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An exploration of the effects of the intensive nurse-patient relationship in the resocialization of the institutionalized, chronic, psychotic patient.

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An Exploration of the Effects of the Intensive Nurse-Patient Relationship in the Resocialization of the Institutionalized, Chronic, Psychotic Patient.

BY

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CHAPTER I

Statement of Problem

This study is an exploration of the nurse-patient relationship as a method in the resocialization of an institutionalized, chronic, psychotic patient. Can the interpersonal relationship between the patient and the nurse be used as a method to change the patient's mode of social participation?

Introduction

Psychiatric nurses in mental hospitals are increasingly expected to manifest their competence in nursing by an awareness of and an ability to handle their interpersonal situations with patients in a therapeutically useful manner.^{1.}

Peplau has dealt thoroughly with interpersonal relations in nursing. She put forth the idea that "Nursing is a relationship between a person who is sick, or in need of health service, and a nurse especially educated to recognize and respond to the needs for help".^{2.}

^{1.} Tudor, Gwen, "A Sociopsychiatric Nursing Approach to Intervention in a Problem of Mutual Withdrawal on a Mental Hospital Ward", Psychiatry, p. 193.

^{2.} Peplau, Hildegard E., Interpersonal Relations in Nursing, p. 161.

There is a growing awareness among some psychiatric nurses of the creativity which they may employ in their ways of responding to the patients' needs for assistance. The psychiatric nurse owes a type of responsibility to patients that goes beyond the use of conventional, technical procedures. She is called upon to use herself in developing unique ways of responding to her preceptions in varying situations.

Psychiatric nurses in mental hospitals are expected to devise methods for assisting the patient toward the highest degree of social competence of which he is capable, by being aware of and acting upon the interpersonal situations which she integrates with the patient; and the nature of the social setting within which these interpersonal situations take place.

Marion Kalkman recognizes the changing role of the psychiatric nurse, and has expressed her feelings in terms of expertness in psychiatric nursing. She feels that psychiatrist and patients demand expertness of the psychiatric nurse.³ The nurse is expected to skillfully handle certain aspects of patient care using her imagination to develop effective methods for achieving favorable results.

3. Kalkman, Marion E., Introduction to Psychiatric Nursing, p. 301.

The patient expects expertness from the nurse in understanding him. The expertness of psychiatric nurses of the past meant expertness in nursing procedures. Expertness of psychiatric nurses today means expertness in interpersonal relationships, that is, a high degree of awareness of the patients' and the nurses' psychological needs, and a high degree of skill in meeting these needs.

Greenblatt, York, and Brown deal with the development of therapeutic potential of personnel. They give accounts of nurses functioning as group therapists. They also state that "Under proper conditions the traditional role of the psychiatric nurse can be augmented to include the function of individual therapist, a function heretofore almost exclusively reserved for psychiatrists."⁴

Psychiatric literature has recorded dramatic results in the treatment and care of acutely ill patients. However, a major psychiatric problem is found in the care of chronically ill patients; especially those who have been institutionalized for long periods of time, and are among the population frequently referred to as "Back ward" patients. Psychiatric nurses are also expected to manifest their competence and

4. Greenblatt, Milton, York, Richard, Brown, Esther, From Custodial to Therapeutic Patient Care in Mental Hospitals, p. 154.

and expertness in therapeutic relationships in the care of these patients.

The need to change the institutionalized, chronic, psychotic patient's mode of participating within his environment has been recognized, and various methods for changing these modes of social interacting have been explored and recorded. VonMerring and King deal with several methods which might be employed in remotivating mentally ill patients. Of the chronic, institutionalized patient, they quote E. F. Galoni as adequately summing up the main theme of their book. He states that:

"The institutionalized patient is more a social problem than a psychiatric problem. Therefore, a treatment program should be aimed primarily toward a remotivation of his interest in the environment and a reeducation in his basic techniques of social adjustment." 5.

Gwen Tudor recognized the need for elevating the psychotic patient's mode of participating within the social context. She deals with a sociopsychiatric approach to intervening in the care of institutionalized psychotic patients. Her beliefs are that the patient's psychosis is his method of participating within the environment and that this

5. VonMerring, Otto & King, Stanley, Remotivating the Mental Patient, p. 395.

mode of participating can be elevated by the activities which others direct toward him.⁶

June Mellow,⁷ Frances Portnoy,⁸ and Alice Robinson⁹ have written detailed accounts on the nurses' way of functioning with patients on an individual basis. In these studies there seems to be consensus that there is a role for the nurse in psychotherapy, especially so since there is no question that vast numbers of chronically ill mental patients are going without any sort of treatment except custodial care.

With others in psychiatric nursing, the writer believes that a nurse can develop the kind of relationship with patients which is conducive to marked patient improvement; that the relationship between the patient and the nurse can serve as a therapeutic force in the treatment of mentally ill patients. With this in mind, the writer approached an hypothesis from the standpoint of "I believe".

⁶ Tudor, op. cit., p. 194.

⁷ Mellow, June, "An Exploratory Study of Nursing Therapy With Two Persons With Psychoses," Unpublished Master's Thesis, Boston University, 1953.

⁸ Portnoy, Frances, "The Nurse and the Patient-- An Introspective Study of the Emotions of the Nurse," Unpublished Master's Thesis, Boston University, 1957.

⁹ Robinson, Alice, "The Role of the Nurse in a Large Public Mental Hospital," American Journal of Nursing, Vol. 55. April, 1955, pp. 441-444.

Statement of Hypothesis

I believe that an intensive nurse-patient relationship can be a method for elevating the institutionalized, chronic psychotic patient's mode of participating within the social context.

The following framework was used by the writer to explore a one-to-one nurse-patient relationship as a method for remotivating a chronic psychotic patient's interest in the environment, and in elevating the patient's mode of participating within the social context.

1. To act in the capacity of participant observer.
2. To keep a detailed diary on the nature of the relationship.
3. To analyze and evaluate the relationship through weekly supervised conferences with a nurse-therapist.
4. To formulate plans for intervening in accordance with the analysis of the data.

Scope and Limitations

The study was conducted on a thirty eight bed female ward of a large state hospital. This building housed approximately one hundred seventy chronically ill female patients. The data is limited to the interactions which transpired between the writer and one patient over a nine month period.

An attempt is made by presenting this study to record the effects of a nurse-patient relationship, and to give an account of an intensive nurse-patient relationship as a method for elevating a chronic psychotic patient's mode of social participation

Preview of Methodology

To collect the data, the investigator functioned as a participant observer while interacting with one patient over a nine month period. Attention was focused primarily upon developing a relationship with the patient during the first four months. At the end of this period, the writer sought supervisory conferences with a nurse who is performing research in nursing therapy. These conferences continued for five months, at which time the relationship was terminated.

The investigator saw herself functioning in three major roles during the process of the study. They were:

Participant Observer

In this capacity the investigator was primarily concerned with effecting a friendly, but therapeutic relationship with a patient. At the same time to observe the patient's mode of participating within the social context, and explore the possibilities for interrupting unhealthy behavior patterns.

Collaborator:

One hour each week was spent in supervisory conferences with a nurse-therapist. Various experiences in the interpersonal relationship were discussed during this time. Specu-

lations on means of handling specific situations were usually arrived at.

Focused conversations with personnel regarding their experiences with the patient were initiated in order to ascertain some ideas of existing attitudes of the personnel toward the patient.

The writer's faculty adviser, student discussion groups, and hospital personnel were available for assistance throughout the course of the study.

Change Agent:

In this capacity the nurse functioned in a therapeutic manner by using herself as a catalyst in interpersonal situations between the patient and personnel; and in specific therapeutic experiences with the patient.

Sequence of Presentation

Account of the relationship as it developed throughout the nine month period are presented progressively. This includes a brief description of the setting with a preview of how the author saw the patient functioning within this setting, and the initial nurse-patient interactions.

Development of the relationship during the period when the patient's attention was primarily focused upon testing the nurse will be dealt with. This will be followed by a phase where the patient was more accepting. It was during this period that the investigator was more able to identify the patient's social needs and interrupt unhealthy behavior patterns. Accounts of the types of interventions which were made are included. Terminating the relationship presented

problems which will be discussed in terms of the effects which it had upon the patient and the nurse.

The nurse-patient relationship as a method will be discussed in detail in a summary which will include a discussion of the application of the overall framework to the method. The relationship of the overall framework to the identification of needs, intervening, and evaluation of the intervention, will be dealt with in terms of how these three elements contributed toward elevating the patient's mode of social participation; and toward remotivating interest in the environment.

CHAPTER II

METHODOLOGYInterpersonal Relationship -- Initial Contacts

As a graduate student in Psychiatric Nursing, a certain number of hours of supervised field study are required. Since my previous psychiatric experiences were focused totally upon male patients, most of whom were acutely ill; I was concerned with working with female patients--preferably those who were chronically ill. I felt, therefore, that I should use this experience to work closely with chronic, female patients. Thus I became acquainted with "X" building.

This three story red-brick building is situated on the grounds of a large state hospital for mentally ill patients. As far as possible, therapeutic, rather than a custodial trend of care, is practiced within this institution. However, in many cases, circumstances have it that certain situations do not approach the degree of patient-rehabilitation that others achieve.

There are six wards in "X" building, two on each floor. X-1, on the bottom floor, is completely open for patients to come and go at their discretion. A large number of these patients work on the hospital grounds or in the city and return to the building for meals and to sleep.

X-5 and X-6, on the top floor, are both semi-open wards. A few patients have out-of-door privileges and are permitted to leave the building whenever they desire, but they are restricted to the hospital grounds. Other patients remain on the ward unless accompanied by personnel.

Three wards are locked. These patients are considered to be less able to care for themselves, and therefore, need more constant care.

Two nurses and one doctor were available to offer professional services for the entire building. Direct patient care, for the most part, was carried out by attendant-nurses.

Having toured the entire building several times, spending a few hours on each ward; I found that I had somehow become particularly interested in X-6. The physical structure on this ward was much the same as the rest. It might be said that they were equipped with the bare essentials. There were large dormitories with at least four beds in each, bedside stands being available for a few rooms.

At the end of the corridor was the day hall where most of the patients spent the entire day. A large, heavy table in the center of the room held a few out-of-date magazines, and also served for games. Several large, wooden benches lined the barren walls, and panes were missing from the long,

curtainless windows. A short hallway led from this room into the bathroom.

Seldom more than two attendant-nurses were present on the same day; therefore, little time was available for recreational or other diversional activities. Large numbers of patients wandered aimlessly about the ward.

The patients on this ward were different from those on the closed wards in that they were more able to follow ordinary social conventions and respond to ward routines. But there were many similarities in the types of behavior being presented between the two wards, differing primarily in degree. Much anxiety was being expressed on X-6, but seldom reached the point of panic or extreme excitement. There were the chronic prancers, those who talked and yelled almost incessantly, some who rocked themselves back and forth on the benches for hours, the demanding ones who constantly sought the attention of the attendants, and a smaller number who were well enough to organize group activities among themselves--usually card games.

For the most part, it seemed that the larger number of patients had adopted a mode of participating which assured them of some form of attention, though it might sometimes be in a negative vein. Within this group, there was one patient who concentrated her efforts on keeping people away from

herself. She usually sat alone on one of the benches, or stood and stared through a window into space. Intermittently, she quietly read from the palm of her hand.

Her physical appearance reinforced her autistic behavior pattern, and emphasized her apparent loss of interest in herself and her environment. The dresses that the hospital supplied were much too large for her tiny frame and usually hung around her ankles or dragged the floor. Her personal hygiene reflected a long period of neglect, and her hair was in a wild disarrangement about her head. People who went in her direction were met by a scornful frown, and she readily moved away from those who came too close.

This patient was never asked to join the small groups who were sometimes taken for walks by the students or attendant-nurses. Patients very seldom sat on the same bench with her. She seemed completely absorbed in her fantastic world, yet so desperately alone. She looked more like a sad, frightened, bizarre child than an adult.

I can remember watching her and wondering what could have happened in her life to cause her to have such a fear of people that she could not bear being even physically close to them. I talked with Miss R., the head nurse, about the patient. She was much concerned over the absence of any noticeable change in the patient's behavior over a long period of time.

"At first I tried to approach her," Miss R. said, "but she always ran away. I never got close enough to talk to her. I haven't tried for quite a while, but I'm sure there'll be no difference. She's still a very sick girl."

When I visited the ward again, I initiated a conversation with an attendant-nurse. She told me the patient's name and that she had been this way for a long time.

"Patti isn't very friendly," she said, "but she's no problem. She never bothers anybody, just sits by herself-- so we don't push her."

Both attendants, Mrs. B. and Mrs. M., had worked on the ward for a long while and were familiar with Patti's pattern of behavior. They had adopted a similar pattern of responding-withdrawal.

Responding to the essential social requirements and basic ward routines was assurance for Patti that the attendants would not have to direct their attention toward assisting her. No coaxing was necessary to have her get out of bed at the designated time. She wore enough clothes to cover her body. When the dinner bell rang, she robotly followed the line of patients to the cafeteria.

These may seem to be the more positive aspects of her personality, but they were also part of her pattern designed to keep people away.

A new group of students came to the ward for orientation. They were busy organizing activities for the patients. Patti was standing at a far side of the room looking out the window. Miss G., a student nurse, went over and stood at a distance from her. After a short while Patti began reading from the palm of her hand. When Miss G. didn't move away, Patti turned toward her and read fast and frantically as if she were reading directly to the student.

Patti moved away and I went to talk with Miss G. She was very nervous as she explained how Patti had been keeping to herself all day.

"I've made several attempts to go near her," Miss G. said, "but I'm terrified of her."

I watched Patti as she stood staring out the window. She looked so terribly unattractive—almost frightful. I thought if her physical appearance could be improved, people might like her and want to be near her. I realized, however, that this was another link in her chain of defenses against the world outside her own.

Two factors within the social context were now obvious. First of all, Patti had adopted a mode of participating within her environment that assured her of not having to interact with her surroundings. She had withdrawn and isolated herself from her external environment, and was absorbed in her

fantastic world to the exclusion of any interest in reality. Secondly, the staff was responding to her with a pattern of withdrawal.

Overtly, it appeared that Patti was asking to be left alone, but a more scrutinizing look would show that this cold, aloof, unresponsive, and indifferent countenance did not reflect her true needs. Patti's behavior demonstrated her intense fear of people. Her entire psychotic pattern seemed to revolve around this fear. It appeared, therefore, that her basic need was to be relieved of this fear. She needed the self-confidence, self-esteem, and general concepts of herself as a worthwhile individual that would enable her to interact with people, thus diminishing her fear of them, and lessen her need to escape into her psychosis.

I felt that an intensive supportive relationship with someone who could assist her in rebuilding her self-esteem should be the basis for any plan of therapeutic nursing care which might be attempted. This relationship should be directed toward stimulating and maintaining an interest in herself, and learning to appreciate herself as a worthwhile individual. To the degree that this is accomplished, the heightened self-image which results could supply her with strength to fight her own illness.

The writer felt that just to show the patient that someone is interested has healthful, expansive powers. To

show interest in the patient's welfare would initiate a sense of self-esteem and importance. In this way an intensive relationship could function to elevate the patient's self-esteem by the nurse communicating to the patient, on a verbal and non-verbal level, positive thoughts and feelings concerning the patient's assets and capabilities. The nurse would function to identify the positive aspects of the patient's personality, then seek to initiate the patient's interest in these aspects and stimulate their development by reinforcing and strengthening the patient's interest in herself throughout the relationship. The nurse-patient relationship would function to elevate the patient's self-esteem by providing the opportunity for the nurse to transfer to the patient her own interest in the patient's welfare.

Patti's state of regression and fear of people at this time was evidence that the second person in the relationship should be able to direct her attention only to Patti. I knew that this would take time, but I was willing to become as much involved as would be necessary to help Patti on the road to recovery.

I felt that it would take considerable time before Patti would make a positive response to me, yet I'd have to be consistent in my contacts with her regardless of her actions until she learned to respond. This, I knew, would not be easy for Patti or for myself. Devising methods of approach-

ing her on her present level of functioning would also be difficult. In her own way, I knew that Patti would have to test and retest the relationship before she would be able to accept me. She would have to learn to accept me to some degree before she could place any value in the interactions which would transpire between us.

Until Patti became more accustomed to my presence, I visited her on the same day each week at very near the same time of day. Since her illness at this time did not permit her to make positive contributions to the development of the relationship, I felt that this much structure was necessary until we became more acquainted with each other. Many of these hours were spent sitting near her, or being in close proximity with little verbal communicating. Meeting the demands of the tests which Patti directed toward me during this time was essential for her to develop the confidence necessary to respond positively to me.

The behavior which she presented revealed her need to know that she could depend upon me, that I was sincere, and that I would accept her in spite of her illness.

Patti tried to frighten me away as she had done Miss C., the student nurse, and others who had tried to approach her. When she saw that I was not afraid, she tried running from me. I was determined to have her know that I wouldn't hurt

her, that I wanted to be her friend, that she could place confidence in me, and I would not disappoint her; and that I would return even when she verbally rejected my presence.

I felt that this behavior had a particular meaning to Patti. Becoming involved with people had somehow become too painful for her. She needed to relearn that contacts with others are not always this way.

The following are episodes from the investigator's diary on the development of the relationship during the testing period. Although various acts of testing were expressed throughout the nine months, these are episodes which occurred during the initial phases of the relationship and are, therefore, of a different nature than subsequent occurrences.

1.

Patti was usually in the area of the day hall when I saw her. She was almost always alone. I remember the first time that I approached her. She was standing alone silently staring out the window into space. I stood beside her for a long while. Neither of us spoke. Without changing her position, she burst into laughter. I asked:

"You're Patti, aren't you?"

She began reading from the palm of her hand. I moved closer and looked on. She became very upset and rushed from the window. Near the center of the floor she danced about in a very disorganized manner. She looked frightful as she performed what looked to be a witch dance.

This behavior seemed to be an effort to frighten me away, or maybe it was to say "See how crazy I am." I reinforced my determination to have her know that she could not frighten me away, and that I could like her in spite of her behavior.

2.

Patti was in bed with a swollen jaw today. She paid absolutely no attention to me when I entered her room and gave no reply to my greeting. I sat at her bedside; neither of us attempted to make conversation. Suddenly she sat up in bed and asked me to leave, stating in an angry tone:

"I don't want company anymore!"

I felt terribly rejected, but explained to her that I understood her discomfort and realized how she could want to be alone. I told her that I would see her on Thursday as I attempted to tuck the covers over her thin shoulders. She jerked the covers away and tucked them tightly over her head.

3.

Patti was sitting on a bench in the day hall when I arrived. She gave no reply to my greeting, and gave the appearance of not recognizing my presence. We sat for a long while, saying nothing. The wind was blowing briskly at our backs through the space where a pane was missing from the window.

"Is the wind too cold for you?" I asked.

"I won't worry about that," she replied.
"Haven't I seen you someplace before?" she asked.
"Aren't you the social worker from "Y" building?"

I found it difficult to help her to understand that I was a nurse. She could not understand why I was there, and refused my explanation

that I was there because I wanted to visit her, and talk with her. Any questions to ascertain her feelings about my being there were replied to by remarks such as:

"I don't care if you come or not."

"If you talk, you talk; if you don't, you don't."

"Don't worry about me, I'm alright as I am."

She left me sitting alone on the bench and did not return. When I was about to leave, I found her and asked if I might visit her again on Tuesday. After a long pause her reply was:

"If you come, you come; if you don't you don't."

To Patti such statements seemed to mean that she would not permit herself to become involved; that she would remain indifferent. This assured her of not being hurt. If she did not expect me, then she would not be disappointed if I did not come. Even so, I'm sure that Patti felt that I would return on Tuesday, and that she might have experienced much anxiety as a result.

4.

I found her crouched in a corner on the bathroom floor. I sat beside her. She tried to ignore me, giving the appearance of being deeply engrossed in her thoughts.

I became very uncomfortable as I sat there. I expected to be rejected. I expected no response, verbally or otherwise until she was ready. Yet, I was ill at ease with the silence. I wanted to do something tangible for her--a card game, I thought. No, maybe I'll comb her

hair or lace her shoes. At the same time, I knew that Patti would accept no such overtures from me.

My own ideas of "Nursing" had begun to bother me; previous training had not been without effect. I had been well endowed with the stereotype of a nurse-- busy, sophisticated, efficient. Presently, I was sitting on the floor in the corner of a dingy bathroom.

My frustration mounted as I realized that I was being stripped of the defenses that former training had supplied. I was taught that nurses do not become involved with their patients, and any display of emotions was taboo.

Becoming involved with Patti was essential to her care; besides, I wanted to really know her. I was skeptical of my ability to handle my emotions in a way that would be an asset to our relationship, yet I could not suppress or deny their existence. I became more anxious as I sat and pondered my feelings of inadequacy.

In a very nonchalant manner, as if she had just realized my presence, Patti said:

"Oh, you're here."

I was startled by the abrupt break in the silence. Guilt soared through me as I became aware of not actually sitting with her, but being in close proximity, and at the same time, very much apart.

"Why did you come today?" she asked.

I told her that I was back because I promised her that I would come to visit her today, and because I liked to visit her. When I asked if she minded my being there, her reply was:

"I don't control what you do. Do what you want."

Patti rejected my presence, but she did not ask me to stay away. I'm sure that she was afraid and had to defend herself against being hurt; but also, her need to have someone to care for her was as great as her fear of them. For the lack of another place, she continued to hide in the bathroom when she knew that I was coming.

5.

I brought her a magazine today. She refused it saying that she didn't need it, so we stood and looked through the window in the small bathroom until she moved away. At the door she stopped to wait for me. This was the first gesture of concern shown me. In the day hall we sat together on a bench.

"What's the magazine for?" she asked.

I told her that I thought she might like it, so I brought it for her, adding that I'd like for her to have it.

She looked at the cover, but did not open the book. She held it on her lap for a while before deciding to give it back, stating again that she did not need it.

When it was time for me to leave, I placed the magazine on the seat beside her, explaining that I wanted her to have it, and it would be there should she change her mind. I glanced over my shoulder as I walked down the corridor, and she was intently looking through the magazine.

The incident with the magazine seemed to reflect ambivalent feelings toward me. To accept the magazine was to show concern for me which she was not sure that she wanted to do. Her first display of interest had exposed too

much of herself, and she had to draw back into her shell and relieve herself of the discomfort which she felt.

Attempts to direct Patti's attention toward her physical appearance were met with equal rejection. Usual responses were:

"The dress is all right for me."

"I won't worry about my hair."

"I won't bother to put strings in my shoes; they're all right for me."

I found it increasingly difficult to work with her toward improving her personal appearance. Her concepts of personal value were practically nil. The fact that some members of the personnel were so repelled by her added to her already well established feelings of worthlessness.

At this time my actions consisted primarily of visiting her, sitting with her and engaging in whatever verbal communications in which she was willing to participate; and in small ways show that I cared about her.

These small gestures gradually elicited more positive responses from Patti. Her verbal communicating was minimal, but as the relationship progressed, she moved away less frequently, seldom acted out her desire to be rid of me; and the palm reading almost ceased.

6.

The Christmas holidays were approaching, and I was going to be away for a few weeks. I explained this to Patti several times before I was to leave. She gave the same indifferent response:

"If you go, you go; if you don't, you don't."

With this, she apparently dismissed the thought from her mind.

The week before I was to leave, I explained the situation to Patti again, and noticed an almost immediate change in her behavior toward me. The few elements of acceptance were suddenly withdrawn; she refused to let me close to her for a while, and completely abstained from verbalizations. Again she tried to hide from me in the corner of the bathroom. I was greatly disturbed over this behavior. I felt that my leaving was causing her to regress, and evidently this is what others in her life had done--left her. I increased my visits and went to the ward almost every day.

When she talked to me again, she continuously expressed her desire to leave the hospital for the Christmas holidays. She was very much preoccupied with this idea; she was much too ill to be considered for leaving, even for a short while, yet she thoroughly believed her fantasy.

Patti's behavior was a reaction to my leaving. She tried to run away from me because it would be less painful for her to leave me before I left her. Her behavior changed, however, when I persistently returned to assure her that I would return, and gave her the specific date to expect me. It seemed that her preoccupation with leaving the hospital was to say:

"When you leave, I want to leave also," or

"I want to go with you."

SUMMARY

In reviewing the course of the participation with the patient to this point, two major aspects become clear. Observing her interactions within the social setting pointed out that her mode of participating was to withdraw from her surroundings both physically and mentally. Her psychotic behavior itself was her pattern of maintaining herself in this state of isolation. This behavior included frightening people away by her actions and appearance, running away from anyone who attempted to approach her, and becoming so completely involved in her fantastic world that others were sealed off by a barrier of coldness and indifference.

The fact that the staff had adopted a similar method of responding to her is the second major aspect which observations revealed. Apparently they had misinterpreted her needs and were responding to her overt behavior, rather than the actual meaning which it had for the patient. Thus, a pattern of mutual withdrawal had developed, each maintaining and reinforcing the other.

Closer observations on the part of the investigator revealed that the patient's behavior was a reaction to an intense fear of people, but that her need and desire to interact with people was as great as her fear of them. The direction toward elevating the patient's mode of participating evolved from the recognition of this basic fear and need.

Testing the investigator's sincerity was essential for the patient before she could invest herself in the relationship. For the most part, her behavior was directed toward asking the following questions:

"Will my behavior frighten her away?"

"If I run away from her, will she continue to come?"

"If I ask her to leave, will she stay away?"

Interpersonal Relationship -- Utilization Phase

I continued to spend much time with Patti, visiting her at least three times a week. Careful analysis of the contacts revealed that the type and level of communications changed in several ways. Periods of silence became less and less frequent, she would reply to my greetings, and there was a decrease in her autistic behavior. She seldom read from her palm. Attempts to frighten me away, run away from me, or ask me to leave had ceased. The patient began to take initiative in conversations. She would make short comments about the weather and gave more complete answers to questions. Her facial expression had changed from a perpetual frown to a more relaxed mien. When asked questions concerning herself like "How are you?" with a half smile she would reply "I feel fine." Previously she would make no reply at all or just "All right."

For a long time I had tried to have her go for a walk with me, or to just walk to the door with me as I was leaving, but got no response. Now, she promised to go at a future day by making replies like "I'll go next time, but I won't go today." She refused to walk with me to the door, but gave a bashful "Good-by" or "I'll see you."

There was little change in her comments on her appearance, but her actions showed more concern. She buttoned her

dress when this was called to her attention, looked at her shoes, and moved her hand to her head when comments were made about her hair or her shoes, but usually gave the same reply, "I won't worry about them".

The first day back from Christmas vacation she greeted me with a half smile as I walked into the door, and moved over to make room for me on the bench. After the usual greeting and a few comments about the weather, we dropped into a natural silence which was broken when Patti asked if I still wanted to go for a walk. I was startled, but very pleased.

We walked about the grounds for more than an hour. She led the way, taking different paths as she came to them. We walked in silence except for her intermittent outbursts of laughter.

After this initial activity, the patient became more relaxed and assumed more responsibility for the relationship. As she indicated the desire to assume these responsibilities, and manifested signs of aggressiveness; I became more passive and relinquished to her whatever her behavior indicated that she was ready to assume.

The following are excerpts from the investigator's diary during the second phase of the relationship. They indicate the nature of the interpersonal contacts and the type

of participation which existed between the patient and the investigator during this period.

1.

I went on the ward today and Patti was not in the day hall as she usually is. I looked through a magazine while waiting for her. I saw her when she came into the room from the corridor but decided to wait and see if she would approach me when she recognized my presence. She came over as soon as she saw me and stood near the bench. I made room for her to sit, and we talked for a long while with a few periods of silence.

2.

Patti was in her bedroom when I arrived. Another patient saw me and ran down the corridor calling "Patti, Patti, your friend is here to see you."

We decided to go for a walk in spite of the cold day. Patti was a long time getting her coat. I went to see what was keeping her, and found her firmly resisting the attendant's attempts to have her wear stockings. I told her that it was cold outside, and I felt that she would be much warmer with stockings, but she was determined not to wear them. She was becoming very irritable, so we left without the stockings.

Intermittently she burst into inappropriate laughter, but seemed to be enjoying the walk. When we passed the building that housed the beautician's shop, I suggested that we go in and look at the shop and meet the beautician. She pretended not to hear me. When I repeated she replied

"I won't go now, maybe I'll go on the way back."

She seemed irritated when I reminded her of the suggestion as we approached the building on the way back. In a very annoyed man-

ner she said that she had decided that she wouldn't stop. We walked back to the building in silence.

3.

Patti had shampooed her hair and was busily drying it when I arrived. I was very pleased and she gave a big smile when I complimented her. I offered to go for her comb if she would tell me where to find it. She said that she did not have a comb and firmly refused to ask the attendant for one. I brought her a comb from the nurses office. When she had finished, we went for a walk to the canteen and had cookies and milk. She wanted a candy bar, and I bought it for her before we returned to the building.

In analyzing the data from which the above were abstracted, changes could be noted in the interpersonal situations surrounding the patient other than those experiences between the patient and the nurse. The investigator noted that her mere presence on the ward with the patient had attracted the attention of other patients and caused them to become very much aware of Patti. This, plus the changes in her behavior, had lessened their fear of her, and in several ways they were interacting with her. Frequently, patients sat on the same bench with her, though they did not talk. If she was not in the day hall when I arrived, a patient would go for her or direct me to her.

Though Patti did not verbally communicate with them, and denied knowing the names of any patients, even her roommates; this type of nonverbal interacting with other patients

had tremendous therapeutic benefits for her and must have contributed much toward the warmth which she now emanated.

Permitting her to express whatever aggressive feelings that occurred in our relationships as well as recognizing and responding to her readiness to accept responsibilities and make decisions which were commensurate with her level of functioning, formed a basis for her developing concepts of self-value. Expressions of self-awareness were now being manifested by sparks of interest in her personal appearance.

An evaluation of the data also pointed out that the patient's mode of participating with the aides showed little change. She maintained a pattern of both physical and verbal withdrawal from them. Necessary contacts were anxiety provoking for the patient. The response of the personnel to these situations was reciprocal to the patient's. They withdrew and made minimal contacts with her.

The attendants' attitudes toward the patient showed obvious repulsion and hopelessness with underlying hostility and contempt. Her unattractive appearance had apparently been repulsive to them; and the experiences which they had with her were primarily failures. They had failed in their attempts to approach her, and in their attempts to communicate with her. Because of these repetitive failures the staff had become indifferent, adopted a defeatist attitude,

and withdrew. This attitude was so intense that they had failed to recognize the gradual changes taking place in the patient's behavior. They were continuing to respond to her on the level that she was before any alterations were made in her behavior.

The nurses and doctor were in much less contact with the patient than the attendants. They were not so intensely repelled by her, but possessed an attitude of hopelessness. This attitude itself inhibited the development of any desire to contact the patient. Since no emergency situations or extreme management problems occurred, it may well be said that the patient was forgotten by them. The problem now at hand was to devise a type of structure that would bring about an alteration in the staff's mode of participation so that they would move in the patient's direction rather than away. The method to be used should be directed toward pointing up the patient's present mode of participating, and bringing about their recognition of the gradual changes which were occurring in her behavior. They could, then, engage in helping to promote and maintain these changes until they were well integrated into the patient's personality.

The first step in this plan was to make the staff more aware of the patient. The fact that they hardly knew her was the root of the problem. If this situation could be

reversed, they might be able to understand her illness as a problem that has to be worked through, and therefore, take an interest in assisting the patient to maintain a higher level of participation.

The investigator engaged in focused conversations with members of the staff at different times. These conversations were aimed at directing the attention of the staff toward the patient.

The following excerpts indicate the type of conversations which occurred.

Mrs. B.

Investigator "I was wondering what you thought of Patti. Do you have the opportunity to talk with her often?"

Aide "Patti isn't any trouble on the ward. She nevers bothers anybody. I never bother her about activities, because she'll only run away and act crazy. I think it's because she can't tolerate closeness."

Investigator "Did she act the same way in your recent contacts with her?"

Aide "Well, I haven't tried recently, but I'm sure she'll be the same. Somehow I think that she doesn't like me."

Investigator "Tell me, did someone help her with her shampoo the other day, or did she do it all alone?"

Aide "I don't know. I didn't notice."

Investigator "I'm here only a few days a week, and I'm with her for a comparatively short while, but I'd like to know what her

behavior is like when I'm not here. Would you mind filling me in on her activities when I come?"

Aide "I'd be glad to."

Mrs. M.

Investigator "I was wondering what you thought of Patti. Will she talk with you?"

Aide "No, she hardly talks to anybody."

Investigator "Did she say anything at all in your recent contacts with her?"

Aide "Just Yes or No. She usually moves away from me."

Investigator "Do you know whether someone assisted her with her shampoo the other day, or did she do it all alone?"

Aide (Thinking) "That was the day when you asked me for the comb?"

Investigator "Yes, it was a few days ago."

Aide "I didn't, but I don't know whether or not someone else did. I was surprised."

Investigator "She was very happy when I told her how pretty she looked."

Aide "I've noticed that she'll sit with you. Does she talk to you?"

Investigator "Yes, very little at first, but more and more."

Aide "She seems so anxious when I go near her--as though she's irritated."

Mrs. E.

Investigator "I was wondering what you thought about Patti. How does she act on the ward?"

Aide "She's no trouble. She keeps to herself most of the time."

Investigator "How is she with other patients?"

Aide "They don't go around her much. I think they're afraid of her."

Investigator "Does she bother them?"

Aide "No, I think that it's the way she looks and acts that frightens them."

The investigator felt that this sort of inquiry might stimulate the aides to really question how they do respond to the patient. It was evident from the type of answers given that they were familiar with her mode of participating, but they were not aware of their own withdrawal. The fact that the aides did not know whether Patti had assistance with her shampoo indicates, first of all, that they had not directed their attention toward changing her appearance, and secondly, that they had not recognized the self-interest which the patient was developing.

Answers to the first question indicate that the aides' attitudes had not changed along with the patient's behavioral changes. Such attitudes could have detrimental effects upon the patient's progress. The vagueness about recent contacts with the patient points up their pattern of avoidance and could well be the reason for not recognizing the changes in her behavior.

"I think that I irritate her;" "I think that she doesn't like me;" "I think that the patients are afraid of her," might well reflect the aides' feelings about the patient rather than her feelings toward them.

This period was also marked by progress in the interpersonal relationship between the patient and the investigator. There was a more relaxed atmosphere, and the interactions were more free and smooth. The investigator was always greeted with a smile. The patient's appearance had improved tremendously. We had now discovered some common interest, and conversation was easier. Patti had become quite involved in having me compliment her on improvements in her personal appearance. At almost every visit there was something new, and I had to be especially alert to notice the particular change and point it out. She chose dresses which were more her size; putting strings in her shoes was one special item of note. During one visit she was holding her hands very delicately in her lap. I noticed that her fingernails were immaculately clean and complimented her immediately. She also permitted the beautician to style her hair.

I was sitting in the day hall one afternoon when she returned from the beautician's shop. She greeted me cheerfully, and apologized for being late. After a shower of compliments she suggested that we go for a walk. She ran about the ward making a fuss over getting her coat, scarf, etc.

When she returned to the day hall she wore make up and was neatly dressed. The only flaw was that she also wore the lipstick for her eyebrows.

We walked about the grounds for a long while before returning to the building where we looked through a magazine together until it was time for me to leave. She walked with me to the door. Before saying good-by we decided on a date and time that I would come again.

The above example is typical of the type of interpersonal interactions that were taking place at this time.

Subsequent contacts with the aides revealed rapid changes made in their contacts with the patient, and in their attitude toward her. The investigator felt that this might be due to two factors. Patti's physical appearance, as well as her responsiveness, was attractive, and the attendants were no longer repelled by her and also found satisfaction in their ability to communicate with her. The second factor is that the aides' attention had been directed toward the patient by the investigator.

The investigator made contacts with at least one aide on each visit. Warm relationships developed between us. Besides enhancing free discussion concerning the patient, the relationship accelerated their developing an interest in

the patient. Change could be noted in incidences like the following:

1.

Aide "I sat with Patti for a while today. She didn't talk much, but at least she didn't run away or act crazy."

2.

Aide "Patti is so much better. You should see her primping. She has to have just the right size dress or she won't change, and she's so careful about her make up. Yesterday she came to ask me for a comb. I can remember when she wouldn't come near one of us."

3.

Charge Aide "I spoke to Miss R., the head nurse, about Patti's improvement. I told her that she should be able to handle ground privileges. She promised to contact Dr. S. about her."

I was ill and did not see Patti for a week. When I returned the head nurse informed me that Patti had been granted ground privileges, and how well she was handling herself. She stated that Patti always comes by the office to tell her when she is leaving and when she will be back. Later in the day I talked with Dr. S. He pointed out the changes in Patti's appearance and behavior, and that she was more active and verbal in group therapy, which was quite a change since she never used to participate. He described her previous behavior there as sitting with her head bowed the entire hour with few outbursts of inappropriate laughter. We discussed

the possibilities of Patti being assigned to Occupational Therapy and decided that she might be able to benefit from it. She was assigned the following day.

These new developments were the subject of many of our conversations. We discussed her Occupational Therapy projects, her trips to the beauty parlor, her walks. She was overjoyed by the fact that she no longer had to be accompanied by personnel when she left the building, and that she could leave and return when she desired.

Her contacts with the aides continued and grew stronger. Though they did not develop to the extent that she had an intensive relationship with either aide, there was mutual warmth expressed in their contact.

SUMMARY

In summarizing the data during the second phase of the relationship, marked changes are noted in the interpersonal situation between the patient and the nurse; and the relationship of this to the total social structure.

Viewing the patient's present mode of participating in contrast with her previous method of interacting, definite changes were noted in the following areas:

1. Level of interacting with investigator and personnel.
2. Physical appearance.
3. Method of communicating.

The investigator functioned in two ways to bring about the above mentioned changes. A primary object was to heighten the patient's self-esteem and concepts of self value so that she could function at a higher level and at the same time be able to tolerate the activities which others would direct toward her. The second method of functioning was to direct the attention of the personnel toward the patient so that they could engage in assisting the patient to develop and maintain a higher level of social participation. With the attendants, the investigator had the following objectives in mind:

1. To make the aides more aware of the patient's present mode of participating, and to gain insight into their own pattern of interacting with her.
2. To bring about the aides' recognition of the gradual changes which were taking place in the patient's behavior.
3. To work toward changing the type of response which the aides were making toward the patient.

The investigator used focused conversations with the aides to bring about their awareness of the existing state of mutual withdrawal. This resulted in better understanding and mutual warmth being expressed.

The patient's initial manifestations of changing was by her increasing acceptance of the investigator on both a verbal and nonverbal level. Taking a more active part in promoting, and maintaining the relationship was concomitant

with her demonstrating evidences of self-value. This was also seen in her ability to impart warmth in her contacts with others. There was remarkable diminution of inappropriate types of acting and reduction in overt manifestations of intense fear of people.

The following paragraphs demonstrate the contrast in the patient's present and past mode of participating.

Her past mode of interacting was characterized by extreme physical and verbal withdrawal which had progressed to the state that the patient was isolated in her own fantastic world. She demonstrated little interest in the outer environment, and her contacts with the outside world were expressed in a distorted manner. She performed only the essential requirements-- those which were necessary for social conformity.

The patient's physical appearance reflected a loss of self-esteem and her lack of interest in the outside world. Her total outward appearance was one of complete unattractiveness and disarrangement. Her mode of communicating was on a nonverbal level and consisted of a series of actions which were essentially the opposite to her actual needs. Her presenting behavior revolved around her intense fear of people; yet her need to interact with people was as great as her fear of them.

Data on the terminal phases of this stage of the relationship shows that she had presently reached a level of verbal communicating which included all facets of the personnel—nurses, doctors, and attendants. She made minimal verbalizations with patients, but her interactions with them had changed from running away from them or frightening them away from her to overt demonstrations of concern for them and warmth in her contacts with them.

At this point, the patient's state of physical withdrawal was non-existent. She made contacts with the people and objects in her surroundings and demonstrated such remarkable ability to maintain herself in reality, that she was able to handle herself both on the ward as well as the broader hospital environment.

Her physical appearance bore little resemblance to her former unattractiveness. She shows concern for her clothing and hygiene. The beautician was among those whom she learned to interact with. She is able to make and maintain designated appointments with her, and possesses enough self-interest and self-direction to meet the appointment unaided.

Though the roots of her psychosis are still present, and were purposefully not dealt with in this study, she has ceased to engage in gross psychotic behavior. Her need to read from her palm, perform disorganized dances, run away

from people and frighten them away from her; and her total pattern directed at maintaining her state of withdrawal was no longer present.

A highly significant aspect in the development of this phase of the study was the investigator's supervision. The investigator was supervised by a nurse-therapist. This supervision was primarily directed toward assisting the investigator to examine the relationship between herself and the patient, and also to provide the investigator with emotional support.

As the study progressed, several situations arose which were anxiety provoking to the investigator. In such cases, supervisory conferences served two main purposes; first of all, the supervisor assisted the investigator in analyzing the situations in order to isolate elements in specific situations which were causing the discomfort. Secondly, supervisory conferences provided the opportunity for the investigator to freely express her feelings concerning any aspect of the study, and receive sufficient assistance and support from the supervisor to prevent the communication of her own feelings to the patient and thus inhibit the progress of the relationship.

The supervisory conferences followed a pattern of discussion where the investigator gave detailed accounts of her experiences with the patient, focusing upon her perception of the situation, her own feelings, including anxiety, anger, pleasure, fear, disappointment, etc., and the type of responses which the investigator made at different times.

The nature of the situations which were dealt with at these conferences were occurrences where there was a conflict between certain aspects of the patient's behavior, and certain elements in the investigator's personality. At such times, the investigator was aware only of the episodes of anxiety and restlessness which she felt after meeting with the patient. In these cases the supervisor functioned to assist the investigator in a detailed analysis of the meeting by the investigator giving step-by-step accounts of what happened during the meeting, and how she felt about specific occurrences. In this way the root of the problem would be brought to the surface and dealt with.

A review of the data points out that the majority of the situations which were undertaken by the investigator and supervisor were a type that could be worked through after being dealt with in conferences no more than twice. However, one situation arose which had to be discussed over a long period of time before the dynamics could be understood.

Throughout the sixth and seventh months of the interpersonal relationship, the patient continuously made demands of the investigator. It began by her asking for money, various small articles, and eventually clothes. At the onset of this type of behavior the investigator felt minimal discomfort, and granted the requests because she felt that the patient would be happy by having certain personal possessions. However, the situation grew to the extent that the patient felt that the investigator was obligated to fulfill her requests, and reacted with anger and hostility when her requests were not granted. At this point, the situation had become anxiety provoking for the investigator, both because she could not afford to meet the demands from a financial angle; and most of all, because she felt that the patient was expressing a deeper need which was being manifested through her demands-- a need which the investigator could not identify.

The situation became more complex as the patient made more demands of the investigator, and it became a point of focus in the supervisory conferences. Each incident where the patient made a specific demand of the investigator was related in detail to the supervisor. The investigator gave step-by-step accounts of the patient's behavior, and her own feelings and actions in the situation. After several such conferences a pattern of interactions was revealed which led the investigator and supervisor to see that the patient's behavior indicated that she was trying to effect a more depen-

dent relationship with the investigator; the kind of relationship where the investigator would be in the role of a mother. The pattern revealed also that the investigator's anxieties were originating from her own inability to handle situations where the patient was attempting to become overly dependent upon her.

Careful analysis of each episode led to the understanding of the dynamics of the situation. Though no attempts were made to solve the investigator's inability to function in a mother role, or the patient's need for a mother; an understanding of what was happening between the patient and the investigator made their contacts less anxiety-arousing. The understanding of the dynamics of the situation enabled the investigator to handle herself in ways that would not permit the patient to become overly dependent upon her, and at the same time enhance the progress of the relationship.

Interpersonal Relationship -- Termination Phase

The patient was aware of the investigator's role as a student throughout the relationship. At intervals during the nine months, the approximate length of time that the investigator would be there was brought up in relation to other problems or in discussing other subjects. This should have given the patient a feeling that there would be an eventual separation, even though it was not a point of focus.

Two months before the end of school, the supervisor and myself decided that we should now concentrate on terminating the relationship. Since neither of us would be available to the patient after two months, we felt that the objectives during this stage of the interpersonal relationship should be two-fold. First, to have the patient realize when the investigator was to leave, and the reason for her leaving. Secondly, to recognize the patient's reactions to the separation and assist her in working through them so that she could make an adequate adjustment after the investigator's departure.

Participating closely with the patient over the length of this relationship had created a degree of involvement that previous evaluations had not brought to the investigator's awareness. The data point up various manifestations of the investigator's anxiety, especially demonstrated in her re-

fusing to accept this as the end; and in continuously post-
poning explaining the situation to the patient, and have/^{her}fo-
cus upon the approaching separation.

Again supervision was significant in helping the investi-
gator to assess her own feelings. Together, the supervisor
and the investigator reviewed the investigator's actions and
feelings concerning the separation to arrive at the reasons
why she could not accept the termination. After several con-
ferences it was concluded that the investigator was reacting
to an ideal perception of nurse-patient relationships. She
felt that the relationship should be continued until the
patient was able to function independently and show spontan-
eous indications of no longer needing the support of the
nurse.

When Patti's present behavior is contrasted with her
previous mode of participating, it can be seen that a much
higher level of social interaction is present; yet the inves-
tigator felt that she could reach an even higher level of
social adjustment if the support could be maintained. Super-
visory conferences revealed that the investigator was uncon-
sciously postponing the separation because she was reluctant
to leave the patient at this level, realizing that though she
had made tremendous progress, she had not accomplished her
potential. With assistance from the supervisor, the investi-
gator became aware of the reasons for the actions. This

awareness enabled her to work through her own feelings about the separation; she could then concentrate upon assisting the patient.

Since there was no one to whom the relationship could be transferred, the investigator contacted Dr. S., the leader of the therapy group of which Patti was a member. After the situation was explained to him, he agreed to observe the patient for any reactions which she might bring to the group, and assist her in handling them, especially after our final meeting.

The following excerpts from the investigator's diary point up the pattern of the patient's reaction during the terminal phase of the interpersonal relationship:

1.

Today I explained to Patti that I would be leaving on the last day of the month. I told her that school would be over, I would be leaving the hospital and would not see her after that day. She said nothing for a while, then made a reply in regard to spring being on the way and how glad she was of this. She completely ignored the explanation about my leaving and continued on another topic. I did not bring up the matter of leaving again. We chattered aimlessly the remainder of the hour.

2.

Patti seemed rather depressed. She did not display as much zest as she usually does, and was not cheerful at all. She mentioned that she was glad that spring was coming, and maybe she could find a job and go home. Realizing that this was an unconscious reaction to my leaving,

I made no comment at all. I felt that it was not the time to point up the unreality of her going home; since she had not accepted my leaving on a conscious level, it would be of no avail to explain her feelings to her.

We discussed the moccasins which she was making in Occupational Therapy. When I asked if she would be finished before I was to leave, she dropped her head and said nothing. Then suddenly, as if she had recovered from a shock, she began a rather forced, cheerful conversation about the approaching spring season.

3.

For the next four meetings, Patti vacillated between states of cheerfulness and what seemed to be true happiness with the whole world, and states of despair and depression. On her happier days we sat and talked, went to the canteen and went for walks around the grounds. She talked about her life before she was hospitalized, the things she liked to do, the kind of work she did, and the little about her family that she could remember. Her father seemed very important to her.

When she was depressed, we sat in the day hall saying very little to each other. During these four meetings I made no mention of my leaving, excusing it on the basis that she was feeling so good that I did not want to depress her, or that she was already depressed, and I did not want to burden her further.

As time passed Patti became more and more preoccupied with leaving the hospital in the spring. In her own way she pressured me to engage in her fantasy by permitting her to believe that this was true. She made statements like

"I'll be glad when spring comes so that I can go home."

"I can't wait to get home; I'm so tired of this place."

"You do know that I'm going home in a few months, don't you?"

I knew that these remarks were a reaction to my leaving, yet she said them with such finality and belief that I found it difficult to direct her attention toward reality. Although she had greatly improved, she was still much too ill to consider going out to live alone. I concentrated on focusing her attention upon this fact, pointing out her remarkable progress, but she asked over and over again if she thought that she should stay in the hospital until she was completely well.

4.

We were discussing the necessity for her to stay in the hospital until she was able to care for herself on the outside. With a very serious expression on her face she said,

"Something is wrong with my mind."

In a half statement half question fashion this was said as though she had suddenly gained insight into her condition.

I explained that her mind was much better now, but that she should let the doctor and nurses care for her until her mind was completely well.

She had a sad expression on her face and sat with her head bowed for the rest of the evening.

5.

I was ill for the next two days that I was to see Patti. I called and had the nurse tell her that I wouldn't be there. When I returned the following Thursday, she was very agitated and depressed. She was now preoccupied with thoughts about her father. She talked about him leaving her there and promising to come back for her. I wondered if she thought that I was leaving her for the same reason that her father had. When I asked

her this, she became very upset and insisted that her father had not left her; that he was there on the ward with her and would never leave her. She took my hand and led me to a patient at the far end of the room whom she introduced to me as her father. I accepted the introduction without making an effort to correct the gesture. Afterwards, we sat together on a bench. She quietly laughed and cried at the same time. I sat with her until she was quieter, and again explained to her the reason for my leaving. I told her that I felt she would continue to get better even though I was leaving. She did not look at me as I talked, and refused to walk with me to the door when I left.

I was disturbed by Patti's behavior. I felt that she was hostile and angry at me for leaving her, and was acting out her feelings because she had not consciously accepted the separation, and therefore, would not verbalize them.

On the way out, I explained the situation to Mrs. B., the charge attendant, partly for my own relief, and so that she could be aware of Patti's behavior and know the reason for it.

6.

When I returned, Patti's glasses were broken, and she had scratches on her face and arms. She talked very little and left me sitting on the bench. While she was away, Mrs. B. explained that she had provoked a fight with another patient on the afternoon of my previous visit. She stated never having seen Patti in such an aggressive state before, but she had calmed her so that it was not necessary to put her in seclusion.

I felt guilty knowing that this anger and aggression which Patti had taken out on another patient should have been directed at me.

Following this overt act of aggression, Patti resorted to her old pattern of running away from me. She interrupted

our conversations by excusing herself and leaving the room, and she usually stayed away until it was time for me to leave. In a milder form she duplicated her behavior of the initial phases of the relationship. Periodically she stared into space; she returned to the corner of the bathroom and stood with her face to the wall. These episodes, somehow lacked the intenseness of previous ones; now, she seemed to be saying "This is the way that I was when you came; if I act this way again, maybe you won't leave".

This same attitude was evident in her physical appearance which she had begun to neglect. She did not show the same interest in herself as she had done before. She missed her appointments with the beautician, her clothes were in a loose disarrangement about her body. This behavior, however, seemed to be on a superficial level and did not reach the depths of unawareness of her previous state.

At the same time that these incidents were occurring, Patti became negligent in her appointments with me. She would leave the ward when she knew that I was coming and stay away until almost time for me to leave before she would return.

7.

I was waiting in the downstairs lobby for her when she came in from the outside. She had an odd, unkempt appearance about her; and she looked tired, as though she had been walking for a long while. She spoke in a rather disin-

terested manner and continued up the stairs. I remained seated on the couch. About halfway up the stairs, she turned and screamed:

"Are you coming, or are you just going to sit there!"

I was startled, but pleased that she could now direct her anger and aggression toward me. We went upstairs and sat in silence for a long while. It was abruptly broken when she asked:

"You're leaving the hospital, aren't you?"

When I told her that I was leaving at the end of next month she said:

"Then I'll never see you again."

She looked like a sad child, and I felt as sad as she did. I could not avoid being honest with her; and at least she was consciously aware of the separation and could work with her feelings on a conscious level.

In subsequent meetings, we discussed the topic thoroughly, even though it added a sad note to the conversations. As time progressed, Patti acted out her feelings to the separation less frequently, and her state of regression diminished. She gradually reassumed the interest in herself and her environment that she had been moving toward for the past nine months.

Patti came to understand and accept the termination of our relationship, but she could not permit herself to believe that she would not see me again. Several times during our discussions on leaving, she made reference to stopping and talking with me should she see me on the street or some other place; and so at our last meeting she said:

"If I should see you on the street or some other place, I'll stop and talk with you."

SUMMARY

The patient's first reaction to the termination was denial, which was shown in her refusal to even hear or respond in any way to the investigator's initial discussions of her impending departure. This made it necessary for the investigator to continuously push the topic toward the patient to make sure that she understood the termination, when and why the investigator was leaving.

The focus upon the topic of separating led the patient to an unconscious awareness of the termination, but she apparently refused to admit it to herself, and therefore, had to act out her feelings rather than verbalize them. Her acting-out behavior was characterized by transitory phases of aggression, regression, hostility and anger. The best results were obtained, however, when she had worked through her feelings to the point that she could direct her anger at the investigator, rather than displace it, and eventually work through her feelings concerning separating on a verbal level.

The investigator's primary concern during this stage of the relationship was to recognize the patient's reactions to her departure, and assist her in working through her feelings

until she was able to accept the termination and maintain herself at a higher level of social participation without the support of the investigator.

CHAPTER III

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONSFinal Summary

The techniques of the intensive nurse-patient relationship being used as a method for evaluating the chronic, institutionalized, psychotic patient's mode of social participation became clear as the study progressed.

The overall framework set the limits for the study and served as the skeleton upon which the method developed.

This framework contained the following elements:

1. Observing
2. Recording
3. Supervision
4. Evaluating
5. Interpreting
6. Intervening

The above elements were applied to: (1) the overall social structure in which the patient maintained a pattern of participating, and (2) the mode of social participation which the patient maintained within this structure. As the study progressed it became primarily concerned with different types of investigator-patient contacts and investigator-personnel contacts. These contacts took place within three distinct phases of the nurse-patient relationship. These phases have been defined as:

Phase I -- Orientation
Phase II -- Utilization
Phase III -- Termination

The method takes on a more detailed form as the elements in the overall framework are applied to the different phases of the relationship, beginning with observations of both the social setting, and the patient's mode of interacting within this structure to:

1. Define the patient's mode of participating within the social context.
2. Become familiar with the patient's mode of communicating.
3. Identify the needs which were being expressed by this pattern of participating and communicating.

These observations led to determining the patient's mode of participating to be both physical and mental withdrawal, where she was using autistic behavior to maintain herself in a state of isolation. This pattern consisted of adopting a disorganized, frightful, unkempt and ugly appearance, accompanied by a series of actions including reading from her palm and performing witch-like dances. These and other gestures were directed toward frightening people away from herself.

Close observations of the patient's presenting behavior conveyed to the investigator the patient's intense fear of people and a deeply rooted sense of worthlessness. This led the investigator to an identification of the patient's needs. She perceived these needs to be as follows:

1. The need to be relieved of her intense fear of people.
2. The need to attain higher concepts of herself; the need for higher self-esteem, the need to have worth and value as an individual. She needed to have a sense of self-value and self-respect, and to be valued and respected by others.
3. The need to be aided by another individual toward fulfilling her need for self-realization, self-confidence; and at the same time, to be aided in developing trust and confidence in people.

The investigator felt that an intensive relationship could be used as a method to convey to the patient through mutual participation that social relationships need not be frightening and anxiety-provoking, but can be both satisfying and security giving.

The relationship which the investigator proceeded to effect was on a friendly but therapeutic basis. It spontaneously took on three phases, each merging into the other, and necessitating close evaluation of the data to differentiate one phase from another, to determine the nature of observations, evaluations, and intervention which were utilized at different stages.

The initial phase of the relationship was concerned with developing a mutual acquaintance. It consisted of spending considerable time with the patient, so that the interpersonal contacts could be experienced and evaluated.

The following steps became clear from the evaluation of the interpersonal contact:

1. It was necessary for the investigator to interact with the patient on her present level of functioning, which at the beginning was predominately non-verbal, and consisted primarily of being in close physical proximity and imparting warmth and concern for her.
2. It was imperative that the investigator be consistent in her contacts with the patient, being sure to meet the appointments at the designated time.
3. The patient's inability to contribute to the relationship was evidence that the investigator should make no demands of her, or to anticipate immediate responses to her overtures; this indicated that the patient should be given sufficient time to respond.
4. It was necessary that the investigator be alert to recognize gradual changes in the patient's behavior and respond appropriately to these changes.
5. It was essential that the investigator interpret the patient's behavior toward herself as well as the general social context, so that she could function adequately with the patient, and be able to respond to the tests which the patient directed toward her.

The second phase of the relationship was marked by the patient demonstrating a higher level of self-awareness and self-confidence. This was manifested by the patient showing more acceptance of the investigator than she had in earlier contacts when she was primarily concerned with testing the investigator's sincerity. She took a more active part in promoting and maintaining the relationship.

Her behavior was characterized by considerable diminishing of inappropriate types of interacting, reduction in overt

manifestations of intense fear of people, accompanied by expressions of warmth in her interactions with them. Evidence of these developments were demonstrated in interest in her own personal appearance, and being able to handle herself in the broader hospital community.

Close observations of the patient's social setting revealed a pattern of mutual withdrawal existing between the patient and the attendant-nurses. Answers to the following questions pointed out that the attendant-nurses were repelled by the patient's unattractiveness; and that recurrent failures in their efforts to communicate with her had caused them to withdraw and adopt attitudes of hopelessness.

1. Are the personnel aware of their attitudes and reactions toward the patient?
2. What are the reasons for their inability to interact with the patient?
3. What can be done to interrupt the existing pattern of withdrawal?

On the basis of these questions, the investigator formulated a plan for intervening in the situation. She had two primary objectives in mind: through mutual participation with the patient, to aid her in developing the self-confidence necessary to respond to the activities which others would direct toward her, and to develop sufficient self-esteem and self-interest to improve her physical appearance;

and secondly, to direct the attendants' attention toward the patient.

With the attendant nurses the following aims were formulated:

1. To work toward changing the type of response which the aides were making toward the patient by increasing their awareness of the patient's present mode of participating, and gaining insight into their own pattern of interacting with her.
2. To bring about their recognition of the gradual changes which were taking place in the patient's behavior, so that they could engage in assisting the patient to maintain herself at a higher level of social adjustment.

Focused conversations with the attendant-nurses were used to accomplish the above aims. The plan resulted in the development of understanding and warmth in the increasing contacts being made between the patient and the attendant-nurses.

During the second and final phases of the interpersonal relationship, the investigator was supervised by a nurse-therapist. This supervision was a highly significant element in the success of the study, especially in directing the progress of the relationship. This supervision served three main purposes:

1. To provide the investigator with an experienced person for didactic assistance.
2. To provide a framework which could safeguard the patient from any adverse therapeutic effects.

3. To provide the investigator with a person to give her emotional support.

The supervision consisted of one hour conferences each week for five months. These conferences, for the most part, were of a non-directive nature where the investigator related to the supervisor detailed accounts of her experiences with the patient. The supervisor then functioned to help the investigator examine the developing relationship between herself and the patient, and to enable her to become more skillful in utilizing this relationship to promote the patient's progress toward recovery. Primarily, the supervisory conferences served:

1. To provide a media for the supervisor to share her own knowledge, skills, and experiences with the investigator. The supervisor functioned to point out opportunities which the investigator had overlooked, to assist the investigator to develop deeper insights into the patient's behavior, and to point out various leads which the investigator might explore in working with the patient.
2. To provide a person for the investigator to share the responsibility of what she was doing and thus reduce her anxieties so that she could work with greater freedom. The investigator received both encouragement from this person and assistance in working through her own emotional reactions which the patient's behavior aroused in her.
3. To keep the investigator reminded that the relationship was a two-way process affecting both herself and the patient.
4. To keep the investigator aware of the effects which her actions had on the patient, and also how she responded to the behavior of the patient.

The third phase of the study was concerned with terminating the relationship between the patient and the investigator. The investigator's primary concern was to withdraw her support from the patient with minimal adverse effects.

The aims of this phase of the interpersonal relationship were to prepare the patient for the termination, starting in time to permit her to work through her feelings about the separation and make an adequate adjustment to it before the final meeting.

The second aim was to recognize the patient's reactions to the separation and assist her in working through her feelings. The patient's first reaction was denial, then aggressive acting-out accompanied by superficial states of withdrawal and regression which disappeared when she accepted the termination of the relationship.

In summary, each phase of the interpersonal relationship had special characteristics, and required changes in the nature of the observations as well as different types of interventions and evaluations; all three being raised to a higher level concomitant with elevations in the patient's type and level of social participation.

Three aspects in the nurse's way of functioning in the interpersonal process become clear. These three functions

give an overall view of the nurse's direction throughout the entire study. They were:

1. To enhance the patient's social participation.
2. To elevate the patient's mode of communication.
3. To recognize and fulfill the patient's social needs.

Slightly revising the following structure set up by Gwen Tudor¹, the following questions were used as a guidepost to direct the course of interpersonal relationship therapy.

1. What is the nature of the social setting in which the patient maintains a definite pattern of interacting?
2. What is the patient's mode of participating, and why is it necessary to maintain a specific pattern and level of participation?
3. What is the relationship of this structure toward enhancing or inhibiting the patient's progress?
4. What is the nature of the interpersonal interactions between the patient and personnel? Does this relationship enhance or inhibit the patient's progress?
5. How can these relationships and the total social structure be altered toward elevating the patient's mode of social participation?
6. How can the nurse become aware of her own feelings regarding the patient?
7. How can she become aware of the feelings of others regarding the patient?
8. What needs does the patient communicate through his type of social participation?

¹ Tudor, op. cit., p. 197.

9. If these needs are recognized and fulfilled, will they foster a higher level of participation?
10. What type of interactions can be engaged in with the patient?
 - (a) Should they begin on a non-verbal level?
 - (b) What is the way of moving on from the non-verbal communicating?
 - (c) What specific forms of communicating can be used?

In view of the above questions, three other aspects in the nurse's way of functioning in relationship therapy become clear. She functioned:

1. To create a therapeutic environment.
2. In the capacity of a participant observer.
3. As a therapeutic agent by using herself as a catalyst in interpersonal situations and in specific therapeutic experiences with the patient.

Conclusions

1. That a supervised, intensive nurse-patient relationship can elevate a chronic, psychotic patient's mode of social participation.

2. That supervision from a person who is not directly involved with the patient enhances the nurse-patient relationship by providing didactic and emotional assistance for the nurse.

Recommendations

1. That intensive nurse-patient relationships should be recognized and utilized as a method in the therapeutic care of mentally ill patients.
2. That Psychiatric Nursing Programs in graduate schools of nursing provide the opportunity for students to receive supervised experience in intensive nurse-patient relationships with individual patients so that they may develop knowledge and skills essential to the care of mentally ill patients.
3. That supervision be recognized as an essential element for nurses who initiate intensive, prolonged, therapeutic relationship with mentally ill patients.
4. That psychiatric nurses in mental hospitals be provided with the opportunity and the freedom to explore and develop new and different ways of functioning in the care of mentally ill patients.
5. That psychiatric nurses in mental hospitals develop the responsibility for recording and publishing their observations with patients, so that a broader background may be formulated in psychiatric nursing.

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APPENDIX

Case History

Patti was a twenty nine year old, thin female with a small frame, but she appeared to be well nourished and in good physical health. She was the only child of an unhappy marriage. Her parents were divorced when she was about three years old. Her mother remarried, but died when Patti was six years old. At this time she went to live with her mother's parents and remained there for twenty years. The grandmother died when Patti was twenty three years old, and she continued to live with and care for her aging grandfather.

Since there was disharmony in the relationship between Patti's father and her grandparents, she knew little about her father; and was instructed by her grandparents not to speak to him. Her only contacts with her father were on her admissions to the hospital.

Before her mother's death Patti was frequently shunted on the grandparents and left there for varying periods of time. Throughout the grandmother's life, she frequently preached to Patti to keep away from people and remain inside the house. There were no other children living in the house, and she was closed up much as if in a box.

Patti did well both in elementary and high school. She liked clerical work and sewing. She did not develop much

social contact, but developed a deep religious interest and became a devout Catholic.

In June of 1946 while Patti was still in high school, she was admitted to the hospital for presenting slightly bizarre behavior and being a management problem for her grandparents. She was nineteen years old on this admission. She was diagnosed as being without psychosis or any other conditions and was discharged after ten days.

Patti completed high school and did piece work in a garment factory until 1954, when she became progressively depressed and bizarre. Her father was contacted, and he had her admitted to the hospital in August 1954. On this admission her record shows her to have normal flow of thought and appropriate emotional tone. She was oriented to time and place, but not person. Her judgment was fair, insight poor; and she demonstrated hearing voices.

During this hospitalization Patti's treatment consisted primarily of physicochemical therapies. She received a series of Electrotherapy Treatments in 1954, and a series of Insulin Therapy Treatments in 1955. She improved and was discharged in her own care in April 1956, since her grandfather had died while she was in the hospital.

Patti was admitted again in February 1957, extremely deluded, withdrawn, and disorientated. She remained on the

acute service for a three month observation period, but did not improve. At the end of this time, she was transferred to a chronic service where she has remained for the past two years.