction and dissatisfaction for nurses in this psychiatric home treatment service. As the nurses working in this area, you are my most valuable source of information. I do not wish to direct your answers in any way but I wonder if you would find it easier to think in terms of four areas:

Sources of satisfaction and dissatisfaction related to patient care.

Sources of satisfaction and dissatisfaction related to the agency.

Sources of satisfaction and dissatisfaction related to interpersonal relations.

Sources of satisfaction and dissatisfaction related to intrapersonal relations.

Are there any further comments you would like to make?

APPENDIX C
INTERVIEW GUIDE II

CONFERENCE BETWEEN AGENCY NURSES,
NURSING CONSULTANT AND AUTHOR

INTRODUCTION:

I have compiled a list of satisfactions and dissatisfactions from your statements and my observation. I would like to share them with you and note the areas of agreement and disagreement. Please feel free to comment.

Category	Satisfaction	Agree	Disagree	Undecided
Patient Care	Freedom to explore various nursing approaches			
	Unlimited time for visits			
	Changes of patient behavior			
	Long term investments in patients interested other team members			
	Increased understanding of patient as family member			
	Home more of reality situation			
	Population of district			
Agency	Participating in research project			
	Validating performance by statistical means			
Inter-personal	Obtaining and presenting information to staff			
	Partial acceptance of nurse as team member			
	Same support by other team members			

INTERVIEW GUIDE II-continued

Intra-personal	Working in a new area Self-development Arousing interest of other team members in nursing			
Category	Dissatisfaction	Agree	Disagree	Undecided
Patient Care	Lack of nurse-patient involvement in depth relationship Type of patient Assignment of patients Lack of contact with social agencies Lack of clinical supervision Conflict between treatment goals and research goals			
Agency	Looseness of research design Expectations of role quite different than reality Unfamiliarity with research methods			
Inter-personal	Functions of team members overlapped Group did not function as a team Individual team members did not always report on progress of patients Nurses reports not requested in detail			