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An exploratory study of help-giving interactions occuring among a selected group of hospitalized mentally ill patients

AN EXPLORATORY STUDY OF HELP-GIVING INTERACTIONS (OCCURRING) AMONG (A SELECTED GROUP OF HOSPITALIZED) (MENTALLY ILL) PATIENTS

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CHAPTER I

INTRODUCTION

Justification of the Problem

Interest in the social interactions that occur among hospitalized mentally ill patients was stimulated by present day thinking that the therapeutic role of the patient as a helper needs to be further examined.[1] It seemed that a study of the kinds of assistance patients give to one another would reveal a frequently overlooked consideration that patients are able, at different intervals during their hospitalization, to help other patients as well as themselves. This study was confined to the kinds of assistance that could be observed among a small group of hospitalized mentally ill patients.

Interest in the problem herein presented dates back to earlier psychiatric nursing experience where, when appropriate, patients were encouraged to help one another in activities of daily living. It was informally observed

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[1]Brown, E. L., Newer Dimensions in Patient Care, "The Therapeutic Role of Patient as Helper," New York: Russell Sage Foundation, 1961, Chapter VI, pp 85-98.

that these activities occurred on continued treatment wards and within the patient government association.

More recent field work experiences, on an acute treatment ward at a large state mental hospital, increased this awareness that social interactions of patients are often mutually supportive. One patient in particular was observed to have been keenly aware of the needs of her fellow patients, offering assistance to them even when she was severely disturbed. It was believed that awareness of patients helping one another was not enough. Thus this study attempts to explore the following questions as they are related to the study group.

Statement of the Problem

If the observable interactions of a selected group of hospitalized mentally ill patients were recorded sociometrically, how many help-giving interactions of a physical and psychosocial nature would be found to occur? What types of physical and psychosocial help could be identified by a study of these interactions?

Sub-Problems

1) How many patients would be involved in help-giving interactions?

2) How many physical and psychosocial help-giving interactions would occur?

3) How many "sought-for" or "spontaneously-offered" help-giving interactions would occur?

4) How many "sought-for" or "spontaneously-offered" help-giving interactions would be refused?

5) How many dyadal and triadic help-giving interactions would occur?

Definition of Terms

In the development of the problem, the terms "physical assistance" and "psychosocial assistance" have been defined as follows:

1) Physical assistance:- Includes those interactions between or among patients in which direct bodily comfort or aid are given spontaneously;

2) Psychosocial assistance:- Includes those interactions in which comfort, praise, gratitude or advice are sought or given spontaneously.

Scope and Limitations of the Study

This is an exploratory study designed to record the observations of the social interactions of twenty-eight female patients.

The ward living room was chosen as the setting for all observations, which, as Maas[2] has indicated, is the natural life setting of the patients. Moreover, the choice

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[2] Maas, H. S., et al., "A Technique for Studying the Social Behavior of Schizophrenic Patients," Journal of Abnormal Psychology, XLVI, 1951, pp 119-123.

of the ward living room was influenced by three additional factors. In the first place, there was no single off-ward activity attended by all patients from the study ward, where observations of the total group could be carried out. Secondly, the structured treatment activities included selected patients from other wards, which introduced an uncontrolled variable. Thirdly, the greatest number of patients found together would be in the ward living room.

The generalizations and conclusions drawn from the discussion and interpretation of the data are confined to the particular group studied. Although some of the conclusions may be useful for similar groups, no such extrapolation is explicitly made.

Preview of Methodology

Some of the techniques used in observing the social interactions of patients were patterned after those developed by Hyde and York.[3] The observers maintained a nonparticipant role and were seated in the same centrally-located position in the ward living room during each observation period.[4]

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[3]Hyde, R. W. and York, R. H., "A Technique for Investigating Interpersonal Relationships in a Mental Hospital," Journal of Abnormal Psychology, XLIV, 1948, pp 287-299.

[4]Diagram of Ward Living Room. Appendix 1, Figure 2, page 45.

A sociometric technique was constructed to record patients' interactions. The effectiveness of this recording instrument was pretested on the study ward and proved to be efficient in recording those interactions pertinent to the study.

The observations of the patient group were conducted simultaneously by the writers. During each thirty-minute observation period they made independent recordings of the help-giving interactions which they saw. Following each observation period they compared their recording and retained those interactions which both observers had seen and classified in the same way.

Variables[5] which are not controlled in this study are:

1) the size and composition of the patient group;
2) the changes in patient population due to transfers and new admissions;
3) the observers' inability to see all interactions taking place;
4) the limited number of two, one-week observation periods which were interspaced by a month interval;

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[5]Delineated in Chapter 3.

5) the larger number of interacting patients during the first week of observation;

6) the varying number of patients who were asleep in the ward living room at the time of observations.

Sequence of Presentation

Chapter II deals with literature pertaining to the problem being studied and with the sociometric technique. In Chapter III the methodology is outlined and the study sample described. Chapter IV is the presentation of findings and Chapter V, the summary, conclusions, and recommendations.

CHAPTER II

THEORETICAL FRAMEWORK OF THE STUDY

Patients Helping One Another

In the past two decades there has been an increasing interest in the social milieu of the psychiatric hospital. Within this framework numerous studies have dealt with the social interactions between staff and patients. As this knowledge increased, it became apparent, also, that the spontaneous interactions, which occurred among the patient population, were of value in the total therapeutic process.

Stanton and Schwartz,[1] in studying the patterns of patient interaction on a psychiatric ward, observed that very sick schizophrenic patients were able to carry on collaborative activity with others. The typical daily activities included the offering of attentiveness, such as patients sitting with a patient receiving a hydrotherapeutic treatment, the giving of fluids and, when necessary, summoning personnel. Other kinds of assistance were offered through mutual sympathy and support when members of the group experienced emotional crises.

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[1]Stanton, A. H., and Schwartz, M. S., The Mental Hospital, New York: Basic Books, Inc., 1954, pp. 175-190.

Bateman and Dunham[2] studied the effects the state mental hospital had upon patients in speeding or hindering recovery. The social organization of patients demonstrated a capacity to develop a type of common, collective life. This increased their interest in helping to ease the newly admitted patient's adjustment to the hospital and efforts to aid in his recovery and discharge.

Similarly, Brown[3] in 1961 examined the potential psychological value of patients giving help to one another in the general hospital. She believed that the therapeutic value may be in patients doing something for someone else or at least sharing common experiences which may serve as a constructive use of free time, the strengthening of their self-respect and returning to them their sense of independence.

Caudill, et al.,[4] observed in their study of the interaction processes on a psychiatric ward that patients set their own expectations for limiting and supporting one

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[2]Bateman, F. J., and Dunham, W. H., "The State Mental Hospital as a Specialized Community Experience," The American Journal of Psychiatry, December, 1948, pp. 445-448.

[3]Brown, loc. cit.

[4]Caudill, William, et al., "Social Structure and Interaction Processes on a Psychiatric Ward," American Journal of Orthopsychiatry, XXII, 1952, pp. 314-333.

another as the need occurred. They also noted that within the patients' social structure a type of therapy, characterized by sympathetic listening and the making of suggestions, would be carried out among close acquaintances. This value system of the patient group was translated into action by ascribing to each patient what may be called a role. This role required that an individual make a conscious effort to channel his personal abilities and resources into the helping of others.

Carter[5] studied patients' perceptions of therapeutic patient-patient interaction on a psychiatric ward and found that they did perceive patient-patient interaction as therapeutic. The patients entered into interpersonal relationships with each other and communicated these to the writer.

Bartmeier[6] postulated that the recovery of some mentally ill patients may occur from the influence of other patients. He suggested this was the result of a combination of wholesome influences rather than any single hospital relationship or other experience. A discussion

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[5]Carter, F. M., "The critical Incident Technique in Identification of the Patients' Perception of Therapeutic Patient-Patient Interaction on a Psychiatric Ward," Nursing Research, VIII, Fall 1959, pp. 207-211.

[6]Bartmeier, L. H., "Therapeutic Results in Mental Hospitals with a Minimum of Professional Help," American Journal of Psychiatry, CXIII, December 1956, pp.515-518.

note in this article indicated that a large federal hospital was trying a plan to abolish "disturbed wards" and "suicidal wards." This was to be accomplished through patient participation in which a patient group would help assume the responsibility for looking after a special patient who might be classed as disturbed or suicidal.

In 1951, Hyde[7] inquired whether the social system of psychiatric hospitals could be organized in such a way that patients who were convalescing from their mental illness could assist in the care of the patients much more acutely ill. Such an opportunity for patients to help one another, particularly during the recovery phase of illness, would facilitate their return to the give and take of community life.

In outlining the principles of remotivation for the mentally ill patient, vonMering and King[8] state,

> . . . "remotivational programs should utilize the idea that the sick can help the sicker and that within patient groups themselves there are potential sources of help toward more mature social interaction."

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[7]Hyde, R. H., and Solomon, H. C., "Clinical Management of Psychiatric Hospitals," Connecticut State Medical Journal, XV, May 1951, p.394.

[8]vonMering, Otto and King, S., Remotivating the Mental Patient, New York: Russell Sage Foundation, 1959, p. 188.

Sociometric Technique

Pertinent literature was surveyed for the use of sociometric approaches and the instruments that had been found most effective for the recording of interactions.

The Patient Activity Chart[9] was developed by the writers without direct reference to previous studies. The recording key (legend) was patterned after a suggestion made by Grace C. Garner[10] who helped them in the development of technique. This technique will be reviewed in the next chapter of this study.

Shauer[11] pointed out the advantage of more accurate and complete recording achieved by using a sociometric approach rather than narrative recording following the observation period. The spatial and temporal remoteness of narrative recording is more likely to allow subjectivity in recording as well as omission of events. A second advantage mentioned was the greater facility of numerical evaluation

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[9]Figure 1, Appendix I. In keeping with the information provided the patients and staff, the word "activity" was considered more appropriate than "interaction" in the event patients or staff observed the recording process.

[10]Garner, Grace C., Assistant Professor of Nursing, Boston University School of Nursing.

[11]Shauer, G., "Social Adjustment In a Mental Hospital Community," Sociometry, IX, May-August 1946, p. 144.

when a sociometric instrument is used.

In an attempt to develop a technique to study social behavior of schizophrenics, Maas, et al.,[12] chose the ward living room as the setting for study. They found that conducting the study during structured activities presented a bias. As their technique was established, the observers entered the living room without making overtures to any patients and took the same seating position each time, along the wall. The observers responded briefly to any overtures made to them. In recording numbers of patients present during an observation period, they counted the number of patients present at the beginning of the period, then added to this number of any who entered later. They did not subtract the ones who left.

Based on the principles described in the foregoing studies, it was decided to use a sociometric approach to record the social interactions of patients.

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[12] Maas, H. S., et al., "A Technique for Studying the Social Behavior of Schizophrenics," Journal of Abnormal Psychology, XLVI, pp. 119-123.

CHAPTER III

METHODOLOGY

Selection and Description of Sample

This study was conducted on a twenty-one bed ward for female patients at a large Veterans Administration neuro-psychiatric hospital in southeastern Massachusetts. This particular ward was chosen for the study for three identifiable reasons. First, it was one of the smallest patient units in the hospital, which would facilitate meeting all the patients in the study group and learning their names. Secondly, the compact design of the ward living room provided a suitable setting for observational methods. Most wards had either a large living room or, in some cases, two small ones. The third influencing factor was its being a locked ward, which presented the likelihood that more of the patient group would be on the ward than if it were an open ward.

A total of twenty-eight patients were included in the sample. The age span of the patient group was from twenty-seven to sixty-nine years, with an average age of forty-eight years. The time since onset of illness was from one to twenty-eight years, with an average length of

eleven years. The average number of admissions for each patient since onset of illness was five, with a range of one to thirteen total admissions. The number of years spent in the hospital since onset of illness ranged from nine to twenty-four years, with an average of five years.

Although the patient population presented a picture of chronic illness, as represented by the computations mentioned above, none of the patients was extremely regressed. Those who were more regressed than the others were helped to maintain good appearance in dress and personal grooming by the staff and their fellow patients. In general, all were oriented correctly to time and place; also, due to intensive treatment regime at the hospital, they had maintained a high degree of socialization ability.

Various diagnostic categories were represented in the sample. Although this was of interest to the authors, it was not within the study design to investigate the differences or similarities in help-giving interactions among patients in categories shown in Table 1.

TABLE I

DIAGNOSTIC CATEGORIES REPRESENTED IN THE SAMPLE

Diagnosis	Patients
Schizophrenic Reactions	14
Affective Disorders	7
Psychoneuroses	4
Chronic Brain Syndromes	3
Total	28

As is shown in Table 2, eleven of the twenty-eight patients were present during both weeks of observation, while seventeen were present one week or less.

TABLE 2

CHANGES IN PATIENT POPULATION

Admissions - Transfers	Patients
Admitted during first observation period	1
Admitted between observation periods	4
Admitted during second observation period	3
Transferred to another ward between observation periods	7
Transferred to another ward during second observation period	2
Total	17

Ten of the twenty-eight patients in the study were assigned to individual work assignments at the hospital while eighteen attended group activities. Most of the patients in the work group were off the ward from 9:00 to 11:30 A.M., and from 1:00 to 4:00 P.M., Monday through

Friday. The patients in the group activities were off the ward from one to four hours during the day. This time was divided into one-half hour to two hour periods. When on the ward most of the patients were in the ward living room as the bedrooms were closed until 6:00 P.M. The patient population varied on Saturday and Sunday depending upon the number of patients who had day or weekend passes.

Tool Used to Collect Data

A sociometric tool was designed to collect the data. A narrative recording method, a check list and a categorical rating sheet were considered before deciding on the form used. The purpose of the tool was to record all of the help-giving interactions which were directly observed.

A copy of the Patient Activity Chart will be found on the next page, with two sample recordings. Following is a description of the recording scheme demonstrated on the chart.

Initials of the patients were put in the circles each time before the observers entered the ward. Whenever there was a new admission or a transfer, the nursing staff on the ward informed the observers.

PATIENT ACTIVITY CHART

RECORDING KEY

1. GIVING - RECEIVING
2. GIVING - REFUSING
3. SEEKING - RECEIVING
4. SEEKING - REFUSING

} a. DYADAL, b. TRIADIC

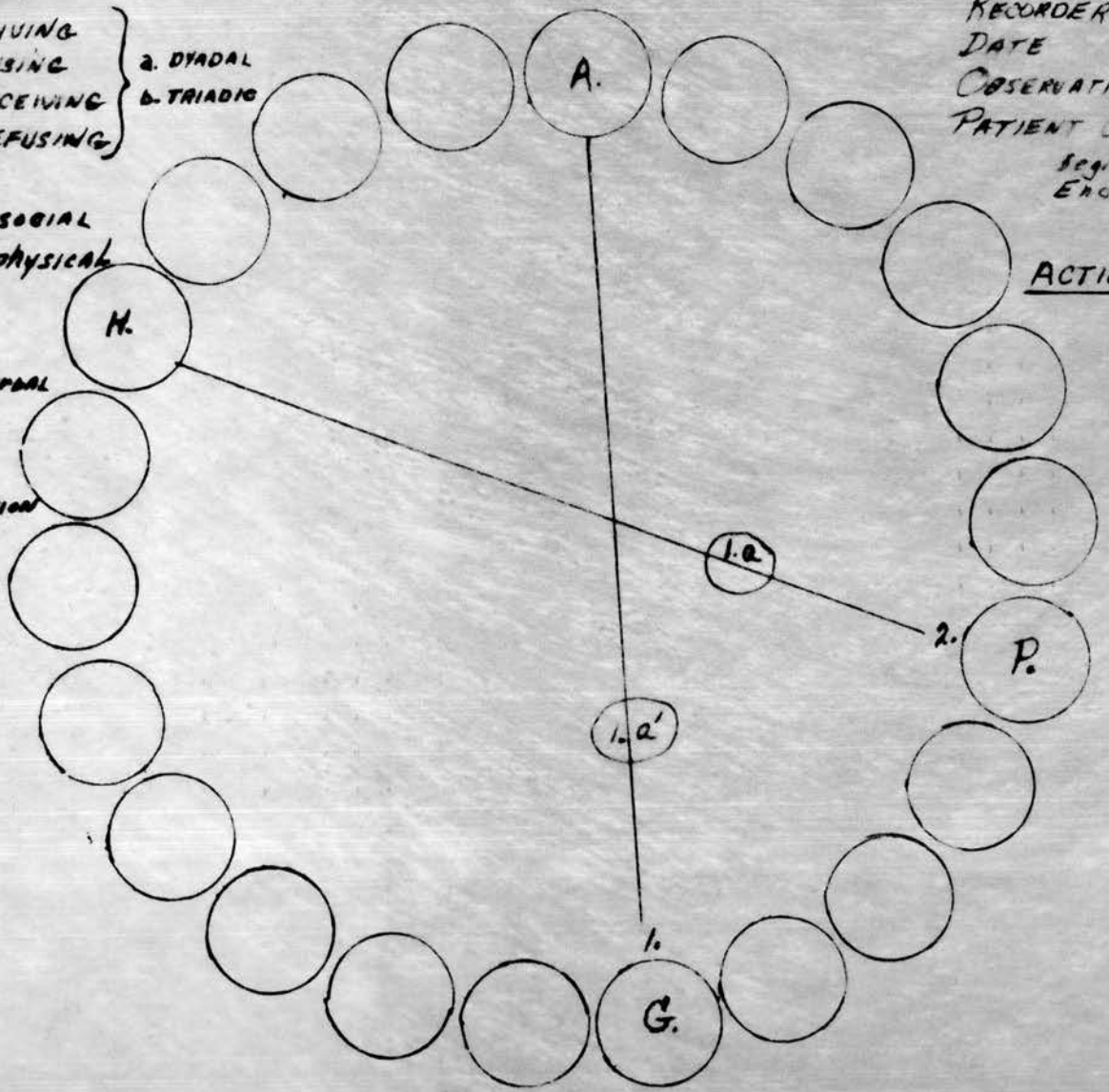
prime = psychosocial
plain number = physical

(No.) = VERBAL

UNCIRCLED = NON-VERBAL

____ 1. = No. of interaction

RECORDER _____
DATE _____
OBSERVATION No. _____
PATIENT COUNT
Beginning _____
End _____



ACTION TAKING PLACE

1. "The dress you made looks nice on you" [G
2. "Here is some warm milk, it will help." [G was feeling cold.]
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.

It can be seen on the Patient Activity Chart that the first interaction was from A. to G. This was denoted by the number of the interaction being placed at the recipient of the interaction. A look at the number of the interaction and then at the right hand side of the page, shows the exact action taking place. By having this description of the action taking place, it was possible to correct any coding errors made in using the recording tool during the observation period. From this it was also possible to determine the specific type of physical or psychosocial help-giving interaction taking place. Another use of this record was in tabulating reasons for discarded interactions.

The (1a') on the Activity Chart means:

(1) giving-receiving
(a) dyadal
(prime) psychosocial
(number and letter circled) verbal

In the second interaction, H., knowing P. was feeling cold, offered her a warm drink. The code describing this interaction was giving-receiving (1), dyadal (a), verbal (number and letter circled), and physical (number and letter without prime). The number of the interaction (2), is placed at the recipient, P.

The date, time, and name of the observer were recorded at the beginning of each observation period. Patients present at any time during the observation period were indicated by a check in the circle with their initial.

Procurement of Data

Trial Study

The tool was tested in a trial study period; only minor changes were necessary.

The trial study was conducted on the study ward for several reasons. The investigators wanted to learn the patients' names, as well as to allow the patients to become familiar with their being on the ward.

The study was explained to the patients at a ward meeting held for this purpose, and patients were encouraged to ask questions.

The primary concerns of the patient group were: the reason their ward was chosen, whether they would be identified by name, how often the observers would be coming and how long they would stay each time.

These questions were answered at the time and then a five by eight card was placed on the patients' bulletin board with the following information.

Patient Activity Study

A patient activity study will be conducted from December 15 - 23, 1961, and repeated January 23 - 28, 1962.

The purpose of the study is to look at the activities which occur in the ward living room. It is hoped that the information we may gather will be useful in improving patient care.

During each week noted above we will observe at various one-half hour intervals from 8:00 A.M. to 10:00 P.M., but not more than four times each day.

You will be able to tell when we are observing by where we are seated in the living room. (The same location each time.)

During the observation period we will be unable to participate in any of the activities or conversations going on.

Names of patients will not be used in the report of our study.

Nancy M. French, R.N., B.S.
Robert M. Teudesman, R.N., B.S.

Graduate Students, Boston University School of Nursing

In order to avoid the risk of inhibiting the spontaneity of social interactions, this study was identified as an activity study. Patients never inquired as to the nature of the activity being studied.

Several meetings were held with the nursing staff for a discussion of the study and its purpose. Staff members were given the same information as the patient group, and a card identical to the one on the patient

bulletin board was placed in the ward nursing station.

One of the primary concerns of the nursing staff was whether they too were being observed. Although assured they were not being observed, it was noted several times during the study that they seemed to feel they were.

During the trial study periods the patients and staff were given an opportunity to discuss or raise questions concerning the study. Although the observers did not enter into conversation during the observation, time was made available immediately following to talk with patients wanting to comment or ask questions. This practice was continued throughout the formal study.

A total of sixteen hours was spent with this trial study which was conducted the week prior to the first week of formal collection of data.

Collection of Data

The first week of observation was December 15-18, 1961, and the second week was January 23-28, 1962. In each of these weeks, twenty-five one-half hour periods of observation were completed, giving a total of fifty periods.

Four observation periods per day were conducted in each week of observation. This provided a time

sampling of the day between 8:00 A.M. and 10:00 P.M. Periods of observation were selected according to times when at least three patients would be on the ward. This was necessary since the authors were looking for both dyadal and triadic interactions. Following is the observation schedule:

A.M.			P.M.		
8:00 - 8:30	xx	o	12:00 - 12:30		
8:30 - 9:00	x	o	12:30 - 1:00	xxx	ooo
9:00 - 9:30	x		1:00 - 1:30	xx	o
9:30 - 10:00	x	o	1:30 - 2:00		
10:00 - 10:30			2:00 - 2:30		
10:30 - 11:00			2:30 - 3:00		
11:00 - 11:30			3:00 - 3:30	x	o
11:30 - 12:00		o	3:30 - 4:00	x	o
			4:00 - 4:30	xx	oo
			4:30 - 5:00	x	o
			5:00 - 5:30		
			5:30 - 6:00	xxx	oo
			6:00 - 6:30	xx	ooo
			6:30 - 7:00	xx	o
			7:00 - 7:30		
			7:30 - 8:00		
			8:00 - 8:30		oo
			8:30 - 9:00	xx	o
			9:00 - 9:30	x	oo
			9:30 - 10:00		o

TIMES OBSERVED
x = First week
o = Second week

During the hours in which no observations were done, all of the patients were off the ward attending activities or eating their meals. The average length of time between observation periods was three hours, with a minimum of one and one-half hours and a maximum of five hours.

The positions chosen provided the best observational opportunities for both seeing and hearing interactions (Figure 2, Appendix I). The observers were closer to the right hand side of the room because the card tables were the center of interaction for the patient group. When the observers were present the television was seldom on and, when it was, patients were usually lying on couches in the center of the room. Little interaction occurred among the patients watching television, as would be expected. When gathered around the card tables, patients conversed with one another, played cards, or worked at such activities as sewing, writing letters, and setting one another's hair.

After the first four observation periods, if patients were sitting in the observers' chairs when they entered, they would usually smile, say "hello," and move to other positions. If they did not move, other patients in the living room would tell them to do so. No angry feelings toward the observers or the patients asking them to move were noted at these times.

A five-minute "warm up" period was maintained throughout the study. This was to give the observers an opportunity to note patients who were present, as well as to provide the patients time to return to the activities in which they were engaged before the observers entered.

(This meant the observers were present in the living room thirty-five minutes each time.)

It was found important to occasionally spend five to ten minutes additional time informally talking to patients after an observation period. This proved to be particularly important the first week of observation, since some of the patients were apprehensive about being observed. After the observers spent brief periods of time talking with them about the study their anxiety seemed to diminish. The primary concerns at these times were whether the observers were sharing their information with the medical and nursing staff, and whether their names were going to be used in the study. One conversation overheard during an observation period was:

J. "I don't think it's nice to stare at people the way they are."

S. "I don't either. It makes me nervous."

J. "Me too."

Neither of these patients left the room, however. Following the observation period one of the observers sat talking with these two patients a few minutes.

Observer "You seem uncomfortable when we are observing."

J. "Yes, I am."

S. "Do you have to look at us all the time?"

Observer "We have to observe everyone here in order to note the activities. I'm sorry this makes you uncomfortable."

J. "I guess it's all right if you have to do it for your study. I hope we can help you. I feel better now."

Both of these patients seemed somewhat more comfortable in the subsequent observation periods.

When the observers were leaving the ward at the end of each observation period, a few patients would say "Goodby" or "See you tomorrow!" Toward the end of the first week, and throughout the second, a more typical response would be "See you later" or "Will you be back?"

As the "getting to know you" phase of the study drew to a close, patient conversation became more spontaneous, and a personal interest in a relationship with the observers developed. It was felt by the observers that they became not merely "data collectors" to the patients but rather "people" whom they wanted to know. The patients would often comment, toward the end of the first week and during the second, that they enjoyed the observers' "visits" with them.

On two occasions the observers were asked if they would be present for an evening ward party. After the observation period conducted during the early phase of the

ward party, the patients requested the observers to stay for refreshments. They stayed for about twenty minutes.

At another time, during the second week of observation, the patients invited the observers into their ward government meeting, which was ordinarily closed to non-patients. The invitation was extended by the president of the group following a vote of confidence by them. This evolved after the president noticed the presence of the observers on the ward and decided to offer the invitation. They attended the meeting, but found, due to the nature of the meeting, an observation period could not be conducted. Therefore the observers stayed another thirty minutes after the meeting was over to do their observation.

Immediately following each observation period, the records of the two observers were compared. At this time coding was checked and corrected when necessary. Also, interactions which could not be used in the study were discarded. The criteria for discarding interactions included: those seen by only one observer, those seen by both but determined not to be help-giving, and those recorded differently. Further analysis of data was conducted after all the observation periods were completed for each week. These will be presented in the next chapter.

CHAPTER IV

FINDINGS

Presentation of Findings

A total of one hundred ninety-three help-giving interactions were recorded during the fifty one-half hour observation periods. As previously defined, these interactions were grouped into physical and psychosocial categories. These were further divided into giving-receiving, giving-refusing, seeking-receiving, and seeking-refusing.

Forty interactions were discarded according to three criteria: first, when seen by only one observer; secondly, when it was recorded differently by the observers; thirdly, when there was agreement the interactions were not help-giving.

TABLE 3

DISCARDED INTERACTIONS

Reason	Number
Seen by only one observer	35
Recorded differently	1
Agreed interaction not help-giving . . .	4
Total	40

The total number of interactions of fifteen patients were reduced by the discards noted in Table 3. Of these fifteen patients, two had a higher number of discards than others; namely, six interactions in one instance and eight in the other. However, both of these patients remained among the patients with the highest number of interactions in the study group. No other single patient had more than four discards.

The average number of help-giving interactions, calculated on the basis of the one hundred fifty-three accepted, was five interactions per patient. One patient gave or sought help twenty-seven times. Her interactions consisted of giving emotional support and needed objects, such as food, clothing, and cigarettes, to her fellow patients. Only occasionally did she seek help for herself from other patients. Another patient gave or sought help twenty-four times. Her interactions were marked by a need to seek large amounts of reassurance and satisfaction of oral needs. She was able to give only once, and this was praise to another patient.

Seven of the twenty-eight patients in the study group did not give or seek help. It was not within the limits of this study to isolate factors accounting for absence of giving or seeking help.

Table 4 illustrates the distribution of help-giving interactions among the twenty-eight patients.

TABLE 4

DISTRIBUTION OF HELP-GIVING INTERACTIONS

Number	Patients
0	7
1-5	14
6-10	1
11-15	3
16-20	1
21-25	1
26-30	1
Total	28

A total of eighty-eight physical help-giving interactions occurred in the fifty observation periods. These were grouped under three headings: an "object"; "information;" "aid with ---." These headings were held constant for giving-receiving, giving-refusing, seeking-receiving, and seeking-refusing.

All of the physical help-giving interactions were dyadal, with the exception of two which were triadic. In one case two patients aided another in looking for her sweater. In the other case two patients worked together in adjusting an arm sling for a third patient.

Table 5 shows the distribution of the physical help-giving interactions under the headings mentioned above.

TABLE 5

HELP-GIVING INTERACTIONS - PHYSICAL

Giving-Receiving

An object

Food or drink	8
Light for cigarette	2
Cigarette	3
Pillow for head	1
Scarf for head	1
Information	0
Aid with ---	
Sewing	3
Package wrapping and unwrapping	3
Bodily comfort	9
Search for lost article	2
Adjust television	1
Total	33

Giving-Refusing

An object

Food	4
Cigarette	1
Clothing	1
Ashtray	1
Information	0
Aid with ---	0
Total	7

Seeking-Receiving

An object

Food or drink	10
Light for cigarette	6
Cigarette	3
Couch (to lie down)	2
Christmas stamps	1
Scotch tape	1
Pen	1
Information	14
Aid with ---	
Bodily comfort	7
Total	45

Seeking-Refusing

An object

Food	1
Light for cigarette	1
Cigarette	1
Information	0
Aid with ---	0
Total	3

"Objects" centering around oral needs occurred most frequently; namely, forty-one of the eighty-eight physical help-giving interactions. Objects, although spontaneously offered, were somewhat more often sought. This is similar to societal situations in that an individual frequently must make his needs for an object known in order to receive.

"Information" was the next most frequently occurring physical help-giving interaction. This was sought fourteen times but never given spontaneously. It is not surprising that information was always sought rather than given spontaneously. In most cases individuals must make their need for information known. Otherwise, those around them cannot be of any help in this area. All information sought was received. Interactions of this nature were primarily in regard to what was the next hospital activity the patients were to attend. Throughout the day there were activities such as visits to the hospital library, to the canteen, occupational therapy, group therapy, and various evening recreational activities. Most of the patients are required to attend these activities. Occasionally patients would ask one another how to find such places as X-ray, and the dental clinic.

The third most frequently occurring physical help-giving interactions were found under the heading "Aid with ---". These interactions dealt with bodily comfort and most resulted from an apparent physical incapacity. Some of the typical interactions in this group were: helping to rise to a sitting position when weak; rolling up or combing hair; assisting to walk when either weak or unsteady on feet; assisting off with coat; moving when a physically ill patient needed to lie down. It seemed the greater the disability, the more frequent was the help spontaneously offered.

Aid with less obvious physical needs, such as adjusting a bracelet, holding a purse while patient was having electro-convulsive treatment, and cleaning glasses, was sought by the person in need. In all, there were nine interactions in this group under giving-receiving, and seven under seeking-receiving. No interactions under this heading were refused. This could be because of the sympathy aroused by patients in physical distress.

The remaining interactions under "Aid with ----," were spontaneously given without physical incapacity or obvious need for help being present.

Psychosocial help-giving interactions occurred sixty-five times in the fifty one-half hour observation

periods. These were grouped under "comfort," "praise and gratitude," and "advice." The above headings were held constant for giving-receiving, giving-refusing, seeking-receiving, and seeking-refusing.

All of the psychosocial help-giving interactions were dyadal.

Table 6 shows the distribution of psychosocial help-giving interactions under the headings mentioned above.

"Comfort" occurred most frequently, both in giving-receiving and seeking-receiving. Twenty-seven comfort giving and fifteen comfort seeking interactions occurred. Two of the spontaneously offered comfort giving interactions and one sought for comfort were refused. The comfort giving and seeking interactions centered around mutual support, reassurance, and concern over physical matters which had emotional components.

Examples of each type of comfort follow:

1. <u>Mutual support</u> (Always seeking-receiving)

   a. J.--"I don't have any Christmas spirit, S."
      S.--"I don't either, J."
      J.--"I don't know why."
      S.--"It's because we're sick, J."

   b. P.--"My mouth is so dry. Is yours ever that way?"
      R.--"Yes. It's the medication I think."

TABLE 6

HELP-GIVING INTERACTIONS - PSYCHOSOCIAL

Giving-Receiving

Comfort	25
Praise and gratitude	12
Advice	8
Total	45

Seeking-Receiving

Comfort	14
Praise and gratitude	1
Advice	1
Total	16

Giving-Refusing

Comfort	2
Praise and gratitude	0
Advice	1
Total	3

Seeking-Refusing

Comfort	1
Praise and gratitude	0
Advice	0
Total	1

2. Reassurance (Both giving-receiving and seeking receiving)

a. C.--"Don't you believe I have a wonderful mother . . . but she just doesn't understand mental illness."
O.--"That's too bad, C."

b. K.--"Do you believe I belong in a mental hospital?"
K.--"You're sick now. You don't make much sense sometimes."

c. S.--"Is this note sarcastic that Mrs. Z. wrote me?"
M.--(after reading note) "No, I don't think so. She was joking."
S.--"Yeah, I guess so. I just must have taken it wrong. Thanks."

3. Physical matters with emotional components (Always giving-receiving)

a. D.--"How do you feel today?"
A.--"Not so good."
D.--"Why don't you lie down?"

b. G.--"What's the matter, B.?" "Are you O.K.?" (B. looked pale and staggered a bit as she stood)

c. M.--(L. soaking foot with sore bunion) "How is your foot today? I hope it's better."
L.--"Yes, thank you."

"Praise and gratitude" were the next most frequently occurring psychosocial help-giving interactions; namely, thirteen of the sixty-five. All praise and gratitude was spontaneously given, with the exception of one which was sought. There were no refusals in this category. Praise centered around appearance (i.e., "You look nice today"

and "You have beautiful hair."). All the praise and gratitude occurred in the first week of observation. At this time patients were going to Christmas parties and preparing to go home for the holidays. Many of the patients had their hair done at the hospital beauty parlor, or fixed it a special way themselves. They were also wearing party dresses in the evenings for the "special" events. There was no special event during the second week for which patients had a special interest in their dress or in fixing their hair.

It is of interest that the third grouping, that of advice, occurred only ten times. The writers felt that the patients seldom sought advice from their peers but preferred to go to someone in authority for this. It seemed difficult for them to seek advice from their peers, possibly out of fear that they might be ridiculed for needing it and from the standpoint of feeling that if they did not know, their peers would not know either. In the same way, one could say that advice was seldom given spontaneously if it might hurt someone's feelings and perhaps harm a friendly relationship. Advice was sought only once and this was in regard to the acceptance of a Christmas gift from someone they didn't care about.

The remaining nine were given spontaneously. On two occasions it seemed there was hostility toward treatment when advice was offered: i.e., "Don't go to the foster home if you don't like it" and "The best way to get along with the doctor and nurse is to go along with them." On another occasion one patient wanted to play cards with a patient who had apparently been lying down most of the day. The patient who wanted to play cards became somewhat exasperated with the other patient and stated "It would be better for you if you played cards rather than lying down all the time." Other advice which was given was of a supportive nature.

There was a notable difference in the number of interactions, both physical and psychosocial, occurring in the first and second week of observation.

TABLE 7

NUMBER OF PHYSICAL AND PSYCHOSOCIAL HELP-GIVING INTERACTIONS OCCURRING IN THE FIRST AND SECOND WEEK OF OBSERVATION

	Physical		Psychosocial	
	Week I	Week II	Week I	Week II
Giving-receiving	25	8	32	13
Giving-refusing	3	4	2	1
Seeking-receiving	30	15	16	0
Seeking-refusing	3	0	1	0
Total	61	27	51	14

As can be seen in Table 7, one hundred twelve help-giving interactions occurred the first week of observation and forty-one the second. The factor which seemed most influential in this difference was the transfer of nine patients to another ward after the first week of observation. These nine patients accounted for 24 per cent of the total (one hundred fifty-three) interactions. A total of seven new patients were admitted to the ward between observation periods and during the second observation period. These seven patients accounted for 3 per cent of the total number of interactions. The cause of the difference in the interaction of the patients in the two groups was not a part of this study.

Another factor influencing the rate of help-giving interactions in the first week of observation was the apparent sympathy aroused in the patient group toward a patient with Alzheimer's disease. She was confused, agitated and presented a picture of pathos. During this time, 11 per cent of the total number (one hundred fifty-three) of interactions were directed toward giving her physical assistance and emotional support. In the second week of observation the above symptoms had been relieved.

Another patient's physical condition influenced both the number of seeking-receiving's and giving-

receiving's in the first week. This patient sought physical assistance in a variety of ways because her arm was in a cast. During this time she also had an apparent chest cold and would have frequent paroxysms of coughing. Patients would aid her in sitting up at these times and would also offer her a glass of water. She seldom refused spontaneously offered assistance and was refused aid that she sought only once. Her need for assistance greatly decreased when the cast was removed between observation periods and the paroxysmal quality of her cough subsided.

Summary of Findings

Of the one hundred fifty-three help-giving interactions accepted for the study, eighty-eight were physical and sixty-five were psychosocial. There were one hundred twelve help-giving interactions during the first week and forty-one the second week. Factors influencing the high number of interactions the first week were: the symptoms of a patient with Alzheimer's disease; the physical disability of one patient; a group of nine patients who accounted for 24 per cent of the total number of interactions. In the second week the conditions of the first two patients were relieved, and the nine patients were transferred to another ward.

Of the one hundred fifty-three interactions, eighty-eight were "spontaneously offered," (giving-receiving, giving-refusing) and sixty-five were "sought for," (seeking-receiving, seeking-refusing). Sixty-four percent of the total number (seventy-one) "sought for" help-giving interactions were of a physical nature while 23 per cent included requests for psychosocial assistance.

There was little numerical difference between the physical and psychosocial "spontaneously offered" help-giving interactions.

Ten of the "spontaneously offered" help-giving interactions were refused, whereas seventy-eight were accepted. Four out of sixty-five "sought for" help-giving interactions were refused.

Two of the one hundred fifty-three help-giving interactions were triadic, leaving one hundred fifty-one which were dyadal. Both of the triadic interactions involved physical assistance.

The average number of help-giving interactions based on the one hundred fifty-three accepted, was five interactions per patient.

CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

Numerous authors within the past decade have indicated that mentally ill patients are able to give assistance to one another in the course of hospitalization. Some studies have suggested that giving help to one another aids in returning feelings of independence, self-respect, and positive social relationships.

These studies gave a theoretical framework to the informal observations the authors had done in both their work and field experience at Boston University. This background provided the impetus to further explore help-giving interactions as they occurred among twenty-eight female patients at a large federal neuropsychiatric hospital. The aim was to class the help-giving interactions seen into physical and psychosocial categories, and to study the types and number of interactions which occurred in each of these categories.

A sociometric tool, developed by the authors, was used to record the help-giving interactions as they

occurred during an observation period. For the purpose of reliability the authors observed together but recorded independently. All help-giving interactions were discarded which were seen by only one observer, seen by both observers but judged not pertinent to the study, or observed but recorded differently.

A total of fifty, one-half hour observations were done within two separate weeks. Each day time samplings were made when patients were in the ward living room between 8:00 a.m. and 10:00 p.m.

A total of one hundred ninety-three help-giving interactions were recorded during the two week study period. Forty of these interactions were discarded and the remainder (one hundred fifty-three) were accepted. Of these interactions, eighty-eight were categorized as physical and sixty-five as psychosocial. Those of a physical nature were related to objects, information, and aid with---. Those of a psychosocial nature were related to comfort, praise and gratitude, and advice.

The average number of help-giving interactions was five per patient. Little numerical difference occurred in the total number of spontaneously offered and sought for help-giving interactions. There was a striking difference

between physical and psychosocial sought for assistance. From a total of one hundred fifty-three help-giving interactions only fourteen were refused whereas one hundred thirty-nine were received. Dyadal interactions occurred significantly more times than triadic ones.

Conclusions

Patients in this study group have a capacity to give one another physical and psychosocial assistance.

When in physical or emotional[1] distress, patients are spontaneously given physical help, comfort and reassurance.

When help is sought or given spontaneously it is received in the majority of cases.

A greater capacity for interaction in one-to-one (dyadal) relationships is evident in this study group.

Recommendations

The recommendations from the experience of this study are as follows:

(1) that an extended study be made, for a more precise investigation, including a larger

---

[1]Emotional distress -- pacing, holding head in hands, expressing fear of treatment or what might happen to them.

sample of patients and more help-giving interactions;

(2) that a study be made, designed to investigate possible differences in help-giving interactions in relation to sex, diagnostic categories, length and severity of illness, and previous social and occupational roles;

(3) that further studies[2] be made to investigate how patients perceive themselves as helping or being helped by one another, and the meaning of this to them as a part of the therapeutic process;

(4) that a knowledge of help-giving interactions and the meaning of them for patients be used for teaching of nursing students, for in-service education, and by nursing administration for stimulating the establishment of projects such as "patient employee"[3] programs.

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[2]Carter, loc. cit. This is the only nursing study found in which patients' perceptions of their helping one another was investigated.

[3]A "patient employee" program is currently being utilized for rehabilitation in the hospital where this study was conducted. Patients who have demonstrated a desire to help their fellow patients in a more formal way are placed with Nursing Service. They may serve as "aides" on a particular ward or as escorts to activities and treatments for sicker patients. Those who work as "aides" are given a course of instruction in patient care so that they may seek employment as "aides" upon discharge from the hospital.

APPENDIX I

FIGURE 1.

PATIENT ACTIVITY CHART

RECORDING KEY

1 GIVING - RECEIVING } a dyadal
2 GIVING - REFUSING }
3 SEEKING - RECEIVING } b triadic
4 SEEKING REFUSING }

prime = psychosocial

plain number = physical

(no) = Verbal

uncircled = non-verbal

____ 1 = No. of interaction

RECORDER _____

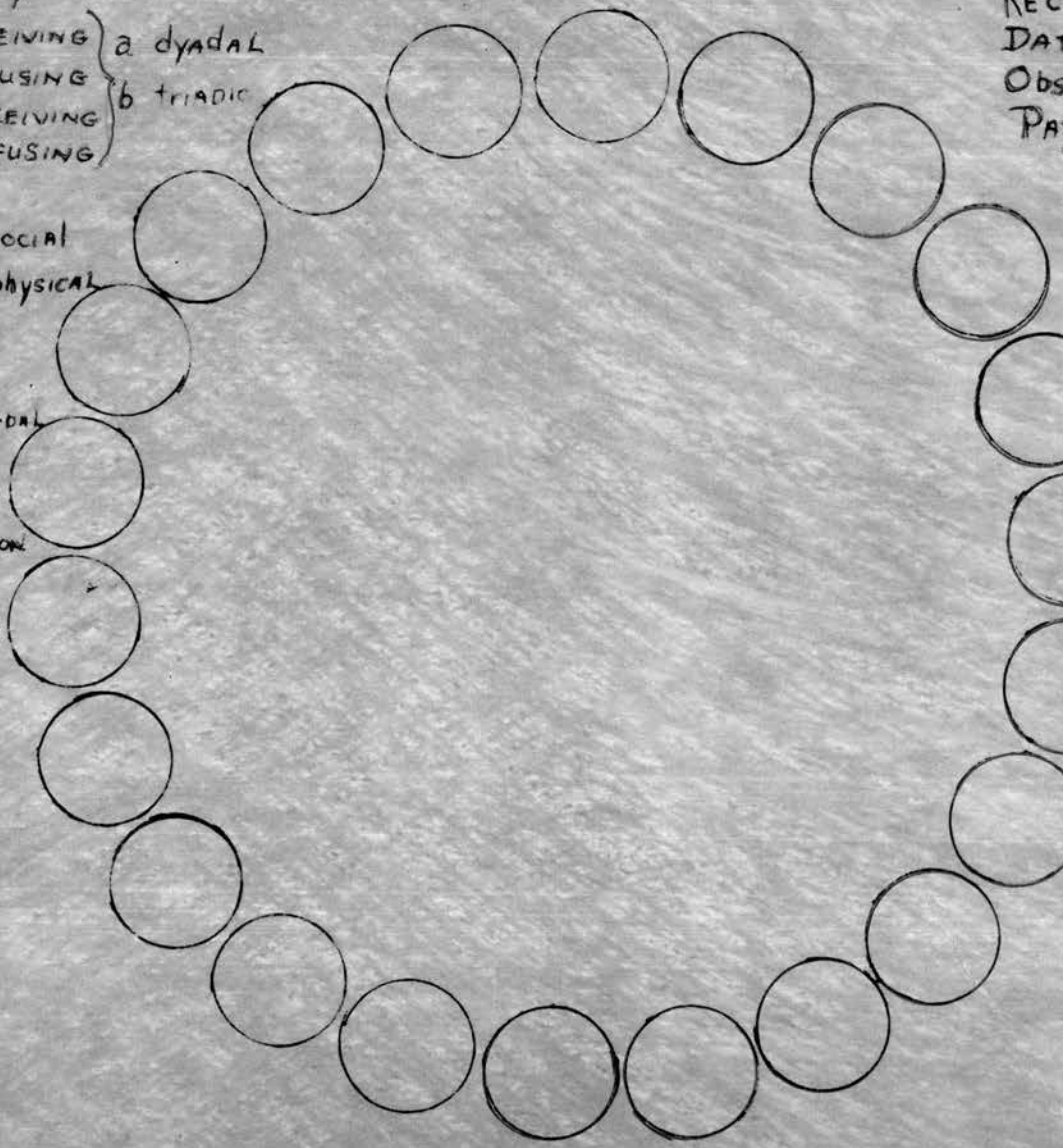
DATE _____

OBSERVATION NO ____

PATIENT COUNT

Beginning ____

End ____

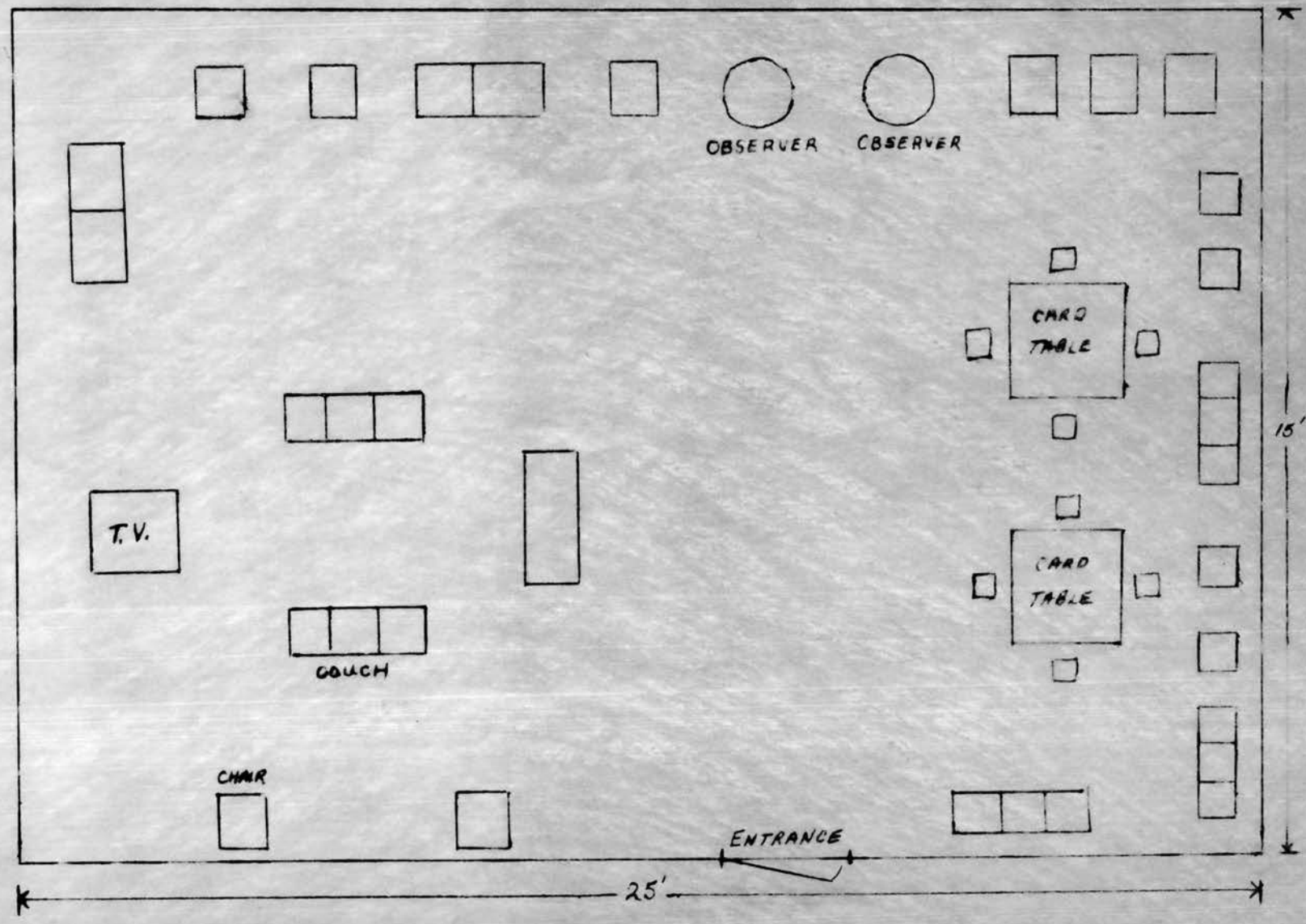


ACTION TAKING PLACE

1.
2
3
4.
5
6.
7
8
9.
10.
11.
12.

FIGURE 2.

DIAGRAM WARD LIVING ROOM



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