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TEACHING COPING BEHAVIOUR
TO PSYCHIATRIC PATIENTS

A thesis presented in partial fulfilment of the
requirements for the Degree of Master of Arts
in Nursing at Massey University.

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1978

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ABSTRACT

A structured programme has been developed to teach aspects of the concept of "coping" to psychiatric patients. The teaching programme is based on the concepts of coping and adjustment developed by Lehner and Kube (1964); Coleman (1969); Lazarus (1969); Sawrey and Telford (1974); and Coelho, Hamburg and Adams (1974).

In order to test the hypothesis that patients' perceptions of nurses will affect their learning, the Massey - Patient -Nurse Projective Test (MPN) has been developed as a diagnostic tool. This is used to select patients for the two groups used in the teaching programme which is carried out by a registered general nurse who does not have a psychiatric qualification. The patients' coping behaviour is measured before and after the teaching programme by a coping behaviour test devised by the researcher for this study.

The development of both groups has been analysed in the light of Whitaker and Lieberman's theory of group development. A content analysis has been used to define categories of patient and nurse behaviour during the teaching programme. In addition the behaviour of each patient has been studied using an idiographic case study approach.

The teaching programme was first tested with eight psychiatric patients at a large psychiatric hospital. The same programme was then given to ten middle-aged psychiatric patients (two men and eight women) at the same hospital. The patients were selected into two groups on the basis of their results on the MPN test.

Grouped results show that patients who initially saw the nurse as "helpful" (Group A) did not change their coping behaviour. This group viewed nurses as "less helpful" at the end of the programme. Also, the group shifted its dependency from the nurse to the group members and ended in an early formative phase.

On the other hand, the group of patients who viewed nurses as "not helpful" (Group B) did show changes in their coping behaviour at the end of the programme. The group shifted their conflict with the nurse onto one of the group members and ended in a middle formative phase.

The content analysis shows that patients in Group B had a higher degree of resistance to learning than patients in Group A and fewer attempts to gain insight. The nurse also showed more stimulation of Group A than Group B to gain insight.

The case studies of the patients show a positive change in one Group A patient who developed self-confidence during the sessions, and improvements in two Group B patients who gained confidence in interacting with others, and in planning for future actions.

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INTRODUCTION

In the past few years, the author has worked with psychiatric patients in Thailand and New Zealand, and the similarity of the patients' problems in both countries has aroused the author's interest.

Firstly, most of the patients that the author came into contact with had experienced a number of stressful life events prior to their admission. This was also noted by Brown and Birley (1968); Paykel et al.(1969); Myers et al.(1971)(1972); and Paykel (1974).

Secondly, some of the patients tended to use particular methods in dealing with their problems. A study was conducted by the author into the history of ten psychiatric patients admitted consecutively to the Manawaroa Psychological Unit in Palmerston North between June and July 1976. One of the findings was that all seven re-admitted patients tended to cope with their problems by using the same method that they had used during their previous breakdowns. For example, several of them had a history of withdrawing from their problems, becoming depressed and attempting suicide. This is also noted by Donovan (1975) in his study of psychiatric patients' background histories.

Thirdly, most of the re-admitted patients with whom the author has worked, at Lake Alice Hospital, Manawaroa, and in Thailand, often claimed that they could not cope with their situation at home when they returned, and they believed that this was the cause of their re-admittance.

These findings, even though they were the subjective impressions of a small number of cases, suggested that some psychiatric patients have problems in the area of coping behaviour. That is, that psychiatric patients have a need to develop new and more appropriate ways of coping with their problems (Armstrong, 1975).

It is believed that effective behaviour can be learned (Rose, 1977) and accordingly, psycho-therapy is essentially a re-education or re-learning process concerned with the altering of maladjustive behaviour (Ullman and Krasner, 1965). Moreover, in the course of psychotherapy, patients are often stimulated to learn more adequate

and effective means of dealing with their problems (Coleman, 1956).

Nurses are the professional health personnel most likely to spend the greatest amount of time with the psychiatric patients (Mereness and Taylor, 1978). Morrice (1975) reports that nurses are held in high esteem by psychiatric patients, and are thus in a position to exert great therapeutic influence. Nurses are therefore, in an ideal position to help psychiatric patients learn new and more appropriate methods of coping. This view is supported by Rankin (1975) who notes that nursing actions strive to maximize existing coping behaviour and explore alternatives for the patients to use in coping with their stress. To do this, the author of the present thesis believes that a structured teaching programme is of importance and such a programme has been developed in the present study.

Besides a well structured teaching programme, the patients' initial perceptions of nurses as helpful is thought to be related to the effectiveness of the patients' learning. This relationship was previously described as a placebo-effect. That is, if patients believe that nurses can help them solve their problems, they will benefit from a teaching programme introduced by a nurse (Fish, 1973).

Statement of Problem

It is evident that a number of psychiatric patients are people who have failed to cope effectively with their stressful life events (Caplan, 1963; Adamson and Schmale, 1965; Donovan, 1975). Thus, there is a need for psychiatric nurses to focus their actions on helping these patients to learn new and appropriate coping behaviours (Rankin, 1975; Pesnecker and McNeil, 1975; Armstrong, 1975).

There are many factors involved in effective learning by patients, such as their intelligence, willingness to participate, symptoms and the perceptions of the nurses who care for them. In the present study the author was interested specifically in the effects that the patients perceptions of nurses have on their learning. That is, in the kind of perceptions that would enable patients to benefit from a teaching programme. If this was known, the nurse-teacher could then assess these perceptions and plan an appropriate teaching programme for these patients.

CHAPTER 1

LITERATURE REVIEW

The unexpected changes which may occur in an individual's environment, such as economic crises, sudden death, unexpected interpersonal encounters or shifts in family relationships, are potentially stressful and may markedly influence the individual's mental health status (Leininger, 1973). Irving (1973) defines mental illness as an "inability or failure on the part of an individual to cope with his life stresses in accord with the expectation of his society", and describes mental illness both as "a faulty way of living" and as "a disease of adjustment". Similarly, mental illness is described by Szasz (1960) as the "expression of man's struggle with the problem of how he should live".

Thus there is a need, particularly for nurses who are involved with psychiatric patients, to study life stresses and the effective and ineffective ways in which individuals cope with these. Knowledge of such behaviour can then be applied to prevent psychiatric illness and to help psychiatric patients strengthen their coping abilities.

The purpose of this chapter then, is to review the literature pertaining to stressful life events; to specifically examine stressful life events; to describe how individuals cope with stressful life events; to describe what happens when individuals cannot cope with stressful life events; and to discuss how nursing actions can be applied to help individuals who fail to cope effectively.

Stressful Life Events

Definitions of "stressful life events" reveal two conceptually different ways of describing the characteristics that make an event stressful.

The first is exemplified by the work of Brown and Birley (1968, p.204) in which they use "a list of events which on common sense grounds are likely to produce emotional disturbances in many people". Brown gives examples such as changing a job, or a major change in the health of the subject, then defines such stressful life events as "negative" or "undesirable events".

The second type of definition of stressful life events focuses on change as the critical factor. This concept has led to the development of two measures of the amount of exposure of subjects to stressful events. The first relatively simple measure was used in a study by Dohrenwend and Dohrenwend (1970). They defined stressful life events as "objective events that disrupt or threaten to disrupt the individual's usual activities". Thus the events in this definition might be either undesirable or desirable in character.

The second more elaborate and sophisticated measure is based on the concept that life change is stressful, and was developed by Holmes and Rahe (1967). They collected a list of life events which were observed to occur together at the time of disease onset, for example, death of spouse or divorce. In their study, stressful life events were defined as events that evoked or were associated with some adaptive or coping behaviour on the part of the involved individual.

It can be seen that these definitions focus on different aspects of the stressful event. Brown and Birley (1968) focus on the quality of the events, that is, whether they are negative or undesirable. In contrast, Dohrenwend and Dohrenwend (1970), and Holmes and Rahe (1967) focus on the effects that the events have on the individual involved, an approach also supported by Gersten *et al.* (1974).

For the purpose of the present study stressful life events are defined by the author as:

Any situation that results in emotional disturbance and requires the individual to adjust either himself or the situation to alleviate the emotional disturbance.

From this point of view, a stressful life event may be either desirable or undesirable for the individual, but it has a negative effect upon his emotions with which he must then try to cope.

Furthermore, in the present study emotional responses to stressful life events are regarded as important. This is in contrast to the definitions of Brown and Birley (1968), Dohrenwend and Dohrenwend (1970) and Holmes and Rahe (1967).

Categorization of Stressful Life Events

Research in the area of stressful life events evolved from psychobiology, which was generated by Adolp Meyer (1948). Meyer invented the "life chart", which provides several items associated with stressful life events and relates these items to the process of

health and disease in man. Holmes and Rahe (1967) followed Meyer's study by developing a scale of items related to stressful life events. Their scale is called the "Social Readjustment Rating Scale (SRRS)", and consists of 43 items representing events which necessitate changes in an individual's life whenever they occur.

Similar items were found by Paykel (1969) in his study of depressed patients. Paykel compiled a list of these "individual events" and grouped them into the three alternative but partly overlapping categories outlined below:

(i) Exits and Entrances. Exits and Entrances can be understood in terms of losing and gaining either loved objects or loved persons. Losing may result from such events as separation from a significant person or loss of a prized possession. Gaining may involve such things as promotion, marriage or parenthood. Both losing and gaining may precede mental disorder (Adamson and Schmale, 1965).

(ii) Social Desirability and Undesirability. "Social acceptance" is used as a criterion to divide stressful life events into two groups: socially desirable and socially undesirable.

(iii) Area of Activity. Stressful life events are grouped together into five areas of activity: employment, family, marriage, health and law.

In contrast to Paykel's categories, Drake and Price (1975) classified stressful life events by using internal and external "sources of disruption". Internal sources of disruption are personal thoughts, attitudes or actions that violate a person's belief, values or normal codes, or interpersonal conflicts that threaten to disrupt the person's sense of self-integrity, self-respect and security. External sources correspond to the "individual events" of Paykel. The internal sources are actually results of the external sources.

Yet another approach was adopted by Presznecker and McNeil (1975) who constructed the "Life and health habits questionnaire", to gather data about each of the following variables: health habits; psychologic wellbeing; social assets; life change and major health change. In fact all of the above studies are describing similar stressful life events and are merely categorizing them in different ways.

In the present study, Paykel's first method of categorizing stressful life events has been selected as a basis for developing the

teaching programme, as "losing" and "gaining" are simple terms which describe events common to every individual. In addition, these terms indicate the effects of stressful life events on an individuals' usual life activities (i.e., whether they are losing or gaining), and it is considered useful for patients to realize that their present lives have been changed in ways which require them to cope with new situations.

Paykel's second and third categories are not considered by the author to be as suitable as the first for the teaching of patients. These categories ("social desirability" and "area of activity") are too broad, and these terms would need to be re-defined in terms of their effects on each patient's life.

Effects of Stressful Life Events

Whenever an individual is confronted with a stressful life event he experiences emotional disturbance. The main effects are psychological conflict and frustration, which usually occur together, and which are important factors in the effectiveness of a person's coping behaviour.

Psychological Conflict

Shaffer and Shoben (1956) defined psychological conflict as:

"The arousing of two or more antagonistic patterns of motivation that cannot be satisfied together."

Similar definitions are also given by Shaffer and Shoben (1956); Coleman (1960); Lazarus (1969); Irving (1973) and Rankin (1975). Furthermore, conflict arising under such conditions is considered to be a cause of stress.

Psychological conflict is generally classified into three types:

(i) Approach - Approach Conflict. This occurs when two positive equal strength situations are evoked together and only one situation may be chosen. This type of conflict tends to be resolved easily by either selecting one alternative whilst ignoring the other, or satisfying one goal and then the other. This type of conflict causes less distress than the two following types.

(ii) Avoidance - Avoidance Conflict. An avoidance - avoidance conflict is evoked by two mutually exclusive negative situations occurring simultaneously. A method of resolving this type of conflict

is to leave the conflict situation and take a third course of action (Coleman, 1969; Irving, 1973). If this is not done, the person will remain in a tense state which is the origin of many apparently irrational forms of adjustment behaviour.

(iii) Approach - Avoidance Conflict. This occurs when two stimuli are presented at the same time in the same situation, and one of the stimuli elicits approach while the other elicits avoidance. Approach - avoidance conflict is difficult to resolve. However, a possible method is to eliminate one aspect of the dual feeling by using whatever coping methods are available (Irving, 1973). Unresolved approach - avoidance conflict produces the same effects as avoidance - avoidance conflict, that is tension and irrational adjustment behaviour. There can be no completely satisfactory solution to a conflict if the person remains committed to two conflicting goals.

Since avoidance - avoidance conflict and approach - avoidance conflict are difficult to resolve, they are emphasized in the present teaching programme in order to enable the patients to examine their feelings and their failures in coping with problems.

Frustration

Frustration is similarly defined by Shaffer and Shoben (1956); Coleman (1960); Kube (1964); Lazarus (1969); Irving (1973); and Rankin (1975), as a condition or feeling that a person experiences when his needs or actions are blocked or delayed. These barriers to goal accomplishment may be internal, such as in an interpersonal situation, or external, such as an environmental factor (Rankin, 1975).

During a person's life time, he frequently experiences frustration in his attempts to satisfy his needs. The ability to handle such frustration is believed to be an important aspect of personal adjustment, and basic to problem solving ability (Lehner and Kube, 1964).

If unresolved, frustration is considered to be one of the most painful problems for patients, resulting in feelings of anger, despair, guilt or anxiety. Therefore it is useful to help patients develop "frustration tolerance". Frustration tolerance is defined by Lehner and Kube (1964) as:

"The ability to endure blocking and delay of satisfaction without turning to disruptive maladaptive behaviour."

According to this point of view, the way frustration affects individuals depends upon how well they have developed "frustration tolerance". In other words, to display adaptive behaviour, individuals have to learn to delay their needs in a situation where their needs cannot be satisfied immediately (Slavson, 1960).

For this reason, background information about "frustration tolerance" is included in the present teaching programme.

Coping Behaviour

What an individual has learned through his interactions with his environment shapes his pattern of coping behaviour (Irving, 1973). Furthermore, since each individual is unique, different individuals develop different methods of coping with stressful life events. It is apparent, however, that there are two basic forms of coping behaviour. These are coping by adjusting the stressful life event and coping by adjusting oneself to fit the stressful situation.

The concept of adjustment originated in biology where the term used is adaptation (Lazarus, 1969). For the purpose of the present study, "adjustment" and "adaptation" are considered synonymous. Adjustment is defined by Coleman (1969) as:

"The process by which an organism attempts to meet the demands placed upon it by its own nature and by its environment." (p.4)

Coleman views adjustment in terms of survival of the organism and its attempts to satisfy its needs. This definition seems to originate from physiological adjustment, and includes animals as well as human beings.

Lazarus (1969) defines adjustment in a similar way, but more specifically mentions the modification of behaviour by the individual. He sees adjustment as:

"A process by which an individual modifies his behaviour in an attempt to deal with or master the demands made upon him."

A further view is held by Shaffer and Shoben (1956), who see the process of adjustment as "a series of such sequences in which needs are aroused and then satisfied".

These three definitions all note the attempts of an individual to meet his needs or the demands made upon him. These demands may

arise from the events in everyday life, which usually result in normal patterns of behaviour. However, when a situation becomes more complex and less easy to master, it may become potentially threatening, frustrating, challenging or gratifying and the individual has to employ additional actions. To describe such drastic situations the term "coping" is more suitable than "adjusting" (Coelho et al., 1974; White, 1974).

The term "coping behaviour" was used by Hamburg et al. (1953) to denote:

"All of the mechanisms utilized by an individual to meet a significant threat to his psychological stability and to enable him to function effectively."

Psychological instability is viewed as a force which makes the individual utilize his coping behaviour to deal with the threat. From their study of the coping behaviour of children, Murphy et al. (1962) commented that:

"When responses are not automatic, when we do not know just what to do, we have to cope with the situation as best as we can."

Living in a dynamic world, it is almost impossible for anyone to alter a stressful life event and the individual has to learn to adjust himself. Thus, for the purpose of the present study coping behaviour is defined by the author as:

The attempt by individuals, whether effective or ineffective, to deal with stressful life events.

The Relationship between Stressful Life Events and Coping Behaviour

The definition of coping behaviour adopted in the present study indicates a relationship between stressful life events and coping strategies. Sidle et al. (1969) describe a stressful life event as a "task" and a coping strategy as a "process", and a number of studies have attempted to understand the "processes" which individuals use to deal with various kinds of stressful life events.

For example, Friedman et al. (1963 d) studied the various strategies that parents employ to cope with the anticipated death of their children, and Chodoff et al. (1964) studied the coping behaviour of parents of children with a malignant disease. These researchers found that the initial reaction of parents to the definite diagnosis

was one of shock or of being "stunned", followed by a tendency to seek information about the disease.

Hamburg et al. (1953 a), and Andreason and Norris (1972), studied the coping behaviour of burned patients and Visotsky et al. (1961) studied poliomyelitis patients. These studies were concerned with the psychological responses which enabled these patients to deal with their predicament, and clarification was sought for the following questions: what are the most difficult and disturbing aspects of the adaptive problem faced by these severely ill patients; and what psychological strategies do such patients predominantly utilize in attempting to cope with these problems?

Verwoerdt (1966), Peck (1972), Lipowski (1972), Mastrovito (1972), Hinton (1973) and Rosillo et al. (1973) studied the coping behaviour of cancer patients. The diagnosis of cancer was a stressful and traumatic event and they found that cancer patients employed a number of "coping styles". Lipowski (1972) and Rosillo et al. (1973) describe "coping styles" as the more or less enduring dispositions to use certain techniques to ward off anxiety, fear, depression and other disturbing affects in order to maintain a sense of harmony and a degree of emotional comfort. These disturbed feelings are thought to produce an automatic immobilization of various adaptive and defensive mechanisms (Verwoerdt, 1966).

The research on the coping styles of cancer patients was reviewed by Miller et al. (1976) who found that every author in this area reported the frequent use of denial as a defense mechanism. Mastrovito (1972) described this denial as the keeping out of conscious awareness the significance of serious symptoms. It was also found that before death occurs, dying cancer patients and their families go through five stages of grief: denial, anger, bargaining, depression and acceptance (Kubler-Rose, 1969).

Silber et al. (1961), Coelho et al. (1963) and Hamburg and Adams (1969) concluded in their studies of the effects of college life that competent adolescents tended to cope with their new life experiences by seeking advance information about the new situation, rehearsing their future roles and making friends. Coelho et al. (1963) further noted that college students use diverse patterns of coping behaviour in the new academic environment. This prompted Coelho et al. (1969) to suggest that student health personnel and counselors should support

the various information seeking activities during the high school - college transition by which students may learn to cope with the college life.

Chodoff (1970) and Dimsdale (1974) examined the stressful conditions of German concentration camps. Chodoff found that docility and submissiveness were adaptive under these circumstances, where identification with the Nazi oppressors relieved some of the psychic tension, as did quarrels with other inmates, and daydreams of revenge. Dimsdale focussed on the effectiveness of various coping strategies used by camp survivors. These strategies included group affiliations, identification with the oppressor, selective focus on the good things, and the will to live.

From these studies of coping behaviour, several points can be made. Firstly, in a stressful situation an individual is required to employ a new pattern of behaviour which is not a habitual, routine or automatic action (Murphy, 1969). Secondly, an individual tends to employ his accustomed method or methods of coping, that is, methods that have been used successfully in the past (Crow, 1964; Hitchcock, 1973; Hamburg, 1974). Thirdly, if the individual is unable to utilize formal coping behaviour, he is in "crisis" (Barrel, 1974) and in this disorganized state the individual needs help, and needs to learn new coping behaviour (Rappoport, 1962). And lastly, all of these studies indicate that, although individuals use different coping strategies, under stressful conditions, individuals generally seek information about the same questions:

1. How can the distress be relieved?
2. How can a sense of personal worth be maintained?
3. How can a rewarding continuance of interpersonal relationships be maintained?
4. How can the requirements of the stressful task be met, or the opportunities utilized?

(Hamburg, 1974).

Information obtained from studies of coping behaviour not only provides knowledge of how people under stressful life events behave, but also suggests how such people can be helped to learn appropriate coping behaviour. In the case of psychiatric nursing, this knowledge forms the basis of programmes for helping both the patient and his family.

Categories of Coping Behaviour

Lazarus (1964) and Coleman (1969) suggest two main categories of coping behaviour, task oriented reactions or direct action tendencies and defense oriented reactions. However, the present study uses four categories to simplify the content of the teaching programme.

(i) Facing and Solving the problem. Attention is focused on the problem and the person utilizes his competencies to solve it directly, for example by seeking more information about the problem (Bell, 1977).

(ii) Running away from the problem. This involves an attempt to forget about the problem for a period of time by becoming involved in other activities such as sewing or knitting (Chodoff *et al.*, 1964; Visotsky, 1961); eating, drinking alcoholic beverages, sleeping (Mininger *et al.*, 1963); turning to religious beliefs (Hamburg, 1974); or expecting the "worst" (Bell, 1977). These coping strategies do not solve any problems, but may help release emotional overloads in the short term.

(iii) Inaction or Apathy. Dimsdale (1974) coined the term "null coping" for a person who does nothing. This may occur when the situation seems so hopeless to the person that he eventually has no impulse to act. Inaction or apathy has in fact been found to be an effective coping behaviour in some situations such as in Nazi concentration camps (Dimsdale, 1974).

(iv) Defense - Oriented Reactions. Whilst defense mechanisms (e.g. denial, compensation, rationalization, etc.) are described as coping behaviour by White (1974); Shaffer and Shoben (1956); Coleman (1969); Lehner and Kube (1964); Lazarus (1964), there is some disagreement with this view (Bruner, 1969).

Defense mechanisms are psychological responses which involve attempts to reduce anxiety arising from a stressful life event, by either avoiding or escaping from reality. Defense mechanisms can be useful and adaptive when used to handle the immediate situation, where they operate to keep the pain of intolerable inferiority, unendurable ideas and threatening perceptions from overwhelming the individual. It is evident in the studies of Hamburg *et al.* (1953 a); Visotsky *et al.* (1961); Kubler-Ross (1969); Engle (1964); Hamburg (1974); and Herman

(1974), that denial is usually employed as the initial stage of the grief process and appears to have a useful function in preventing the individual from being overwhelmed by his grief.

However, an individual should not consistently use defense mechanisms because he will lose his flexibility in coping with his stressful life events. These mechanisms may be useful for permitting the individual to make a more gradual transition to other methods and thus avoid shock when facing an immediate stressful life event.

The Quality of Coping Behaviour

The quality of coping behaviour can be evaluated in two ways either as good/bad, or as effective/ineffective. The description of coping behaviour as "good" or "bad" depends largely on the values of the particular culture or subculture (Lazarus, 1969). In general, "good" coping behaviour is that behaviour which is acceptable to a particular group of people while "bad" coping behaviour is that which is not. Thus "good" or "bad" coping behaviour refers to judgements of the patterns of the action rather than to the quality of the action and therefore "good" coping behaviour may not necessarily be effective.

The term "effective" coping behaviour refers to the "degree of fit" between the coping strategy used and the particular stressful life event. To obtain the effective coping behaviour, two conditions must be satisfied. Firstly, the behaviour must meet the demands of the stressful life event, and secondly, the behaviour must satisfy the person's feelings about that stressful life event. To meet these requirements, an individual may have to use several methods of coping, such as, running away, using a defense mechanism, and/or facing the problem. In contrast, ineffective coping behaviour is the lack of fit between the stressful life event and the skills of the person (Barrel, 1974).

Lazarus (1969) identified four main classes of symptoms which can be used to evaluate the ineffectiveness of coping behaviour:

(i) Psychological Distress. This is the first symptom of adjustment difficulties and often brings an individual to the attention of a mental health worker.

(ii) Psychosomatic Diseases. There are a number of studies which have investigated this class of symptom: Rahe et al. (1964, 1967, 1973); Rahe and Paasikine (1971); Cline and Chosy (1972). It is manifest by

the appearance of a physical illness in response to the individual's stressful life event.

(iii) Deviation of behaviour from the standards of the society. Neurotic, psychotic and psycho-pathological symptoms are included in this class.

(iv) Impaired effectiveness. Under stress conditions, effective behaviour may be badly organized. One common instance of this is the alcoholic who uses drinking to control his stress.

The present study evaluates coping behaviour in terms of effectiveness. This kind of evaluation has the advantage of being independent of social or cultural limitations.

Dynamics of Ineffective Coping Behaviour

The relationship between stressful life events and psychological impairment has increasingly become the focus of psychiatric research. The findings, however, have been conflicting. Forrest et al. (1965) found only a partial relationship between stressful life events and psychiatric illness. This finding is supported by Hudgens et al. (1970), who from their review of the literature concluded that a cause-effect connection between stressful life events and psychiatric illness has yet to be convincingly established.

In contrast, a large number of recent studies conclude that there is in fact a substantial and positive relationship between stressful life events and psychiatric illness (Parkes, 1961; Steinburg and Durell, 1968; Birley and Brown, 1970; Brown, 1972; Brown et al., 1973; Morrice, 1974).

Brown and Birley (1968) and Paykel et al. (1969) reported from their controlled studies that hospitalized psychiatric patients had experienced more stressful life events than non-hospitalized people. Paykel (1974) also found that subjects who had attempted suicide had more stressful life events than did a control group from the general population.

Meyers et al. (1971) found that the greater the number of stressful life events, the more likely it was that the mental status of an individual would have substantially changed. And Fontana et al. (1972) reported that stressful life events are related not only to the occurrence of illness but also to its severity. Furthermore, Holmes

and Rahe (1967) state that the occurrence of each stressful life event evokes, or is associated with, some adaptive coping behaviour on the part of the involved person. That is, they suggest that it is not the stressful life events themselves that cause mental illness but the failure to cope with them.

The failure of coping behaviour occurs when the stressful life events demand responses that are beyond the individual's adaptive resources (Phillips, 1968). The individual employs a defense mechanism in an attempt to cope and if this mechanism becomes inadequate the individual may regress to the level of "neuroses" (Meninger *et al.*, 1963; Lehner and Kube, 1964). These neurotic symptoms represent an effort to cope with inner conflicts. At this stage, the person may continue to employ defense mechanisms, but in a highly disorganized and complicated way. With a long exposure to stress with unimproved skills in coping, the individual becomes very disturbed and reality is abandoned. The individual then protects himself from this unmanageable state and he may function at a near vegetable level. With this last attempt to cope with his stress, the individual is defined as "psychotic".

This sequence of events was confirmed by Donovan (1975) in his study of the background of acutely ill psychiatric patients. He found that most of the patients were actually people with chronic difficulties in coping with their stressful life events.

In conclusion, it can be seen that coping behaviour ranges between two extremes. At one extreme there is adjusting behaviour, while at the other extreme there is psychotic adjustment (Lazarus, 1969; Sawrey and Telford, 1971; Coleman, 1969).

Implications for Nursing

It is evident that competencies in coping with stressful life events are one of the major concerns of psychiatric patients. Thus psychiatric nurses* need to direct some of their time and effort towards studying the concepts of life stresses and coping behaviour. Pesznecker and McNeill (1975) suggest that with such knowledge the nurses' role

* For the purpose of the present review the term "psychiatric nurse" refers to all nurses working in a psychiatric setting whatever their training.

needs to expand to include new types of actions such as health teaching, in order to help patients strengthen their coping abilities.

Teaching is an essential part of the nurse's role in every nursing field, but the development of the nurse's role as a teacher has been extremely slow (Bryan, 1974), particularly in psychiatric settings. Indeed, a review of nursing literature during the past two decades shows very little evidence of research dealing with teaching psychiatric patients. One exception is the study of Hays (1961) which was carried out to explore the patterns of teaching that evolved when a nurse taught patients the concept of anxiety. However, no attempts were made to evaluate the effectiveness of the teaching. Even so, Hays' study provides a description of the phases and steps of experiential learning which may serve as a basis for further studies of the effects of such teaching on patients.

The absence of literature on the concept of teaching psychiatric patients possibly reflects the general neglect of this aspect of the psychiatric nurse's role. This is evident from Butler's (1961) study which found that "teaching patients" ranked fourth out of the five categories used to classify psychiatric nursing tasks. These categories were: supportive emotional care; physical care; liaison; patient education; and administration. It may be that psychiatric nurses generally view psychiatric patients as incapable of learning. On the other hand, perhaps many nurses in psychiatric settings lack the understanding, expertise, and confidence for teaching which relates to the patients' psychological problems.

The present study attempts to demonstrate that teaching can benefit psychiatric patients. Two factors are taken into account. The first factor is the readiness of the patient, which refers to the patient's ability to communicate and his willingness to participate in the teaching programme. The second factor is the readiness of the nurse-teacher. This refers to what Gage (1975) calls "cognitive validity", that is the degree to which the nurse possesses and reflects a "valid systematic cognitive structure" and the principles of the concept she is trying to teach. In other words, the nurse-teacher must have a firm knowledge of what she is teaching and apply it accurately to the patients' problems.

Group Teaching

Teaching can be done individually or in groups and the choice of the most suitable approach depends upon the specific aims of the teaching programme. For example, Dalzell (1965) found that individual counseling was significantly better than group teaching for teaching a prenatal programme, while Meszanotte (1970) reported that preoperative patients received benefits from group teaching that they would not have received if the teaching had been given individually.

Opportunities for teaching a group exist wherever learners with similar learning needs can be assembled (Pohl, 1973), and there are several advantages to using a group. The theory of group learning states that "through participation in groups, a person is apparently stimulated to meet goals beyond those he would conquer as an isolate" (Bonner, 1959, p.14). Individuals also have a tendency to identify with others having similar goals or problems, and they gain moral support and encouragement through this identification. This means that the individual behaviour both influences and is influenced by the various attributes of the group (Cartwright and Zander, 1968). Such behaviour, if in agreement among members of the group, will become group norms. In a therapy situation if the group norms are allowed to develop and are effectively maintained by the therapist, they may serve as efficient therapeutic tools (Lawrence and Sundel, 1972).

To obtain effective psychiatric teaching, the nurse has to develop an atmosphere of active learning, and stimulate the group to work together as a unit. Working as a group provides the patients with an opportunity to learn and practice many behaviours as they respond to the constantly changing group demands (Rose, 1977). The possibility of the group members sharing ideas, life experiences, and individual problems in coping offers benefits to the patients that are not possible in individualized teaching programmes. The group discussion also provides its members with a major source of feedback about a member's behaviour. This is particularly helpful when the patients cannot pinpoint their own problems. Lazarus (1966) notes that many facets of a problem can become clear during or after an intensive group discussion. To obtain successful group teaching, the nurse-teacher has to focus her attention on the group as a unit rather than on the individuals. This does not mean that the nurse never focuses on a particular patient, but that she approaches the individual via the group and the group via the

individual (Whitaker and Lieberman, 1965).

Teaching can be structured or unstructured. Structured teaching refers to the implementation of a content and method based on a theoretical framework related to the particular concept to be taught (Van Aernam and Lindeman, 1971). In contrast, unstructured teaching refers to teaching that takes place without a plan and which depends for direction on the nurses' view of the situation at the time. As unstructured teaching was found to be less successful than structured teaching (Monteiro, 1964; Van Aernam and Lindeman, 1971; Lindeman, 1972) structured teaching has been adopted for the present study.

Both structured and unstructured teaching present a variety of teaching - learning challenges to the nurse which involve the investment of time and emotional energy. The nurse has to prepare herself to learn and to share her experiences as well as encourage patients to learn and share theirs. In teaching psychiatric patients, the psychiatric nurse has to be aware that she cannot teach specific solutions, but must help them to learn for themselves behaviours which can be adapted to their particular problems. In other words, only techniques which enable them to cope with their problems should be taught. To do this the nurse uses the patients' own problems as a tool to help them learn these techniques. That is, she teaches the patients to explore their own problems, feelings, and capacities to cope with their problems. When they have done this, the nurse then helps them understand why they have failed to manage their problems, and how to set goals in an attempt to cope with them successfully. Once this stage is reached, the patients are ready to plan their future actions (Carkhuff, 1969).

Patients' Perceptions of Nurses

Most psychiatric patients have some contact with nurses during a stay in hospital, and it is these interactions that shape the patients' perceptions of, and assumptions about, nurses in general. However, these may not necessarily correspond to what the nurses "really" are. Sullivan (1953) refers to this as the act of perceiving which is interpolated between whatever outside is, and what the patient has in his mind. Thus some patients may react negatively to nurses because of unpleasant past experiences (Pohl, 1973, p.27). On the other hand, if the patient experiences some nurses as helpful, he will tend to perceive other nurses as being helpful also. Such an experience becomes

a basis of effective therapy (Irving, 1973). Consequently, teaching or therapy for such a patient when conducted by a nurse is likely to benefit him. This effect has been described as a placebo-induced modification of expectations (Fish, 1973). That is the success of the therapy is attributed to the patient's faith in the nurse rather than what the nurse says. Thus the source of the placebo is one of the most important ingredients in the effective therapy. The patient who has positive perceptions of a nurse will tend to develop a good rapport with her. Although this will not of itself guarantee successful patient teaching, it is a condition that facilitates teaching and is a factor that to a large extent the nurse can control (Pohl, 1973).

Methods for Evaluation of the Patient Teaching Programme

Evaluation of the effectiveness of a teaching programme involves measuring the resultant behavioural outcomes and interpreting the results in terms of the desired behaviour change (Redman, 1972). Redman further says that all measurements may be said to involve observation of the learners' behaviour. These observations may be either direct or indirect. The direct approach involves viewing the actual behaviour of the learners as it occurs, while indirect methods involve the learners' responding to substitute situations.

While direct measurement seems to be more accurate than indirect measurement (Redman, 1972), direct observation is restricted to the "real" situation, and this is not always possible. For example, if the evaluation of a teaching programme involves direct observations of the learners' coping behaviour, this can be done only when the learner is facing a stressful event. Furthermore, the effects of the teaching programme may require long term measurement which is difficult for the teacher to do in a psychiatric situation if the learners are discharged from the hospital.

Thus, indirect measurement may be necessary to enable evaluation of the teaching programme immediately after it is over. The effectiveness of indirect measurement has been reported by Dalzell (1965), who developed an objective type test to evaluate a prenatal teaching programme.

Verbal communication is also believed to provide important psychological data about the intentions, perceptions, and personality of the communicator (Sorensen, 1967). Thus the effectiveness of a

teaching programme can be evaluated by analysis of the verbal interactions between the teacher and the patients. The Technique used for analysing verbal communication is called "content analysis", and has been effectively used in analysis of counseling and psychotherapy interviews (Murray et al., 1954; Murray, 1954, 1956; Auld and Murray, 1955). Rosenberg (1962) also found that content analysis could give a quick, clear and integrated picture of the dynamics of the group sessions of student nurses. The details of the content analysis used in the present study are contained in Appendix A.

Summary

The literature review suggests that very little work has been done in an attempt to help psychiatric patients cope with their stressful life events, that the need to do this exists, and that it is possible for patients to learn to improve their coping behaviour. Furthermore, the role of the psychiatric nurse can and should be expanded to include the teaching of patients about life stresses and coping behaviour in an objective and systematic manner.

Statement of Hypotheses

The literature review has suggested the following hypotheses which are to be examined in the present study:

1. A group of patients who have positive perceptions of nurses as helpful will attempt to learn more than a group of patients who have negative perceptions of nurses as helpful.
2. A group of patients who have negative perceptions of the nurses as helpful will show greater resistance to learning than a group of patients who have positive perceptions of nurses as helpful.
3. There will be a significant difference between the before and after measure of actual behaviour for both positive and negative groups of patients.
4. A group of patients who have positive perceptions of nurses as helpful will improve their coping behaviour more than a group of patients who have negative perceptions of nurses as helpful.
5. The patients of both positive and negative groups will see nurses as more helpful after the teaching programme.

CHAPTER 2

METHOD

There are four main parts to the study and these are described in this chapter. Firstly, a Massey - Patient - Nurse Projective Test (MPN) was developed to determine psychiatric patients' perceptions of nurses as helpful. Secondly, a Coping Behaviour Test (CBT) questionnaire was developed to use as a before and after measure of the patients' coping behaviour. Thirdly, a teaching programme was developed and given to two groups of patients, one of which showed positive and the other negative perceptions of nurses as helpful on the MPN test. And fourthly, the teaching programme was evaluated by applying a content analysis technique to the patients' and the nurse's verbal behaviour. A descriptive account of the group development methods is given in Chapter 3, and a case study of the members of Groups A and B is given in Chapter 4.

This chapter describes the instruments, procedures and methods of analysis which were used in the study.

Subjects

The various groups of subjects used in the study were drawn from three sources:

Group 1: Thirty-one patients residing in a large psychiatric hospital were selected by their respective charge nurses as being capable of communicating coherently. The patients were arbitrarily divided into two groups, containing sixteen and fifteen members respectively, to score as subjects for the development of the MPN test. On the basis of the MPN test results, four patients were assigned to Pilot Group A for having positive perceptions of nurses as helpful, and four were assigned to Pilot Group B for having negative perceptions of nurses as helpful. Each of the eight patients was told about the teaching programme and asked whether they wished to participate.

Group 2: A further thirteen verbally competent middle-aged psychiatric patients were selected and given the MPN test. On the basis of these results, five patients (all females) with positive perceptions of nurses as helpful were assigned to Group A and five patients (two males

and three females) with negative perceptions of nurses as helpful were assigned to Group B.

Group 3: Ten middle-aged non-nurse volunteers known not to have a diagnosed psychiatric illness formed a non-patient group.

Instruments

The Massey - Patient - Nurse Projective Test (MPN)

The MPN test has been specifically developed to examine two factors related to patient - nurse relationships.

1. The patients' perception of nurses as helpful or unhelpful.
2. The patients' willingness to seek help from a nurse.

The test is based on a modification of the TAT (Thematic Apperception Test) first developed by Murray (1938). It is based on the assumption that when an individual is shown an ambiguous picture he will pay attention only to the items which are significant for him and ignore those which he considers insignificant. When he is asked to construct a story about the picture, the individual is assumed to reveal his perceptions by utilizing information, partly from his immediate perceptions of the picture, and partly from conscious and pre-conscious imagery based on past associations (Bell, 1948; Zubin, 1966).

There are some empirical data to support these assumptions. Kagan (1965) asserts that the child's perceptions of different figures in his environment may be reflected in his description of thematic figures. Also, Cummings (1951) reports that neurotic children are more likely than "normals" to describe parent figures as rejecting and punishing. Furthermore, Liccione (1955) found significantly greater mother - offspring interaction than father - offspring interaction at the five age levels represented in his thematic stories.

Thus, if a nurse is present in a TAT picture, a patient is likely to reflect both his perceptions of, and his experience with, nurses. The MPN stories may then be analysed by the nurse or therapist to examine the patient's perceptions of the nurse as helpful or unhelpful, and his willingness to seek help from a nurse.

Description of the MPN test

The MPN test consists of ten black and white photographs, each of which focuses on a depressive patient who has difficulty in mixing with other patients in the ward. A nurse appears in every photograph except for photograph one. Photograph one depicts death, and the other nine photographs represent various situations in a psychiatric ward (see Appendix B).

The roles of nurse and patients were played by six female asian students.

Development of the MPN Test Instructions

The MPN test can be administered in two ways. The subjects can be asked a series of questions about each photograph (Schwartz, 1932), or they can be asked to tell a story about each photograph (Coelho et al., 1962; Silber et al., 1965). To determine whether one approach was more appropriate and to develop a set of suitable instructions for each, both approaches were discussed with four post-graduate students at Massey University and instructions drafted. The instructions were then tested using two groups of psychiatric patients. The first group of sixteen patients was asked the following questions:

1. What do you feel when you see this photograph?
2. What is happening in this photograph?

If the patients did not mention the nurse and/or the depressive patient in the photographs they would be further asked:

3. What is the nurse doing?
4. What is the patient doing? (pointing out the specific patient)
5. What would you do in this situation if you were the nurse?
6. What would you do if you were this patient?

The second group of fifteen patients was simply asked to tell a story about each photograph.

The responses from the two groups were scored using the scheme outlined on page 24. No difference was found between the responses from the two groups. In general, it was found that patients who do not mention the nurse or the specific patient in the photographs say, "I don't know" when they are specifically asked about them. If subjects are prompted by asking further questions, the responses may be influenced by the subject's motivation, judgement, imagination or cognitive

activities. Zubin et al. (1965) suggest that responses which involve these factors can not be regarded as perceptual acts. For this reason, the second method, that is, telling a story, was chosen for use in the experimental study.

Instructions for Administering the MPN Test

The subjects were tested individually and were informed that:

"This is a test of perception, that is how different people see the same thing. I am going to show you a series of ten photographs and I want you to make up a brief story about what is happening in each one of them."

Then each of the ten photographs is given to the subjects in turn for a period of one minute each.

The subjects' verbal responses to the photographs are recorded by writing notes, and in some cases, recorded on a magnetic-tape cassette.

Rating Scheme and Scoring Procedure for the MPN Test

A simple rating scheme was developed for categorizing the activities of the nurse and the patient. In scoring the MPN test stories, three categories were used:

Category 1: Ability to Communicate - A distinction was made between the responses where the subjects developed a story by using their own experiences and feelings, and those where the subjects did little more than describe the physical characteristics of the photographs.

Category 2: Perceptions of Nurses as helpful - Statements were counted in which the subject mentioned the nurse, and the kind of nurse activity described was classified into subcategories.

Category 3: Seeking Help from Nurses - The scorer determined whether the patient in the photographs was described as seeking help from the nurse, or if the attempt to seek help was described.

The details of these categories are outlined in Appendix C.

Within each of these categories, the responses were scored as either 0, 2, 4, or 6, according to the criteria outlined in Appendix C.

Reliability of the Scoring Procedure used on the MPN Test

Although the author served as primary scorer, two judges (post-graduate students from the Nursing Studies Unit and Education Department) were instructed in the use of the operational definitions of the categories, and in the use of the scoring scheme. The two judges scored independently a sample of 150 randomly selected MPN test stories or 450 responses. The inter-rater agreement between the three judges' independent ratings was 87.12%. After discussing the scores, some errors of misunderstanding of the categories were corrected and agreement increased to 97.78%. It has to be noted that the latter score may be misleading because the two judges may have been influenced by the author.

The Coping Behaviour Test (CBT)

The CBT was used as a before and after measure of the patients' coping behaviour to assess the effectiveness of the teaching programme. It has been developed on the basis of the concept of coping behaviour as used in the teaching programme (see "The Teaching Programme" below). The CBT consisted of eight, seven point scales. The extremes of each of the scales were defined by polar-opposite behaviours, such as: I don't know my problems/ I know all my problems. The patients were asked to describe how they see themselves ("Actual") and also how they would like to be ("Preferred"), (see Appendix D).

The Teaching Programme

The teaching programme was related to aspects of coping behaviour derived from an examination of concepts of coping and adaptation (Lehner and Kube, 1964; Lazarus, 1969; Coleman, 1969; Sawrey and Telford, 1974). The teaching programme was divided into six one hour sessions with each session consisting of two parts. Part one involved concept teaching, and part two was an exercise related to the concept taught during the session. The session topics were as follows:

Session 1 - "Introduction to the Concept of Coping Behaviour"

Exercise 1 - "How much I know about the concept of coping behaviour"

Session 2 - "What is a Stressful Life Event?"

Exercise 2 - "What is my stressful life event?"

Session 3 - "Emotional responses to a Stressful Life Event"

Exercise 3 - "How do I feel when I am frustrated?"

Session 4 - "Learn to improve our Coping Behaviour"

Exercise 4 - "How much I know about how I deal with my problems?"

Session 5 - "How do we cope with our problems?"

Exercise 5 - "Plan to cope with some stressful life events"

Session 6 - "What is effective and ineffective coping behaviour?"

Exercise 6 - "My coping behaviour"

(see Appendix E for details).

A daily program was chosen for use in the experimental study in spite of the possibility this may develop more tensions in the patients than weekly sessions. The evaluation of the pilot study suggested that the patients tended to forget what they learned in a previous session if there was a long period between sessions, and the study of Ebbinghaus (1964) suggests that concentrated learning produces more success than distributed learning. Furthermore, another finding of the pilot study was that when the patients went on leave between the teaching sessions they were often faced with some problems with their families at home and they found it difficult to concentrate on the teaching programme when they returned.

Data Analysis

Content Analysis

Content analysis was used to analyse the verbalization of the nurse and patients in Group A and Group B. The categories used to describe the patient and nurse verbalizations are based on learning theory and in the context of the present study the most relevant categories were those concerned with the stimuli and responses associated with learning.

Development of the Patient and Nurse Categories

To develop the patient and nurse categories random samples of the verbal content of the nurse-teacher and the patients in the pilot study of the teaching programme were transcribed. The typescript was then scored using the following steps:

(i) Unitizing. The unit used is the "statement" or "meaning phrase". The set of rules for unit scoring outlined by Murray (1956) was applied in the present study and appears in Appendix F. Scoring consisted simply of making a stroke after each string of words judged to be a unit. The units were then numbered in order to simplify categorization.

(ii) Categorizing. Twenty-nine simple nurse categories and thirty patient categories were devised to describe the verbal content. These categories were based on the following two questions:

1. How does the nurse encourage the patients to learn?
2. How do the patients learn in the group?

Scoring Procedures

The scorer first read through the whole page which had been unitized and had numbered units. The number of each unit was then recorded in the appropriate category on a prepared record sheet.

The results of the pilot study disclosed minor inadequacies in the categories, and a difficulty with using them. That is, some categories overlapped, while some units of verbal content were either irrelevant, or did not belong to any of the categories. Thus additional categories were developed and the original categories modified until the deficiencies were eliminated.

This set of revised categories was to be used to analyse the content of the experimental study, but required further modification as there was still a little difficulty in categorizing some units. This was probably due to the limited sample of nurse and patient verbal content originally used to develop the categories, which clearly did not represent all of the characteristics of verbal content usually encountered.

To further improve the categories, a post-graduate student with a background of psychiatric nursing and content analysis was asked to score the section of content from the experimental study that had caused difficulties for scoring. The ensuing discussion resulted in further revision of categories, until finally, a workable set of categories for both the patients and the nurse was derived. The descriptions of the revised patient and nurse categories are as follows:

Patient Categories: Six categories were used to score the patient verbal content. These were defined in terms of the response to learning. The six categories are:

1. Passive learning
2. Active learning
3. Exploring
4. Gaining insight
5. Planning for actions
6. Resistance to learning

Each category consisted of several sub-categories which appear in Appendix G.

Nurse Categories: Six categories were used to define the nurse's verbal behaviour in terms of the stimulation of patients by the nurse. The six categories are:

1. Orientating/Introducing
2. Stimulating to participate
3. Stimulating to explore
4. Stimulating to gain insight
5. Stimulating to plan for actions
6. Discouraging learning

Each category consisted of several sub-categories which appear in Appendix H.

The Use of the Categories in the Teaching Programme

The six one hour sessions of both groups were transcribed by the nurse-teacher. The author checked the accuracy of the typescript by reading it while listening to the tape recording.

The procedures of unitizing and categorizing described for the development of the categories were applied to these transcripts. In cases where the statements were ambiguous, the author listened to the tape recordings to clarify the meanings.

Reliability of the Coder

A post-graduate student was trained to unitize and categorize, then given a randomly selected 10% sample of units to unitize. The intercorrelation of the two judges was .94 ($P < .001$).

To test the reliability of the coder, 254 nurse units and 176 patient units of verbal content were randomly selected then categorized

by the student. The inter-rater agreement for the nurse categorizations was 60.80%, and 75.57% for the patient categorizations. After discussing the conflicting scores, some errors caused by misunderstanding the categories were corrected and agreement increased to 92.13% and 94.89% respectively.

Group Analysis

The development of the present groups was studied by applying Whitaker and Lieberman's theory of group development.

Case Study of Individual Patients

An idiographic case study approach was applied to study all ten patients who participated in the programme.

Statistical Analysis

To test for significant differences between the scores of Group A and Group B on the CBT questionnaire, the MPN test and the Content Analysis, t tests were used. The statistical calculations were computed using the Statistical Package for the Social Sciences (SPSS) on the Massey University, Burrough's B6700 computer.

Procedure

The present study was conducted in two phases. In phase one a pilot study was conducted to test the teaching programme and the various analytical techniques, and implement any necessary modifications. In phase two, the teaching programme was executed. Both the pilot study and the teaching programme were conducted by the same nurse-teacher, who was a general nurse studying for her diploma in nursing in the Nursing Studies Unit, Massey University, and who was running the teaching programme as a part of her course. She had had some experience in teaching but little in group practice. The nurse-teacher was given the general background of the teaching programme and introduced to the concept of coping behaviour by the author. She then studied the teaching content and performed the exercises, and problems were discussed before the pilot programme was conducted. Her understanding of group interactions was improved by having her listen to the tape sessions of the two groups after the first three sessions of the teaching programme.

The Pilot Study of the Teaching Programme

Pilot Groups A and B were to be conducted twice weekly for a total of six one hour sessions. However, as Pilot Group A was unable to attend sessions two to six,¹ the results of Pilot Group A for session one were discarded and the pilot programme was only run with Pilot Group B. Pencils and papers were used by the group members to record their written answers to the exercises, and a tape recorder was used to record their verbal comments. At the beginning of the programme patients were informed that a tape recorder would be used to record the sessions.

The group was also observed by the author, who sat away from the group but in the same room.²

The CBT questionnaire was given to both the patients and the nurse before the first and after the last session of the teaching programme.

After each session the nurse-teacher and the author discussed the nurse-teacher's behaviour, the feelings of the group and any problems that occurred in the group.

At the end of the teaching programme one and a half hours from the total of six hours of the taped sessions was randomly selected and transcribed for use in developing a set of patient and nurse verbal behaviour categories for the content analysis.

The content of the teaching programme was evaluated by the author and the nurse-teacher and determined to be appropriate for use in the experimental study.

The Experimental Teaching Programme

The patients in Group A first met the nurse-teacher at 9 to 10 a.m. on a Friday and then on Monday to Friday of the following week. The patients in Group B met the nurse-teacher on the same days as Group A but from 10:15 to 11:15 a.m. The teaching programme and the procedures were the same as those used in the Pilot Study.

The MPN test was given to the patients before and after the teaching programme.

¹Some patients went to school at that time and the school decided after the teaching programme had started that the patients should concentrate more on their study to prepare themselves for a new school in town.

²There was a one way mirror in the room but this was unsuitable as the group could not be heard.

The Use of the MPN test by Non-Patients

The MPN results of the thirteen middle-aged patients in Group 2 and six arbitrarily chosen middle-aged patients from Group 1 were selected for comparison with the MPN results of the ten middle-aged non-patients of Group 3. This was done to test whether the MPN test could be used effectively with non-patients.

CHAPTER 3ANALYSIS OF THE GROUP

The longitudinal development of Group A and Group B has been examined in the light of Whitaker and Lieberman's theory of group development. Whitaker and Lieberman (1977) conceive of the group as continually involved in a "focal conflict" between shared wishes and shared fears, and concerned with the relation between the inner needs of its members and the suitability of the group situation for them. This may result in the group acting as if it does not believe in the safety of the group.

Whitaker and Lieberman divide the development of the group into two phases. The first is a "formative" phase, in which patients are chiefly concerned with their expectations and hopes for the group. The second is an "established" phase where the patients begin to establish hope for therapeutic gain, and this results in some commitment to the group. The importance of an established phase is that the group has by then generated a set of constructive solutions which make the patients feel comfortable and safe (see Appendix M for further details).

Whitaker and Lieberman (1977) assume that "the manifest content of discussions in groups, no matter how seemingly remote, refers to here-and-now relationships and feelings in the group" (p. 17). They say further that the patients are not likely to be aware of the underlying issue of the manifest material, but that the observer is in a position to grasp this underlying issue.

Throughout this study, the author assumes the role of the observer. Following Whitaker and Lieberman, personal issues, worries, impulses and concerns which the patients have expressed during sessions have been analysed as if they were the patients' expressions of their current situation in the group.

GROUP A - SESSION ONE

The first session was an introductory phase. That is, the members of the group got to know each other and learn about the design of the programme. They were also asked to do the pretest of the CBT questionnaire and the group exercise on "How much I know about the concept of coping behaviour" (see detail in Appendix E).

The group was started when the nurse welcomed patients to the group and asked them to choose their seat. The nurse sat on the floor with three patients (B, A and D). J and E sat together on a sofa.

The nurse introduced herself and asked the patients to do the same, then introduced the teaching programme. Mrs. B moved to sit on a sofa away from the group. Perhaps she was not comfortable sitting on the floor. This made the group look very distorted and Mrs. E seemed to be left out. The patients, except Mrs. J, showed interest in hearing about the teaching programme. Mrs. J did not seem to listen to the nurse but tried to make eye contact with Mrs. A by flashing a challenging smile while Mrs. A was carefully listening to the nurse. Sometimes Mrs. J, who sat back with her arms and legs crossed chewing bubble gum, talked to Mrs. E while the nurse was talking to the group. J's behaviour could be interpreted as a challenge to the nurse.

However, the behaviour of Mrs. J did not interest anyone in the group. The nurse was busy explaining to the rest of the group who were carefully listening. At the same time they asked the nurse question after question about how to do the pretest. This demonstrated both their low intelligence and their dependency on the nurse. Perhaps the patients' behaviour in seeking help at this stage is a product of the patients' positive perceptions of the nurse as helpful.

While the group was discussing the pretest, Mrs. B used the group exercise as a means of letting the nurse know that she wanted the nurse to help her. Perhaps she came to the group with high expectations of help from the nurse, as is suggested in the following excerpt:

Nurse: So you think that others can't help you solve your problems except maybe only very occasionally. What do you think, now, that you'd like to be like?

Mrs. B: Help me more.

The situation here is similar to that noted by Whitaker and Lieberman (1977), that is, that patients always enter a group therapy

with certain expectations about how the group may be able to help them, and about the way in which they can be helped. The other patients also showed their expectations of help from the nurse by revealing their problems. This indicates that the patients were willing to take a risk to open-up early on. Whitaker and Lieberman suggest that at this stage it is a patient's role to provide data about himself and the therapist's role to provide help. Again, this assumption is related to the patients' positive perception of the nurse as helpful.

During the session, Mrs. J began to be friendly with the nurse and opened-up when the nurse asked her to relate the group exercise to her life problems. She suddenly told the nurse that her husband wanted to separate from her. Two other patients (A and E) then talked about their life problems as well.

Unfortunately, as time was limited, the nurse had to rush the patients and did not feel relaxed. The patients probably felt this as well. The teaching programme was not very successful, and the nurse's behaviour may have been a contributing factor. For example, the following excerpts indicate that the nurse seemed to cut the patients off:

Nurse: So that's a pretty large problem that you're moving to use methods to cope with at the moment.

Mrs. J: Yes.

Nurse: We could perhaps come back to that one if you like, some other session. I'm sorry we're sort of pushing things abit. E?

Mrs. E: ...I got a very similar problem to J's. At the moment I don't know whether my husband wants me or not. We're not communicating in any way. I have to try and learn to cope.

Nurse: So what sort of numbers did you give yourself?

Mrs. E: I gave myself a 3 and 1 is my goal.

Nurse: So you think you're trying pretty hard and you're succeeding. Well, I am sorry we seem to be sort of clock watching. Thank you very much for coming.

The patients were beginning to tell the group about their problems. Mrs. E's behaviour also can be interpreted as asking for help from the group. She implied that she had to try to cope very hard on her own with very stressful problems, but she could not cope very well and really needed help to cope successfully. Unfortunately the nurse saw the expression of her problems as a part of the exercise

and did not give her support or show interest in these expressions, but rather closed the session.

Overall, the patients seemed to be friendly to the nurse and supported her, as can be seen when the nurse asked them to try to come to every session. They all agreed and said that they were not planning on making difficulties for the programme. However, from the beginning to the end of the session, the patients' did not show any involvement with each other but focused their attention on the nurse. In fact the nurse did not encourage the patients to get involved in conversations with each other, only with herself. Conversation in the group was always started by the nurse questioning one patient and then proceeding to each of them in turn. In general, the group atmosphere was similar to the atmosphere of a classroom in which students are silent and the teacher attempts to get each student's individual answer.

Thus, in the first session, a clear focal conflict could not be identified.

GROUP A - SESSION TWO

There were only two patients (E and J) present for the scheduled start of session two. Three patients were not allowed to come because there was no record on their supervisor's diary about the programme for that day. However, the author did manage to get the other patients to the group which started fifteen minutes late.

It is interesting to note that the group started with a warm atmosphere and involvement among the group members. Perhaps, the mix up that occurred led the patients to share their feelings and activities with each other, for the patients questioned each other about what had happened to them. They also asked the nurse to ring and ask the ward to record their programme time-table for the rest of the sessions.

In this session, the group exercise was "What is my stressful life event", and was related to the concept taught by the nurse.

Every patient opened up and showed her interest by quietly listening to the other's problems. There were some questions and comments from some patients from time to time, but overall, the group remained inert. However, there were some occasions when one patient (J) attempted to involve the others, but her behaviour can be inter-

preted as an attempt to dominate the others when they showed their helplessness. For example, very soon after the nurse told the patients to do the group exercise, two patients (E and A) showed their helplessness, attempting to get attention from the group. But Mrs. J responded with an attempt to dominate them as illustrated in the following excerpt:

Mrs. E: I can't do this.

Mrs. J: Well try (in a strong voice)

Mrs. A: I can't write with my left hand.

Nurse: You can't write with your left hand?

Mrs. J: Don't say I can't. There's no such word as can't.

Mrs. J seemed to show her feelings of superiority over the nurse as well. Perhaps she was not confident in the nurse. Mrs. J always clarified other patients' problems and in general behaved like a co-leader of the group. However, she attempted to explore and analyse her problems and sometimes asked for support from the nurse. It is interesting to note that the nurse cut her off when she asked for support, for example:

Mrs. J: But I think its about time I moved on. Do you?

Nurse: No; I don't know, I've only met you for the second time, and you're the best judge of your world. We've only got about five minutes left. Does anyone want to pick up on anything?

Mrs. J: A, you've led a life all on your own. Don't you feel that you've missed out on something?

Mrs. A: No.

Instead of giving support or encouragement to Mrs. J for further self-exploration, the nurse refused to go further with Mrs. J's problem. Perhaps the nurse was not confident enough to give any support or suggestions to Mrs. J. This may have disappointed Mrs. J, for she turned to Mrs. A and asked her a question. From the patients' point of view, the question is about whether Mrs. A felt that she had missed out on something. But the underlying issue was that Mrs. J felt that she did not get any help from the nurse or anybody in the group since the nurse had refused to support her. Thus she wanted to share her feelings of being on her own in the group, with Mrs. A. Unfortunately, Mrs. A refused to do so. Moreover, Mrs. A said that she was used to everything in a mental hospital. This can be interpreted as

Mrs. A not caring about what happens in the group, so she is not interested in sharing any disappointment with anyone in the group.

The nurse's behaviour also showed her lack of understanding of Mrs. J's need to seek support. In fact the nurse treated all patients in a similar way, giving less help than the patients expected. The patients' expectations of the nurse helping them were demonstrated by their constant asking for help and showing dependency, but instead the nurse tended to cut the patients off while they were attempting to talk about their problems. This was true for both Group A and B. The nurse did not seem to be aware of her behaviour for she continued to overlook the patients' problems. For example at nearly the end of the session, Mrs. E, who looked sad and depressed, attempted to reveal her problems to the group. The nurse did not seem interested in her problems though the rest of the group were sadly listening to her without any comment. The following excerpt describes the nurse's behaviour:

Mrs. E: I just don't know what to do about it.

Nurse: About all you can do about it - about all I can ever do about anything anyway, is work on right now, today, and take tomorrow when it comes round.

Mrs. E: Well ever since I've had the operation I've not been coping too well. Up until now the doctor's always given me something to help me cope with them. Now they've taken me off everything like that and I'm not coping.

Nurse: So you've got quite a lot that you have to do at the moment.

Mrs. E: I don't know what to do about it because I haven't got anywhere permanent to go. I came from a broken home. No relations or anything like that I can turn to.

Nurse: I think you really come down to working on today. Crossing your fingers and something will come up. Believing that something will come up.

Mrs. E: A close friend said that she was going to ring the doctor, but she didn't and my husband was going to ring the doctor and he hasn't bothered and I feel that he doesn't care at all.

Mrs. E and the nurse were not communicating at this point. The nurse did not seem to receive Mrs. E's message asking for help. Mrs. E did not respond either to the nurse's words. They were talking on different levels. That is, Mrs. E tried to tell the nurse that now she had no one to help her and she desperately needed help. In addition, she referred to her close friend and her husband not doing what they

said they would. From this it can be inferred that Mrs. E was trying to show her disappointment in the nurse from whom she had expected help, but who did not seem to care at all. The nurse, on the other hand, did not seem to be interested in Mrs. E's problems, for she tried to tell her not to be worried about her future and just live for now. The nurse refused to get involved in Mrs. E's problems. None of the other patients were involved in this conversation so Mrs. E did not get help from anyone.

Overall, the group does not seem to be developing. The patients still do not share any feelings verbally with the group. Again, a group focal conflict cannot be identified, or has not yet emerged. Thus progress by the group is retarded.

GROUP A - SESSION THREE

All five patients were present in this session. Mrs. E claimed that she did not feel well enough to participate in the group but asked to lie down on a sofa in the group therapy room. The rest of the group did not show much attention to her despite the fact that she looked depressed.

The nurse chose to sit on the floor while all the patients sat on chairs. Mrs. B sat away from the group. Perhaps she did not feel part of the group. In fact, Mrs. B always remained quiet in the group and this led to her being slighted by the group. The nurse did not attempt either to encourage her to participate in the conversation or pay any attention to her unless it was her turn to report the group exercise. Thus, the group now formed a small sub-group by excluding Mrs. B and Mrs. E (who lay on a sofa). It is interesting to note that the "sub-group" became close.

In this session, the nurse presented the knowledge about "Emotional Responses to Stressful Life Events" and the group exercise was "How do I feel when I am frustrated".

Before introducing the topic of this session the nurse asked the patients to review what they had learned in the previous sessions. The patients did not do very well but at least they tried. When the nurse was presenting the concept teaching the "sub-group" showed much interest and tried to make comments on the concept teaching. The nurse seemed to be pleased and relaxed. Then the nurse asked all the patients to do the group exercise. Mrs. E got up to do the exercise

but still did not want to talk. The group atmosphere at this stage was more friendly than the previous sessions. This may be because some patients (A, E and J) sat close together to smoke and shared the same ashtray while the nurse was explaining the answer to the group exercise. It seemed that the group was keen to share non-verbal activity, though not verbal behaviour. The patients also enjoyed the group exercises in this session, which involved a problem requiring the joining of nine dots by four straight lines, and fitting words to pictures representing three frustrating situations. The patients were interested to know what the others had answered. The nurse also attempted to relate the group exercises to the concept of coping behaviour, but only Mrs. J actually related the group exercises to her past experiences as can be seen in the following excerpt:

Mrs. J: I've done it in my own life, I've tried to get around the situation and void it, and got to the state where I didn't want to do anything.

Nurse: Mmm. It saves an awful lot of energy. If you're like me and you don't like telling total strangers to take their hats off, or whatever, if you can avoid the situation you save yourself a lot of work.

Mrs. J: That's what I did, I tried to avoid the situation that I had, and consequently I landed here.

The nurse differed from Mrs. J in life experience and attempted to show that avoidance could be useful. But Mrs. J let her know that she had experienced the nurse's method of coping before and it had caused her to break down. Mrs. J at this stage showed some insights into her problems. She also inferred that such a method of coping behaviour might work for the nurse but not for herself. Mrs. J had probably lost her confidence in the nurse.

There were still no attempts from any of the others to involve themselves in this conversation. Overall, the patients concentrated on the group exercise and centered their discussion around this, while the nurse dominated the conversation as in the previous sessions.

GROUP A - SESSION FOUR

All five patients were present in the group. The nurse still chose to sit on the floor while the patients sat in the chairs. The patients seemed to be friendly and close to each other as could be seen in their greetings and smiles to each other before the group

started. Every patient looked cheerful and the group atmosphere began to warm, with the patients interested in the group.

This session was about "Learn to Improve Our Coping Behaviour" and the group exercise was "How much I know how to cope with my problems". Before the nurse started to talk about this topic she asked the patients to review what they had learned from previous sessions. The patients were willing and did so very well.

As in the previous sessions, the patients were asked to do the group exercise after the nurse had finished presenting the concept teaching. Again in this session some patients (A and B) needed the nurse to re-explain the group exercise a few times. However, when they understood what they were supposed to do, and they started to report their exercise with the nurse helping them to explore their problems further. The patients at this stage were keen to talk about their problems in everyday life and their unusual life problems. They also showed their helplessness in dealing with these problems. For example, Mrs. B mentioned:

Mrs. B: Well I've got things that always bother me are locked doors. My feelings toward these things are, annoyed. For the first reaction I put, I can do nothing about it. My feeling afterwards is, frustrated.

Nurse: O.K. And then we said, if it happened again, what happens next?

Mrs. B: You can do nothing, can you?

Mrs. B did not try to think of an alternative way to deal with her problem, but instead she kept on showing her helplessness. When Mrs. B's problem is examined in depth, it can be inferred that Mrs. B is frustrated with authority of the ward staff. Perhaps she wanted to express her frustration and share it with the group. The nurse at this stage helped Mrs. B express her feelings as well as asking the other patients to share this feeling with her. Unfortunately, it is unclear whether the rest of the group had picked up Mrs. B's underlying message. The following excerpt shows the confused situation at that time:

Nurse: Alright. Now this is a very tricky one. Why is it a tricky one? I won't tell you why I think it is, does anyone else think its tricky?

Mrs. J: Its like trying to join up those dots yesterday.

Mrs. D: It's not natural, is it?

Nurse: I was thinking in terms of the kind of things we've said the last three days, what kind of things have we said you can do, that you can't do, when it comes to these locked doors?

Mrs. E: Have to accept it?

Mrs. J and Mrs. D did not answer the nurse's question directly but instead mentioned the group exercise of the previous session. Perhaps they tried to compare the authority of the ward staff as being tricky like joining the nine dots with four straight lines, which was too difficult for them to do. Mrs. E suggested the group accept it because there was nothing that the patients could do about it.

In focal conflict terms, the group behaviour at this stage was unclear therefore unidentifiable.

Soon after this Mrs. E reported her group exercise. She also showed helplessness in dealing with her problems, but did show some insights into them. That is, she knew that she had to try and cope with her problems even though other people tried to help her. Her behaviour is illustrated by the following excerpt:

Mrs. E: Yes. I'm trying to accept being in hospital, and I know I've got to try and cope knowing people are trying to help me.

Nurse: Well it seems to me as if you are putting a lot of work into it, which is the first step.

Mrs. E: I haven't been putting as much work into it as I should. I get these headaches all the time, and I can't cope with the situation. Yesterday, and just couldn't participate.

Nurse: No. You used a very interesting word, actually, you said should, and should is a word form that triggers off a number of little warning bells....

Mrs. E: Yeah.

Nurse: And often I think I should, or perhaps I should, but I can't right now, so I don't like that word, at all. For me. Might be different for you.

Instead of helping Mrs. E gain more insight into her problem, the nurse changed to another topic. That is, she tried to criticize the word "should" which Mrs. E had used. Mrs. E then became silent, and the nurse's criticism of the word "should" stimulated Mrs. J to express her feelings as follows:

Mrs. J: I feel that way too. I should be at home with my children, and knowing very well that from now on, I'd only fall backwards, and land back here again. Its hard to accept that you can't mother your own children.

Mrs. E: That's how I feel. Because my children were all my life, and I devoted all my time to them.

Nurse: So both of you, you've got a very similar challenge. You've got to devote a lot more of your life to what you are and what you want....We might come back to that. We've got A left...Sorry D?

Mrs. J, in a similar way to Mrs. B and Mrs. E, displayed helplessness in dealing with her problems. She seemed to be pessimistic about her ability to cope with the problems in her family. Furthermore, she had no faith in the treatment at the hospital, for she said she would only fall backwards. At this stage, Mrs. E had a further chance to express her feelings in relation to Mrs. J's problems. Unfortunately, the nurse continued her pattern of cutting the patients off. Thus, there were no further self-exploration and the nurse asked Mrs. D to tell the group her answers to the group exercise.

However, at nearly the end of the session, the nurse encouraged the patients to talk about their life problems and think about their future actions. That is, what they could do when they went out of the hospital, and what kind of jobs they could aim to do. The group then discussed a variety of jobs but still showed their lack of confidence in planning any action.

Overall, the nurse dominated the conversation and did not give any patient a chance to initiate discussion. Perhaps the nurse felt responsible for maintaining the conversation in the group and was no longer aware that she should encourage the patients to be involved with each other. Consequently, the group was unable to show its pattern of development. The nurse tended to tell the patients when to start and stop their conversation and this group consisted of passive participants who tended to obey the nurse and rarely spoke if not asked. Only one patient (J) sometimes attempted to initiate a topic of discussion, but was not very successful when she did.

Again, a group focal conflict cannot be clearly identified.

GROUP A - SESSION FIVE

All five patients were present in this session. The patients looked tired and were quiet, in contrast to the previous session. In particular, Mrs. J and Mrs. B often sat back and closed their eyes.

This session was about "How Do We Cope With Our Problems" and the group exercise was "Plan to cope with some stressful life events".

The atmosphere of the group was inert at the beginning. However, when the nurse asked them to review what they had learned in the previous sessions, they did it correctly. The nurse then started the topic of this session by telling the group about her car accident the day before, as an example of her stressful life event. The patients showed their interest and concern for the nurse, which indicates a positive relationship between the nurse and the patients.

As in the previous sessions, some patients (A and B) asked the nurse to help them by explaining the group exercise again and again. The nurse was very patient and she tried to get them to understand correctly. The group atmosphere at this stage was again similar to that of the classroom in which the teacher is looking after her pupils when she gives them work to do. The following excerpt describes the group behaviour at this stage:

Mrs. A: Can you help me please?

Nurse: Mmmm. How are you doing?

Mrs. A: My feelings towards these people.

Nurse: Alright, people that always bother you. That's people taking your smokes?

Mrs. A: Mmm.

Nurse: Alright what do you feel. Do you feel annoyed, do you feel happy, do you feel sad....What do you feel?

Mrs. A: It annoys me.

Nurse: It does make you annoyed, does it? O.K.

Mrs. B: I don't know what to put.

Nurse: Well lets see.

Mrs. A: How do you spell annoyed?

Nurse: People who always bother you might well be people who lock doors from what you said yesterday. What else annoys you?

Mrs. B: When they take in all the milk.

Nurse: Right, people who take all the milk.

Mrs. A: How do you spell annoyed?

Nurse: A-N-N-O-Y-E-D

Mrs. J: I can't concentrate.

Nurse: Blame it on the weather....

Mrs. A: How do you spell wild?

Mrs. J: W-I-L-D

Mrs. B: What else can I put here?

This kind of situation continued for about half of the session, and the nurse then could not spend much time on exploring patients' problems.

In this session, Mrs. E showed her need to talk about her problems. It is surprising that the nurse did not show her any sympathy. The nurse's behaviour was more teaching oriented than warm and understanding. This can be seen on one occasion when Mrs. E referred sadly to the five stressful life events given in the group exercise:

Mrs. E: They've all happened to me!

Nurse: Have they? Well, with all that practise you must be really good at some of them by now.

Mrs. E: No, I'm not, that's why I'm in the state I'm in.

The nurse is perhaps not aware that patients who are admitted in a psychiatric hospital often have had experiences of stressful situations in the past which still have effects on their distressed feelings in the present. To say that Mrs. E must be really good at solving some of the stressful life events indicated the nurse's own lack of understanding of psychiatric problems.

However, Mrs. E went on telling the group her problems after she was told by the nurse to do so. There was no involvement from any of the other patients, who all listened quietly and reported their own answers to the group exercise when their turn came.

Overall, the patients still did not share any feelings or activities in the group, and a group focal conflict had not yet emerged.

GROUP A - SESSION SIX

All five patients were present in the group. The nurse sat at the same place on the floor while the others sat on chairs. The patients were silent at the beginning of the group and Mrs. E looked sad.

This session was focused on "What is effective and ineffective coping behaviour", the group exercise was "My coping behaviour".

As in the previous sessions, the patients were asked to review what they had learned and they did this correctly.

Mrs. A and Mrs. B still needed extra help from the nurse to understand the group exercise. Mrs. B always said that she could not

do the group exercise before she even tried. She really showed her helplessness and dependency on the nurse. For example:

Mrs. B: I'm afraid I can't.

Nurse: Well think, can you imagine that first day you had to get up and go to work. Did you feel happy? Did you feel worried? Did you feel angry about having to go to work? What kind of feeling can you vaguely remember?

Mrs. B: No. I'm afraid I can't.

Nurse: O.K. Well sit there and see if anything else comes up.

Perhaps, the nurse tired of Mrs. B's helplessness because she did not even want to try to think of anything, but left her to think on her own.

Soon after this Mrs. D raised a topic about "loneliness" by telling the group that she felt lonely when she had to shift from place to place. It is interesting that Mrs. J, who had previously attempted to share her feelings with the group, was eager to clarify Mrs. D's problem, as can be seen from the following excerpt:

Mrs. J: It shows that obviously you want companionship.

Mrs. D: That's right.

Mrs. J: With a male.

Mrs. D: Yeah, and with the children.

Mrs. J: And your husband has died, has he?

Mrs. D: No, no.

Mrs. J: Well, why are you here?

Mrs. D: Well all the children left home, and I got very depressed about it.

Mrs. J: They all leave home at once, did they?

Mrs. D: No, not quite, no.

Mrs. J tended to lead the conversation. Perhaps she wanted to share her feelings of loneliness with Mrs. D. This can be interpreted as the patients' sad feelings towards the ending of the group. They felt sad and the ending of the group meant the departure from each other. The nurse was not involved with this conversation. Perhaps she wanted the patients to help each other express their loneliness. On the other hand, the nurse may have been aware of the patients' feelings about the ending of the group and she perhaps felt the same way. This group behaviour is also noted by Yalom (1970) who said that patients often talk about death or loss, which indicates sad feelings at the ending of the group.

Furthermore, Mrs. J implied that Mrs. D needed to continue group therapy but with a male therapist, for she suggested that Mrs. D obviously wanted male companionship. Mrs. J's attitudes toward males in this session were related to a previous session when she told the group that she wanted to work with males rather than females. The nurse did not seem to receive Mrs. J's underlying message, that neither Mrs. J nor Mrs. D wanted to work with a female therapist like her, for she did not respond to Mrs. J's behaviour at that point. Mrs. J also tried to get another patient (B) to share her loneliness with them, and this was successful as can be seen from the following:

Mrs. J: Your life must have been very dull.

Mrs. B: Yes it has been a bit lonely.

Nurse: ...Does it happen very often?

Mrs. B: Yes, Very often.

Nurse: Do you find that, coming into a group or something, you get a bit less lonely, or do you think it doesn't make any difference?

Mrs. B: No.

Nurse: It doesn't or it does?

Mrs. I: It doesn't.

At this stage the nurse helped Mrs. B to express her feelings of loneliness further. The nurse also indirectly asked Mrs. B to evaluate the helpfulness of the programme in terms of helping her to be less lonely. Unfortunately, Mrs. B directly evaluated the programme as unhelpful to her.

This was the first time that the patients discussed the same topic. It could be considered as Mrs. J's achievement in getting the group to share its feelings. Thus, a group focal conflict had developed which can be conceptualized as follows:

<u>Disturbing Motive</u>	<u>Reactive Motive</u>
wish to express feelings of anger at the nurse for not providing help/wish to be helped	fear of anger reactions of nurse and of being denied
	X
	<u>Solution</u>
	get the group to express a feeling of loneliness and evaluate the group

The patients expressed their wish to be helped, and expressed feelings of anger at the nurse for not providing help. This disturbing motive was in fact initiated by Mrs. J in previous sessions but it was not picked up by anyone. Perhaps it was the knowledge that this was the last session that led the patients to group together and express their feelings.

Toward the end of the group, the patients seemed to shift their dependency from the nurse to each other. When the nurse asked the patients to evaluate the programme, only Mrs. E asked the nurse to continue the programme. Perhaps, the patients considered the programme as less helpful than they had expected and so did not want it to continue. Furthermore, according to the results on the MPN test, the patients' perceptions of nurses as helpful changed negatively.

GROUP A - SUMMARY AND DISCUSSION

The group developed very slowly, perhaps because the patients did not share a "common group tension" (Ezriel, in Whitaker and Lieberman, 1977). That is, they did not share an underlying common group problem. Mrs. J was the person who attempted to let the members of the group know how she felt towards them and the one who also tried to get the other members to share their feelings with her. Unfortunately, her cues were not picked by any other patients during the first five sessions. In the last session the patients probably felt sad about the ending of the group life so that they turned to each other and a focal conflict developed.

But even at this stage, the group was just starting to work together and was only in an early formative phase. It is very difficult to predict what would have happened if the group had continued because these patients needed a great deal of encouragement. Group A was passive and showed little substance, involvement or prospects for change in either its discussion or non-verbal behaviour.

This group is similar to the group described by Laing and Cooper (1964) as a "serial group". That is, the patients remain in the group so as to "be there" for the duration of the schedule. They may have in common some external object, but the relations between group members are anonymous. Gustafson (1976) further explains the "serial group", noting that unless there is a patient in the group who threatens them

all, they tend to want to have as little to do with one another as possible. The present group fits this explanation very clearly, for Mrs. J had attempted to threaten the rest of the group to share their feelings or do something about the group, but it took her five sessions to really get them to express their feelings of loneliness. If Mrs. J had not behaved in this way, patients would have continued to use the group in the way a series of people use a bus. That is the patients just go along "for the ride" with no need to learn or share any experience (Gustafson, 1976). In this kind of group it is very difficult for the leader to get the patients to do more than that.

In the present group, Mrs. J can be considered as a sophisticated patient in terms of her analysis of her problems. However, the rest of the group are unsophisticated patients who are likely to think in terms of advice (Whitaker and Lieberman, 1977).

GROUP B - SESSION ONE

All five patients were present and were welcomed into the group by the nurse who told them to choose a seat. The nurse chose to join two of the patients (R and N) on the floor while the rest of the patients sat on chairs.

The group was started by the nurse who introduced herself as a nurse from the Nursing Studies Unit, Massey University. She then asked the patients to introduce themselves. The atmosphere at the beginning of the session was friendly and warm. The patients looked active and lively and were enthusiastic about getting to know one another. All seemed to be articulate, except Mr. G who was quite shy and quiet.

The first session was mainly an introductory phase. The patients got to know one another and to see how the programme was organized. They were also asked to do the pretest CBT questionnaire and the group exercise about "How much I know about the concept of coping behaviour".

In contrast to group A, Group B did not find the pretest too difficult to understand and the nurse did not have to repeatedly re-explain. On the one occasion when a question was asked, the patient (N) was challenged by the nurse. This is shown in the following excerpt:

Mrs. N: What if you put all "1's"?

Nurse: Well then you're perfect.

Mrs. N: Well I wouldn't say I'm perfect.

Nurse: You can teach the rest of us to be perfect too then.

Mrs. N: I wouldn't say that's being perfect.

Nurse: You wouldn't?

The nurse did not give a direct answer, but instead critically reflected the patient's question. The nurse's behaviour here can be regarded as a challenge to Mrs. N. Perhaps the nurse just wanted to tease this patient as a sign of friendliness, but it was too soon for such behaviour as the patients had not yet got to know her. It is known that patients come to group therapy with hopes and fears of how they will be treated by others (Rice, 1969) and also that they interpret situations in light of their past experiences with a group or people in general. Furthermore, the patients may fear that they will be ridiculed when the group finds out how "silly" their problems

are (Whitaker and Lieberman, 1977). Thus, in the present group, the nurse's challenge may have threatened Mrs. N, and this might have led the other patients also to develop negative attitudes toward the nurse. Whatever the reason, such attitudes could be seen during this episode when the nurse interrupted the members of the group while they were doing the pretest and asked them to come again next session. The patients unexpectedly refused, with each patient giving similar reasons for not being able to come, as the following excerpt shows:

Nurse: Can you promise to be present next week?

Mrs. N: We don't know whether we can come. We may have visitors, if they come, they come for us.

Mrs. R: Mine are the same too.

Mrs. C: Mine are the same too.

Mr. T: On Monday I can say for certain I won't be here, my visitors are coming.

Mrs. N: You see, you're asking us a subject that we can't answer.

Nurse: I'm asking you, "Can you try?"

Mrs. C: I'll ask the doctor if I could come.

Here the patients are grouped together against the nurse. This may be because of their basically negative perceptions of nurses (see the results of the MPN test) and/or because of negative perceptions developed at the beginning of the session, or because of the development of counter-dependence.

In focal conflict terms, this may be summarized as follows:

Disturbing Motive

angry toward the nurse

Reactive Motive

fear of abandonment and
of the nurse's angry
reaction

X

Solution

band together against
the nurse

However, after the nurse attempted to explain some benefits of the programme and asked them to try to come, they agreed to do so. The patients seemed to be saying that the nurse was not a powerful boss who could tell them what to do, but they would come if they decided to do so. From a focal conflict point of view, the nurse's intervention has led to a shift in the reactive motive. Thus, a new reactive motive and a new solution arose which can be summarized as follows:

New Reactive Motive

fear of guilty feeling about
telling inappropriate reason for
not coming to the group

New Solution

give up attempting to go against
the nurse; turn to support the nurse

At this point the group has achieved an enabling solution. After they had all agreed to come to the group, Mrs. N suggested that the group finish a bit earlier on the last session, as she claimed that lunch on Fridays started about 11:15 a.m. However this suggestion was not supported by any of the others and the nurse did not make a definite decision at that time either but told the group to think about it. The nurse then suggested that the group go on with the pretest.

During the ensuing discussion of the pretest, Mr. T raised a question about one item that interested him; "others can help me solve my problems". He said he did not think others could help him solve his problems because people did not listen to each other and he would like to be open to his own suggestions as well as those of other people.

This may be related to the conflict previously mentioned, where the nurse put off the discussion concerning the finishing time for Friday's session. Perhaps he tried to hint to the nurse that "I don't think you can help us because you don't listen to us" and "I wish I could say what I want to and I would let others do so as well". It is likely that the nurse was not aware that this patient was using the topic to attack her personally. Mr. T was intelligent and often expressed his feelings towards others through the exercises. For example, later, in session four, Mr. T used an exercise to attack Mrs. N.

However, in this case, the nurse cut Mr. T off to ask Mr. G to present the answer he gave on the pretest. While the nurse was talking with Mr. G, Mrs. C raised an irrelevant topic with the group as follows:

Mrs. C: Psychology and psychiatry, there must be a lot of jealousy between the two.

Nurse: We're lucky, you see, we're not in either of them.

Mrs. C: I don't think they'd give you any credit, for your work. I don't think they appreciate you rather.

Nurse: Me, or who?

Mrs. C: I don't think they appreciate them here.

Nurse: I don't know. We're lucky that we're nurses and they treat us as nurses. What did you pick N?

It would appear as if Mrs. C is showing how she feels toward the nurse but she uses the terms psychology and psychiatry instead. This is similar to the situation discussed by Whitaker and Lieberman, noted earlier, that certain assumptions, hopes or fears are expressed quite indirectly. The nurse may have been aware of this but she made the excuse that she was a nurse and she implied that "we are nurses, you can't include us with people you don't like". However, this was unsuccessful because Mrs. C persisted, implying that "nevertheless, you are still not appreciated here".

The nurse then cut her off to ask Mrs. N to discuss her exercise. It is interesting that Mrs. N as well as the rest of the group chose to discuss what Mr. T had raised in the group. That is, "others can help me solve my problems". The group opened the discussion on this issue but disagreed with Mr. T. At this stage Mr. T was also being criticised by the nurse for delving into this topic in depth and having different ideas from the others. The nurse then suggested another topic to discuss, i.e., "I can cope with all my problems", and she was first attacked and then reassured by the group, as is shown in the following excerpt:

Nurse: I don't think I can cope with all my problems.

Mrs. N: Who can? Don't you?

Nurse: It depends what they are.

Mrs. C: It's probably lack of experience.

Nurse: Some of them are things I've never had to do before.

Here the nurse showed her weakness and insecurity, a move regarded by Whitaker and Lieberman (1977) as a therapeutic error. The group then tried to reassure the nurse that nobody could cope with all their problems and that is "what the nurse had her flatmates for". The nurse could not control the situation and develop security in the patients and at this stage the group probably felt superior to her. It seems that the group will attack anyone who shows his or her weaknesses or differences from the rest of the group. This can be interpreted

as lack of security in the group, and a lack of confidence in the nurse. In this kind of situation, it may be difficult for an inexperienced therapist to understand the underlying themes of the topics being raised by the group.

At the end of this first session a patient raised a topic "the people outside are the ones that should be in and the ones in should be outside", and this was supported by two other patients. Again, this may be an attempt to hint to the nurse that they (the patients) are more capable of coping than she is, and that they are able to reassure the nurse in her inadequacy. In other words, the patients should be outside rather than in the hospital. Unfortunately, this topic was not discussed further. The nurse did not respond directly to the issue but suggested that the group return to the group exercise. However, this did not stop the patients' expressing their feelings about the nurse. For example, Mrs. N and Mrs. C related their ideas on this issue to the exercise, by discussing the failure of treatment in the hospital. Furthermore, they said that they gained nothing by seeing their psychiatrist.

At this point Mrs. N and Mrs. C paired together to introduce the idea of evaluating the session as having failed to help the patients. They did this by using the psychiatrist as a focus for discussion, which can be interpreted as the patients wanting the nurse to guarantee that the programme will be worthwhile to continue. In addition, they want the nurse to let them talk freely. A focal conflict can be conceptualized in the following manner:

Disturbing Motive

wish to be helped
by the therapist

Reactive Motive

fear of being denied

X

Solution

discuss the unhelpfulness of
treatment in the hospital

Finally, the patients revealed their desire for therapeutic help. Possibly they had become aware that they were not expressing their personal problems, for they went on to do this very early in the second session.

GROUP B - SESSION TWO

This session involved only the three female patients, as the two males did not attend. A female nurse from Villa 6 was also unexpectedly present but did not participate. The atmosphere became warmer and more friendly than in the first session. Whether it was the absence of the opposite sex or the small size of the group that made the difference is not clear.

The planned topic for this session was "What is a stressful life event" and the exercise was "What is my stressful life event?". The patients talked about their personal problems, and became involved in each other's problems early in the session. While the nurse was introducing information about stressful life events, Mrs. C started to relate this material to her personal problem. The following excerpt describes the group situation at this point:

- Nurse: ...we go through all kinds of things in our lives we can't help it, the world changes around us....
- Mrs. C: That's the reason why I smoke, the stress of life.
- Nurse: ...there are things that go out, which can involve the death of your parents, that's a loss.
- Mrs. C: It took me three years to overcome the sorrow of my father's death.
- Nurse: Hang on to that and we'll come back to it.
- Mrs. R: What makes you like that dear?
- Mrs. C: We were very close Dad and I.
- Mrs. R: Is your dad dead?
- Mrs. C: I wouldn't be here if Dad had been alive.
- Mrs. R: He'd be up in Paradise. Don't worry about him dear.
- Mrs. C: Yes.

Mrs. R involved herself with Mrs. C's problem and also tried to support her regarding the nurse's attempt to continue her introductory presentation. This suggests that the patients had begun to support each other emotionally.

After the nurse had finished her presentation she asked each patient to talk about their personal problems which she attempted to clarify as illustrated in the following excerpt:

- Nurse: What feelings does that make you have?
- Mrs. R: Sad feelings.
- Nurse: What do you try to do?

Mrs. R: I try to, I want to see the social welfare, and get my child back from his grandmother.

The nurse was relaxed at this stage and she attempted to stimulate Mrs. R to explore her feelings and her problems. The other two patients were not involved in this conversation because they were busy writing their own answers on the group exercise sheet, and were not encouraged by the nurse to participate in Mrs. R's problems.

Mrs. N expressed her anger while talking about her personal problems but she did not directly receive support from the other two patients. Nobody asked her any questions but they gave support indirectly through their comments relating to other similar situations which they had experienced. This can be seen in the following excerpt:

Mrs. N: I stood there and I thought, what did you crawl from under? He treated me as if I was dirt, as if I was a bit of shit in the gutter....

Nurse: I'm sorry, it is time, is there anything else someone wants to say?

Mrs. C: I think it is a case of the ones that are in should be out and the ones that are out should be in.

Mrs. R: I believe in that too.

Mrs. C: Yes.

Nurse: Well, I'll see you tomorrow.

Mrs. C and Mrs. R seemed to be sympathizing with Mrs. N and relating to her problem. Perhaps the nurse did not want to become involved with Mrs. N's problem because it was time to close the session. The nurse seemed to be teaching oriented and did not appear to be interested in the patients' needs.

Overall, the patients seemed to satisfy their needs for talking about their personal life problems but there were no clear focal conflicts shown.

GROUP B - SESSION THREE

All five patients were present and the two male patients were welcomed back to the group. The patients were friendly to each other and shared their cigarettes and matches. Mrs. R appeared to feel insecure, as she often changed her seat during the session.

This session was about "Emotional responses to stressful life events" and the exercise was "How do I feel when I am frustrated".

Before the nurse presented the background information on this topic she asked the group to review what they had learned in the previous two sessions. Mrs. C claimed that she could not remember anything. However, the rest of the group attempted to recall what they had learned.

During the nurse's presentation of the background information about "loss", Mrs. N attempted to relate her own personal problem to the concept being taught. For example:

Mrs. N: Now take me for instance, I used to be a stamp collector. I used to collect stamps.

Mrs. R: I used to collect stamps too when I was a child.

Mrs. N: I had them right up until I was about 16 and I went looking for them. I was going to exchange. I had two stamps to exchange and I was going to, one for another. Do you think I could find any of the damn things? They'd taken legs and walked like everything I had.

Mrs. R: You're like me dear. Everything I have walks too.

Mrs. N: So I started to be hung strug and quartered and I've been had the same for all my life.

Mrs. C: I've lost things in my house when its been left unlocked and I never talked about it because of my persecutions. I can't talk about it because I am here.

Mrs. N: Well I used to lock things up and ...

Nurse: Right lets just get finished through this list.

Mrs. N: Maybe I am bitter over it.

Mrs. C: You can't talk about those things.

Nurse: Lets come back to discussing at the end in case we run out of time.

Mrs. N: No but they help build up your character. What you'll be and what you're like.

Mrs. C: You can't talk about those things.

Nurse: Well you can, but how about we leave it to the end...

Mrs. N attempted to share her life problems with the group by raising the example of stamp collecting. She implied that her being unable to exchange stamps was similar to the situation where she could not have what she wanted in the rest of her life. Mrs. R and Mrs. C tried to support Mrs. N by relating her problem to their own. At this point, Mrs. C warned Mrs. N not to talk about her problem or express her feelings in the group, as she (Mrs. C) also had the same problem and she did not talk about it. This can be interpreted as Mrs. C distrusting the group and she seems to control the situation

of the group. On the other hand, she may be trying to tell Mrs. N that "It is useless to tell any of your problems in this group because the group cannot do anything for you". It is evident that Mrs. C probably found that she gained nothing by telling the group about her problems in session two. Thus, she began to see the group as inappropriate for displaying openness by anyone.

The nurse did not get involved with their conversation at all but rather seemed to be very content oriented, for she attempted to cut them off several times. However these attempts to interrupt were unsuccessful, as Mrs. N and Mrs. C still continued their conversation. It seems that the patients tried to satisfy their needs to express their feelings and personal problems, while the nurse tried to satisfy her need to present the background information planned for this session. Thus, the patients' and the nurse's needs were often in conflict.

Soon after this the nurse was interrupted by Mrs. N who argued with the nurse over the teaching material whilst the other patients seemed to support the nurse. It is interesting to note that the rest of the group tried to support the nurse, but not the content presented by her. The following excerpt shows that Mrs. C raised another topic irrelevant to what Mrs. N and the nurse were discussing:

- Nurse: Some children grow up and they really want something, and they think, you know, when I grow up I'm going to be a famous heart surgeon, and they grow up and they don't become a famous heart surgeon. They become a dentist and they feel guilty. It's quite funny the things we want.
- Mrs. N: All I wanted to grow up was to have a love and happy home, and never got it. That's what I thought home was for.
- Nurse: That's a good saying.
- Mrs. C: What about psychiatry, Nurse?
- Nurse: No.
- Mrs. C: You'd do more good there. I'm a devout Catholic, and I think its wonderful the work you do for these hospitals.
- Mrs. R: I always wanted to be a nurse.
- Mrs. C: Very rewarding.
- Mrs. R: I always wanted to be a nurse.
- Mrs. C: So did I.

The nurse gave an unrealistic example to the patients and this was disagreed with by Mrs. N who looked realistically at what she wanted from her life and expressed disappointment. Mrs. C and Mrs. R

attempted to support the nurse and stop the conflict situation involving the nurse and Mrs. N.

Mrs. C and Mrs. R's behaviour can be explained as attempting to encourage the nurse to continue her role in the group and not become upset with Mrs. N. In addition, Mrs. C and Mrs. R showed their rejection of Mrs. N. On the other hand, Mrs. C and Mrs. R might be leading the nurse on, but this behaviour is unclear and the nurse does not seem to be aware of it. The above behaviour may be seen as a solution to the developing focal conflict which can be conceptualized in the following manner:

<u>Disturbing Motive</u>	<u>Reactive Motive</u>
wish to be unique and singled out for special gratification from the nurse	fear of the nurse paying more attention to only one patient (Mrs. N)
X	
<u>Solution</u>	
band together to reject Mrs. N and support the nurse	

With help from some of the members of the group the nurse began to relax and the group atmosphere became less tense. Mrs. N was now on her own in the group and the rest of the group supported the nurse. This is possibly what led Mrs. N to talk a lot in the group, and to show her hostility which may have indirectly been expressed towards the other group members as well as towards the nurse. This hostility was shown in the answer she gave to the group exercise, in which she began to give unrealistic examples. For example, a hypothetical problem was introduced by the nurse concerning an elderly aunt who came to visit a woman and her kids. However, the house was very small and the kids did not want the aunt there although the woman did. The question was, how she should deal with the problem. Mrs. N's comments were as follows:

Mrs. N: Oh yes there's an alternative. Can the old lady drive?

Nurse: Well I'm not thinking of a particular old lady.

Mrs. N: No but I say, can the old lady drive? Well has she got any money. Say about \$2,000?

Nurse: Lets say she's got a pension.

Mrs. N: Well she can manage.

Nurse: She may have to.

Mrs. N: She'd manage.

Nurse: Anyway...

Mrs. N: If she can drive she'd have a better life than you. She could go from camp to camp, in the summer time, from the spring to the autumn, and just bed down with you for the winter, and take off again. She could work in orchards, gardens, picking, could go round henhouses picking up hens eggs and all that...

Nurse: O.K.

It appears as if the nurse is tired of Mrs. N's talkativeness, for she was negative towards Mrs. N and did not directly answer her question. It seems that Mrs. N is very insecure in the group and she probably needs some assurances from the other group members. However, nobody was involved with her at this stage. The other patients were just looking on and smiling during the exchange between Mrs. N and the nurse.

Mrs. N's need to express her hostility seemed to increase. Shortly after the above event, Mrs. N showed her hostility in her answer to one of the group exercises. For this exercise there was a picture of a female patient with her suitcase waiting to go home, when a nurse came in and told the patient that "the doctor changed the order this morning, and you are not allowed to go home today". The patients were asked to fill the empty space on the group exercise sheet with what they would say if they were the patient in the picture. Mrs. N unexpectedly told the group in an angry voice that she put "Bloody sh___. Not again!" However, she laughed after she said that and this led the members of the group to laugh as well. This caused everyone in the group, including Mrs. N, to feel a little more relaxed. Perhaps the swearing had released the tension and hostility.

GROUP B - SESSION FOUR

This session was about "How to improve your coping behaviour" and the exercise was "How much I know about how I deal with my problems".

All five patients were present for the session, and seemed to be glad to see each other, for they had had a chat and smoke together before the group was started. The session began with the nurse asking the group to review what they had done in the previous sessions and this they did very well.

In this session some changes were apparent. Mrs. N still talked a lot and also tried to argue with the nurse while she was presenting the background information. For the first time, Mr. T began to become

involved with the other patients, as when having finished answering the group exercise, he turned to Mr. G and asked him whether he had also finished. He showed greater initiative than during the first three sessions. Mrs. C now often asked Mr. T to comment on her problems, and supported what he said, for example:

Mr. T: ...I don't think people say a lot about that.

Mrs. C: That's true T.

Mr. T: Attached to a psychiatric hospital.

Mrs. C: That's true.

Mrs. C's behaviour in supporting Mr. T was very clear and direct. She seemed to have a hidden agenda at this point, which became apparent later in the session when she supported Mr. T in his attack on Mrs. N. The group was changing and everyone tried to participate in the group, but they did not listen to one another. At this stage they were not yet involved in each other's problems.

For most of the session Mrs. N tried to dominate the conversation in the group. Before the session ended she continued to talk about her personal life and did not seem to want to stop. The nurse then cut her off to ask the rest of the group whether anyone wanted to say anything. Mr. T took this chance to indirectly attack Mrs. N for being too talkative. The following excerpts illustrate the group situation at this stage:

Mr. T: Well I've got, I filled in the second one (in fact, the nurse did not ask anyone in the group to do this exercise for she forgot about it).

Nurse: Did we not ask your second one? I'm sorry N, we missed out a bit of T's.

Mr. T: My second one is people who bother me is over talkative people.

Mrs. R: Bothers me too.

Mrs. N: Am I one R?

Mrs. C: It bothers me too.

Mrs. N: And yet normally I was quiet and shy. It's only since I've been in this group, I've never spoken before.

Mr. T: My feelings towards him is - here we go, a perfect example.

Nurse: (laughs) Hang on a second N (Mrs. N tried to say something)

Mr. T: ...annoyance at their verbosity. And their feelings towards me is "Why don't they listen?" That's their, that's the record they play.

Mrs. C: True.

Mr. T: My response to them is "Why don't they come to the main point?" And their response towards me is a total immersion in words.

Mrs. C: I'll tell you what it says in my homeopathic medical book. It says about nerves, vivacious talking, it says, they never know when to stop.

It seemed that the members of the group had been waiting to express this feeling towards Mrs. N but no one wanted to start a conflict with her. But when Mr. T raised his topic, Mrs. C and Mrs. R spontaneously supported him. Mr. G, even though he did not give verbal support, seemed to be pleased at the attack on Mrs. N, for he laughed.

Mrs. N was in a difficult situation, and she tried to explain her actions to the group. Unfortunately, she was stopped by the nurse. Perhaps the nurse wanted to satisfy her need to express her own feelings of boredom with Mrs. N. This could explain why she tried to cut Mrs. N off and encouraged Mr. T to go on with his group exercise. Mr. T's change in behaviour can be explained as seeking support from the members of the group, who would agree with him if he attacked Mrs. N then, whereas if he had attacked Mrs. N earlier, without group support he might have been rejected. Mrs. C's change in behaviour became manifest at this point, as she led the support of the group which gave Mr. T the confidence to attack Mrs. N.

At this point, a focal conflict can be conceptualized as follows:

<u>Disturbing Motive</u>	<u>Reactive Motive</u>
wish to express anger, and bored feelings towards one patient	fear of guilt feelings for tattling
X	
<u>Solution</u>	
get the most intelligent patient to express angry/bored feelings	

After the nurse let the patients express their feelings towards Mrs. N, she turned to make excuses for sometimes talking too much herself:

Nurse: I'll tell you something, that this rings bells with me T, because I know that it is a fault of mine sometimes. Not all the time, but in the last three weeks my flatmates have been away. And when they came back I had three weeks worth of things saved up to tell them. So I went "vvvvvvv" you know?

Mr. T: Yeah.

Nurse: And it can be hard to stop once you get wound up.

....

....

Nurse: So I'll tell you something T. My particular feeling is, well like here there are six of us, and I work on the theory that we all know something that the others don't know, as I've said. What makes me very happy is if all of us talk vaguely about a sixth of the time. Right?

Mr. T: I agree with that.

Nurse: So I don't really mind. I don't sit here and sort of say "You've spoken for five minutes, you speak for five minutes".

Mr. T: I was a bit worried.

Nurse: But it is nice to have in the back of your mind this is something that somebody told me about last year, that if I am talking I cannot listen. If I'm not listening to someone else I can't learn from them. So every now and again I think "Hey, I've been rabbiting on and rabbiting on. Shut up, someone might tell me something that's worth hearing". That's my own rule of thumb, because that can be a fault of mine. Quite definitely.

The nurse was perhaps pretending that she did not know who was being attacked in the group. In fact her behaviour was confused and it was not clear exactly what she aimed to do. That is, she at first made an excuse that she herself talked too much sometimes, in her flat. It is noticeable that she did not mention her talking in the group situation. Then she tended to imply that if anyone talked too much in the group, it was not her responsibility and the group could not blame her, as she actually wanted everyone to talk equally. Finally, she seemed to imply that she did not talk too much and if anyone knew that he/she talked too much, it meant that he/she could not learn anything. It is difficult to interpret the nurse's behaviour at this stage. However, the nurse helped release the tension of Mrs. N at this point, who began to get involved with the group conversation again. Mrs. N then said to the group that she did not mind talkative people because they could say what they wanted to say, but they had to get straight to the point. Mrs. N now seems to be half protecting herself and half going along with the other members of the group. Perhaps she was ambivalent about fighting with the others or supporting them. None of the others got involved with Mrs. N at this point and the session ended very soon after this.

GROUP B - SESSION FIVE

All five patients were present in this session. The session was held in the "medical office" because the group room was being used. Everyone sat on chairs in a small circle due to the small size of the room. The group looked overcrowded and the patients seemed to be agitated. Their enthusiasm to participate differed from previous sessions, perhaps because of the overcrowding and physical closeness their feelings of anxiety were aroused (Lothstein, 1978). For example, Mr. G, who had remained quiet in previous sessions showed a greater attempt to participate. In this session, also, the nurse showed her rejection of Mrs. N by sitting next to her with her back towards her, trying to encourage the other group members to participate. It seemed as if the nurse was afraid that Mrs. N might start to talk and would not stop, as in the previous sessions. The rest of the group, in particular Mr. T, was probably aware of the nurse's behaviour. He tried to report his group exercise without the nurse asking him, as he had done sometimes when Mr. G was reporting. Mr. T's behaviour could be interpreted as expressing feelings of superiority to the group, but in a different manner than Mrs. N.

This session was about "How do we cope with our problems", and the exercise was "Plan to cope with some stressful life events". Before the nurse went on with the details of the topic, she praised Mr. T for doing the second page of the previous group exercise, which she had not been aware of. Mrs. C laughed and said that "T's our brain" and "wish I had T's brain". It is implied that "T is clever to know what the group wants". Mrs. C perhaps admired Mr. T for his attack on Mrs. N in the last session. However, this was not mentioned further by anyone as the nurse asked them some review questions about what they had learned in previous sessions, which they all attempted to answer.

During the discussion of the group exercise Mrs. N reported that people who always bother her were talkers but she would listen to them, however if they went on and on she began to get impatient. Mrs. N might have been aware that she was attacked in the last session, and may have felt she now was rejected by both the group members and the nurse. She tried to tell the others to accept her as being like them. However, she also implied that "although we don't like talkers, we should try to listen to them". Mrs. N at this point was perhaps

insecure and needed help from the others, that is, by listening to her problems. However, the nurse did not seem to receive Mrs. N's message as she did not give any support. Furthermore, the nurse's seating in the group isolated Mrs. N from the rest of the group, and this might have had secondary effects on Mrs. N's feeling of rejection. The other patients at this stage remained silent, though this together with the nurse's behaviour may have been judged by Mrs. N as ignoring her wish to become part of the group. From this point on Mrs. N appears to have decided to fight the others in the group on her own. This can be seen from her increased attempts to participate in the group, which was not as easy as before because everyone in the group also attempted to actively participate. Nevertheless, Mrs. N did not miss her chances if she could possibly comment on anything. The nurse was not very friendly to her at this time and they often argued with each other. At one occasion while they were arguing, the nurse asked for support from the rest of the group. Some patients (Mr. T and Mr. G) turned to support Mrs. N's ideas and Mrs. R supported the nurse. Mrs. C showed her cleverness at this point as she tried to support both of them. The following excerpt describes the group behaviour at this time:

- Nurse: But if a person say you go to the doctors and the lady sitting next to you in the queue tells you all about her varicose veins, and the operation she had on her finger last year, and her son's appendicectomy, and how she's got to go and have an x-ray next Tuesday and her father died of a weak heart you know, can you say to her, look I don't really want to know about your illness? Can you just make that.
- Mrs. N: Well that's being rude. In a way.
- Nurse: You feel that's rude? So you won't do it.
- Mrs. N: In my aspect that's being rude because she's releasing her tension.
- Nurse: Yeah but you might not want to have it released at you. Could I ask the rest of you, could you directly come out?
- Mrs. N: No but that's not what the case I meant.
- Nurse: No I just wondered.
- Mr. T: I was just wondering how you'd chop diplomatically in a situation like that where would you change the topic, is the move I'd try and make, or because I'd be embarassed by hearing all these personal details, quite frankly.
- Nurse: Well you could imagine that it's a guy, you know, a guy's operations, perhaps, not a woman, but do you ever, this is something that interests me, can you ever come out in that

situation and say something like 'Look I've had a tiring morning, I really don't'

Mrs. N: You can't.

Nurse: You can't? YOU can't. Now hang on. How about the rest of you?

Mrs. N: I don't think you can.

Nurse: No, you think YOU can't. I'm saying how about the rest of the people here?

Mr. T: Here's another one who can't.

Nurse: You find it very difficult?

Mr. T: Yes, quite difficult.

Nurse: R?

Mrs. N: You've got to let her talk.

Mrs. R: What's the question again please?

Nurse: If you're in a doctors waiting room and the lady next to you told you all these hundreds of things, could you say something like I'm quite tired, right now, I don't really want to know about your operation.

Mrs. R: Yes I'd tell her that I'm tired.

Nurse: An you think she'd stop talking?

Mrs. R: Yes.

Nurse: All right.

Mrs. C: Within reason. I might be able to be of help to her, but I wouldn't encourage her to talk too much.

Nurse: Mmmm.

Mrs. N: I don't think you could because you're all patients in there together, and she's just releasing her tension.

Nurse: But what if you're sitting there with a splitting headache, and she's making it worse?

Mrs. N: Well you might know it was a splitting headache, you might not catch every word, but I'd just listen and I'd be silent and let it ride over me.

Nurse: You're very tolerant. Who have we not had? I'm pushing it a little bit but I want to get on to the second one. R you're the last.

The nurse did not constructively discuss Mrs. N's comments and did not seem to understand what Mrs. N was attempting to tell her. The nurse persisted in implying that she did not want to listen to anybody's problems, while Mrs. N was insisting that the nurse listen, because that enabled her to release her tensions. Mr. T and Mr. G, even though they had attacked Mrs. N previously, turned to support her. Perhaps they also still wanted someone to listen to them and the nurse may have lost

the confidence of the group because of her unwillingness to listen to patients' problems.

The nurse cut the conversation off at this point to ask Mrs. R to report on the group exercise. Very soon after this the nurse showed her unfriendliness towards Mrs. N when Mrs. N commented on Mrs. R's answer to the group exercise. This is shown in the following excerpt:

Mrs. N: You're getting too close to the knucklebones.

Nurse: Oh well that's the whole thing you see. I don't think you really learn unless you get a little bit close to the knucklebones every now and again.

Mrs. C: You've got to be more tolerant.

Mrs. N: You've stumped me for answers.

Nurse: Well that's good, if you're being stumped for answers then you're making bits of your brains work that might have had a holiday for five years. Now this second one here.

Mrs. C: I think R got to be more tolerant.

Mrs. R: Pardon?

Mrs. C: I think you've got to be more tolerant, and have more love.

Mrs. C's behaviour is not quite clear at this point. She suggested that Mrs. R should be more tolerant even though Mrs. R was not in the conversation. Perhaps she wanted to tell the nurse to be more tolerant to Mrs. N and not lose her temper.

The nurse became even less patient with Mrs. N than in previous sessions and also expressed her anger towards her. This might have been noticeable to Mrs. C, who attempted to warn Mrs. N to be patient.

Overall, in this session conflicts between Mrs. N and the nurse were clearly shown. Mrs. N perhaps resented the nurse for refusing to support her at the end of the last session, and again early in this session. The general atmosphere of the group was tense. There was no clear focal conflict.

GROUP B - SESSION SIX

All five patients were present in this session which was about "What is effective and ineffective coping behaviour". The group exercise was "What is my coping behaviour". The patients were pleased to see each other again, and had a chat and smoke before the group started. Thus the atmosphere at the beginning of the session was warm and friendly.

The nurse started the group by asking the patients to review what

they had learned in the previous sessions and they all did this well. At this stage Mrs. N was knitting and was perhaps feeling insecure and anxious and very soon after the group started, Mrs. R moved out of the group to sit on a sofa. Her behaviour may have reflected her feelings of being left out, but although this may have been noticed by the others, no comment was made. As the nurse continued to give information about the topic Mrs. N listened carefully while she knitted. Once again she started an argument with the nurse. She put her knitting down, and looked at the nurse while she was arguing with her. This seemed to annoy the nurse as can be seen in the following excerpt:

Nurse: I could not go click, cope like that. Its too...

Mrs. N: You could click and cope.

Nurse: No I couldn't.

Mrs. N: You could.

Nurse: You might, I couldn't. I'll go through this.

The nurse was interrupted by Mrs. N, who seemed to distrust her and tried to show the group that she knew more. Again Mrs. N's behaviour was not supported by anyone in the group. The nurse seemed tired of her and tended to show negative feelings towards her as is shown in the following excerpt:

Mrs. N: How do you spell either? re or er?

Nurse: I think its either depending on whether you're French or English.

The nurse did not tell Mrs. N directly how to spell "either" and her behaviour indirectly showed her anger towards Mrs. N, but it was not clear whether Mrs. N was aware of this. However, the conflict between them did not finish here. It was continued later when Mrs. N reported her exercise and was questioned by the nurse. Mrs. N resisted answering the nurse's question, and went on telling and repeating her story. The following excerpt clarifies Mrs. N's behaviour at this stage:

Mrs. N: I've got for my stressful life event I've got parking and forgetting to put money in meter.

Nurse: Getting traffic fines, Mmmmm

Mrs. N: I didn't get the fines, my feelings towards them, honestly I completely forgot, didn't see the meter maid, and I wasn't on a mission of mercy.

Nurse: Is that a feeling?

Mrs. N: What do you mean?

Nurse: You said you forgot. Is forgetting a feeling or -

Mrs. N: I completely forgot. If you wait on I'll come to it.

Nurse: You're going to get to the next bit. O.K.

Mrs. N: Now then, my good behaviour,

Nurse: How about your feeling, that second column, when you realized -

Mrs. N: I wasn't on a mission of mercy.

Nurse: That's not a feeling. A feeling is happy, sad, angry, hurt.

Mrs. N: I told you I completely forgot, I walked away and never gave it a second thought.

Nurse: Perhaps you mean something by forgetting that I don't. Because I would say forgetting is not a feeling. You see.

Mrs. N: Well let me go through and I'll come back to it.

Nurse: Alright.

Mrs. N: And then my behaviour, I put reasonable. Because it's been done before. I haven't done it before but other people talk about doing the same thing. And then for behaviour, bad, I've got a question mark, because I'm shy and quiet normally.

Mrs. C: (?)

Mrs. N: And then the reason, I am a patient person.

Nurse: O.K. So your reason for doing things is that you want to be patient.

Mrs. N: No, it's just the way I am. And then I've got well-adjusted coping behaviour, go and pay for it. I had money, I'd just been paid.

Nurse: O.K.

Mrs. N: The other reason, I had a dozen things on my mind.

Mr. T: What have you got for the well-adjusted coping behaviour?

Mrs. N: I've got, cripes, go and pay for it.

Nurse: O.K. The well-adjusted person's going to go and pay the fine.

Mrs. N: Yes.

Nurse: Fine, I like that, the only one that still puzzles me is that second one, could we go over it again?

Mrs. N: I'll give you the last one first, the reason, well I had a dozen things on my mind. And honestly I completely forgot, didn't see the meter maid, and I wasn't on a mission of mercy.

Nurse: O.K. Yeah. But what about the second bit?

Mrs. N: I forgot it, honestly, you go into town and you'll see something and you have a list in your mind. You get out of the car and your mind's a blank, you don't know what you're thinking about.

Nurse: I'm not puzzled by what you said, at all. What you said sounds fine, you said you forgot.

Mrs. N: Yeah.

Nurse: What I'm puzzled by is that to me forgetting is not a feeling. To me a feeling is I'm happy, I'm sad, I'm hurt, I'm puzzled, I'm bewildered, I'm angry, I'm anxious, I'm tense, but not I forgot. Forgot goes on up here. What went on in your stomach when you realized that you didn't put money in the meter?

Mrs. N: Well you relax. When you forget you relax.

Nurse: So you feel happy?

Mrs. N: You relax, you don't give a darn.

Nurse: You feel calm?

Mrs. N: You feel calm, you just park the car, walk away, until you come back and see the meter maid, and you think, no money in the meter. Crikey, I forgot about it. Then you look at the shopping list and you forget everything.

This excerpt shows that Mrs. N answered Mr. T's question but avoided answering the nurse's questions. Perhaps Mrs. N became resentful when the nurse did not tell her directly how to spell "either". Mrs. N also seemed to feel lost and confused. The nurse tried really hard to get Mrs. N to understand her questions but a barrier had built up between them. Other members of the group were not involved at this stage. Mrs. C, who usually clarified others' problems, was silent here but later joined in when another patient began reporting.

During the second half of the session each patient evaluated the programme. In general, they found the programme very interesting but thought that it needed to be more flexible in order to satisfy each individual as well as the group's needs. The nurse explained to the group the structure of the programme which was designed to give them techniques with which they could help themselves improve their coping behaviour. However, the nurse apologised for sometimes having to cut them off because time was limited. All the patients asked that the programme be extended.

Mrs. N added that the nurse acted as a magnet and helped her very much to be able to talk about her problems with others, something she had never done before. Perhaps Mrs. N felt guilty for attacking the nurse and talking too much during the programme, so that she claimed that the programme was the cause of her change. In fact her ward nurse reported that Mrs. N was always talkative. In other words, Mrs. N appears to be apologising to the nurse and the members of the group for being talkative.

In this session patients often raised irrelevant topics to talk about together while the nurse was talking to the group, thus ignoring

her. This behaviour can be described as a resistance (Chance, 1971) or as seen as a decline in the dependence on the nurse by the patients, with an increase in their dependence on each other.

GROUP B - SUMMARY AND DISCUSSION OF GROUP DEVELOPEMENT

Two stages can be identified in the development of Group B:

First, the group was dominated by a focal conflict, with the nurse as the central point, which was a product of three factors. These are described by Whitaker and Lieberman as: "the patients' expectations about the group; the structure of the group; and the composition of the group". Firstly, a reactive motive was expressed as the fear of abandonment by the nurse. Such fear emerged in conjunction with the patients' wish to express their anger towards the nurse for not providing help for them, such as when Mrs. N asked the nurse to clarify the pretest and the nurse challenged her. The first reactive motive was shifted to the fear of feeling guilty and led to the group achieving a solution when the patients changed to supporting the nurse. Secondly, in the same session the reactive motive shifted to the fear of being denied by the nurse which arose from wishing to be helped by her. This reactive motive was solved by discussing the unhelpfulness of hospital treatment. Thirdly, the reactive motive moved to fear of the nurse paying more attention to one patient (Mrs. N) than the others. This reactive motive came from the patients wish to be unique and singled out for special treatment by the nurse. The patients tried to solve this conflict by banding together to reject that one patient and support the nurse.

In the second stage, the conflict shifted from the nurse to one of the patients and this was expressed quite noticeably both directly and indirectly. The disturbing motive was anger at this patient but the group feared guilty feelings about tattling. Thus, the group got the most intelligent person in the group to express the angry feelings. In the last two sessions, the focal conflicts were not so clear. Perhaps, as the group proceeds, concise description becomes more difficult because of the more complex and extended history (Whitaker and Lieberman (1977)). Thus, the group moved through a number of focal conflicts, with disturbing motives, reactive motives and consequent solutions.

The development of Group B ended in a middle formative phase.

CHAPTER 4CASE STUDY

An idiographic case study approach is used in the present study to develop a description of the patients' development in their group. This approach enables the comparison of each patient with him or herself over time (Ogilvie, 1966), and is recognized as a useful source of hunches (Allport, 1962) leading to understanding the individual patient's behaviour.

The idiographic approach was used to examine the problem of interpretive validity of content analysis, by Ogilvie (1966). Ogilvie's study focused on one of ten members in a training group, which met for one hour three times a week for a total of seventysix sessions. A revised form of the Bales Interaction Process Analysis System (IPA) was used to categorize observations of their interactions, and Ogilvie found that by using an idiographic approach with a content analysis technique, he could understand how the subject dealt with both his environment, and his interpersonal conflicts. Ogilvie concluded that his study gave a picture of a person who was almost neurotically "other-directed". Thus, this kind of study should be very useful for assessing the personality of subjects enabling a method to be found to help them.

Another study (Paige, 1966), studied the personality structure of an elderly woman. The data were a series of one hundred and sixty-seven letters written by the subject, Jenny Masterson (a pseudonym), to her son's college roommate and his wife. Two main approaches were used to develop a description of the structure of Jenny's personality. Both were idiographic, and compared Jenny with herself over time: firstly, the day to day shifts of mood and of immediate environment that led to the changing topics discussed in her letters; and secondly, the gradual structural changes in personality that led to the emotional disorganization that was evident toward the end of Jenny's life. The content analysis technique provided a more accurate description of the changes in Jenny's personality than could the clinical observer. This study did not attempt to observe the subject directly but rather provided a method of indirectly studying her personality structure. The results of the study, show that an idiographic approach using

content analysis can provide accurate data in a psychological study.

Therefore, the present study adopted an idiographic case study approach to examine changes in the two groups of five patients over six sessions of one hour group meetings.

The use of the content analysis method in a case study will be illustrated by an analysis of the effects of the teaching programme on changes in the verbal behaviour of each patient. From the point of view of learning theory it would be expected that in successful cases problems dominate at the beginning and insight and plans dominate at the end (Snyder, 1945; Seeman, 1949). In addition, it would be expected that patient categories for resistance to learning would show a decrease in percentage during the course of teaching.

Two patterns of analysis are involved: firstly, an analysis of the patients' verbal behaviour development in each of the six categories (see Appendix G) over the six sessions; secondly, an analysis of the patients' distribution of statements compared to that of the group.

Procedure

The Development of Patient Verbal Behaviour Within Each Category

Graphs representing the patients' development in the group were constructed by calculating for each patient the percentage score for each category. This was done separately for each of the six sessions.

Each patient's verbal behaviour will be analysed separately. The first five patients were in Group A, and the last five in Group B.

Patients' Statement Distribution Over Sessions Compared to Group Statement Distribution

The graph was constructed in the following manner. To obtain the group percentage scores, the group totals for sessions one through six were summed separately for each of the six categories, and these six summations were in turn divided by the grand total of all scores. Each patient's percentage scores were obtained by the same procedure after his or her totals were extracted from the group's total (Ogilvie, 1966).

MRS. BDescription of the Patient

Mrs. B was a late-middle aged woman, a widow who claimed that the death of her husband caused her to be admitted to a mental hospital. She walked and spoke slowly. She was silent in the group, and showed little interest or involvement in the group. In the first session she showed marked anxiety, as could be seen from her agitation. She first sat on the floor, then moved on to a chair outside the group and wandered around but came back to her chair every time. From the author's observations, she seemed to feel left out and uncomfortable in the group. The group, however, did not pay attention to her behaviour. This is not surprising, because everyone was new in the group and was more aware of what was happening to themselves than to the others.

When she was asked to do the exercise, she found it difficult to understand. It is interesting to note that even though she was quiet and not involved with others, she continued asking question after question to clarify the exercise.

In the last two sessions she showed more confidence in reporting her exercises.

Development of the Patient in the Group

Figure 4.1 shows the change in verbal behaviour of Mrs. B over the six sessions, for each category. This patient showed high active learning in the first session. This can be interpreted in terms of how she dealt with her anxiety; that is, she was anxious and insecure so she attempted to clarify the exercise by repeatedly asking questions. In addition, her question asking showed her low intelligence. However, the proportion of time spent in active learning decreased with each session, while her resistance to learning increased. It is interesting to note that in the last session, Mrs. B did the same test as in the first session, but claimed that she did not know how to do it, and instead of asking the leader for clarification she just sat still and refused to do it. This can be interpreted as attention seeking. That is, she probably wanted the nurse to approach her, and this was successful because the nurse came to explain the test to her.

For self-exploration, she tended to talk about her problems concerning people in the ward, rather than her own personal life problems. The degree of exploration was dependent on the stimulation

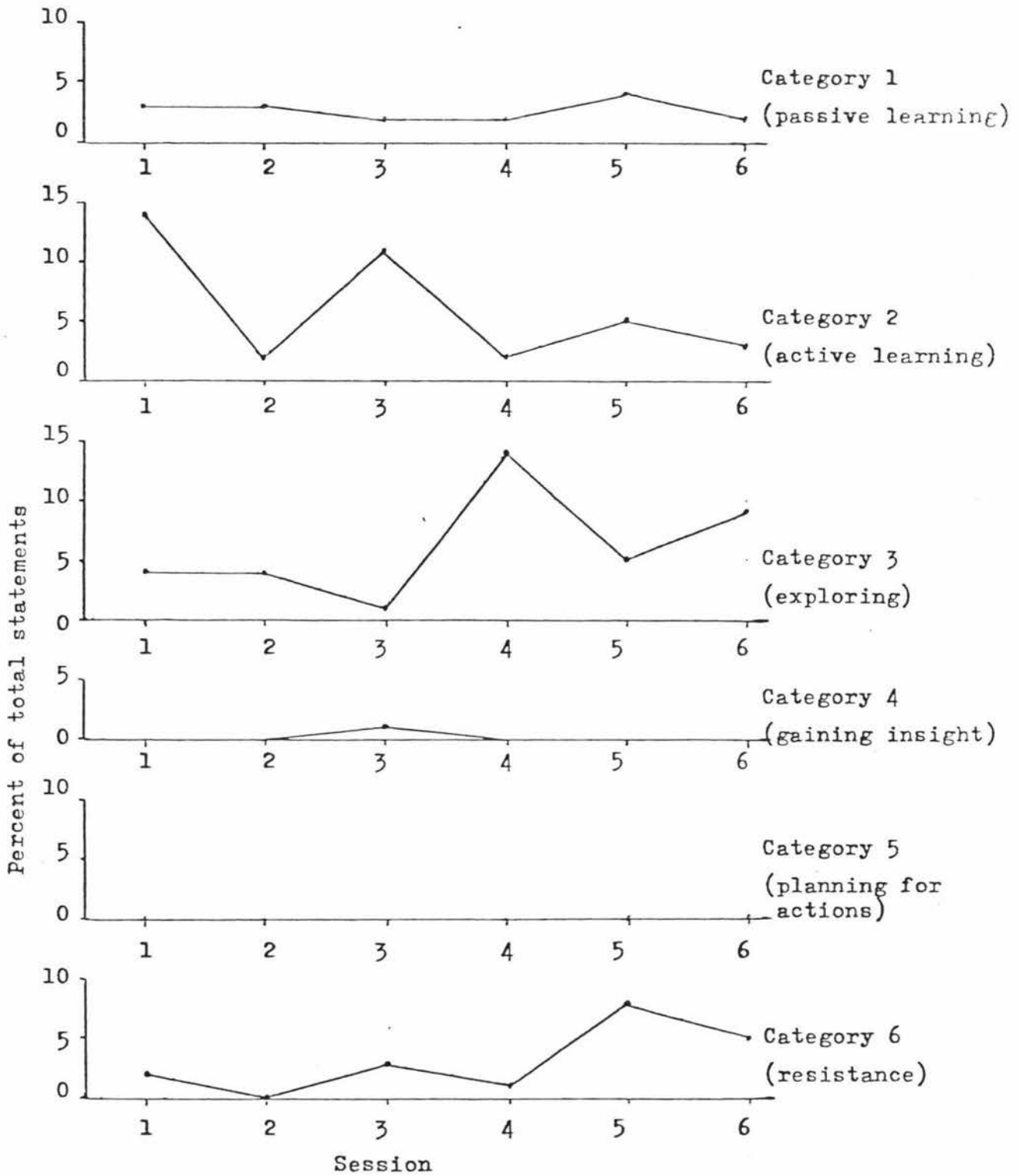


Figure 4-1 . Distribution of verbal statements of Mrs B.

of the exercises.

She showed very little of "gaining insight" and none of "planning for the future actions".

Overall, the salient characteristic of this patient in the group was active learning (clarifying exercises). Mostly she was silent and little involved with anyone in the group. Her self-exploration mainly concerned her complaints about everyday life problems in the ward, and these were quite realistic. For example, she told the group that locked doors in the ward annoyed her very much.

Over a period of six hours, the author got the impression that she was a lonely widow. She hoped to get out of the hospital although she could not plan what to do after that.

Comparison of Patient with the Group

Figure 4.2 shows Mrs. B's distribution of statements compared to the group. She showed a higher proportion of both active learning and resistance to learning but lower proportions in self-exploration, gaining insight and planning for actions.

Evaluation

It is difficult to evaluate whether or not she benefited from the programme, as her verbal behaviour showed no signs of improvement. Perhaps a group with supportive members and encouraging leaders would be more appropriate for her.

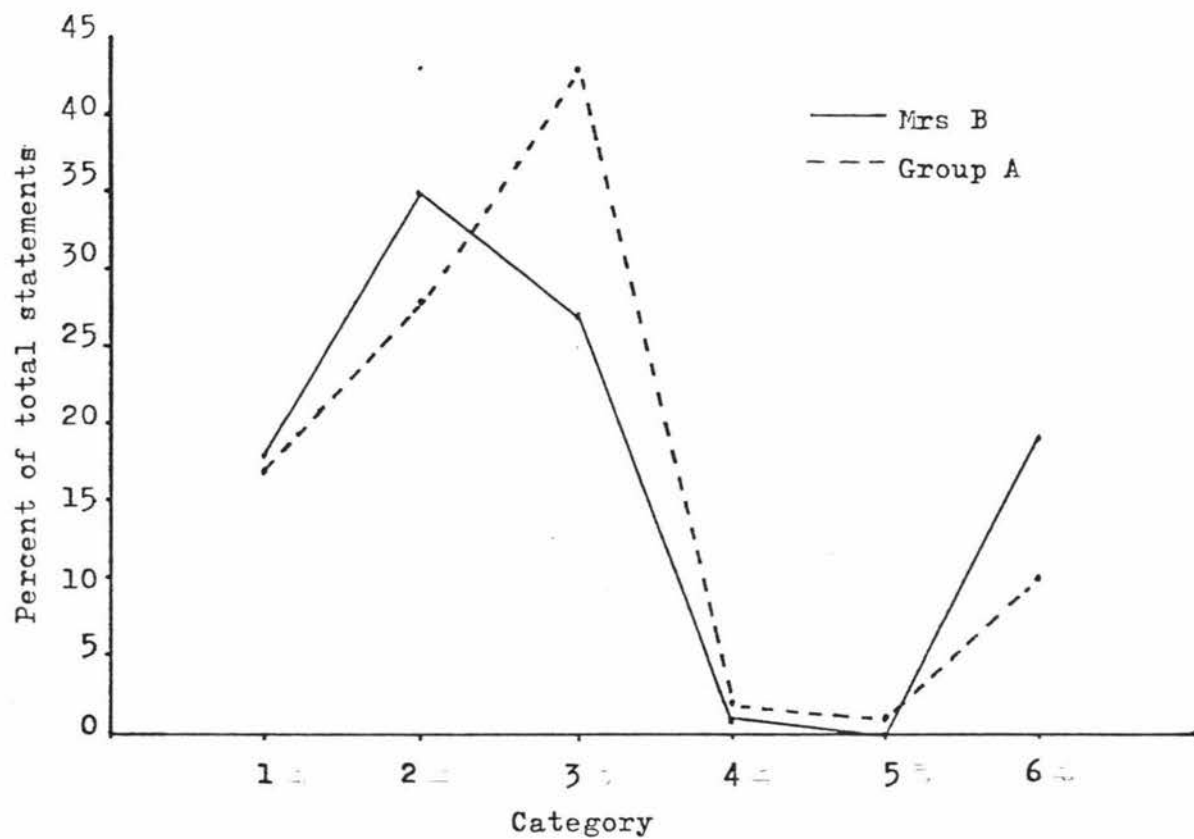


Figure 4-2 . Statement distribution for Group A and Mrs B.

MRS. ADescription of the Patient

The patient was a middle aged Maori woman. She was inarticulate but she was a cheerful and friendly person. She was willing to come to the sessions and showed interest in what was going on in the group. While sitting in the group, she often smoked and gave some of her cigarettes to the others. Although she was not good at writing or spelling, she tried hard to spell correctly by asking the nurse or the others in the group for help.

She was aware of what was happening in the group, as could be seen in Session five for example, where she woke up another patient who had closed her eyes. She also showed her feelings of involvement in others, for example, when a patient in the group was talking about a distressed period in her life, Mrs. A was silent, sad and looked like she was going to cry.

Mrs. A seemed satisfied with her present life in the hospital, for she said that she wouldn't mind staying in the hospital for the rest of her life.

Development of the Patient in the Group

Figure 4.3 shows changes in verbal behaviour of Mrs. A over the six sessions for each category.

The patient came to the first session with eagerness to see what would happen in the group. She was not afraid to ask the leader any questions about what she did not understand. Thus, in her first session she showed reasonably high active learning. In session two, Mrs. A increased her self-exploration but her problems were rather every day life problems in the ward than her personal life problems. She refused to admit that she had any worries about anything except when people asked her for smokes.

The following excerpts illustrate the patient's verbal behaviour in self-exploration:

Mrs. A: They always ask me for smokes and I get annoyed.

Nurse: What do you do about it?

Mrs. A: I just give them one.

Nurse: Can you think of any other major things that have upset you in your life?

Mrs. A: No.

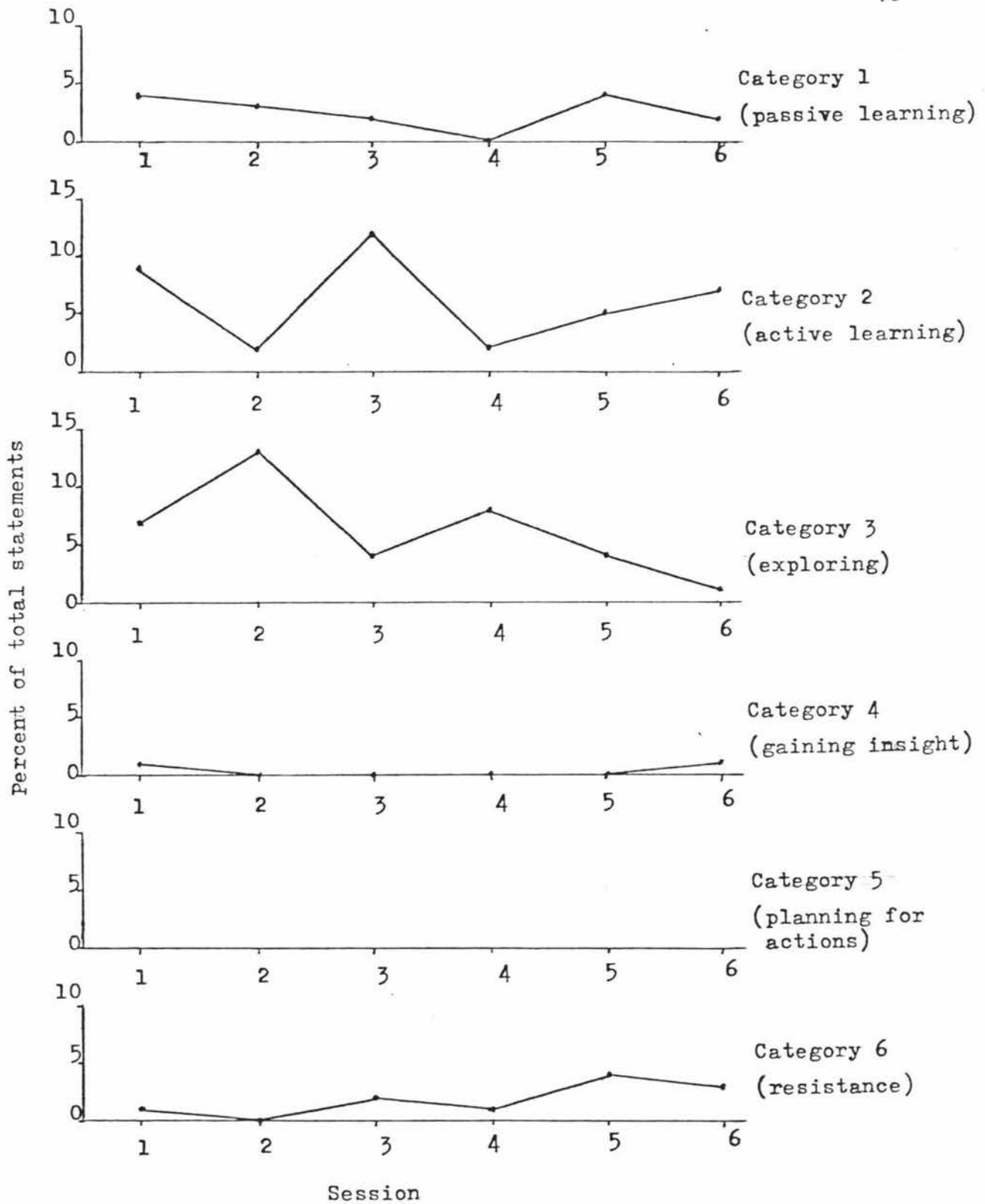


Figure 4-3 . Distribution of verbal statements of Mrs A.

Nurse: None at all?

Mrs. A: No.

Nurse: Do you think there were any and you've forgotten?

Mrs. A: I've got no worries, really.

It is interesting that at nearly the end of Session two, while the nurse was talking about loss and how to cope with it, the patient suddenly opened herself up. She told the group about the death of her parents when she was fourteen and claimed that this was what led her to come into the mental hospital. She then went on to tell the group about her personal life after she was asked by another patient. From this point of view, the author believes that most of the patients have something on their mind that they want to share with others. However, to get them to explore their own feelings and problems depends largely on how they are stimulated to do so. In this case, the patient felt at ease to talk about her personal life when another patient asked her but not when asked by the nurse. From the author's observations, the nurse did not feel relaxed in her role or show real interest in knowing the patient's problems. Rather, the nurse controlled the time and this might have caused the patient to have feelings of uneasiness. However, this is a reflection on the design of the teaching programme not the nurse's inefficiency in working with patients.

After Session two, Mrs. A's statements in self-exploration decreased, while statements in both active learning and resistance to learning increased. Her statements of resistance to learning tended to reflect her refusal to explore her personal life. Although her resistance to learning showed an upward trend, this was not very great.

Mrs. A made few statements of gaining insights in the first and last sessions, and there were no statements at all of planning for future actions.

Overall, the patient did not show any gross changes in her verbal behaviour. She used the same event (i.e., people always asked her for smokes) in the exercises right through the six sessions.

Comparison of the Patient with the Group

Mrs. A differed from the group in her high active learning and low self-exploration. Even though she had a very low percentage score in gaining insights and no score in planning for future actions, she was not very different from the group in general (see Figure 4.4).

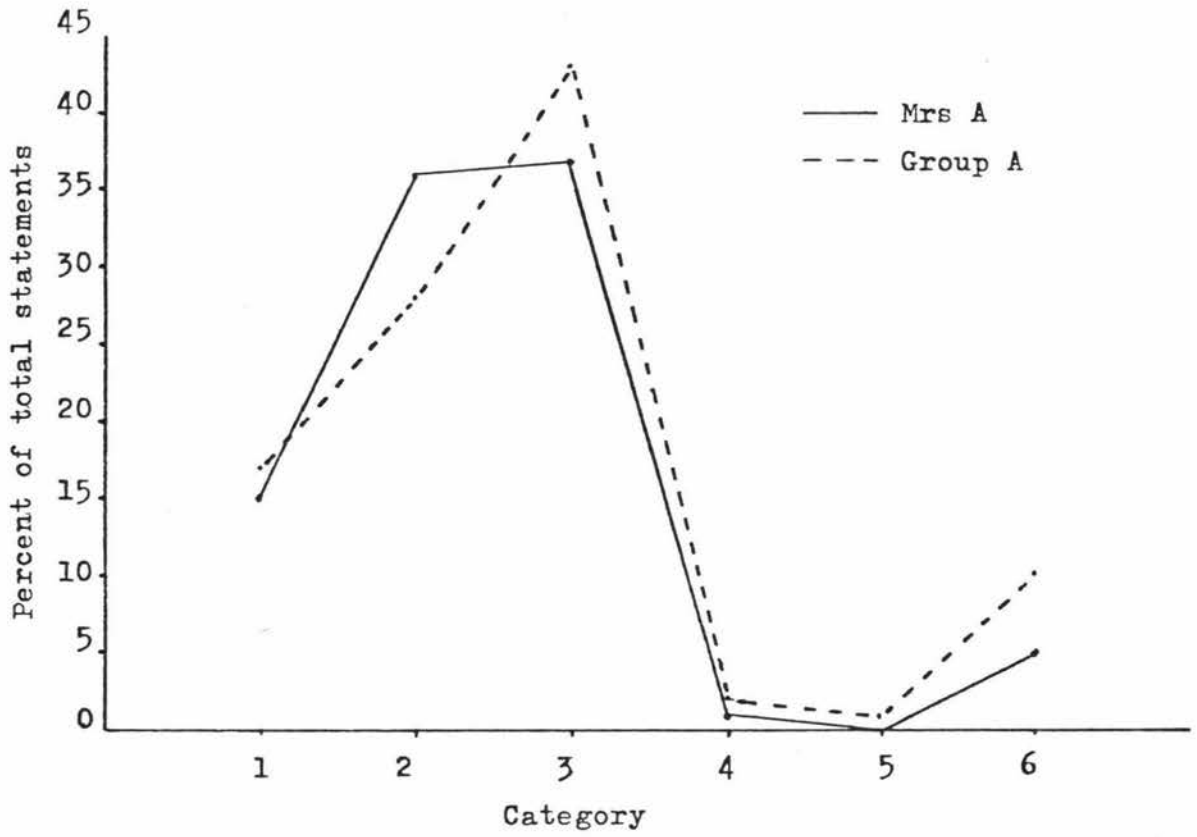


Figure 4-4 . Statement distribution for Group A and Mrs A.

Evaluation

Although there were no marked changes observed in Mrs. A, the patient seemed to be satisfied to come and talk to other people in the group. In addition, she enjoyed meeting other patients in the ward. After the group was finished she stayed to have morning tea with them.

Eight weeks after the programme was over, when the author came to follow up the patient, she was still in the hospital. This is not surprising because she was quite happy there and, as she told the group, she was now so used to life in a mental hospital.

MRS. DDescription of the Patient

The patient was a late-middle aged woman, thin, active, intelligent and articulate. In the group she did not talk much, but showed lots of interest. When she came to the first session she was excited to find that the group was different from what she had expected. She commented to the author that the group was interesting and structured, and she preferred to come to this kind of group rather than to a group where the patients just sat and waited for someone to say something. In addition, she felt relaxed in the group.

Even though she did not communicate much verbally, she always showed lots of interest and involvement in the group through her physical gestures. However, she was keen to share her exercises and problems with the group if it was her turn.

Development of the Patient's Verbal Behaviour

Figure 4.5 shows changes of Mrs. D's verbal behaviour for each category over the six sessions.

Overall, the patient showed a high degree of active and passive learning. She was responsive to what the nurse said to the group, and eager to learn in the group. Her pattern of change in active learning changed inversely to her self-exploration. That is, when active learning decreased, self-exploration would increase.

In the group she was happy to share her life problems with others. In Session two, she started telling the group how difficult it was for her to cope when her husband had to shift often. Because this problem did not worry her husband she had to try hard by herself to cope with it. Unfortunately the patient did not have a chance to make further progress with this self-exploration, as she was cut off by the nurse at this point, as can be seen in the following excerpts:

Mrs. D: When I had to shift so often when my husband was transferred I was most unhappy, but managed to cope alright.

Nurse: What kind of things did you do, to try and cope?

Mrs. D: Just get on with making the house like home again, like I had before.

Nurse: So you'd be a little bit similar to me, you'd leave behind all the neighbours and people that you knew.

Mrs. D: That's right.

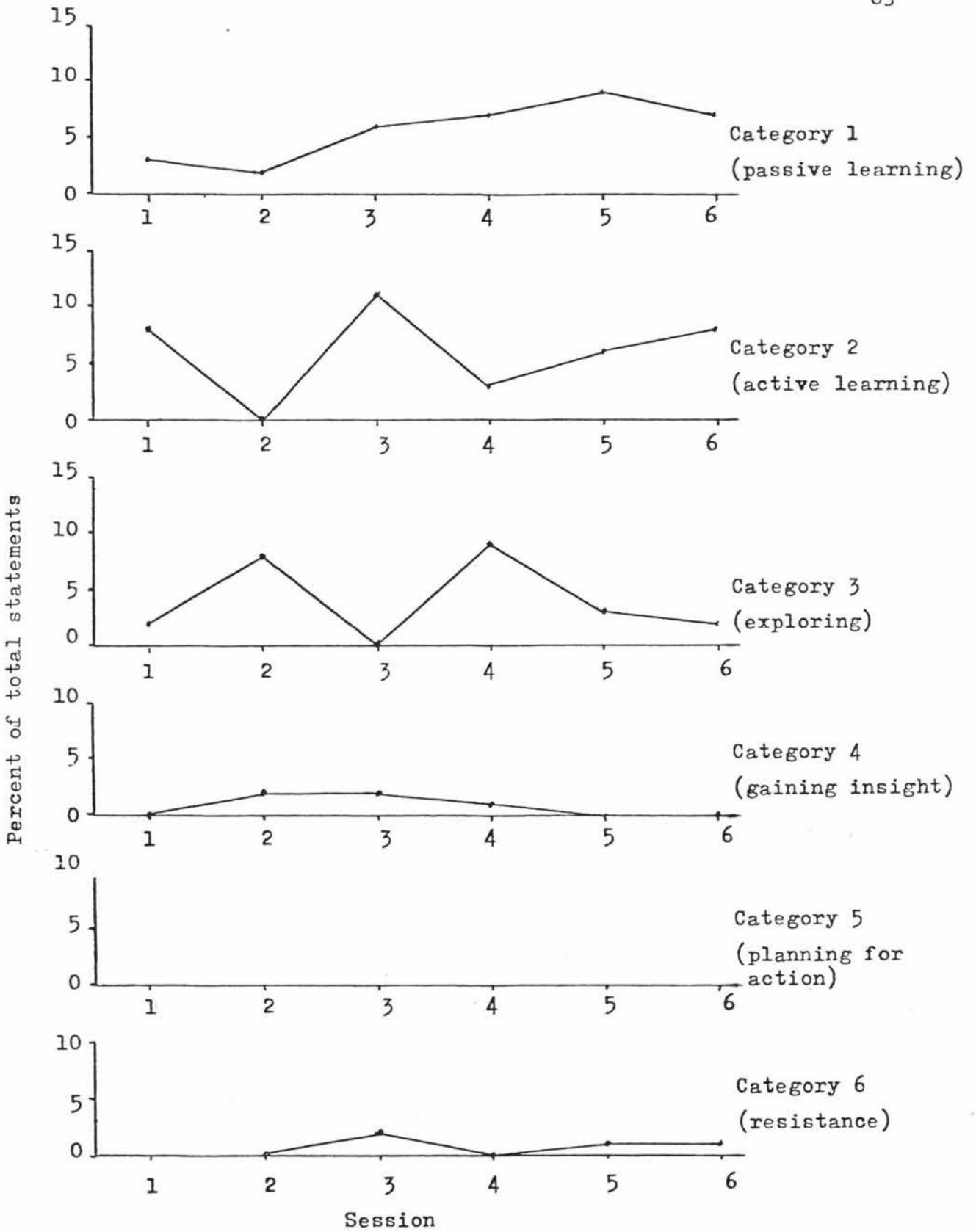


Figure 4-5. Distribution of verbal statements of Mrs. D.

Nurse: Did you find it very easy to go out and make lots of new friends?

Mrs. D: No, not at first.

Nurse: I find it quite hard too. But you just went on coping. B (name of a patient) what have you got?

In actual fact, her problems could have been discussed by the other patients in the group so that the group could learn and share together in this kind of problem. The patient was not encouraged to relate her past problems to present problems at all. In this case, it cannot be expected that much progress will occur in the patient's verbal behaviour in the group.

Furthermore, she told the group that she lacked self-confidence and wanted to gain more. The group members did not agree that this was a problem because the group had the impression that she showed such a high degree of confidence in herself. Thus, she did not get satisfactory advice from the group, but the group perhaps made her realize that she was not so lacking in confidence as she supposed.

The patient showed some insights in the concept teaching which could be seen in sessions two, three and four, while she did not make any statements about planning for future actions, and her resistance to learning was very low.

Overall, the patient demonstrated strong attempts to learn in the group. She showed little involvement in other's problems by her verbal behaviour, but reasonably high involvement by her non-verbal behaviour. However, in the last session she made an attempt to clarify a patient's problems. This may indicate her feelings of greater confidence.

Comparison of the Patient with the Group

The patient showed much higher passive and active learning than the group but was much lower in self-exploration. This can be explained in terms of her quietness in the group and the lack of stimulation by members of the group. She also tended to let the others talk while she listened. She was slightly higher than the group in gaining insights but lower in planning for actions and resistance to learning (see Figure 4.6).

Evaluation of the Patient

The author believes that this patient would be a good candidate for group psychotherapy if she is given a chance for self-exploration.

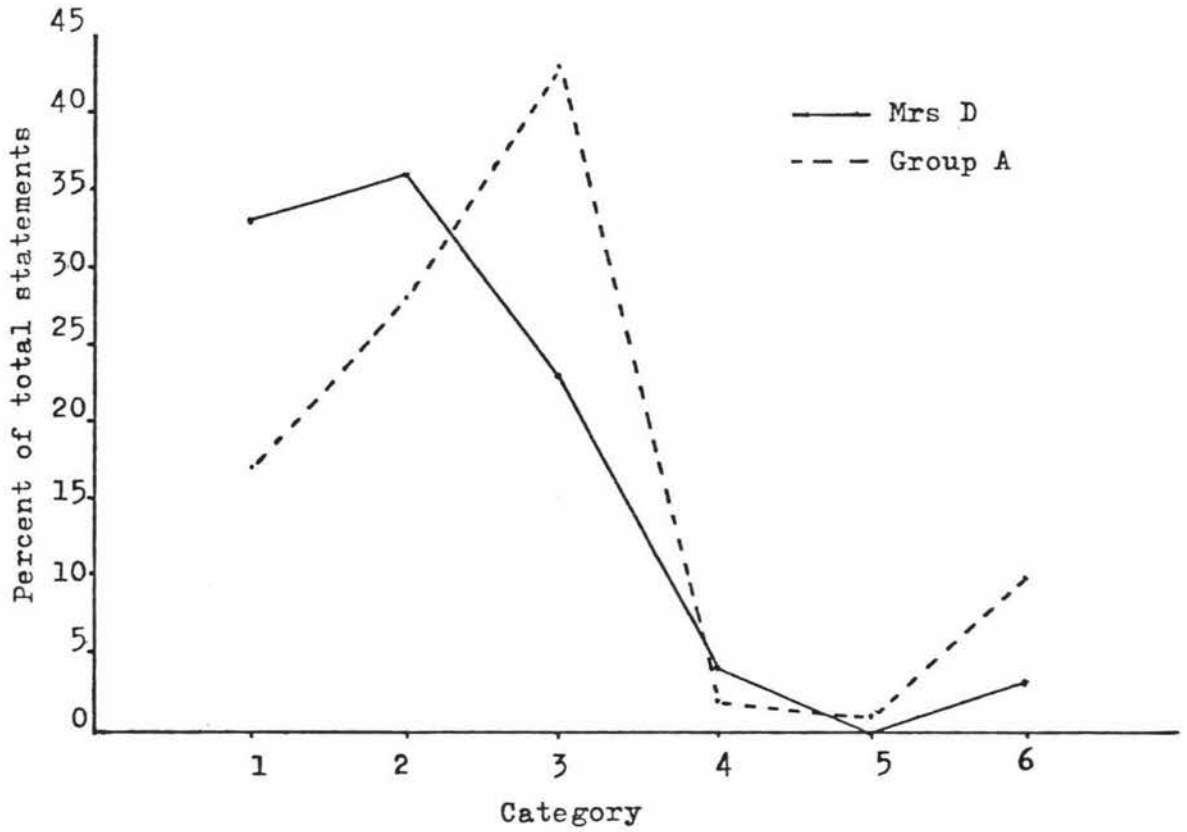


Figure 4-6 . Statement distribution for Group A and Mrs D.

In addition, with a warm and encouraging atmosphere the patient could gradually develop more self-confidence in her communication with others.

MRS. J

Description of the Patient

The patient was a middle-aged woman who dressed neatly and tended to dominate the others. In the group she was articulate and intelligent. When she came in the first sessions, she seemed to challenge the nurse, as can be seen from her non-verbal behaviour. That is, she smoked and tended to ignore what the nurse was saying by talking to another patient. Sometimes, she looked at the nurse, or patient who was talking to the nurse, with a smile on her face. Furthermore, she had bubble gum in her mouth and blew and popped bubbles when the patient whom she was attempting to influence was talking about her problems with the nurse.

These gestures can be interpreted as a lack of trust in the nurse's ability. Thus, she seemed to test the nurse. On the other hand, she was insecure in the group and perhaps needed group support.

Development of the Patient's Verbal Behaviour

Figure 4.7 shows changes of Mrs. J's verbal behaviour for each category over the six sessions.

The patient showed an increase in passive and active learning from the first to the last session. She had very few responses in the first session for each category, which corresponds to her high degree of resistance to the nurse as shown by her non-verbal behaviour. It is interesting that although she seemed to ignore the nurse, the nurse tended to have eye contact with her more than the other group members. This might have led her to feel more secure, for in session two she showed a very high degree of self-exploration. She told the group about her problems with her children and her husband which she found too much for her to cope with. From what she told the group she seemed to understand her problems, but did not actually gain insights into her problems, as can be seen from the following excerpts:

Mrs. J:I found I just couldn't cope and it frightened me, because of these things my husband was getting more and more demands on him by me asking for support, and then I was pushed too far and took an overdose and my husband does not want to have me home again.

Nurse:

Mrs. J:

Nurse:

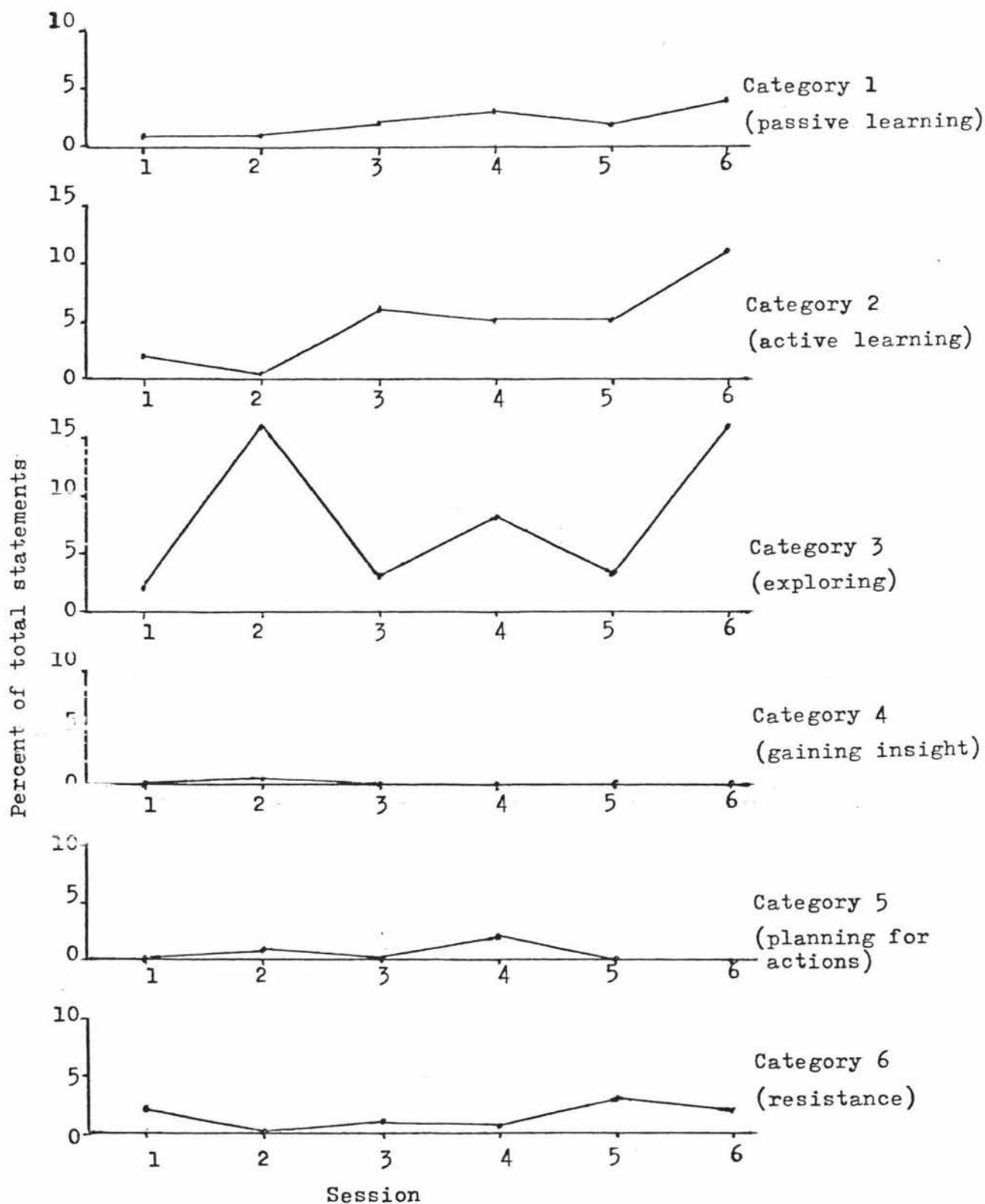


Figure 4-7. Distribution of verbal statements of Mrs J.

Mrs. J: I'll go back home to mum and dad then get out and get a flat and get a job, though I'm not very brainy so I'm not sure what sort of job I can do.

Nurse: Something will turn up. We'll keep our fingers crossed. E?
(asked another patient to go on with her exercise)

The patient tended to look toward the future but she was not quite confident in herself. At this stage the patient needed to build her self-confidence to go ahead with her future plans. Unfortunately, her plans were not discussed further by the group. Her self-exploration dropped in sessions three, four and five but increased again in session six. Although she tried to work out her problems, she showed mixed feelings toward both her children and her separation. She loved her children very much, but she felt that they demanded too much from her and made her freeze up. At this stage she had to try hard to cope with these problems. This was known to her as she said she had to get on with her problems and not feel depressed and bad.

The salient characteristic of this patient was that she showed a lot of interest in others' life problems, for example, by asking them to clarify their problems. This may be interpreted in two ways. Firstly, she may want to know the others' stories so as to compare with her own, or secondly, she may feel superior to the members of the group, as was suggested by her attempt to dominate a patient who came from the same ward. The following excerpts from session two indicate the latter:

Mrs. E: I can't do this (an exercise)

Mrs. J: Well try. Don't say I can't. There's no such word as can't.

Mrs. E was talking to the nurse but Mrs. J manipulated Mrs. E before the nurse could say anything. However, Mrs. J showed less dominance and more concern with the rest of the group. She showed very little insight into her problems and little planning for her actions. Her resistance to learning was not high but tended to go up a little bit in the last two sessions.

Overall, Mrs. J was an active member of the group who broke the silence in the group. She showed changes in her attitudes toward the group therapy and the nurse leader. That is, she tended to be more relaxed and friendly than when she first came to the group.

Comparison of the Patient with the Group

Figure 4.8 shows Mrs. J's distribution of statements compared to that of the overall group.

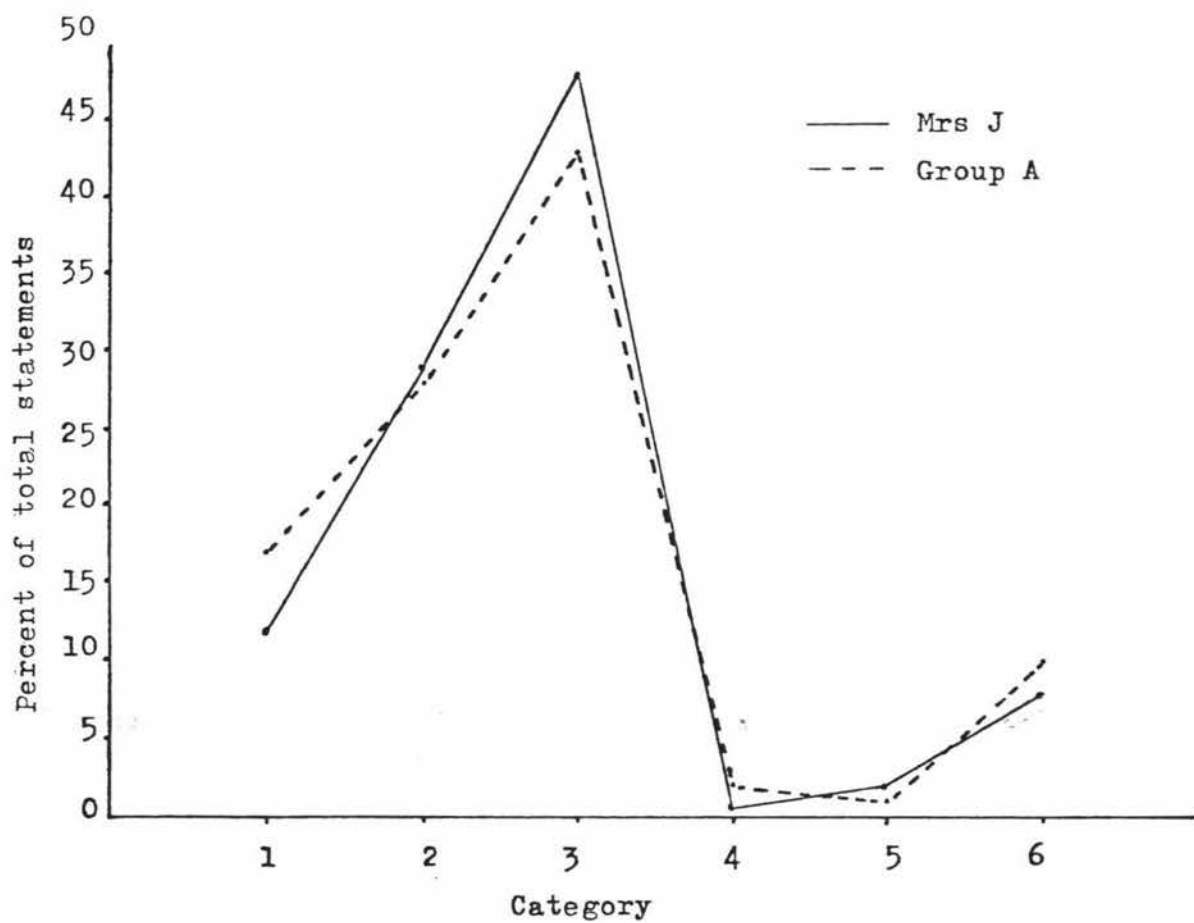


Figure 4-8. Statement distribution for Group A and Mrs J.

The patient's pattern of verbal behaviour is similar to the group except that she had a slightly higher percentage score in self-exploration. Perhaps she was a member who had influence on the group.

Evaluation

The patient was quite helpful to the group in terms of stimulating the group members to further explore their problems. Over the six sessions, she showed that she could change her attitudes and behaviour. Further, group therapy in depth would be of value to help her cope with her feelings toward her children and the separation from her husband.

The patient was discharged from the hospital before the eight week follow-up.

MRS. EDescription of the Patient

The patient was a thin, pale, married woman with three children. She looked depressed and helpless. She was very keen to participate in the group and hoped that the group would be able to help her solve her problems. She also showed her support for the nurse in the first session when she said, "we're not planning on making problems", when the group was asked to come in every day. Due to her weakness and helplessness, she was dominated by Mrs. J. Perhaps she in turn needed to be dependent on someone.

The patient came to every session but she did not participate in session three where she claimed that she did not feel very well. In fact, Mrs. J told the author that Mrs. E would not come to the group, but when Mrs. E saw the author and the rest of the group were going to the group room she came in and asked to stay with the group, but not participate. The author felt that she looked miserable, very depressed and confused. Perhaps, she wanted to feel secure by staying with the group. Therefore, the group allowed her to lie down on a sofa and listen in. The author had to admire her for her attempt to be part of the group. That is, she got up to do the exercise but felt too depressed to share her exercise with the group.

In general, Mrs. E worked hard in the group to explore her problems and feelings but she also showed a great deal of dependency on the nurse. This characteristic pattern of the patient's tended to make the therapy more difficult as the nurse had first to encourage Mrs. E to be more independent.

Development of the Patient's Verbal Behaviour

Figure 4.9 shows changes in verbal behaviour by Mrs. E in each category over the six sessions.

The patient showed low passive and active learning, and both types of learning had the same pattern of change over sessions.

The interesting thing is the high self-exploration found. The patient spent most of her time exploring her problems with her husband and children. Her development of self-exploration is worth close examination.

When she first came to the group, the patient did not open herself up but more or less attempted to relate her general past

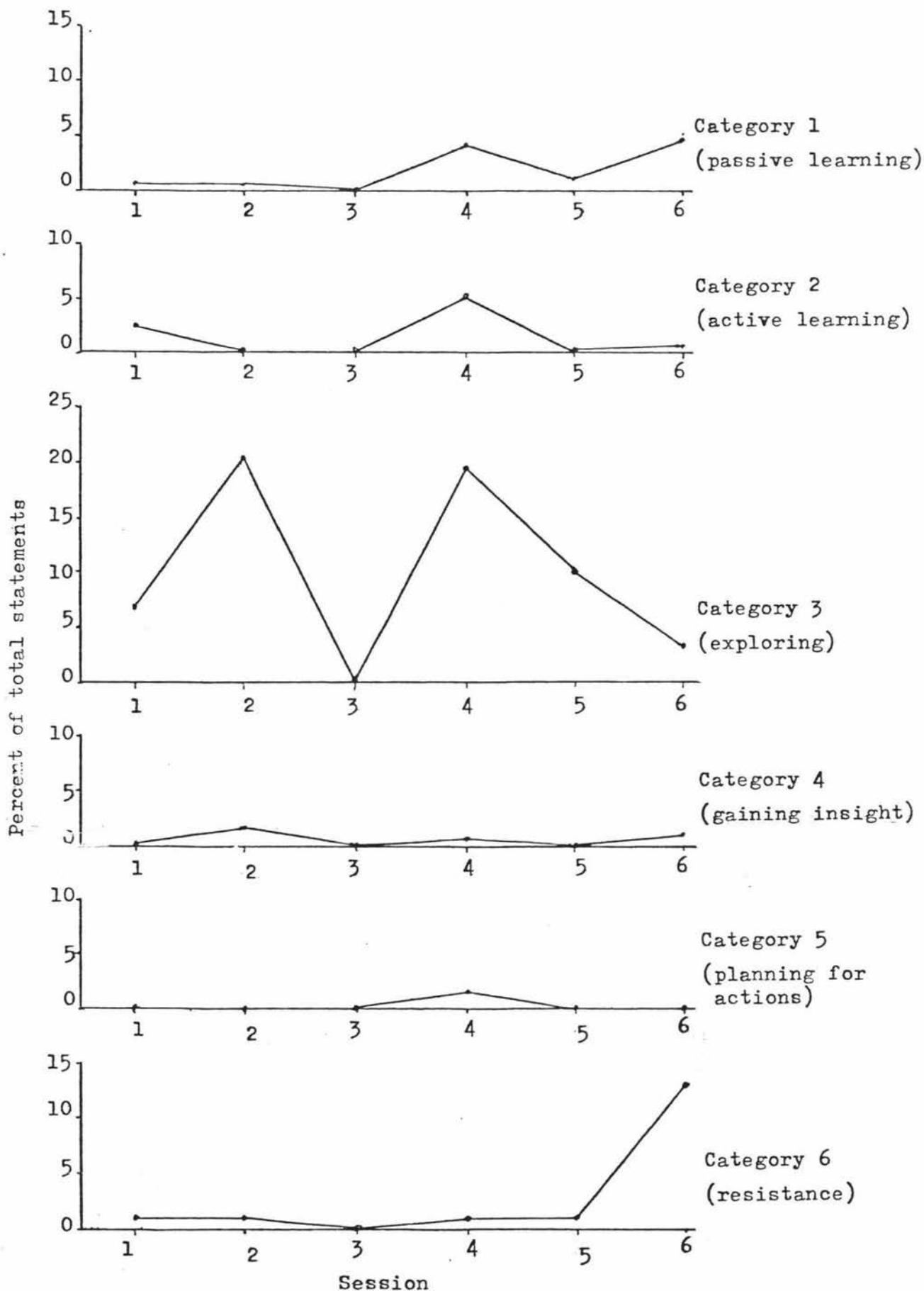


Figure 4-9. Distribution of verbal statements of Mrs. E.

experience to any topic raised in the group. This is not surprising because the first session was only an introductory phase and the patients needed more time to look at the group situation. From session two onwards the patient started to tell the group her life problems. However, she started off in general by talking about shifting into a new area where no one was friendly, and that this upset her but she came out of it. Then she had a hysterectomy after which she claimed that she went to pieces and was depressed. She then moved from the area to see if that would help her, but she said she was just too far gone and ended up in a mental hospital.

At this stage she expressed no hope of becoming well again, for she said:

Mrs. E: Now I've lost my family and that really upsets me. The doctor said I can't go back home. I can't even build hopes of going back home.

Perhaps this only showed her dependency on the doctor and was a plea for support and empathy from the nurse.

Unfortunately, the nurse did not give her support or any encouragement to build her hopes as she responded:

Nurse: Sounds a little bit dogmatic. In six months time, who knows? I don't think he can tell the future.

Mrs. E: If he had said anything, well I'm not allowed to go home. My husband said he'd have me home more or less as a housekeeper for the children's sake, where he leads his life and I lead mine, but the doctor won't have that.

She demonstrated her weakness in decision making, and absolutely left any responsibility to the doctor.

It is interesting to note that after refusing to participate in session three, the patient became more active and stronger in her ideas about herself. This may be either the compensation for missing one session (this could be compared with Mr. G's responses after missing one session) or the stimulation of the teaching programme.

She expressed her ideas in future plans as can be seen in the following excerpt:

Mrs. E: My second reaction would be to try and accept the situation, and improve my life. My feeling afterward, would be relief, when everything is tied up and neatly and then look for a flat and a job and become self-sufficient.

She also mentioned about a town in which her girl friend offered her house to her to stay after leaving the hospital. Perhaps she

could look for a job in a city near the town. At this stage she showed to the group a noticeable change in her ideas about herself although some dependency could still be observed.

Then in session five Mrs. E went on to open up about her problems with her husband who had been unfaithful to her twice. She said she felt very hurt and rejected when she found out. However, she was still not sure whether it was this that caused her to break down or the financial difficulties and being in a new environment. It is surprising that she never showed any resentment towards her husband but she tried to feel good about this by saying that her husband thought somebody had pimped on him. Perhaps she had ambiguous feelings about it, for she mentioned that she suspected her husband when he slipped up twice by calling her by the wrong name while drunk, but when she asked him about it he refuted that it was true. However, she then mentioned that her husband said it would never happen again.

Unfortunately at this stage she was not supported by the group and no one shared their ideas about her problems. She was interrupted by Mrs. J asking the nurse a question, and then the nurse asked another patient to tell about her exercise. From this point of view, a patient who needed support or encouragement from the group might be disappointed, since she took a risk in opening up and was then ignored.

In the last session, the patient changed her behaviour to a new pattern, where she showed marked dependence and demands for support from the group. She seemed to be confused and worse than in previous sessions. This was discussed in the group as can be seen from the following excerpts:

Mrs. E: At the moment I've got nothing to look forward to and to work towards.

Nurse: You were saying yesterday you might go to a friend at Waiouru.

Mrs. E: No.

Nurse: No, but it's worth starting to keep in mind. Anyone want to tell E anything? Or ask her anything?

Mrs. J: I feel E is going backwards, to what she was a week or two back.

Nurse: I don't know that. I wasn't here.

Mrs. B: But why is she letting herself go back?

Mrs. J: I think she gets up to a stage where she thinks she can cope, and think about the problems in her life that she's got, and as soon as she's got there she smashes up her (?) against a glass door. Suddenly she can see, she can perceive her problems, but that glass door's there, and she shrinks back again.

Nurse: That sound like you?

Mrs. E: Yes it does.

Nurse: I feel that you know a lot about yourself, but maybe you still need that rest, but I would find it very interesting for me - it's getting very clear here, for me, not necessarily for you - I would like to know if you could sort of say I need another three weeks and then I'll try and do something. You don't have any time limit on that, when you try your next turning and facing it and working at it.

Mrs. E: I'm going through a big problem at the moment. They're trying to get me off drugs and that.

Nurse: Do you have any idea, any sort of next week, or fortnight or in three weeks will do, or are you just sitting and resting and not putting any limits on it?

Mrs. E: Well I can't put time limits or anything on it because there's nothing positive at the moment.

Nurse: This is just, you know, my world, I'm just interested in it, because I often find that days go by so fast, and that unless I count them and label them every now and again, I don't even know how many have gone. And I wondered if that was perhaps your world too.

Mrs. E: Time just drags.

Nurse: O.K. Well perhaps we'd better look at sheet two, which is your pretest again, to see for your own interest whether you have moved.

From this conversation, the author feels that Mrs. E might have felt lost knowing that this was her last session and that she was not ready to leave the group. She had in fact said that she wished the group could go on.

Although the programme was brief, Mrs. E showed some changes in her verbal behaviour. She started with talking about general events, then moved on to her problems in general (i.e., her shifting and children) and finally she specified her problems with her husband. The patient could now have been encouraged to gain more insight into her problems, but unfortunately she was not. Perhaps the time was limited and the nurse had to work with individual patients in the group and thus, not spend much time with her. In an attempt to predict this patient's progress, the author is unsure whether this patient would be successful in therapy if she was encouraged to have insight into her problems. This is because the patient had a weak personality and was very dependent. Murray (1954) described in his case study a similar situation:

"The patient now has insight into his problems but can't extricate himself from them. Because of a general character weakness it is improbable that short term therapy will be of much more value."

Mrs. E could perhaps be compared to Murray's patient because she seemed to be occupied with her stressful life problems and it must be difficult for her to extricate herself from them. Thus, to help her formulate future plans may be very difficult. On the other hand, if she could plan her future life, it would not be easy for her to start implementing her plans unless her character was more strongly developed than it is now. Consequently, she must gain more self-confidence and bravery to face anything happening in the future, because the patient was presently very frightened of things that had not happened yet and was afraid to do anything.

Comparison of the Patient with the Group

Figure 4.10 shows Mrs. E's statement distribution compared to that of overall group.

Compared to the group, Mrs. E showed: (1) lower passive and active learning, (2) higher self-exploration and resistance to learning, (3) slightly higher gaining insight and planning for future actions.

From this it can be said that she did reasonably well in the group. In fact, she worked harder than the others in the group, but she could not be considered more successful. Perhaps her weakness of character led the author to believe that she did not show reasonably high improvement, although she showed higher gains than the group in gaining insight and planning for future actions.

Evaluation of the Patient

The patient showed some changes in her verbal behaviour particularly in her self-exploration. She might benefit from the teaching programme in terms of being able to talk problems over with others with some security. The group probably helped her very little in solving her problems. Long term group therapy would be of value to help the patient solve her problems.

However, the patient was on leave before the eight weeks follow up.

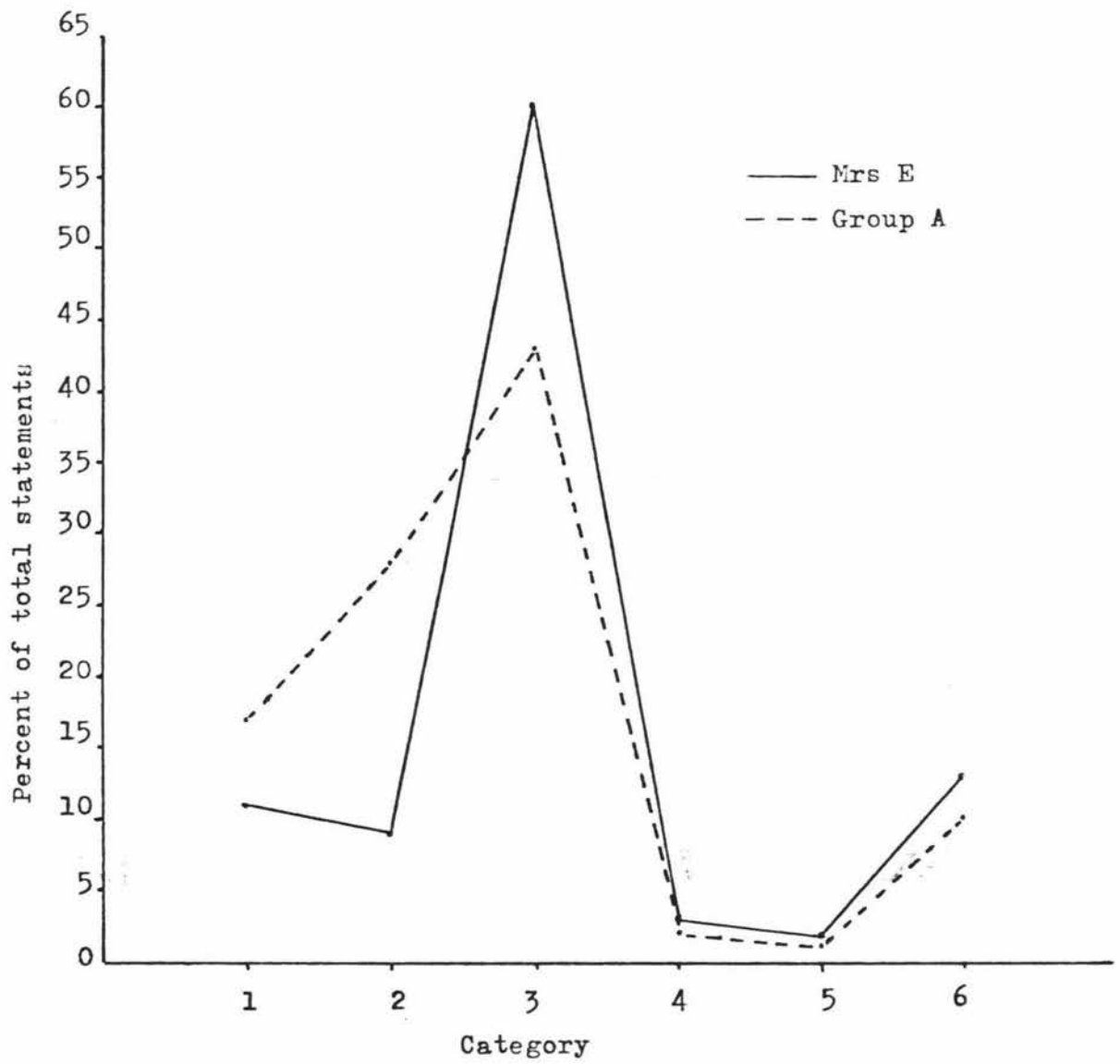


Figure 4-10. Statement distribution for Group A and Mrs E.

MR. GDescription of the Patient

The patient was a medium built, middle-aged man. He was quiet and soft spoken. It is the author's impression that he was a lonely person and not keen to make friends. However, he showed willingness to participate in the teaching programme and this was his first time in a small group therapy. He also showed interest and involvement in the group, but mostly with non-verbal behaviour.

He made some progress in the programme, particularly from session four, when he started to actively participate and became more involved with the problems of others. His behaviour in the group gave an impression that he lived just for now and for himself, and he commented on the way people lived from week to week and compared it to himself. He had no future plans for living outside the hospital, indeed, the hospital seems to be his only place in his life.

He came to every session except session two. In this instance he came to the ward where the teaching was taking place but he was not let into the group room since he did not ask a nurse to unlock the door. So he sat outside the ward until the group was finished, and the author came out and found him. This event supports the impression of his behaviour in terms of shyness, low initiation and slow decision making. However, he asked a nurse to let him into the group room after that time, showing more confidence and willingness to approach.

Development of the Patient in the Group

Figure 4.11 shows the change in verbal behaviour of Mr. G over the six sessions for each category.

He demonstrated little verbal response in the first session. This is not surprising because he was shy and quiet as mentioned previously. But when he came back from missing one session, he showed a high percentage in active learning. Perhaps, he felt more involved in the group and wanted to make up for the session he missed. The patient did not start talking about himself until session four. However, he talked about his problems in the ward and his feelings towards some people in the ward rather than his personal life problems. It may be difficult for a shy and quiet person to discuss anything about himself unless the group is very supportive and the leader is capable of giving encouragement. In this case the teaching content and the

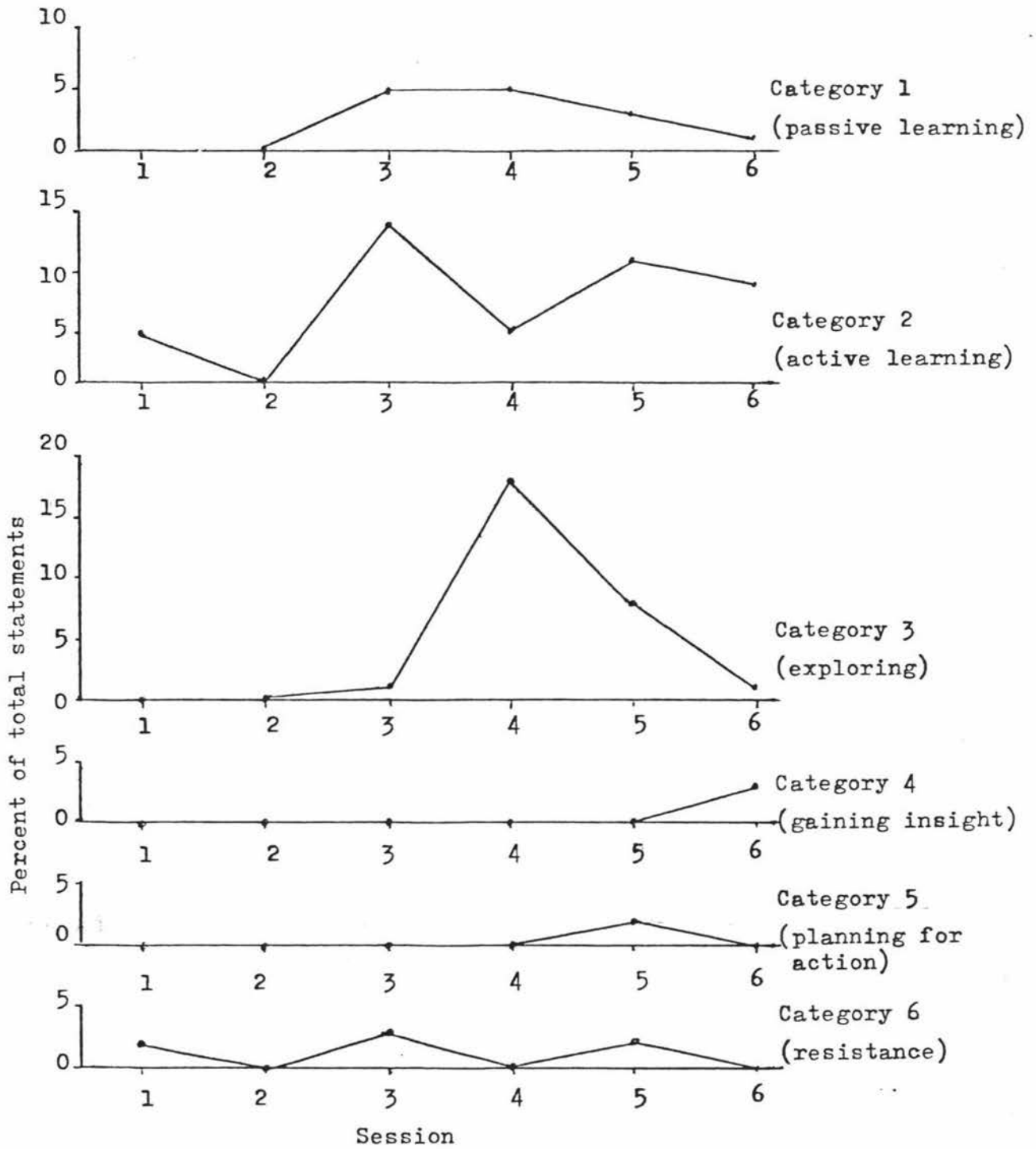


Figure 4-11. Distribution of verbal statements of Mr. G.

exercises were very helpful in stimulating him to look at his problems, explore his feelings and discuss them with the group. In general, he was cooperative and willing to share his problems with the group when he was given a chance.

In session five, he became very involved in the programme. It was obvious that he attempted to share his ideas with the group. He also tried to discuss and plan how to cope with problems and people in the ward. Unfortunately, he was often interrupted because he was slow and spoke softly. In addition, he was not taken much notice of by the group leader. However, he showed an effort to plan for his future actions in relation to his problems in the ward.

In the last session, he still showed a high percentage of active learning, but was low in self-exploration. However, it is interesting to see that he demonstrated some insight into his problems which he never had in previous sessions.

It is important to note that even though Mr. G was quiet in the group, his non-verbal behaviour showed considerable involvement. Thus, content analysis alone does not give an accurate picture of his involvement or behaviour.

Comparison of the Patient with the Group

Figure 4.12 shows Mr. G's distribution of statements compared to the overall group distribution.

He was not too far from the group in terms of improvement in learning. He demonstrated higher percentage score in passive and active learning, but slightly lower for self-exploration than the group. His percentage score in gaining insights and planning for actions was not much different from the group. He showed markedly lower percentage scores than the group in resistance to learning. This is reflected in his non-verbal behaviour as well.

Evaluation

Even though the teaching programme was brief and the changes were probably not fundamental (see Murray, 1952) the patient's behaviour in the group showed that he benefited from the teaching programme in some way. This is confirmed by his verbal behaviour in the last three sessions. That is, he made some progress in the programme by getting more involved, and sharing his problems with the group. Thus the author believes that further supportive group therapy would be valuable for him.

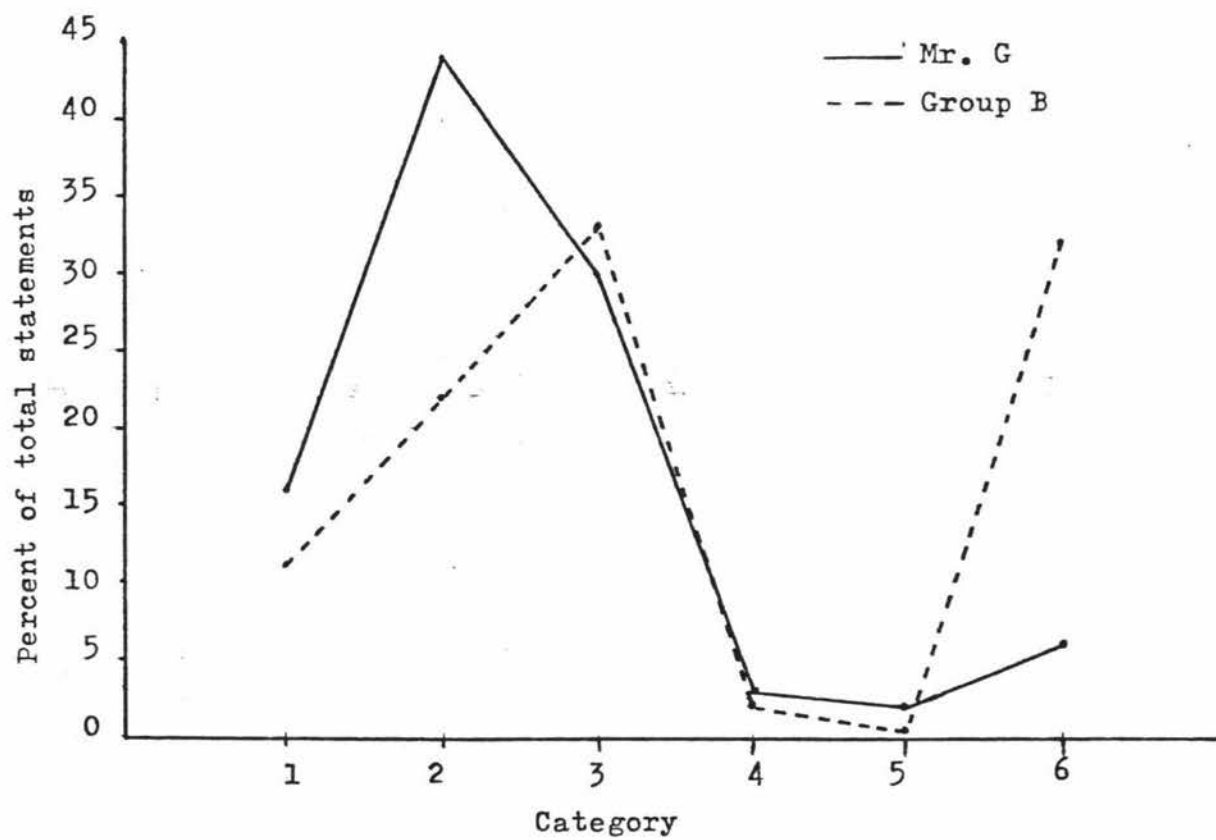


Figure 4-12. Statement distribution for Group B and Mr. G.

MRS. RDescription of the Patient

The patient was an attractive middle-aged Maori woman with nine children. She had married twice and both of her husbands had died. She was willing to come to the group but showed very little interest in what was happening there. She was agitated and could not concentrate on the group. This can be seen from her non-verbal behaviour; for example, she did her knitting, lay down on the floor, pulled the curtain and changed her seat.

Most of the time she seemed to feel left out, as she moved herself out of the group after being interrupted in session two.

Development of the Patient's Verbal Behaviour

Figure 4.13 shows Mrs. R's changes of verbal behaviour for each category over the six sessions. The patient showed a small proportion of passive and active learning and large proportions of active learning in session five. The salient characteristic of this patient was her degree of exploration. In the first session the patient showed no statements of exploration but in session two the proportion was quite large (21%). The patient told the group about her stressful life event, that is, that she could not have her eleven year old son back from her mother. The reason behind this, which was known to the patient, was the patient's repeated admissions to the psychiatric hospital.

In session three she started to talk about her husbands and her hard life with them but got cut off by the nurse. The patient immediately walked out of the group and lay down on a sofa. Perhaps the patient felt cut off or too sad to talk about her stressful life events.

From session three onwards the proportion of exploration decreased until the last session.

Overall, she gained very little in gaining insight and not at all in planning for future actions.

Her proportion of resistance to learning was generally large and tended to increase from session four. In session six, the patient showed a marked increase in resistance to learning, and this was evident in the way that she seemed to ignore the nurse and raised or maintained irrelevant topics with another patient. This might be because she was disappointed in not being able to extend the programme as she had requested.

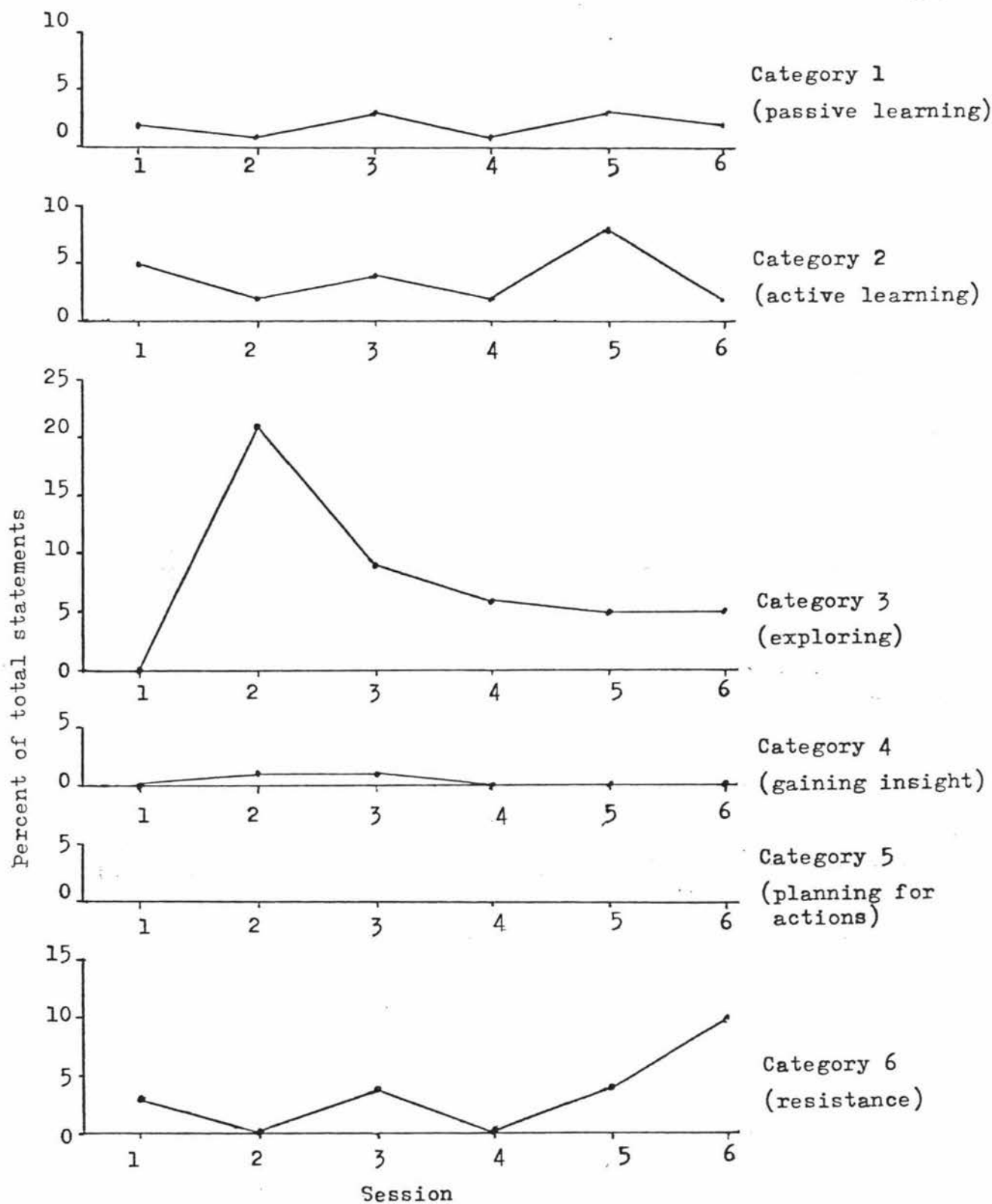


Figure 4-13. Distribution of the verbal statements of Mrs. R.

Comparison of the Patient with the Group

Figure 4.14 shows Mrs. R's statement distribution in each category over the six sessions.

Mrs. R was different from the group in exploration and resistance to learning. That is, she was very much higher in self-exploration and slightly lower in resistance to learning.

Evaluation

The patient did not seem to be a good candidate for group therapy because she was too agitated and could not sit still for long. This could be because the group did not attract her or because she felt insecure in the group.

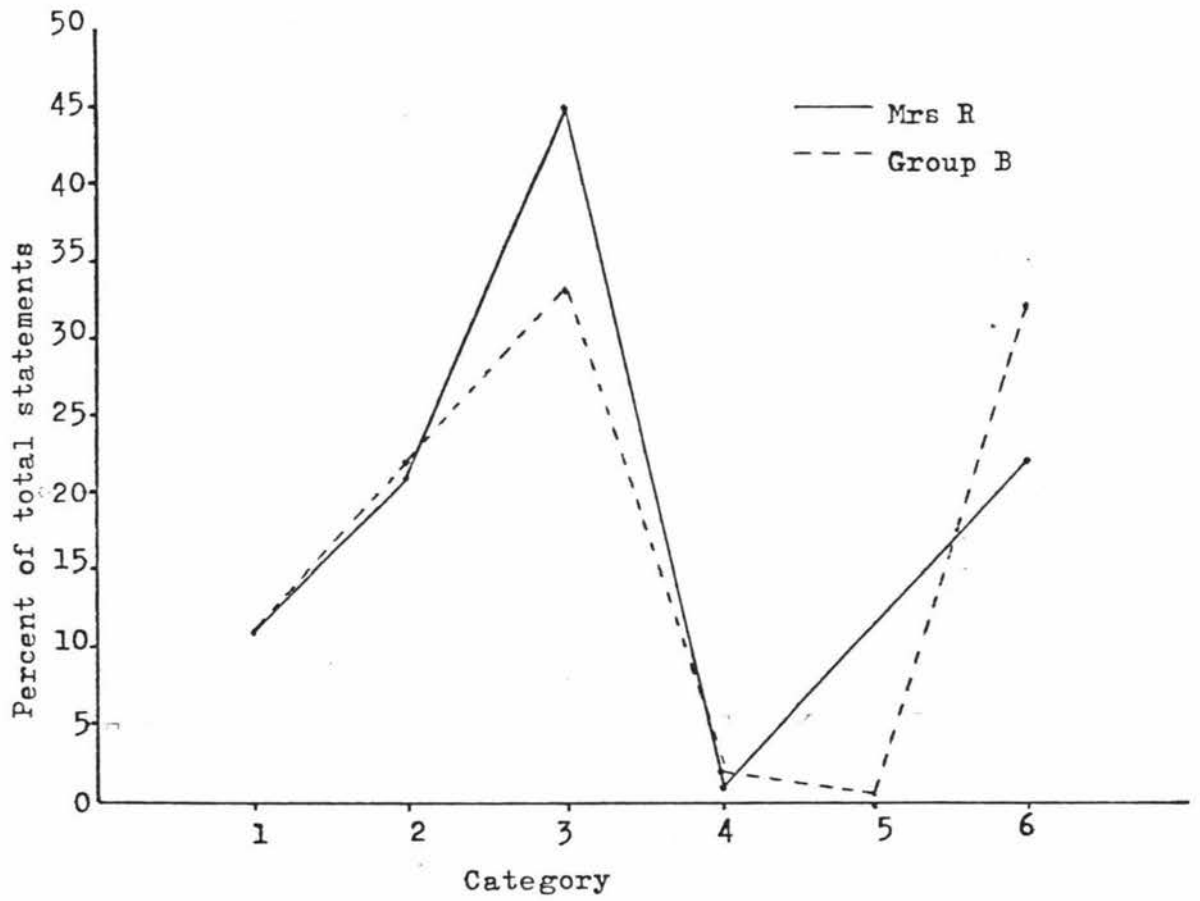


Figure 4-14. Statement distribution of Group B and Mrs R.

MRS. NDescription of the Patient

Mrs. N was a married middle-aged woman who looked depressed and confused. She talked very much in the group and tended to repeat the same story of her life without being aware of how the others felt. She also showed anger and hostility in her story. She was resistive, as could be seen in her arguments with the nurse, which occurred often. This might be because their ideas were different. She was a person who had experienced lots of dreadful situations and tended to perceive the world as she wished it to be and this was in contrast to the nurse. On the other hand, she might be insecure which may have led her to distrust the nurse.

Development of the Patient's Verbal Behaviour

Figure 4.15 shows Mrs. N's changes of verbal behaviour for each category over the six sessions. From Figure 4.15 the patient maintained a small proportion of passive learning over six sessions. This is not surprising because she was very verbal and active. However, she did not have a large proportion of active learning. Most of her verbal expression of active learning appeared in session one and session three. The proportion of exploring statements was quite large, particularly in session four where the patient started to tell the group some of her painful past experiences, such as when she applied for a job and she was told she was too old for this job (she was 36), and a woman who was about 48 got the job. She was very upset, felt like an old woman, and wandered around. Before this session she talked about herself in general such as, how she kept her house clean. In session two, when she was asked what her stressful life event was she declined to write it down and claimed that her mind was blank. However, she told the group that the only one she could think of was finishing her work and expecting to go on a holiday to see her daughter in England, but coming into the mental hospital instead. She kept on telling the group that this was the only one she could think of because all the others were too painful to recall. In session three, the patient was still talking incessantly about her hard life in the past and did not seem to stop. She admitted that she was bitter over it. However, she was told off by Mr. T, indirectly, in session four for being over talkative, though this did not stop her.

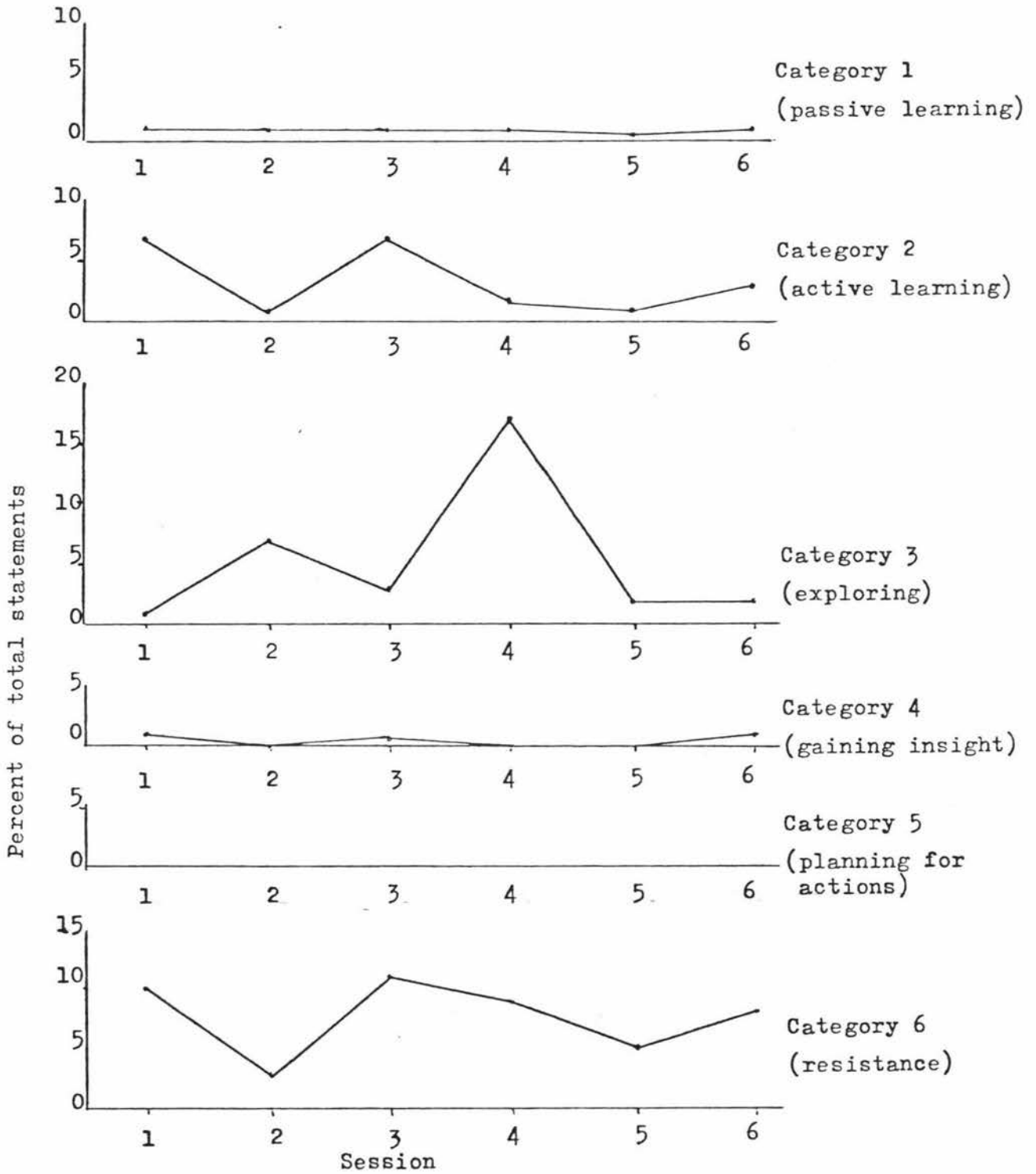


Figure 4-15. Distribution of the verbal statements of Mrs N.

It is interesting that in session five, Mrs. N told the group that people who always bother her were talkers, but she would listen to them if they did not go on and on until she became impatient. This can be explained in two ways. Firstly, the patient might want to show the group that she was the same as everyone else in the group and did not like talkative people. Secondly, she gave the group a hunch that she realized she was being attacked, and that the group should listen to her.

Finally at the end of session five she opened herself up and told the group that she had been through a dreadful experience of having an unfaithful husband. The group did not discuss this further, perhaps because they were afraid that she might not be able to stop talking about it.

In the last session, the author noticed that the patient was feeling lost, confused and very resistive as can be seen in the excerpts reported in Chapter 3, Group B - Session 6 (p. 67).

In the above mentioned excerpts, the patient used another event instead of the stressful life event which had been mentioned before. It is hard to explain why she did this. Perhaps this event was related to something that upset her or this event itself upset her very much and she could not forget it. She looked very depressed and angry while she was talking about it. It was unfortunate that she was not encouraged to explore this deeply or directed to the real point of her comments. The author feels that most of the events she raised in the group were meaningful to her but they sounded nonsense to the others in the group due to the way she told them. In actual fact this is understandable as she felt too depressed and painful to organize her thoughts. The patient was perhaps a sensitive person and had a weak character which led her to become easily upset.

Although the patient talked very much about herself, she did not come to the main point of her problems. This could be a reason which caused the group to become impatient and not want to listen to her.

The patient showed a small proportion of gaining insights and made no statements about planning for actions. This is not surprising because the patient was very occupied with her past experiences and she could not think about anything else.

It was evident that the patient showed a large proportion of resistance to learning in every session. This can be explained in terms

of her insecurity. This insecurity was shown in the patterns of hostility and distrust of the nurse whom she often argued with.

Overall, nearly half of this patient's statements showed resistance to learning. Her verbal behaviour did not change much and she was still confused in her own problems at the end of the programme.

Comparison of the Patient with the Group

Figure 4.16 shows Mrs. N's statement distribution compared to the group's statement distribution. The patient showed a similar pattern of verbal behaviour to the group except she had a higher proportion of resistance to learning and was slightly lower in active learning. This gave the impression that she was likely to influence the group's pattern of statements.

Evaluation

The patient had learned something from the group as she said at the end of the last session that the programme had helped her tremendously as she had been a shy and quiet person. This means that she was aware how the group felt about her being over-talkative so that she claimed the group as the cause of her change. In fact, the author knew her background from a staff nurse and she always talked a lot before she came to the group.

Group therapy might not be very helpful for her unless the leader could help her to explore her real problems. It might be painful to the patient to recall (as the patient mentioned) or explore, so this would require a skillful therapist.

The patient was in a very distressed stage at the time and she wished someone could help her get away from this stage. For example, the patient was fearful and asked the author to help her. It is also notable that the patient did not open herself up in the group as much as she did to the author. This is not surprising as it is the author's impression that the group lacked a friendly atmosphere for the patient.

The patient was discharged before the eight weeks followup.

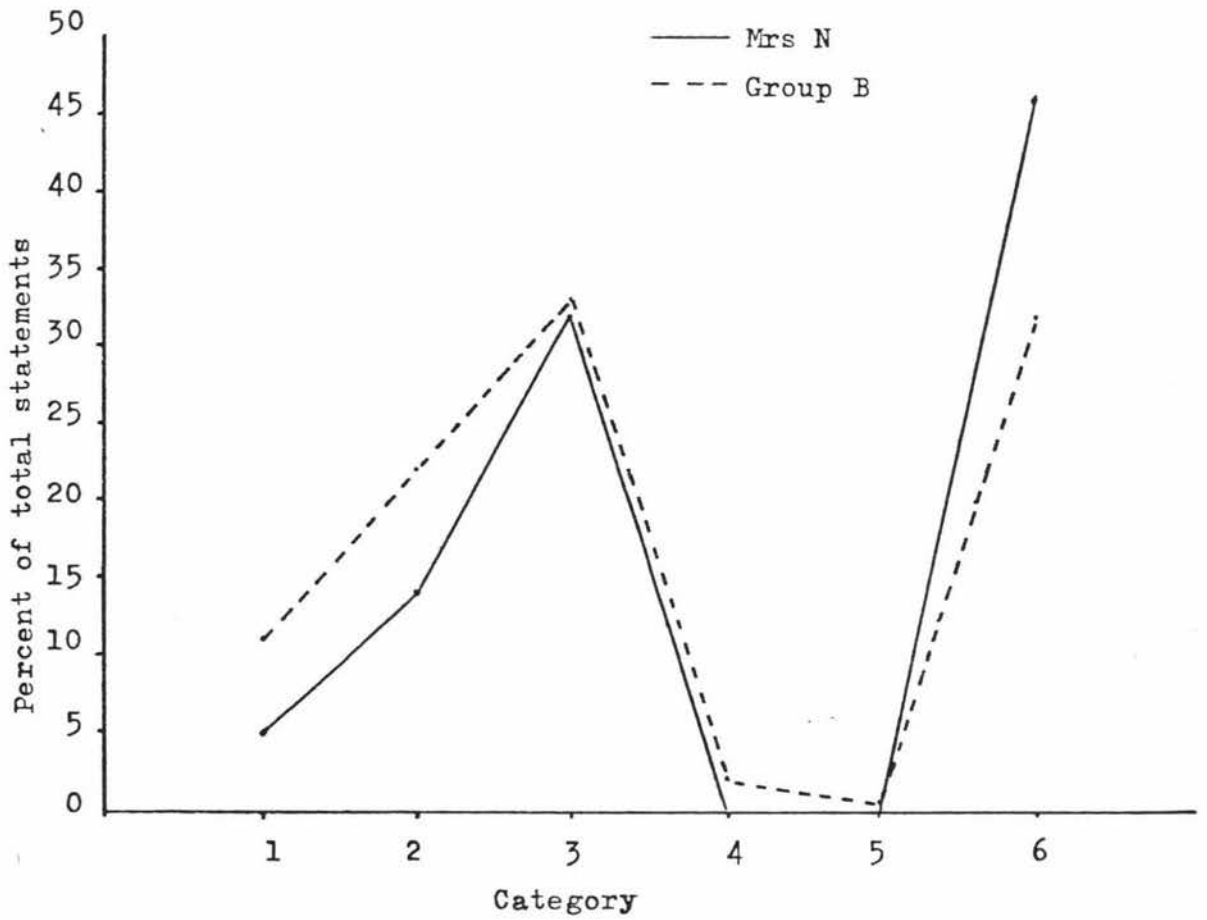


Figure 4-16. Statement distribution of Group B and Mrs N.

MR. TDescription of the Patient

The patient was a tall middle-aged man who appeared knowledgeable and intelligent (more so than the other patients in the same group). He always offered his cigarettes and matches to other patients.

He was hoping to be discharged soon.

Development of the Patient's Verbal Behaviour

Figure 4.17 shows changes in verbal behaviour by Mr. T over the six sessions for each category. Over all of the sessions, Mr. T showed a consistent pattern of statements of passive learning, active learning and exploration. It can be seen that he became more active in the group from session four. His salient characteristic in the group was the way he explored the concept teaching. Although he showed reasonably high exploration, the group did not know anything about his personal life problems. That is, he spent most of his time in exploring the concept teaching and getting involved with the problems of others in the group. However, it may be that the description of category four ("exploring"), which includes self-exploration, getting involved in others' problems, and exploration of concept teaching, does not adequately distinguish between these factors. His verbal behaviour can be analysed, however, by a close examination of his pattern of exploration.

In the group Mr. T always impressed other patients with his sophisticated use of language, which was noticeably different from their's. He also seemed to be thoughtful in the exercises or any topic raised by the group, as can be seen in the following excerpt:

Mr. T: What I see coming through too is that idealistically, I'm in the middle of the line but I'd like to be at the other side....I like to solve my own problems, but living in this community of ours, I put a 3 - 4.

His attempts to explore the concept teaching led to the admiration given by Mrs. C, who called him the "brains of the group". In addition, other patients often asked him to give some ideas about their problems. This made him feel proud of himself and superior to the others in the group. Thus, in the last three sessions the patient became more involved with other patients. This can be seen in the following statement:

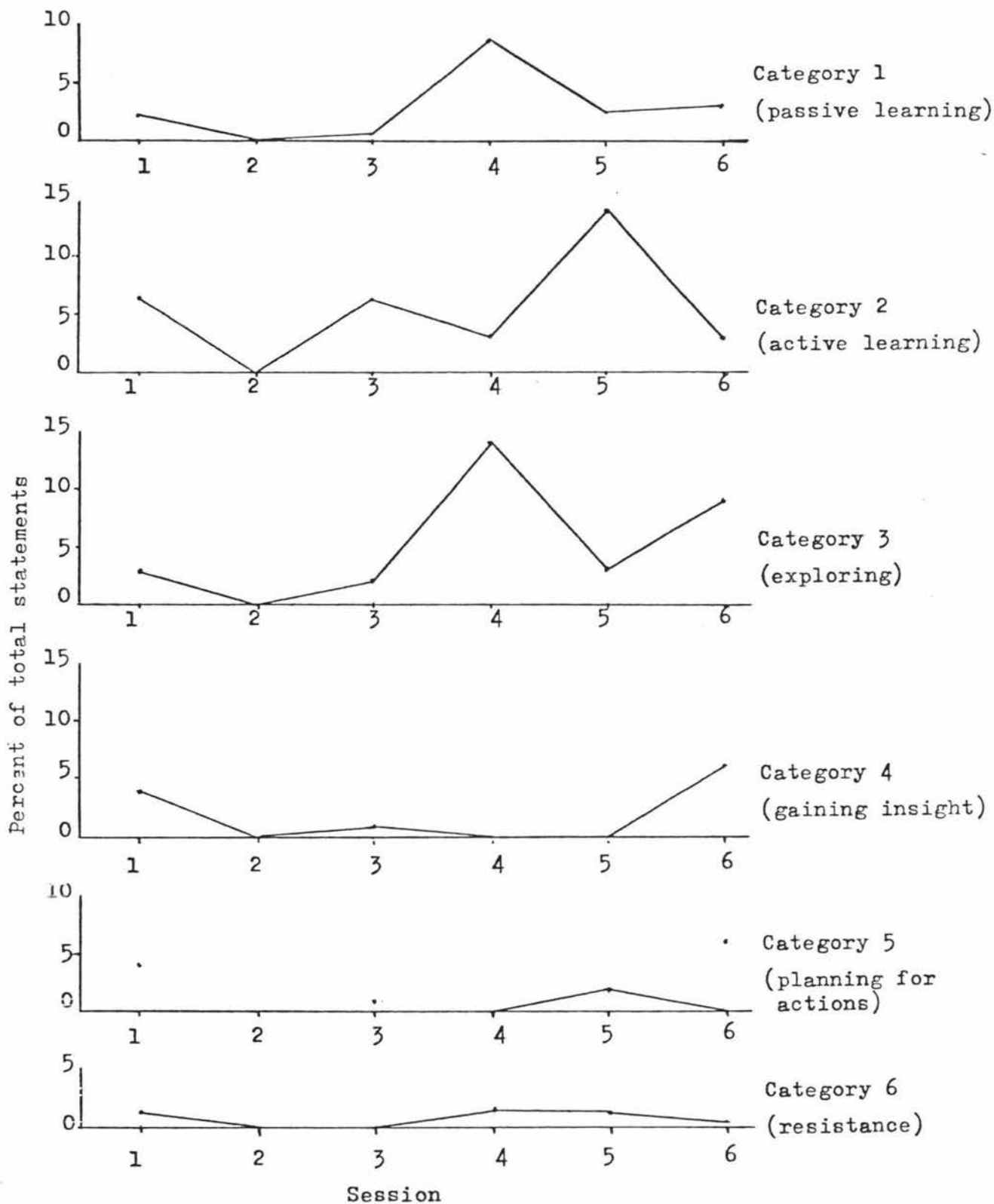


Figure 4-17. Distribution of the verbal statements of Mr.T.

I was just wondering about G, what friendship moves you make? What moves you make to make a friendship? ...Just curious, you don't have to answer.

His statements made Mrs. C laugh and proud of him. The author feels that Mr. T's feelings of superiority and pride in himself led him to attack another patient (Mrs. N) who was very talkative. He was intelligent enough to use the exercise as his tool to attack that patient. The following excerpts indicate his behaviour:

Mr. T: My second one is people who bother me is over talkative people.

Mrs. R: Bother me too.

....

....

Mr. T: My feelings towards him is - here we go, a perfect example - annoyance at their verbosity. And their feelings towards me is 'Why don't they listen?' That's their, that's the record they play.

Mrs. C: True.

Mr. T: My responses to them is 'Why don't they come to the main point?'

His behaviour was supported by another two patients in the group. It was very noticeable that after that episode Mr. T became talkative and sometimes he attempted to report his exercise while another patient was reporting to the group or nurse. This high active learning in session five is shown in Figure 4.17.

In session six, the patient increased his insight in the concept teaching. This can be seen from his discussion of his results on the post test of the CBT questionnaire. He found that he had a significant increase in his belief that other people could help him solve his problems. He further mentioned that perhaps the group changed him. However, the patient showed few statements about planning for his future actions after he left the hospital. The author got the impression that he was very optimistic about his future life and he seemed to look at it too simply, for he said that if he lost a job he would quickly find another one because of his qualifications and experience.

Overall, the patient showed lots of interest in learning, and changes in his verbal behaviour. He had very low resistance to learning.

Comparison of the Patient with the Group

Figure 4.18 shows Mr. T's distribution of statements compared to that of the group. He was quite different from the group in that he showed much higher a degree of active learning and gaining insight, and a slightly higher degree of planning for future action. It was noticeable that he had a very much lower resistance to learning than the rest of the group.

The graph seems to show that the patient was better than the group in terms of gaining some insights. It was true that he gained some insight in the concept of coping behaviour but he did not show how much he applied the concept to his problems. Thus, it was not known whether he gained more insight into his life problems than the group.

Evaluation

Mr. T seemed to benefit from the group in terms of preparing himself to live outside the hospital. This was realized by the patient as well, for he was looking forward to being discharged as a day care patient where he could work.

He was on a home leave trial before the eight weeks follow up.

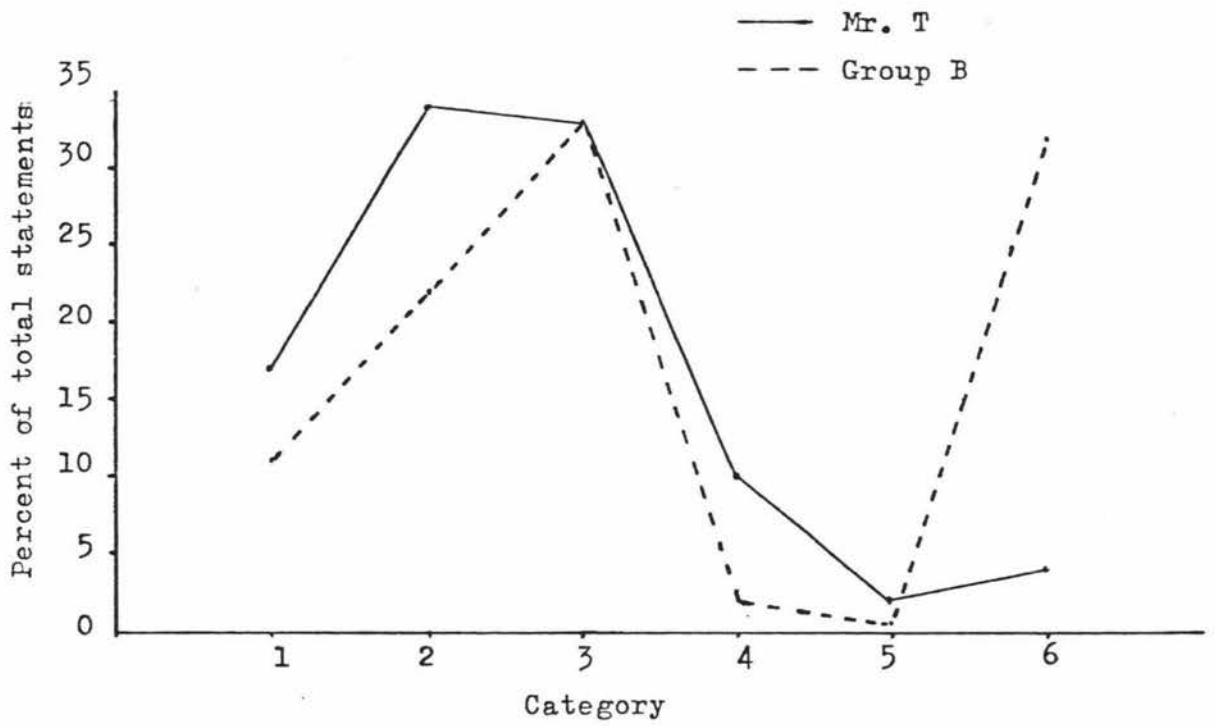


Figure 4-18. Statement distribution of Group B and Mr. T.

MRS. CDescription of the Patient

Mrs. C was a good looking middle-aged woman who dressed neatly.

She came to the group with high resistance to learning but she showed her resistance differently from Mrs. N, that is, she tended to be passive.

Development of the Patient's Verbal Behaviour

Figure 4.19 shows Mrs. C's changes in verbal behaviour in each category over six sessions. She demonstrated a small proportion of passive learning but was consistent over the last three sessions. The proportion of active learning was also small and decreased in the last session and the proportion of exploring was reasonably large over all sessions. In fact she did not open herself up much even though her pattern of exploring changed over sessions. That is, in session two, the patient began to talk about the death of her father and her sorrow in parting. She claimed that if her father had been alive she would not have been in the psychiatric hospital now. She did not show any feeling of sadness while she was talking about her father. From session three the patient tended to talk about any topic raised in the group. Sometimes she related her own story or made comments on other patients' problems.

It is interesting that from session four, Mrs. C obviously showed her admiration of Mr. T. She said that she would like to have his brains and often asked him to comment on her exercises. Furthermore, she supported what Mr. T said. For example:

Mr. T: ...I don't think people say a lot about that.

Mrs. C: That's true...

Mr. T: Attached to a psychiatric hospital.

Mrs. C: That's true.

She was very involved in the group as she always asked other patients to clarify their problems. It struck the author that the behaviour of Mrs. C in the group during the last three sessions was similar to that of Mr. T. That is, both of them attempted to clarify other patients' problems. Perhaps Mrs. C tried to imitate Mr. T's behaviour. It could be interpreted that Mrs. C was very close to her father and she commented that her father was a knowledgeable person;

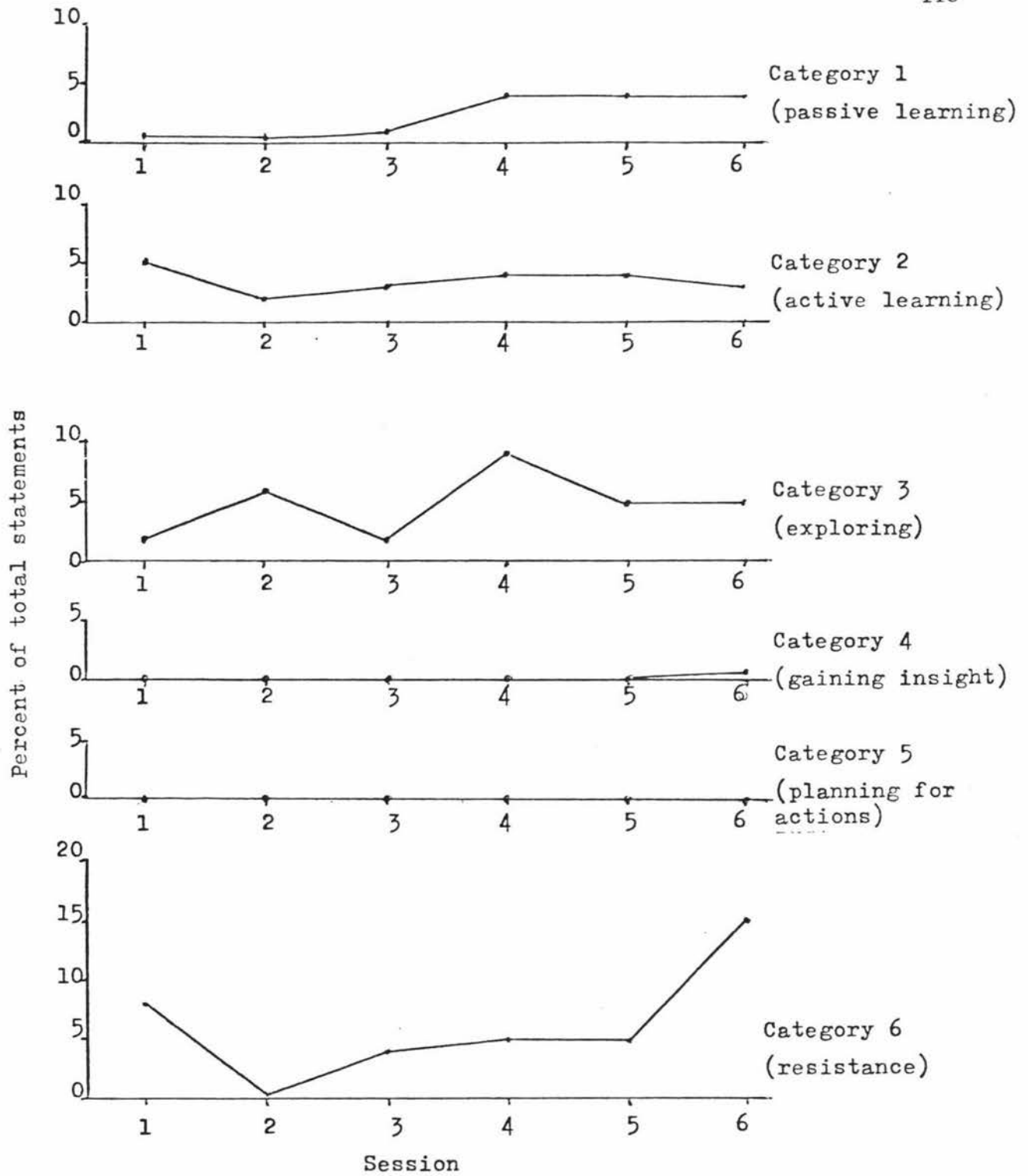


Figure 4-19. Distribution of verbal statements of Mrs C.

thus Mr. T might have represented the character of her father, so she admired him and also tried to be like him.

Overall, Mrs. C showed little gaining of insight and this only in session six. There were no statements of future planning and she did not seem to look forward to her future life.

The salient characteristic of the patient was resistance to learning, which tended to increase towards the end of the programme. This was expressed by raising irrelevant topics in the group. Sometimes she showed disbelief in the nurse and she commented that the nurse lacked experience in life.

Comparison of the Patient with the Group

Figure 4.20 shows Mrs. C's statement distribution compared to the group. Mrs. C was another patient along with Mrs. N who tended to influence the group's pattern of verbal behaviour. She was slightly lower than the group in exploration and gaining insights.

Evaluation

Mrs. C could be considered as a stimulator of the group as she always questioned other patients about their problems. Further group therapy with a male therapist would probably make some difference to her.

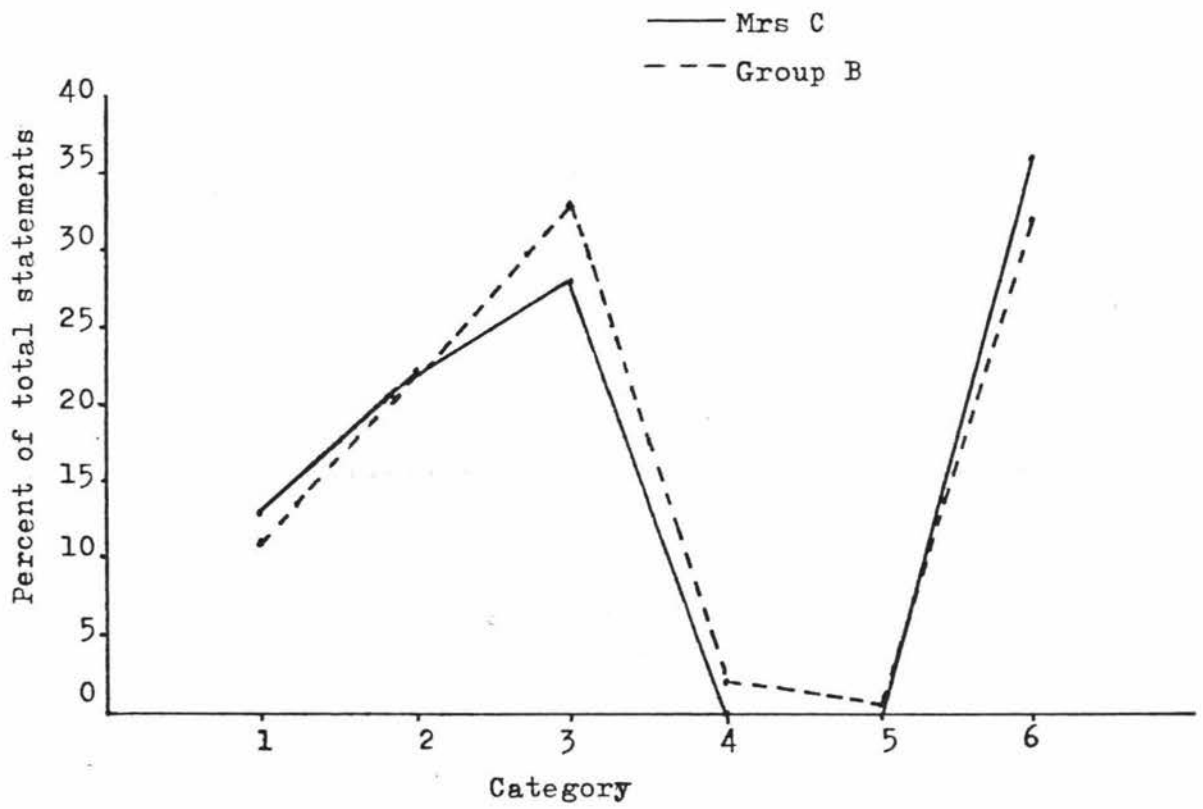


Figure 4-20. Statement distribution of Group B and Mrs C.

CHAPTER 5

RESULTS

This section of the results is reported under three headings: Section 1, MPN Test; Section 2, CBT Questionnaire; and Section 3, Content Analysis.

Section 1: MPN Test

Comparison between the responses of patients and non-patients

The MPN test responses of the patient and non-patient groups were compared for each of the three MPN categories: Category 1 - Ability to communicate; Category 2 - Perceptions of nurses as helpful; Category 3 - Seeking help from the nurse. The group mean scores for each category were then derived from the responses to all ten photographs, and are displayed in Table 5.1. It can be seen from the results of the t tests that there were no significant differences between the two groups in any of the three categories.

However, when the group mean scores are compared in each category for each photograph separately, there are four photographs for which the patient and non-patient group responses are significantly different (see Appendix I for complete t test results). For photographs four, six and ten, there was a significant difference between groups in category three (seeking help from nurses). Patients made more category three statements than non-patients in photograph four ($P < .006$) but less in photographs six ($P < .07$) and ten ($P < .05$). For photograph ten, there was also a significant difference between groups for category two statements, with non-patients viewing nurses as more helpful than patients ($P < .02$).

Patients' response on the MPN test before and after the teaching programme

Two groups of patients, Group A and Group B, were tested with the MPN test before and after the teaching programme. Group A comprised patients who had positive perceptions of nurses as helpful, while Group B comprised patients who had negative perceptions of nurses as helpful.

Table 5.1

Mean Scores On The MPN Test
Patients vs. Non-Patients

CATEGORIES	PATIENTS* Mean (S.D.)	NON-PATIENTS** Mean (S.D.)	<u>t</u> Value
1. Ability to communicate	44.15 (9.67)	47.2 (10.88)	.74
2. Perceptions of nurses as helpful	23.5 (9.43)	23.2 (10.70)	.06
3. Seeking help from nurses	17.8 (10.05)	21.8 (8.02)	.72

*N = 19

**N = 10

The scores from all ten photographs were summed in each category for each group.

Table 5.2 shows the mean responses of Group A and Group B before and after the Teaching Programme, and the results of comparison within and between groups before and after teaching.

For category 1, the mean scores of Group A significantly decreased ($P < .05$) after the teaching programme, but there was no significant change for Group B. For category 2, Group A significantly decreased its mean scores ($P < .005$) after teaching while, in contrast, the mean scores of Group B significantly increased ($P < .05$). For category 3, Group A slightly decreased its mean scores after teaching although not significantly, while Group B increased its mean scores after teaching, but again not significantly.

When responses on the MPN test of Group A and Group B were compared, there was no significant difference between groups in category 1, either before or after the teaching programme. For category 2, there was a significant difference between the two groups before the teaching programme ($P < .005$), when Group A viewed nurses as more helpful than Group B. However, after the teaching programme Group A viewed nurses as less helpful than Group B, although the difference was not significant. For category 3, there was a significant difference between Group A and B ($P < .05$) before the teaching programme, when Group A sought help from nurses more than Group B. This difference was still apparent after the teaching programme, although not significant.

Section 2: CBT Questionnaire

Difference in mean before and after CBT scores for Group A and Group B

For Group A and Group B, t tests were applied to the before and after CBT scores. The before and after differences in mean scores for the two groups are presented in Table 5.3.

For Group A, no significant difference was found between the before and after measures for either the "actual" or the "preferred" behaviours. Although the scores of preferred behaviour were significantly greater than the scores of actual behaviour both before and after teaching ($P < .005$). The difference between actual and preferred behaviour scores before teaching were the same as the differences after

Table 5.2

Mean MPN Scores Of Groups A and B
Before and After The Teaching Programme

CATEGORY	GROUP A ⁺ Mean (S.D.)	GROUP B ⁺ Mean (S.D.)	<u>t</u> value
1. Ability to communicate:			
Before	52.40 (5.55)	43.60 (9.42)	1.11
After	42.80 (6.41)	41.20 (5.02)	.44
<u>t</u> value (Before:After)	2.53*	.50	
2. Perceptions of nurses as helpful:			
Before	40.40 (9.83)	14.80 (7.29)	4.67**
After	19.60 (11.52)	28.00 (7.61)	1.36
<u>t</u> value (Before:After)	4.91** ^(a)	2.80* ^(a)	
3. Seeking help from nurses:			
Before	28.50 (13.78)	10.40 (11.52)	2.19*
After	20.40 (4.56)	15.20 (10.64)	1.00
<u>t</u> value (Before:After)	1.03	.64	

*P < .05

**P < .005

⁺N = 5

(a) = one-tailed test

Table 5.3

Differences In Mean CBT Scores of Groups A and B
Before and After The Teaching Programme

BEHAVIOUR	GROUP A ⁺		GROUP B ⁺	
	Difference	t value	Difference	t value
Change of Actual (A2-A1)	1.6	.38	6.8	2.26*(a)
Change of Preferred (P2-P1)	.4	.10	-2.0	.29
Initial discrepancy (P1-A1)	14.4	4.02**	3.6	.67
Final discrepancy (P2-A2)	14.4	4.08**	-5.2	.95
Change in discrepancy (P2-A2)-(P1-A1)	0	0	-1.6	3.79**

⁺N = 5

*P < .05

**P < .005

(a) = one-tailed test

teaching ($P < .005$). The difference between actual and preferred behaviour scores before teaching were the same as the differences after the teaching, and thus there was no change in the absolute discrepancy scores.

For Group B, the mean scores of actual behaviour were significantly increased ($P < .05$) after teaching, however the mean preferred behaviour scores before and after were not significantly different. The difference between actual and preferred behaviour was not significant either before or after teaching. Scores of final discrepancy indicated that scores of preferred behaviour were less than actual behaviour, which is an unexpected finding. This was investigated and is discussed in "Discussion". The change in discrepancy was significantly different ($P < .005$).

Comparison of mean CBT questionnaire scores of Groups A and B

Table 5.4 presents a comparison of the mean scores of Actual and Preferred both before and after teaching for Groups A and B.

The scores of Actual Behaviour before teaching differed significantly between the two Groups ($P < .005$), with Group B having greater scores than Group A. After the teaching programme, there was also a significant difference in Actual Behaviour scores between Group A and Group B ($P < .0005$), with Group B again having higher scores. Group A showed slightly higher scores than Group B for Preferred Behaviour. However, there were no significant differences between groups for preferred scores either before or after teaching.

The scores of change in Actual Behaviour between the two groups were significant at ($P < .05$) level, with Group B showing higher change in scores than Group A. The differences in change in Preferred Behaviour between groups was not significant. However, the difference between Preferred and Actual Behaviour between the two groups was found to differ significantly both before and after teaching ($P < .01$, $P < .005$ respectively). However, change in discrepancy between the two groups was found not to be significant.

Section 3: Content Analysis

The data obtained from the patients' and the nurse's verbal behaviours was converted into percentage scores in order to adjust for variations in the total number of statements made from hour to hour

Table 5.4

Comparison of Mean Scores of Groups A and B
Before and After The Teaching Programme

BEHAVIOUR	GROUP A ⁺ Mean (S.D.)	GROUP B ⁺ Mean (S.D.)	t value
Actual ¹ (A1)	35.6 (5.8)	45.2 (4.76)	2.86*
Actual ² (A2)	36.2 (5.71)	52.0 (4.18)	4.99**
Preferred ¹ (P1)	50.00 (5.52)	48.80 (10.08)	.23
Preferred ² (P2)	50.40 (6.65)	46.80 (11.54)	.60
Change in Actual (A2-A1)	.60 (7.82)	6.80 (5.93)	1.41****(a)
Change in Preferred (P2-P1)	6.40 (5.45)	-2.00 (16.29)	.31
Initial Discrepancy (P1-A1)	14.40 (8.59)	-2.40 (11.19)	2.66***
Final Discrepancy (P2-A2)	14.20 (8.10)	-5.20 (12.23)	2.96*
Change in Discrepancy (P2-A2)-(P1-A1)	-.20 (9.65)	-7.60 (12.32)	1.06

¹ = before the teaching programme

² = after the teaching programme

⁺N = 5

*p < .005

**p < .0005

***p < .01

****p < .05

(a) = one-tailed test

(Murray, 1955; 1956). Thus for each session, the category percentage scores were computed by dividing the number of statements placed in a category by the total number of statements made during that session.

Comparison of the Category Percentage Scores of the patients in Group A and Group B

The verbal responses of the patients were assigned to one of the six categories: category 1 - passive response to learning; category 2 - active response to learning; category 3 - exploring; category 4 - gaining insight; category 5 - planning for actions; category 6 - resistance to learning. Post hoc t-tests were then used to compare the scores of Group A and Group B in each category for each session (see Appendix J). Only one significant difference was found. In category four of session four, Group A patients showed a greater degree of "gaining insight" ($P < .10$). When Group A and B were compared in each category with the six sessions combined, no significant differences were found for categories one to five. However, there was a significant difference for category six, in which Group B showed significantly greater resistance to learning than Group A ($P < .005$) (see Appendix K).

The results from Figures 5.1 to 5.6 will be discussed separately for each category.

Category 1: Group A and Group B showed similar trends over the six sessions and both groups showed little variation from session to session. However, Group A scored consistently higher than Group B (see Fig. 5.1).

Category 2: Both groups showed similar trends in change over time except in session six where the Group A score increased while the Group B score decreased (see Fig. 5.2)

Category 3: As in categories 1 and 2, the two groups showed the same pattern of change over the six sessions. There is a marked difference although not significant, between the groups in session one, where Group B showed little "exploring" (see Fig. 5.3).

Category 4: Both groups showed very low percentage scores over the six sessions, and trends were not consistent (see Fig. 5.4).

Category 5: The number of statements made in this category was extremely low for both groups, with scores only in sessions two and four for Group A, and only in session five for Group B (see Fig. 5.5).

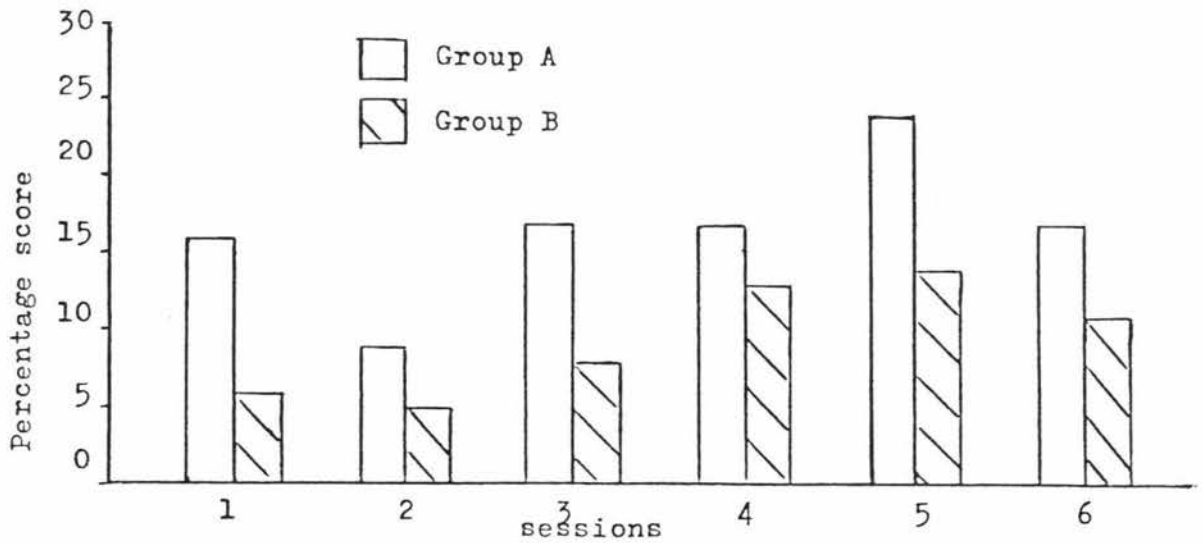


Figure 5-1. Percentage scores of Group A and Group B patients for Category 1 (passive response to learning).

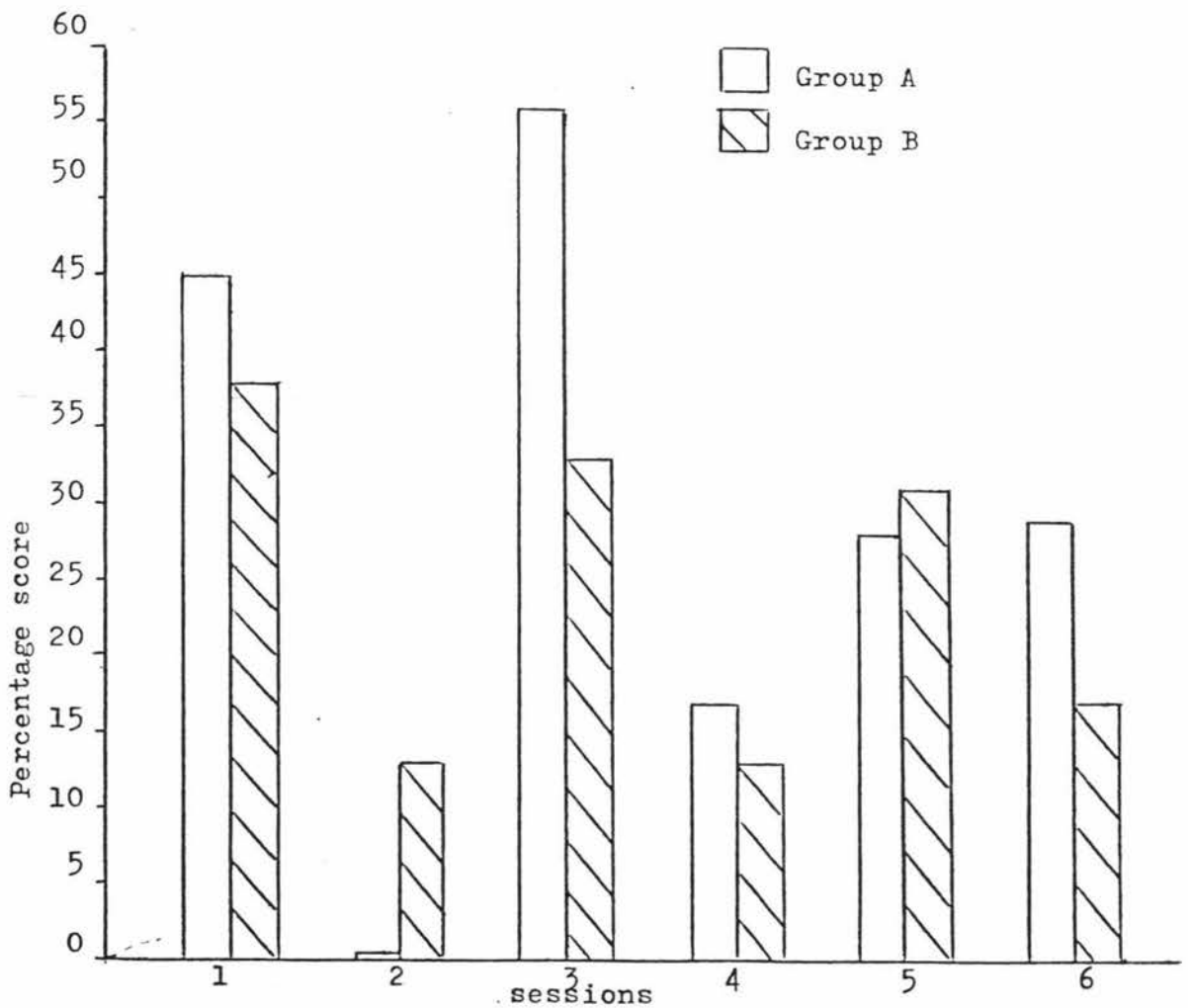


Figure 5-2. Percentage scores of Group A and Group B patients for Category 2 (active learning).

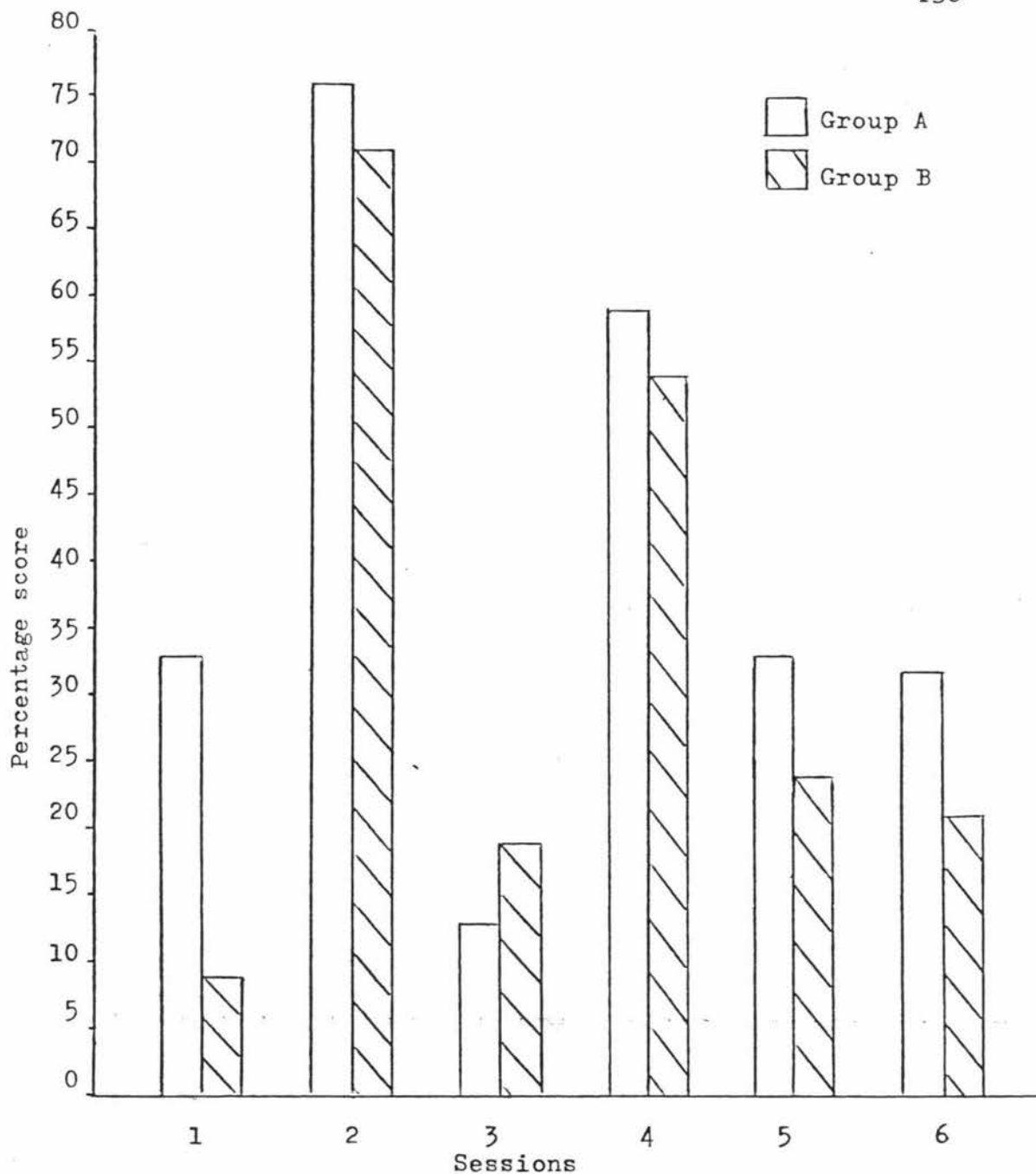


Figure 5-3. Percentage scores of Group A and Group B patients for Category 3 (exploring).

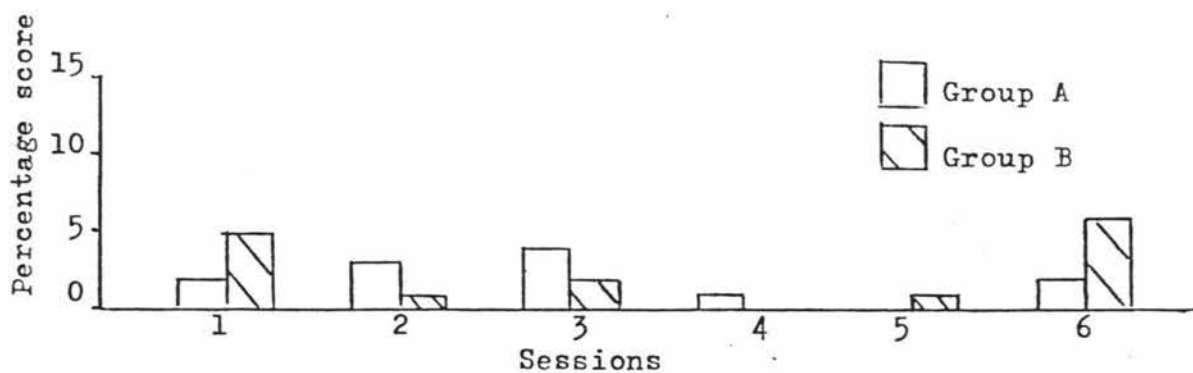


Figure 5-4. Percentage scores of Group A and Group B patients for Category 4 (gaining insight).

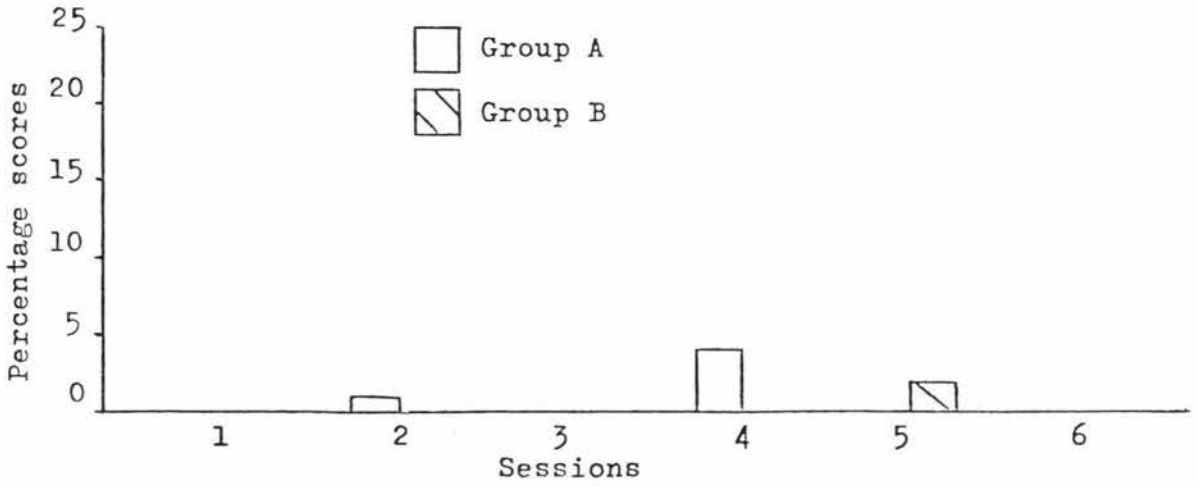


Figure 5-5. Percentage scores of Group A and Group B patients for Category 5 (planning for actions).

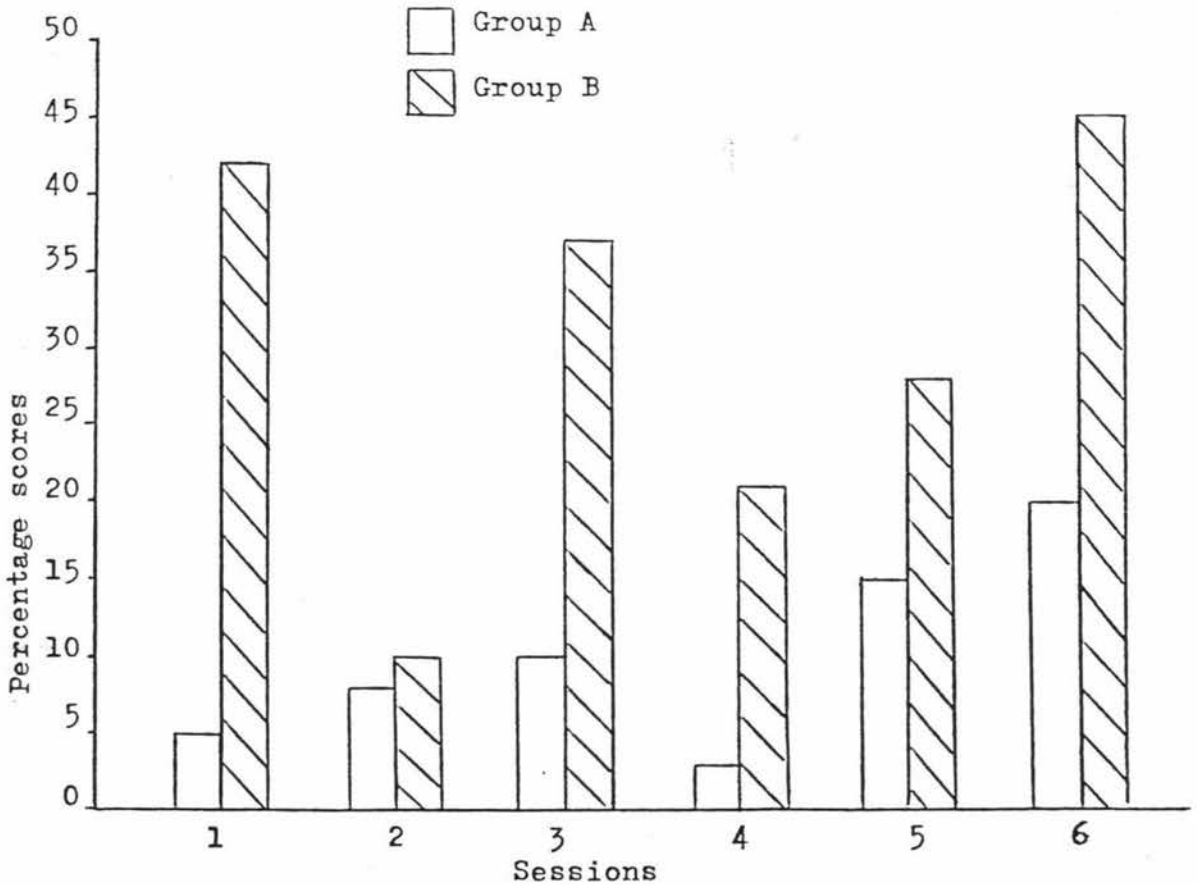


Figure 5-6. Percentage scores of Group A and Group B patients for Category 6 (resistance to learning).

Category 6: Group A and Group B displayed grossly different scores for all but the second session. Group B tended to have far higher percentage scores than Group A, showing greater resistance to learning throughout the programme (see Fig. 5.6).

Comparison of the Category Percentage Scores of the Nurse for Group A and Group B

The units of verbal behaviour used by the nurse during each session were assigned to one of the six categories: category 1 - orientating; category 2 - stimulating to learn; category 3 - stimulating to explore; category 4 - stimulating to gain insight; category 5 - stimulating to plan for future actions; and category 6 - discouraging learning. Category percentage scores were then computed for each session, and also for all sessions combined. The percentage scores of Group A and Group B were compared using t-tests in each category with combined sessions (see Appendix L). The only significant difference was in category four (stimulating to gain insight) where Group A scored significantly higher than Group B ($P < .03$).

Figures 5.7 through 5.13 show the percentage scores of the nurse during each session for categories one through six in Group A and Group B.

Figure 5.7 shows the category 1 percentage scores for the nurse in Groups A and B during each session. The change in the scores was in the opposite direction for the groups in every session. The greatest difference between the groups was in session one, however, no significant differences between groups were found for any of the sessions.

Figure 5.8 shows the percentage of category two statements to Groups A and B. They show a similar pattern of change between sessions and overall Group B tended to receive a higher percentage of category 2 statements than Group A. Again, there were no significant differences between groups for any of the sessions.

Figure 5.9 shows the percentage of category 3 nurse statements to Groups A and B. The nurse generally made a lower percentage of statements in this category to both groups than in categories 1 and 2, and overall, the percentage of statements to Group A was slightly higher than to Group B. However, this difference was not significant. There is a similar pattern of change over sessions in both groups, except session five, where there was a large percentage increase to Group A, but no change in Group B.

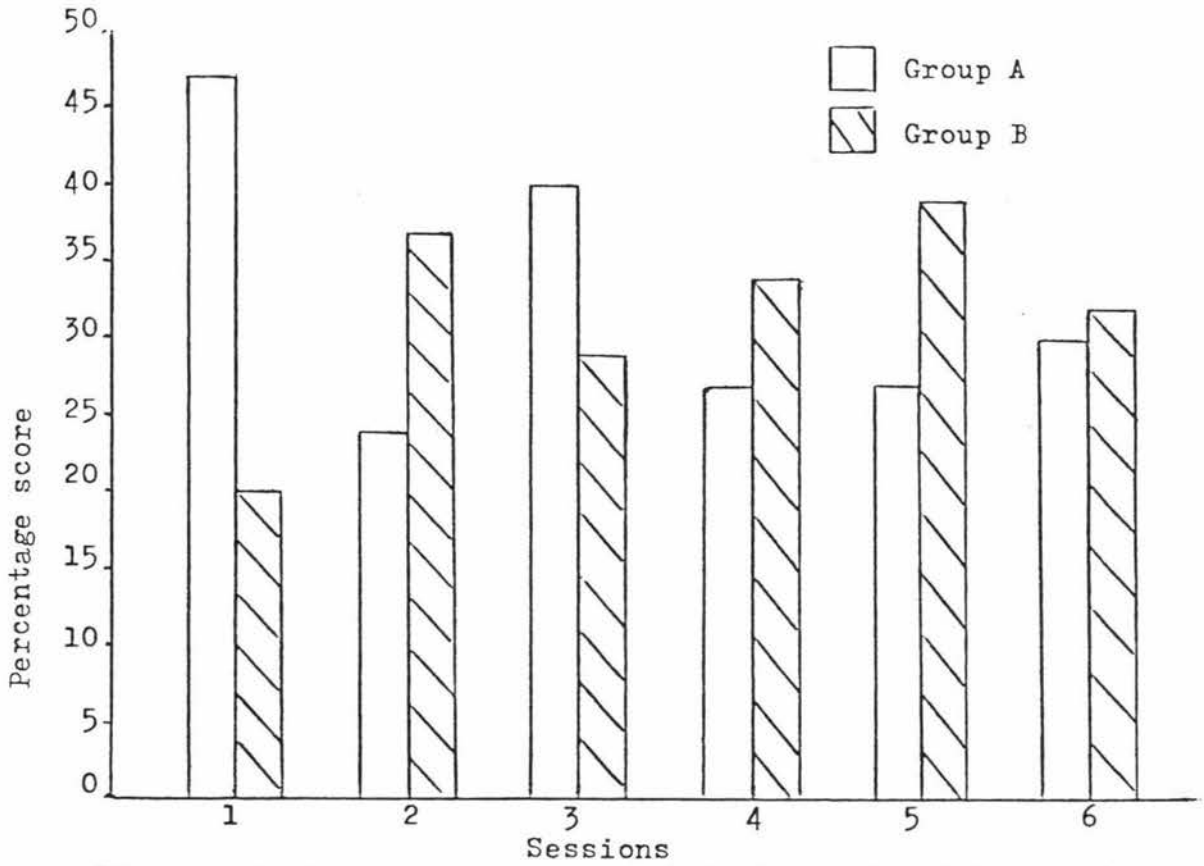


Figure 5-7. Percentage scores of the Nurse for Category 1 (orientating).

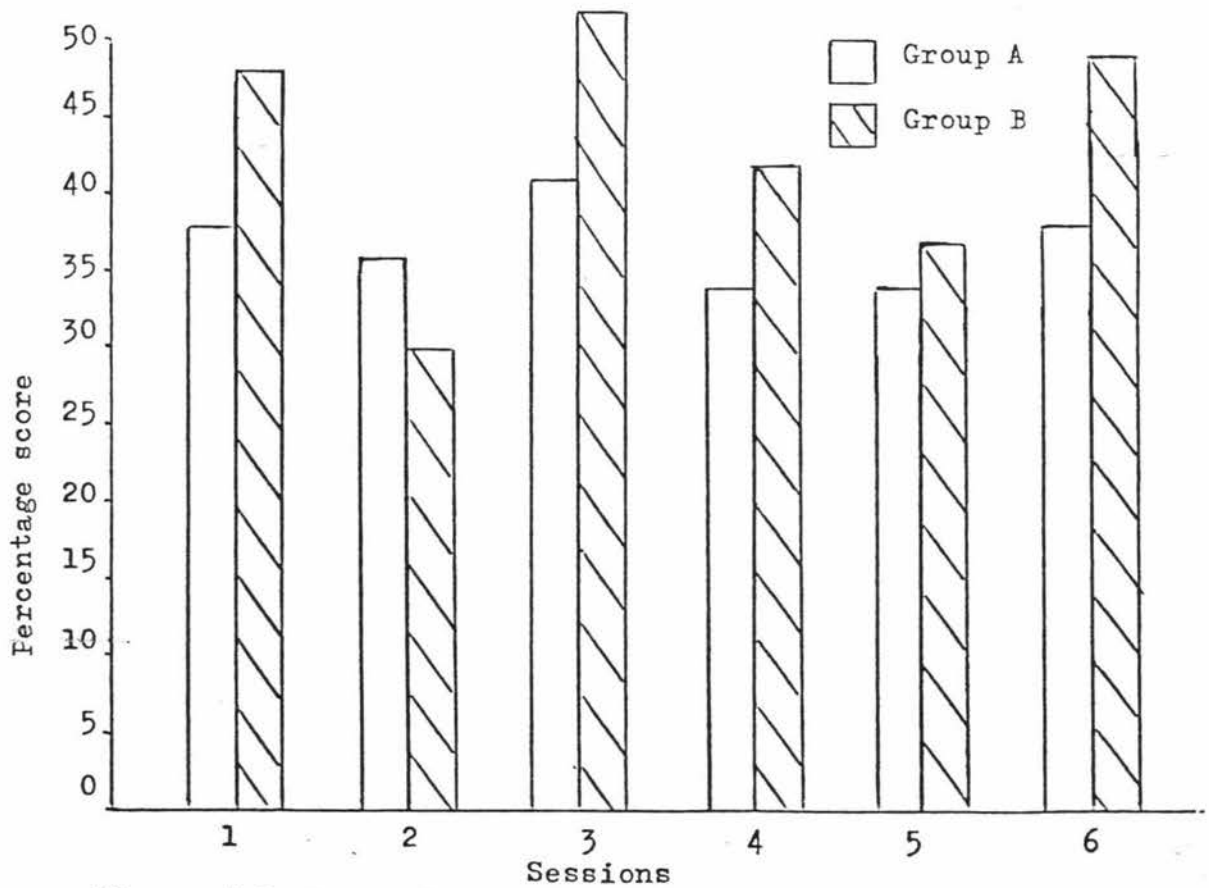


Figure 5-8. Percentage scores of the Nurse in Category 2 (stimulating to learn).

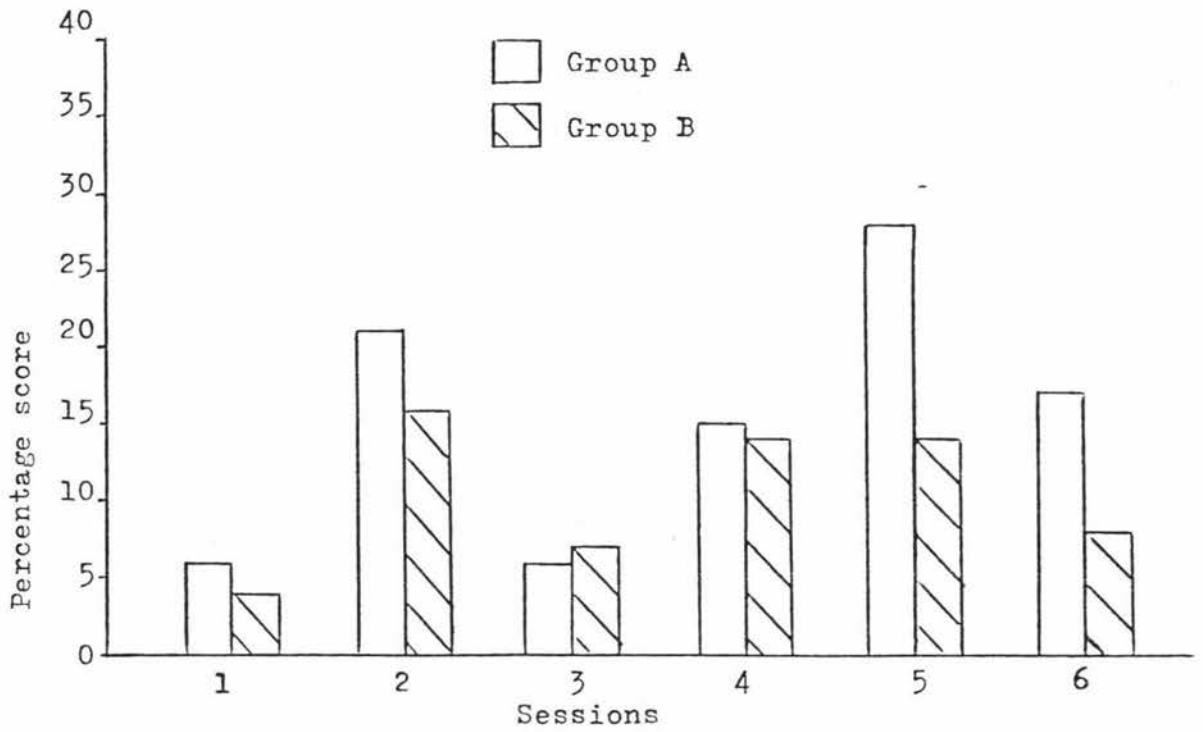


Figure 5-9. Percentage scores of the Nurse for Category 3 (stimulating to explore).

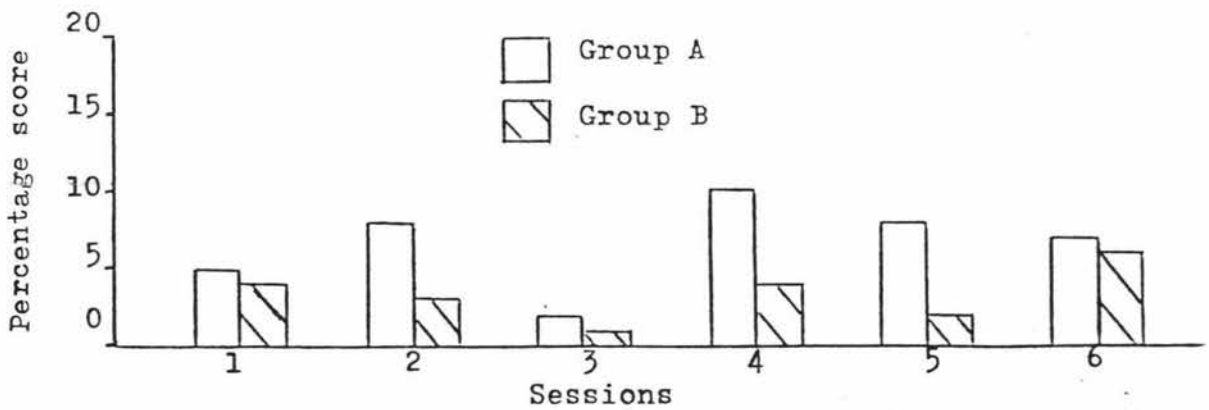


Figure 5-10. Percentage scores of the Nurse for Category 4 (stimulating to gain insight).

Figure 5.10 shows the percentage of category 4 nurse statements made to Group A and Group B. The percentage of statements made in this category was low, with a higher percentage of statements made to Group A than to Group B in every session. Over all sessions the difference between the two groups was significant ($P < .03$). Thus the nurse stimulated Group A to gain insight more than Group B.

Figure 5.11 shows the percentage of category 5 statements by the nurse to Groups A and B. In both groups the percentages were generally very low. The nurse only made statements related to "stimulating planning" in session two for Group B, and sessions two, four, and six for Group A. There was no significant difference between the percentage of statements made to the two groups over the six sessions.

Figure 5.12 shows percentage of category 6 statements by the nurse to Groups A and B. With the exception of session two, Group B tended to receive a higher percentage of statements from the nurse. There was a marked difference between the groups in session one, although not significant and there was no significant difference between percentage of statements made to both groups over the six sessions.

Comparison of the percentage of Nurse Statements to Group A and Group B, in each category over all sessions

Figure 5.13 shows the pattern of the nurse's verbal behaviour to Group A and Group B for each session. The pattern of the nurse's verbal behaviour is similar for both groups. That is, both groups received a high percentage of statements from categories 1 and 2, decreasing percentages from categories 3, 4, and 5, respectively then an increased percentage again in category 6. The coefficient of correlation for the statements made in each category to each group is significant, $r = .97$ ($P < .0005$)

Comparison of Nurse and Patient Category 6 Statements (discouragement of learning - resistance to learning)

Relationship of the nurse's statements discouraging learning and the patients' statements of resistance to learning will be discussed separately for Group A and Group B.

Group A: The category 6 nurse percentage scores were calculated for each of the six sessions. Similarly, a category 6 Group A percentage score was calculated for each session by totalling the number

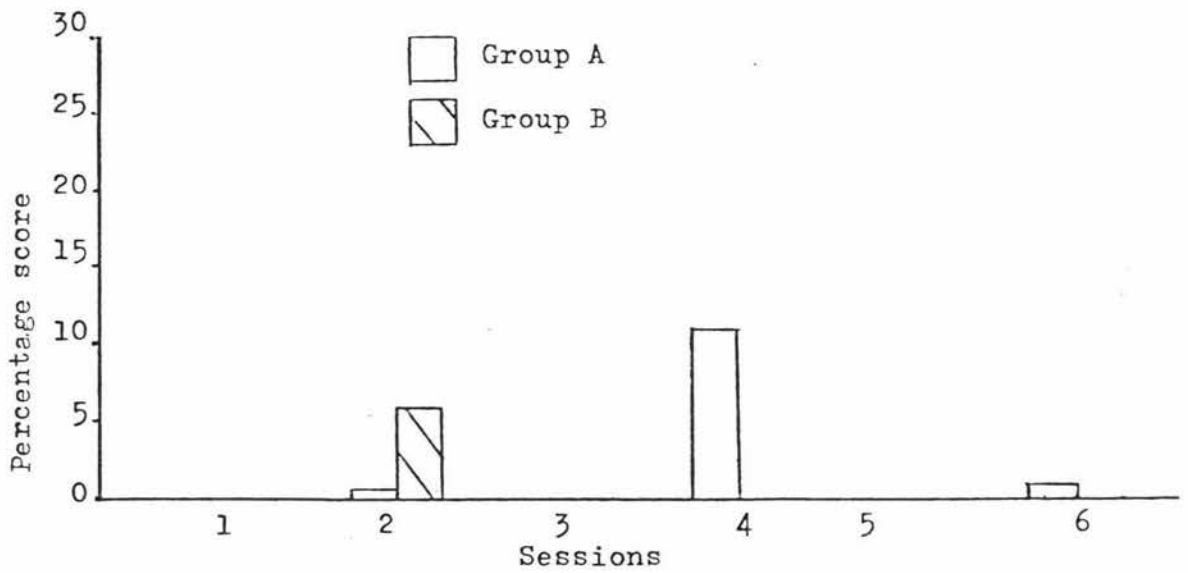


Figure 5-11. Percentage scores of the Nurse for Category 5 (stimulating planning).

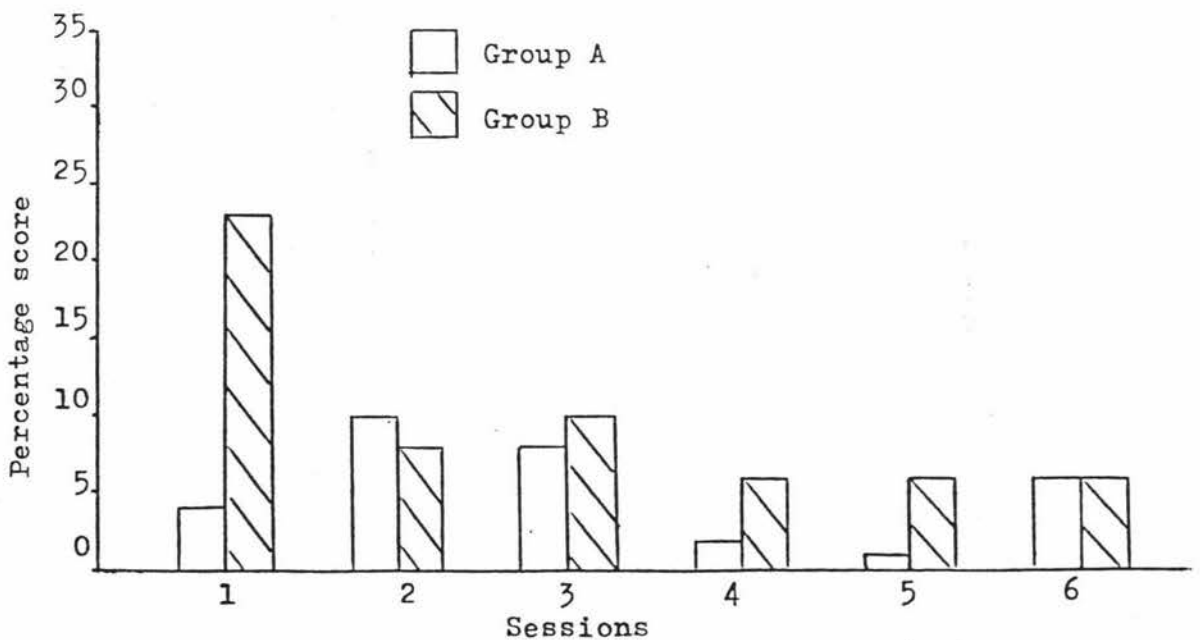


Figure 5-12. Percentage scores of the Nurse for Category 6 (discouraging learning).

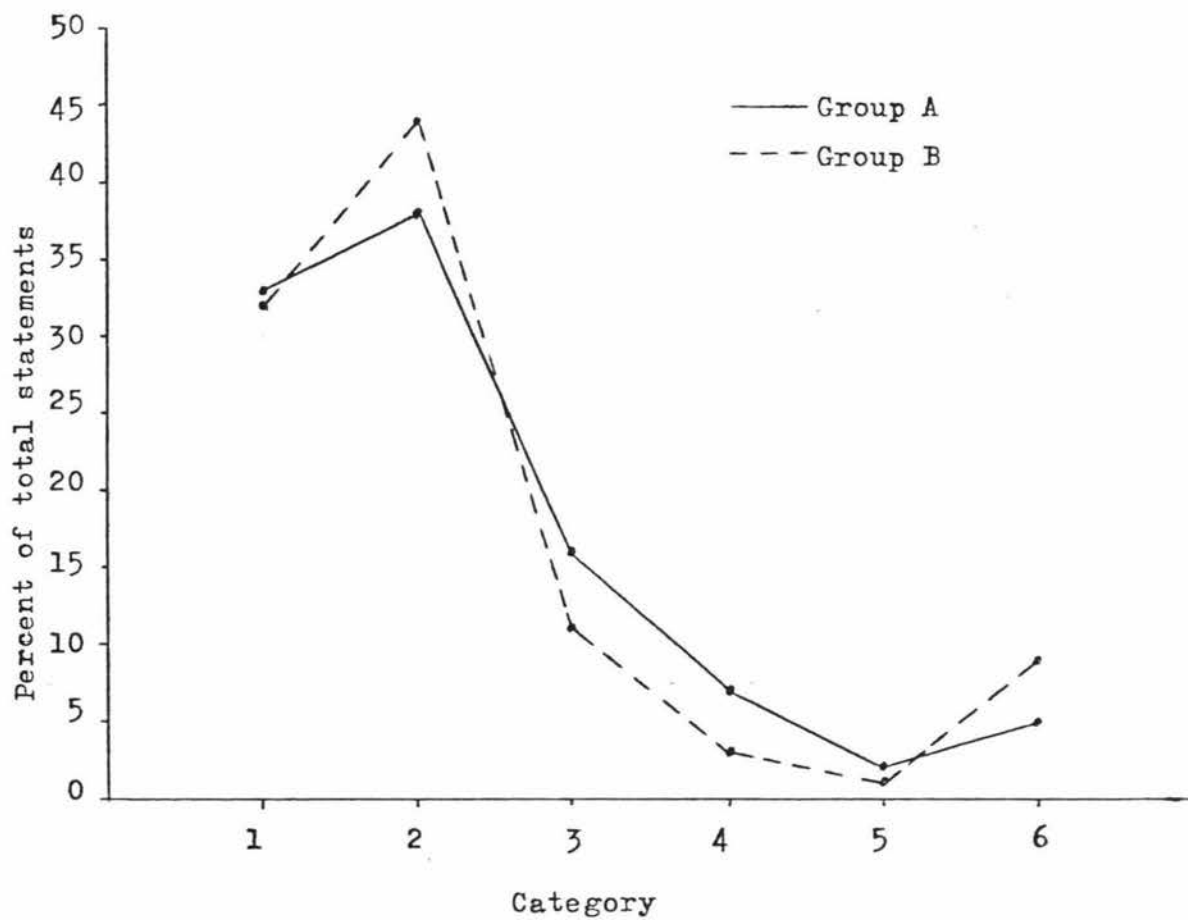


Figure 5-13. Distribution of Nurse statements to Group A and Group B over all sessions.

of category 6 statements from all the patients in Group A. The resultant category 6 percentage scores are displayed in Figure 5.14.

It is apparent that a reversal occurred in sessions three and five. That is, the nurse made high percentage scores in session three and the patients showed low resistance to learning. In contrast, the nurse made low percentage scores in discouragement in session five but the patients showed high resistance to learning.

The nurse percentage scores on discouraging learning and the patients percentage scores on resistance to learning was correlated $r = .21$ and was not significant.

Group B: The category 6 percentage scores were calculated as for Group A and are displayed in Figure 5.15. It can be seen that very similar patterns occur except for session six. However, the correlation of coefficient between the nurse and the patients' percentage scores changes was not significant $r = .39$.

Comparison of Group A and Group B Statements of Attempting to Learn (passive response to learning - active response to learning)

For this comparison, category 1 and category 2 were combined as they are considered to represent the patients' attempts to learn.

Figure 5.16 shows percentage scores of both groups in attempting to learn. Overall, Group A tended to show higher percentage scores in every session except session two. However, both groups showed a similar pattern of changes in each session. This indicates that the teaching programme consistently stimulated both groups in a similar way.

When a t-test was calculated to compare the scores of the two groups over all sessions, no significant difference was found.

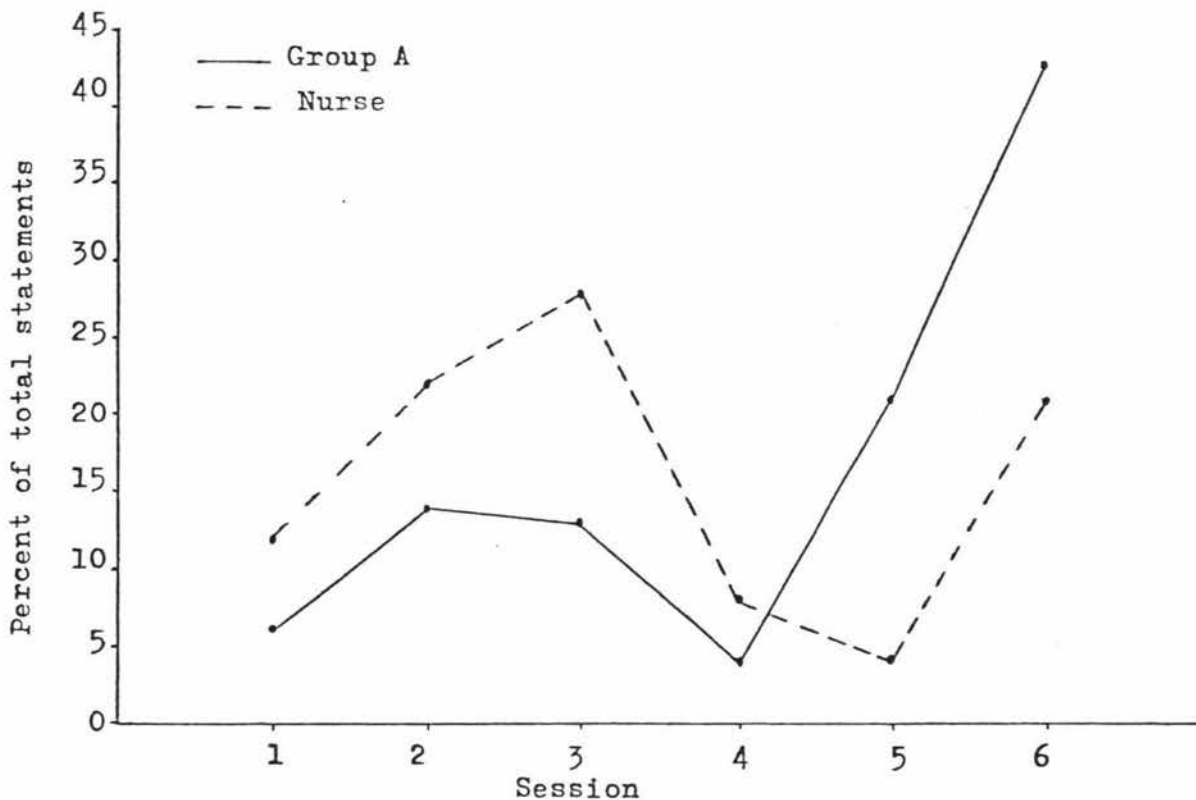


Figure 5-14. Distribution of the Category 6 statements of the Nurse (discouraging learning) and Group A (resistance to learning).

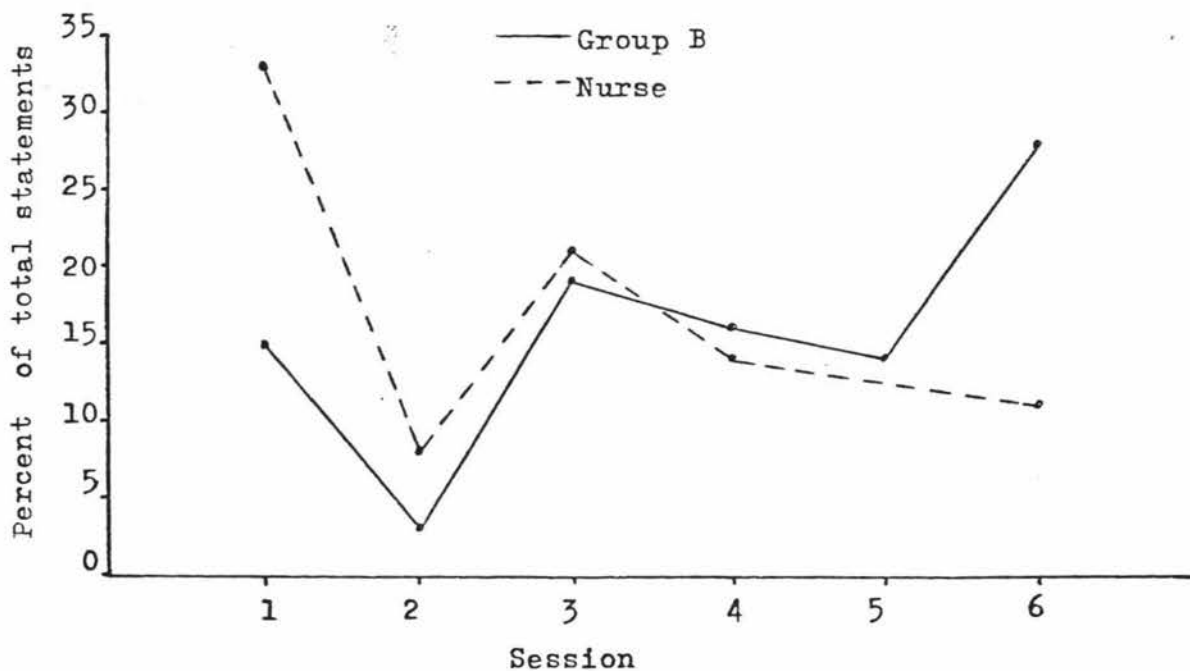


Figure 5-15. Distribution of the Category 6 statements of the Nurse (discouraging learning) and Group B (resistance to learning).

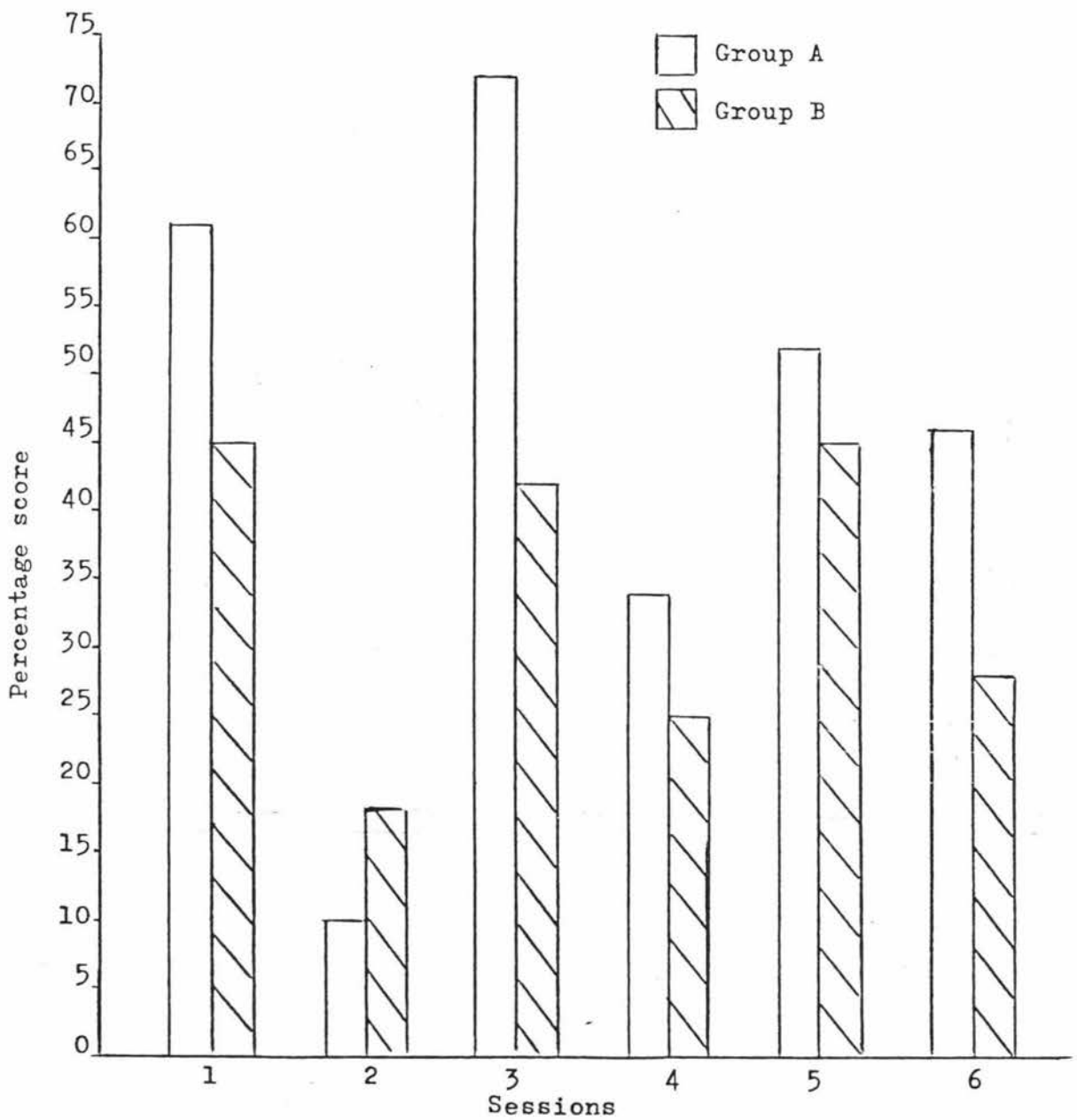


Figure 5-16. Percentage scores of Group A and Group B for "attempting to learn".

CHAPTER 6DISCUSSIONConfirmation of HypothesesHypothesis One

The results of the content analysis showed no significant difference between Group A and Group B in the area of attempting to learn. Thus Hypothesis One, that "A group of patients who have positive perceptions of nurses as helpful will attempt to learn more than a group of patients who have negative perceptions of nurses as helpful", was not supported. In fact both groups had similar learning patterns over sessions. While this implies that neither positive nor negative perceptions of the nurse as helpful affect a patient's willingness to learn, it is also possible that the content of the teaching programme has over-ridden any effects the patients' perceptions of nurses may have had on their attempts to learn. On the other hand, these results are unlikely to be due to differential group treatment by the nurse, for she seemed to act equally as a stimulus to both groups.

Hypothesis Two

Hypothesis Two, that "A group of patients who have negative perceptions of the nurse as helpful will show greater resistance to learning than a group of patients who have positive perceptions of nurses as helpful", was supported. The results indicate that patients' perceptions, whether positive or negative, affect the verbal responses of the patients. This is in agreement with Sapolsky's (1960) finding in a laboratory setting that the positive or the negative qualities of the interpersonal relationship between subjects and the experimenter have related effects upon the subjects' performance in a verbal conditioning situation.

Sapolsky further mentions that in a therapy setting both positive and negative transference relationships between patients and therapist can also affect the outcome of the psychotherapeutic procedure. This finding is also supported in the present study in the category designated "Exploring". That is, Group A patients attempted to explore

their personal life problems early in the first session while Group B patients expressed their resistance to learning. Moreover, over all sessions Group A tended to explore their personal life problems while Group B tended to explore the teaching material.

This finding can be explained by postulating that "positive" patients, i.e. those who believe that nurses can help them (Group A) will be more cooperative and open than "negative" patients who do not hold such beliefs (Group B). In addition, the negative patients will not take the risk of "opening up", and will avoid this task and focus on the teaching material instead. On the other hand, patients in Group B had higher scores than Group A on the CBT questionnaire and this might explain the difference in self-exploration. Synder (1945) described the difference in "exploring of self" by patients in terms of "successful" and "unsuccessful" cases. He found in his study that the topics of discussion by successful cases changed during the treatment, with problems discussed at the beginning of the treatment and insights and plans discussed at the end. This change was not observed in unsuccessful cases. Thus, in terms of the CBT scores in the present study Group B would be classified as successful. However, this would not be the case for the content analysis scores where the pattern of behaviour of both groups changed over sessions but there was not a consistent change in direction.

This lack of consistency may be due to deficiencies in the teaching programme and/or the form of presentation used by the nurse-teacher. Although each session of the teaching programme had its specific aims for stimulating the patients, analysis of the results showed that these objectives were not met. Rather than varying the teaching patterns of each session as planned, the nurse adopted a similar pattern for all sessions which was high on information presentation and stimulation to learn, but low on stimulation to explore, gain insights and formulate plans. She was also anxious about the time limits of the session and tended to cut off the patients while they were engaged in self-exploration. The resultant domination of the patients' verbal behaviour by superficial self-exploration may be related to the lack of encouragement given by the nurse to engage in self-exploration in depth. Truax and Carkhuff (1967) and Truax (1968; 1966a; 1966c) note that the therapist characteristic of warmth and understanding lead to greater self-exploration by patients and thereby

enhance positive outcome.

The actual objectives for the teaching programme were to stimulate the patients to increase self-exploration during the first three sessions while increasingly stimulating the patients to gain insights and formulate plans through to the end of the last session. However, the patients' verbal behaviour did not reflect these intentions. This failure to meet the objectives may be explained by the inadequate training given to the nurse-teacher and emphasises the need to clearly define the specific objectives of the programme. An important modification to the teaching programme should be to increase time for the patients to express themselves and work out their problems.

Another weakness of the teaching programme was the failure to develop "groupishness", that is, group cohesiveness, which Berne (1976) believes is itself curative. Rose (1977) reported that lack of group cohesiveness resulted in dull meetings and poor attendance by the members.

Group A in particular developed very little group cohesiveness, with each patient tending to work with the nurse-teacher rather than the group working as a unit. Consequently, the nurse had to work hard encouraging each individual patient to work with her instead of getting the group to encourage its members to work with each other.

While group cohesiveness was greater for Group B, it developed slowly and inadequately, again the result of failure of the nurse-teacher to perform group teaching. However, perhaps this group cohesiveness, although slight, is what made the difference between the improvement in coping behaviour seen in Group B but not in Group A.

Hypothesis Three

Hypothesis Three stated that, "there will be a significant difference between the before and after measure of 'actual behaviour' for both the positive and negative groups of patients". This was supported in part, for Group B (negative group) significantly increased its scores on the CBT questionnaire after the teaching programme. However, the Group A scores did not change.

Rosenthal and Frank (1956) stated that if the patients were known not to be positive placebo reactors, then demonstrated improvement would constitute evidence of efficacy specific to the form of psychotherapy. This implies then that the teaching programme is more likely

to benefit patients in Group B than in Group A and this is supported by the CBT scores.

It is difficult to show improvement in coping behaviour from the content analysis alone. The verbal behaviour of patients in Group B showed a significant difference from that in Group A only in the category of "resistance to learning" and "gaining insight". Sapolsky (1960) found that for resistive or negativistic patients an evaluation of the effectiveness of the programme may not be possible at the time therapy is taking place. It may be that for such patients, the influence experienced during treatment will be expressed only after termination of the therapy. Thus, the CBT questionnaire may be more reliable than content analysis in measuring changes in the coping behaviour of patients in Group B.

Hypothesis Four

Hypothesis Four, "A group of patients who have positive perceptions of nurses as helpful will improve their coping behaviour more than a group of patients who have negative perceptions of nurses as helpful", was not supported. Firstly, the positive group had much lower scores on the CBT questionnaire before the teaching programme, and in a short teaching programme, patients with low scores can not be expected to improve rapidly. Secondly, the evaluation period may be too short to reliably assess changes in the patients behaviour particularly where changes are likely to be slight. And thirdly, Group A patients were more dependent upon the nurse than those of Group B so they may need a longer period of encouragement to learn. Thus, even though the nurse showed greater attempts at stimulating Group A to gain insights, it still showed less improvement than Group B.

The teaching programme in its present form may not be suitable for patients who have very low coping ability and a high dependency upon the nurse-teacher and these may have to be set as selection criteria. Also, the teaching programme may have to be extended and be made more flexible. Hays (1953) suggests that the nurse leader should change her approach in the group to suit patient readiness rather than adhering to a prearranged time schedule. To do this the nurse must be trained to recognize the patients' needs and state of readiness, and be able to respond appropriately.

Hypothesis Five

Hypothesis Five, that "The patients of both positive and negative groups will see nurses as more helpful after the teaching program", was not fully confirmed. Group A viewed nurses as less helpful after the teaching programme, however, Group B did view nurses as more helpful after the program significantly more than at the start.

The findings can be explained in the following way. Sloane *et al.* (1975) found that patients who showed greater improvement tended to see better therapeutic qualities in their therapists than those who improved less. This can be explained in terms of a "conflict of expectations" which Douglas (1976) defines as "when a member attends a group because he believes that it will meet certain of his felt needs and then becomes aware that such is not the case". In the present study the positive group (Group A) entered the group with expectations that the nurse would help them solve their problems, and they developed strong passive dependent needs upon the nurse. Kounin *et al.* (1956) used the term "halo effect" to describe this situation and they found that subjects with strong passive dependency needs were more likely to be disappointed in the relationship with the therapist after exposure to an interview. Furthermore, Polansky and Kounin (1956) found that establishment of an appropriate nurse-patient relationship was an essential condition for psychotherapy.

Thus, the members of Group A may have been disappointed with the nurse when they found that she was not as helpful as they had expected her to be. On the other hand, Group B was initially at an 'unsure' stage and with little effort the nurse could change their perceptions of her in a positive way. Thus it would seem that the present teaching programme is more suitable for teaching patients with negative perceptions of nurses as helpful. On the other hand, the nurse-teacher's perceptions of the nurse play an important part, and an experienced nurse must be able to modify her teaching appropriately once she has analysed the MPN tests and is aware of the patients' perceptions of nurses. In particular, the nurse would need to be trained in the skills of using the group to help the patients explore their problems, thus avoiding cutting off the patients, which has detrimental effects on the learning, especially for patients with high expectations of help from the nurse.

Patients' and Non-Patients' Responses on the MPN Test

The results of the MPN test showed no significant differences between patients and non-patients for any of the three categories. However, TAT type tests are generally effective in assessing differences between groups with different past experiences. For example Lakin (1953) developed a TAT test to study the attitudes and feelings of mothers of colicky infants in terms of role relationship situations. He found very significant differences between the TAT stories of the control group and the experimental group. Similarly, Psathas (1968) used a Role Projective Test (RPT) consisting of ten photographs depicting a number of hospital situations to explore student nurses' perceptions and attitudes in relation to specific nursing roles and hospital situations. He found that first year students expressed a degree of idealism and optimism which was not found among seniors. Thus in the present study, where no significant differences between the groups were found, it is possible that both groups of subjects have had similar past experiences with nurses in general. For example, the non-patients or their relations may have been hospitalized in the past, thus providing contact with nurses, and providing them with perceptions of nurses similar to those of the patients.

Even so, the patients grouped on the basis of their positive (Group A) or negative (Group B) perceptions of nurses as helpful tended to respond to the nurse in the first session in a way consistent with the rest of the group. For Group A, the patients seemed to show their dependency on the nurse, while Group B showed independence and displayed high resistive behaviour. Consequently, the patients' resistive behaviour affected the nurse's verbal responses and the nurse tended to display a high degree of discouraging behaviour towards Group B.

Thus, the MPN test appears to have been an effective tool for the selection of patients for the present teaching programme.

Responses to the CBT Questionnaire

The results of the group B patients on the CBT questionnaire after the teaching showed lower scores for the Preferred Behaviour than the Actual Behaviour, which is unexpected. However, this can be explained by the results of a single Group B patient (Mrs. C) who showed very low "Preferred Behaviour" scores which biased the Group B total.

This patient's behaviour may be explained as showing a high resistance to change. That is, she might feel that she had learned something from the teaching programme, but it was probably too soon for her to accept that she could change her behaviour. Thus, her preference was to cope less well than she actually was coping, and this preference was expressed in her low "Preferred" scores and her high "Actual" scores.

CHAPTER 7

COMMENT ON RESULTS

This study was undertaken to test the central hypotheses that psychiatric patients could learn to improve their coping behaviour and that patients who believed that nurses were helpful would improve their coping behaviour more than patients who did not. A method of selecting patients (MPN test), a behavioural test and a structured teaching programme were developed and tested.

The grouped results show that the patients' perception of nurses did not correlate positively with their coping behaviour but did correlate with some of their verbal responses to the nurse in the group. That is, patients who did not see nurses as helpful (Group B) made a large number of statements in the category "resistance to learning", even though they improved their coping behaviour scores on the CBT questionnaire.

On the other hand, patients who viewed nurses as "helpful" (Group A) made fewer statements in the category "resistance to learning" and showed no improvement in their coping behaviour.

An examination of the development of both groups, the case studies of each patient's behaviour, and the content analysis showed that the nurse tended to be content rather than process oriented in her teaching. That is, she tended to give information and control discussion rather than encouraging members of the group to explore their own feelings.

These findings indicate some weakness in this study. Firstly, the reliability of the instrument measuring the patients' coping behaviour (CBT questionnaire) has not been established. This instrument needs to be tested with a number of subjects and the results correlated with observed behaviour of these subjects in stressful life situations.

Secondly, there are inadequacies in the teaching programme. Some of these may be inevitable in a real life change situation, but other problems could be overcome. These include the rigidity of the sessions, the short duration of the programme and the inadequate training of the nurse-teacher.

The intention of introducing a different topic during each of the six one hour sessions imposed an undesirable rigidity which hindered the development of the groups. The patients often had a need to discuss their personal problems with the group, but were not able to do so due to the time limits on the session. Thus the nurse had to cut patients off to enable her to cover the content of the session. Consequently, the patients had little chance to share and discuss their problems with the group and so could not learn new ways of coping with their problems. The teaching programme should be more flexible in terms of content and allow time for the patients to discuss their problems. In this situation, the programme should have an unspecified number of sessions to serve the patients' needs and should terminate when the therapist considered the patients were ready. Six sessions spread over eight days may not have been sufficient to produce the changes predicted by the author.

The nurse-teacher in the present study was a trained general nurse with some teaching experience but very little experience with psychiatric patients. She did cover the teaching material designated in the programme, but she was unsuccessful in dealing with the psychiatric problems of the patients. This was probably due to her lack of experience in psychiatric nursing (for further detail see "Analysis of Groups" and "Case Study"). The nurse's lack of understanding of the patients' needs led her to avoid exploring these areas and she rarely encouraged the patients to work as a group, dealing with them individually.

These problems could have been reduced or eliminated by a well designed training programme for the nurse-teacher in which the aims of each session were clearly defined. Also the nurse should have been trained to gauge the progress of the patients' from their behaviour and been taught the appropriate responses for encouraging the patients to take further steps. In fact, some training was given in the pilot study, but this was obviously not extensive enough to enable this nurse to adapt adequately in a new field of nursing.

Implications for Nursing

Training of Nurses to Use Teaching Skills in the Clinical Situation

To improve the skills of the nurse in a group teaching situation, the training programme for the psychiatric nurse-teacher should include:

1. Information about stress and coping behaviour. This would help develop the nurse's confidence and expertise in diagnosing the patients' particular psychiatric problems and needs.

2. Training in the skills of group teaching in a psychiatric situation. This is necessary to ensure that the needs of each patient in the teaching group are recognized and dealt with appropriately. Furthermore, it is essential that the nurse suppresses the expression of her own needs and negative emotions so that these do not interfere with her attempts to satisfy patients' needs (Heller *et al.*, 1966).

Group teaching skills can be developed in the following way:

(i) The group of nurse-teachers should observe a group teaching session run by an experienced leader. After the session, the nurses' observations and perceptions of the patients' needs, and the appropriate nurse responses are discussed with the group leader.

(ii) Each nurse is given the opportunity to run a group while observed by the experienced leader and the rest of the nurses and the session is discussed afterwards. It is also advantageous for the session to be taped, so that the nurse-patient and patient-patient interaction can be analysed in detail. This enables the nurse to plan appropriate behaviours to use with the patients in the next session.

(iii) The development of methods for teaching psychiatric patients in a structured teaching programme should be encouraged as an essential part of psychiatric nursing. This method of teaching, used in the present study, is also appropriate for other concepts, such as frustration, aggression and depression. Also, concept teaching can be practiced in other kinds of nursing situations where the programme can be well integrated with other activities such as socializing experiences and therapy in a one-to-one relationship. The emphasis should be on meeting patients' needs as they arise.

Prevention Programme

The findings of stress and coping behaviour research suggest that the development of a psychiatric illness can be prevented before a breakdown occurs. This kind of nursing intervention can be done in a community mental health clinic. That is, a nurse would help people who have difficulties in coping with their stressful life events to learn appropriate ways for dealing with their stressful life events. In this situation, the nurse would also act as a resource of help for these people.

Conclusion

Despite the problems in this study, it is possible to conclude that the MPN test was successfully used to select patients with similar perceptions of nurses as helpful. That is supported by the results of content analysis where each patient in the same group responded to the nurse similarly. Also, each group with different perceptions of the nurse as helpful responded to the nurse differently.

Although, the value of the present study is limited, the findings indicate possible developments which may lead to more meaningful actions by psychiatric nurses. In particular this study does show that there is a relationship between patient behaviour and nursing action.

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Appendix A

CONTENT ANALYSIS

Definitions of content analysis have tended to change over time with developments in techniques. Berelson (1952) initially defined content analysis as:

"A research technique for the objective, systematic and quantitative description of the manifest content of communication."

The use of the term "manifest" is intended to limit content analysis to the semantic and syntactic aspects of communication (Marsden, 1965).

In contrast, Berelson, Budd, Thrope and Donnew (1967) suggest that inference should be included in the technique. They define content analysis as:

"A systematic technique for analysing message content and message handling...the analyst is concerned not with the message per se, but with the larger questions of the process and effects of communication."

However, the current standard definition according to Carney (1971) is:

"Content analysis is any technique for making inferences by objectively and systematically identifying specified characteristics of messages."

(Holsti, 1968).

The differences of the standard definition from Berelson's are first, that the standard definition emphasizes the making of inferences as the major purpose of the content analysis. Secondly, it aims to assess specified characteristics of the message. Thus, "the quantitative description of the manifest content" of Berelson has been deleted.

The levels of Content Analysis

A distinction is made in content analysis between that done at the "manifest level" and that done at the "latent level" (Fox, 1970).

"Manifest level" refers to content analysis of what the respondent said with nothing assumed or interpreted. Thus content analysis at the manifest level can be accomplished with a high reliability. The validity of the content analysis at this level

may be low because the meanings in the manifest content may not be the same as the meanings actually understood by the different coders or intended by the communicator.

In contrast, to determine "latent level", the researcher attempts to analyse the meaning of the response. In content analysis at this level it is difficult to achieve a high reliability. According to this view, categories used have to be clear and easily distinguished and coders have to be knowledgeable in the area being studied. This leads to a high validity. In order to achieve high reliability and validity, the present study investigated the patients and the nurse's verbal content at the manifest and latent levels.

Models of Content Analysis

Classical Model

The classical model was developed by Berelson (1952). It is aimed at achieving objective and systematic results, that is, to obtain high reliability in the study. This is done through the analysis of the manifest content.

The psychological studies conducted within the classical model can be placed into four groups on the basis of the following attributes:

1. Characteristics of patients (Auld and Murray, 1955; Braaten, 1961; Kiesler, Mathieu and Klein, 1964; Murray, 1956). All these studies determined the patient characteristics in one-to-one interview situations.
2. Characteristics of therapists (Bandura, Lipsher and Miller, 1960; Winder et al., 1962). The therapist's behaviour in response to patients' behaviour was investigated in these studies. Bandura et al. (1960) examined the therapist's reaction to the patients' hostility, and patients' responses to the therapist's reactions. Using a similar approach to Bandura, the present study examines the reactions of the nurse and the patients in terms of the stimuli and responses of the patients and nurse to each other.
3. Characteristics of patient-therapist interaction: Bales (1950) developed an interaction process technique to study patient-therapist interactions in problem-solving groups.
4. Investigation of internal psychodynamic states: The Discomfort-Relief Quotient (DRQ) is one technique used in this approach

and was introduced by Dollard and Mowrer (1947).

Pragmatic Model

The pragmatic model uses content analysis at the latent level.

Dollard and Auld (1959) developed a complex technique of content analysis. Their categories ranged across the areas of overt behaviour and symptoms and aspects of the therapeutic process. The essential focus was on the conscious or unconscious motive stage of the patient.

Sklansky et al. (1960), however, found the scores obtained from using a pragmatic model to be unreliable.

Nonquantitative Model

Unlike the two models above, the nonquantitative model lacks methodological homogeneity (Marsden, 1965). Studies in this area are attempts to develop alternative approaches for measuring the intensity of communication. In addition, these studies investigate factors that are significant indicators of intensity, and the situations in which they become important. Linguistic analysis is a highly developed nonquantitative technique.

Procedure in Content Analysis

The actual procedures involved in content analysis are unitizing, categorizing and performing reliability measures.

Unitizing

"Unit" is a statement or meaning phrase that is used in scoring system of content analysis. Units may be counted from the whole series of the interviews or group sessions; an utterance or sentence; a word. The important thing in counting units is the establishment of a set of rules or instruments for determining units which affect the reliability of unitizing.

Dollard and Auld's (1959) developed a set of instructions which showed agreement between two judges ranging from 83% to 91%. However, Murray's (1956) set of instructions showed a higher reliability, that is 88% to 94% with a phi coefficient of +0.96. Thus, Murray's set of instructions is used in the present study.

Categorizing

The success of content analysis depends upon the selection and definition of the categories (Berelson, 1952). That is, the categories

must set out clearly with criteria for the details of how the items are to be recognized (Carney, 1971). To develop appropriate categories, aspects of a particular theory concerning the problem being studied must first be selected.

To obtain a high reliability of categorizing, both coders and categories are of the same importance for the overall results of the study (Holsti, 1966).

Coder Reliability

Coder reliability can be tested by computing the percentage of agreement between any coder and the rest of the judges. Training is usually necessary to enable all coders to judge within the same frame of reference.

Category Reliability

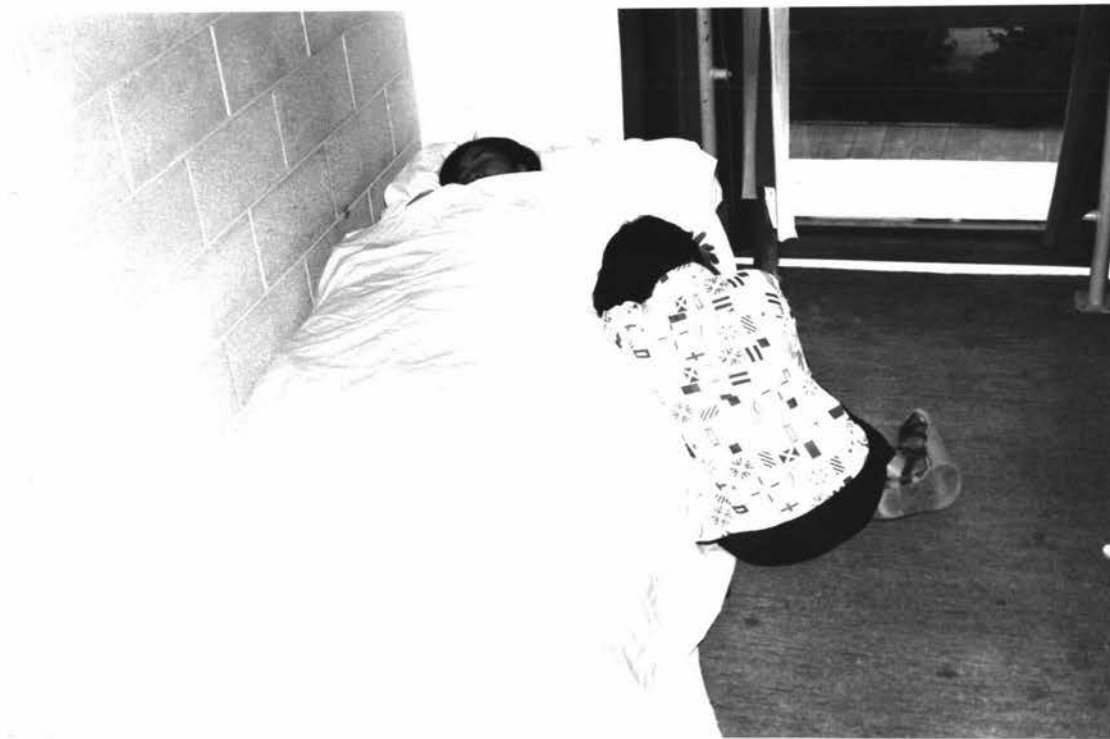
Holsti (1965) noted that:

"High reliability can be achieved for simple forms of content analysis. Conversely, as categories and units of analysis become more complex, they are likely to become both more useful and less reliable."

In actual fact, useful categories can have both simple forms and high reliability. It depends largely on questions being studied and competency of the analyst to use simple forms of categories which are still based on the theory chosen. Furthermore, complicated categories are likely to have less reliability and they are not necessarily useful if they are too complicated to use.

APPENDIX B

The MPN Test



Photograph 1



Photograph 2



Photograph 3



Photograph 4



Photograph 5



Photograph 6



Photograph 7



Photograph 8



Photograph 9



Photograph 10

Appendix CDESCRIPTION OF THE MPN CATEGORIES

Category 1: Ability to communicate

6 marks

The subject - tells story appropriately by using some past experiences in the description.

- expresses feelings or mentions feelings.

4 marks

The subject - tells the story appropriately but without any past experiences involved

- tells what is going on in the photograph without any feelings expressed.

2 marks

The subject - tells what some of the people in the photographs are doing but does not mention everyone in the photograph.

0 marks

The subject - mentions objects, buildings, etc.

- tells about one person and goes on to mention the objects in the photograph.
- cannot concentrate on the photograph (tells something about himself instead).

Category 2: Perceptions of nurses as helpful

The subject reports that the nurse in the photograph -

6 marks

- is talking to the patient.
- tries to help the patient.
- tries to encourage the patient.
- is concerned or worried about the patient.

4 marks

- may come to talk to the patient.
- may ask the patient to join in.
- is listening to the patient.

2 marks

- the nurse is engaged in another activity.
- just looks on, smiles.
- is busy.

0 marks

- does not want to help the patient.
- is annoyed with the patient.
- nurse is not mentioned.

Category 3: Seeking help from nurses

The subject reports that the patient in the photograph -

6 marks

- is talking to the nurse.
- is coming to see the nurse.
- is listening to the nurse.
- is asking for help from the nurse.

4 marks

- might come to see the nurse.
- might ask the nurse.
- is looking at the nurse.
- is thinking of coming to see the nurse.

2 marks

- is unsure whether to come to see the nurse.
- does not know what to do.

0 marks

- sits alone.
- does not want to do anything.

Appendix D

This exercise is designed to help you look at the way you deal with your problems.

After you have read each phrase write in the left hand column (Actual) the number which best describes how you feel. Then in the right hand column (Preferred) write the number which best describes the way you would like to be.

		Actual	Preferred
1.	Things never bother me	1 2 3 4 5 6 7	Things always bother me
2.	I know my problems	1 2 3 4 5 6 7	I don't know my problems
3.	I can cope with my problems	1 2 3 4 5 6 7	I cannot cope with my problems
4.	Others can help me solve my problems	1 2 3 4 5 6 7	Others cannot help me solve my problems
5.	I can understand my feelings	1 2 3 4 5 6 7	I cannot understand my feelings
6.	I know how to cope with my problems	1 2 3 4 5 6 7	I don't know how to cope with my problems
7.	I try to understand how other people feel	1 2 3 4 5 6 7	I never try to understand how other people feel
8.	When I fail to use one method to cope with my problems I always try another method	1 2 3 4 5 6 7	When I fail to use one method to cope with my problems I never try another

Appendix E

A TEACHING PROGRAMME
ON
"Learning to Cope"

INTRODUCTION

This programme has been developed to help clients who have failed to cope with their "life stresses", improve their coping behaviour. The programme does not presume to offer methods of coping with a specific problem, but it is rather a guideline for the nurse to enable the clients to explore and understand themselves and further, to help the clients learn new and appropriate ways of coping with their problems.

The material in the programme is based on concepts of coping and adaptation (Lehner & Kube, 1964; Coleman, 1969; Lazarus, 1969; Sawvey & Telford, 1974; Coelho, Hamburg & Adams, 1974).

This programme will be helpful to clients, only if the nurse is capable of encouraging them to participate and learn in a group situation.

Darunee Tangamonsiri
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.1978

Coping Behaviour Test

This exercise is designed to help you look at the way you deal with your problems.

After you have read each phrase write in the left hand column (Actual) the number which best describes how you feel. Then in the right hand column (Preferred) write the number which best describes the way you would like to be.

			Actual	Preferred
1. Things never bother me	1 2 3 4 5 6 7	Things always bother me		
2. I know my problems	1 2 3 4 5 6 7	I don't know my problems		
3. I can cope with my problems	1 2 3 4 5 6 7	I cannot cope with my problems		
4. Others can help me solve my problems	1 2 3 4 5 6 7	Others cannot help me solve my problems		
5. I can understand my feelings	1 2 3 4 5 6 7	I cannot understand my feelings		
6. I know how to cope with my problems	1 2 3 4 5 6 7	I don't know how to cope with my problems		
7. I try to understand how other people feel	1 2 3 4 5 6 7	I never try to understand how other people feel		
8. When I fail to use one method to cope with my problems I always try another method	1 2 3 4 5 6 7	When I fail to use one method to cope with my problems I never try another		

SESSION I

TOPIC: "Introduction to the concept of coping behavior"

AIMS:

1. To get to know each other
2. To introduce the concept of coping behavior.
3. To provide general information about the teaching programme.

THE PHASE OF INTRODUCTION:

The nurse introduces herself and asks the patients to introduce themselves.

The nurse informs the patients of the time, length, frequency and duration of the group meetings.

The tape recorder is explained and the patients are assured that the data will be used without identifying their names.

Aims of the teaching programme are given to the patients to enable them:

1. to get to know each other
2. to talk over some problems
3. to obtain some background knowledge about coping behaviour
4. to share and learn from the group means of coping with problems

SESSION DETAIL:

In learning to improve our ways of coping, we have to learn to:

1. explore our problems and our feelings towards our problems,
2. understand our problems and feelings,
3. act by utilizing the knowledge we have gained, from exploring ourselves and sharing our problems with the group.

The group will help us to work through these steps. The most important thing is to be open and willing to learn new ways of coping behaviour.

In general, when we face any problem we will try to cope with it as best we can. How well we can cope with it, depends on how we see our problems and how much it means to us, and our capacities for problem solving. Methods which each of us use to cope with our

problems are different, some may avoid the situation, some confront it, or some may use various kinds of self-defence activities. Our approach to solving problems is mostly influenced by our past experience. That is, how we have learned to cope in the past with previous problems. It is also believed that we can learn to cope effectively if we are taught to do so. When we are unable to use our former coping behaviour, we are in a crisis situation and we need new coping methods.

Once the problems are managed by effective methods, we learn new coping methods and strengthen our coping ability.

EXERCISE:

"How much I know about the concept of coping behaviour."

Do the exercise on your own and then share it with the group.

EXERCISE
INSTRUCTION

"How much I know about a concept of coping behaviour"
Read the following items and write "T" in front of
the items that you think they are true and write
"F" in front of the items that you think they are
false.

- _____ 1. People can learn how to cope effectively with
their problems.
- _____ 2. People who never go to see a psychiatrist are
not bother by anything.
- _____ 3. There are many ways that people can cope with
their problems.
- _____ 4. The effective way to cope with a stressful
situation is to change the situation.

SESSION II

TOPIC: "Stressful life events"

AIMS:

1. To understand what kind of situations can bother us
2. To explore our stressful life events.

SESSION DETAIL:

Stressful life events refer to any situation which disturbs our feelings and requires us to change in some way.

Many things happen to us; some are good (desirable), and others are bad (undesirable). On the other hand, we can look at these situations and "Losses and Gains". Losing and gaining may involve either loved objects or loved persons.

Gains refer to things that happen which involve introduction of a new person or new object into our life which require us to adjust to them, for example, marriage, birth of a child, a new job.

Losses refer to things that clearly involve departures from our usual life activities or any situation that takes away our loved person or loved object, for example, a death of a family member, divorce, unemployment.

These situations are out of our control. If we accept that there may be many obstacles which will interfere with our life, we can start thinking about how to cope with them instead of trying to control or change them. For example, a situation such as a death of loved one cannot be either controlled (stopped) or changed.

When a stressful life event happens to us we are wise to get to understand it, seek more information about it, explore its effects on us, and consider whether we can alter the situation. If not, we have to try to alter ourselves. In other words, we have to try to cope with it, or adjust ourselves to fit the situation.

Let us think of what has happened in our life or some people that we know, which has changed our or their usual ways of living. There are many things, for example having someone new in the house, being married, being pregnant, getting a divorce, the death of a loved one, illness, financial problems, a spouse having an extra-marital affair, losing a job and so on.

These situations, once they happen to us, we have to cope with. Sometimes our coping methods are effective, but at other times they

are not. This is because we are changing to some extent all of the time and every moment we continuously face some new tasks which we have never faced exactly the same way before. These situations make extra demands upon us for which our usual coping methods may not be used successfully. They are difficult to accept and cope with since they affect our feelings in many ways. However, we have to cope with them if we want to survive.

Many people face similar problems. Some people can cope, but some cannot and may become ill. This is because the same situation has different meanings to each of us.

Let us consider why we sometimes respond to a situation differently from other people. If we take a look at death of parents, to some people it may mean just a sad feeling of losing a loved one forever. But to others of us it may mean much more than sadness. We may feel lost, lonely, and guilty for not having done much for our parents when they were alive. It is difficult for us to deal with and may take years to get over, depending on how appropriate the ways we use to cope with the situation.

Whenever, we feel very disturbed, that is frustrated, anxious, or unhappy, we may ask ourselves: What is the thing that really keeps us feeling this way; and why does this thing affect our feelings?

EXERCISE:

"What is my stressful life event?"

INSTRUCTION:

Try to think of anything that has happened to you which hurt you and that you feel that you cannot forget.

Then ask yourself how you feel/felt about it, why, and what it meant to you.

Share it with the group after you have written it down.

EXERCISE

"What is my stressful life event.?"

SESSION III

- TOPIC: "Emotional responses to stressful life events"
- AIMS:
1. To understand affects of stressful life events on individuals
 2. To understand how we feel with our stressful life events

SESSION DETAILS:

Life would be very simple indeed if we could have everything we want, and succeed in every thing we do. But as we know, we live together and we have our needs, some of which are complicated; so we all experience losses, failure, illnesses, conflicts, pressures, lacks and delays. These are results of everyday problems and unusual problems. Most of the everyday life problems are easy to cope with. However, most of us may face difficult situations such as; a serious illness of ourselves or a loved one, a broken engagement, problems in marriage and so on. These problems make us very worried and severely strained. They require much effort to cope with and if we cannot cope effectively, the stress will continue and be more severe. We know these feelings as frustrations, conflicts and pressures.

Frustration

This is a feeling when we want something but we cannot get it or we want to do something but we cannot do it successfully. This may be because of:

1. Delays - we want to do something but we have to wait, e.g., we want to buy a house but we have to wait until we have enough money.
2. Lack of resources - many people are very frustrated when they cannot have what they want, e.g., a couple who are eager to have children but they find they are unable to do so.
3. Losses - loss of something we love always makes us feel deeply frustrated. For example, loss of: loved ones; financial independence; one's abilities. These are highly frustrating because losses often are beyond our control, and once they have occurred there is nothing we can do about them.

4. Failures - we have to remember that no athletic team is likely to win all of the time. Even when we do very well we may feel we have failed if we have not done as well as someone else. Any failure is frustrating but we have to learn very hard to accept it, and profit from it.

Guilt may be a result of a failure. Guilt is a feeling we get as a result of doing something we feel is wrong, or when we are not doing what we feel we should. This will be very frustrating if we cannot resolve it.

When we feel frustrated, it does not mean that we are unable to do anything good. Some people develop skills because they are frustrated in their failures. On the other hand, most people become aggressive or hostile in order to release their frustration. This is rather harmful to others and self and may lead to feelings of guilt.

Conflicts

Often our problems do not come from a single conflicting situation but from a conflict when we have to make a decision between several conflicting situations.

Conflicts can occur in three ways:

1. The approach - approach conflicts: We must resolve a conflict between two equally desirable goals - between two things that we want but we have to choose only one. Most people resolve this type of conflict by selecting one and ignoring the other.
2. The avoidance - avoidance conflicts: In this case we must make a choice between two equally undesirable goals. We do not want these two things but we have to choose one of them. Most people resolve this kind of conflict by leaving the conflict situation and taking another course of action.
3. The approach - avoidance conflicts: When we have to do something that we like and dislike at the same time. For example, we have to stay here in the hospital which we do not want to do because it takes us away from our family. On the other hand, we want to get better and we know that being here in the hospital we can get better. In this situation we have to get rid of one

aspect of the dual feeling by using whatever coping methods seem suitable for us.

When we have to make a choice in any of these three types of conflict we are frustrated. It is believed that how well we can solve our problems depends on how well we can handle frustration.

In fact, we are different in our flexibility for problem solving. Some people try to solve their problems by using only the method that has worked before and they become incapable of considering other possibilities.

We have to remember that, in trying to solve any problem, we have to be flexible, that is, to try different methods if one method does not work. This is because one method of dealing with problems may be effective in one situation at a certain time and not at another time.

EXERCISE:

"How do I feel when I am frustrated?"

Exercise (a): The following well-known problem illustrates problem solving flexibility. Try to do it and discuss with the group how you did it and whether you tried many methods to draw the lines or only tried starting from the same point every time.

Exercise (b): After you put the first words that come to your mind in the spaces, tell the group what you wrote down and how you felt about it.

Discuss effects of frustration on your ability to solve the problems (Exercise (a) and (b)).

SESSION III Emotional response to stressful life events

- Frustration, conflict, anxiety

EXERCISE How do I feel when I am frustrated?

a) NINE POINT TEST

. . .
. . .
. . .

INSTRUCTION Without lifting the pencil from the paper it is possible to draw four straight lines that will pass through all the nine dots. Try to think this out without drawing the lines - 3 minutes allowed.

b) To help you understand your reactions to a few frustrating situations, the following pictures are presented.

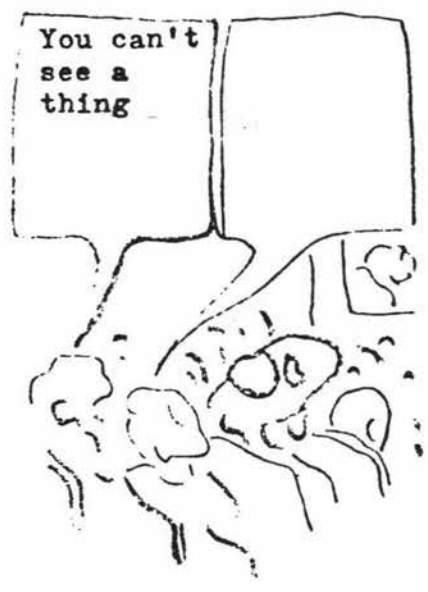
INSTRUCTION Write in the blank box the very first answer that comes to mind.

Share your answer with the group and tell them why you wrote it down as you did.



picture 2 Rosenzweig Picture Frustration Test (1948)

picture 3



SESSION IV

TOPIC: "How can we improve our ability to cope with problems?"

AIMS:

1. To learn some methods of improving our coping behaviour
2. To learn to understand others' behaviour and feelings in response to our behaviour

SESSION DETAILS:

All of us learn some methods for dealing with problems, but not all methods are appropriate or effective. If we want to improve our ability to cope with our problems we must do two things:

1. Increase our ability to delay frustrating situations without becoming disturbed. To do this we have to:

- 1.1 develop increased awareness of relationships between ourselves and the problem by analyzing what we are doing and effects of it;
- 1.2 develop flexibility in re-interpreting our problems;
- 1.3 develop flexibility in selecting various possible ways to cope with our problems. This may help us discover alternative ways in approaching our problems;
- 1.4 extend the amount of time allowed for solving problems.

2. Improve our ways of interacting with others. We have to learn how we interact with others, and also why we interact as we do. To do so we have to increase our:

- 2.1 self-awareness - we can increase our self-awareness by learning to see how we usually relate to others and our environment. In addition, we should become aware of our strong points so that we can utilize them to better advantage, and we should discover our weak points which always lead to failure of interacting with others.
- 2.2 other-awareness - we cannot relate to others successfully if we are aware only of our own needs and ways of doing things. It is important to be aware of others' needs also. This can be done by training ourselves to notice, remember

and anticipate how others will react. We may then try to modify our own behaviour to fit the behaviour of others in order to achieve a mutual feeling of satisfaction.

Being aware of others' needs will also help us to know when they need our support, our interest and our companionship. If we are aware of their needs as well as ours, our relationships with them will be greatly achieved.

2.3 problem - awareness - we have to examine our problems realistically and from several points of view.

EXERCISE: "How much do I know about how I deal with my problems?"

This exercise will help you reconsider how you deal with things that bother you, your feelings toward your behaviour, and your feelings towards other peoples' behaviour.

SESSION IV Learn to improve our coping behaviour

EXERCISE "How much I know about how I deal with my problems"

Things that always bother me	My feelings towards these things	My first reaction	My feelings afterwards
My second reaction		My feeling afterwards	

-2-

People who always bother me	My feelings towards these people	Their feelings towards me

My responses towards them	Their responses towards me

SESSION V

TOPIC: "How do we cope with our problems?"

AIMS:

1. To learn how other people handle their problems
2. To look at the ways we handle our problems

SESSION DETAILS:

As we said before there are many ways that we can use to cope with our problems. These can be grouped together in four different ways:

1. Facing and solving the problem

After we understand what our problem is we will try to solve it. If we cannot solve it we will look for something else that may serve as an appropriate alternative. For example, if we lose our loved child, we become very sad. Time might help to heal the wound, but we can do better than that by adopting a child if we cannot manage to have another one ourselves.

This method of coping is considered realistic for solving a problem. In some situations that frighten us or make us angry, we cannot cope well with the problem, so we have to try to be calm or suppress our disturbed feelings. Then we will find it easier to think about how we can solve our problem.

Sometimes, when we cannot solve our problem realistically, it may be because we lack skill or knowledge about our problem. Therefore, we have to learn more about it before we try to solve it. Groups of people can be useful because they enable us to share our feelings and learn other coping methods.

2. Running away from the problem

We try to forget about the problem for a while when we find it too difficult to face our problem. Some people may spend more time in knitting, sewing, gardening, sleeping and so on.

We have to remember that running away from our problem may be the best method of coping with our problem at a certain time. But we should not use it often or for a prolonged period of time because it does not solve the real problem.

However, some of us may be able to leave a difficult situation permanently and redirect our effort to a new activity.

3. Inaction

When the situation is too much for us we may feel hopeless and become unable to do anything.

4. Defense mechanisms

We are not always aware of our problems, or react realistically. Sometimes, we may find ourselves doing something in an attempt to escape from the reality which we feel we cannot tolerate any longer. Such defense mechanisms are:

- 4.1 Day Dreaming - we just spend our time in a dream world in which we can manipulate things as we like. But in fact, day dreaming does not help to solve the problem.
- 4.2 Rationalization - it is the way we fool ourselves when we try to give some reasons for our failure - the "sour grapes reaction" and the "sweet lemon reaction". When we feel frustrated in our failure we try to cope with our frustration by giving good reasons which distort the facts.
- 4.3 Compensation - if we know that we are inadequate in one area we may try to satisfy ourselves in another area. This can be seen in a physically handicapped person who develops his intellectual capacities.

We have to remember that defense mechanisms are harmful to use if we make any of them a way of life because we will lose our flexibility in coping with our problems.

However, we may use any of them at a certain time when we feel overwhelmed and we cannot cope with our problem realistically anymore. Defense mechanisms can keep our anxiety down but for only a short period.

EXERCISE:

"How do we cope with some stressful life events?"

This exercise will benefit the group if the group share and discuss each of the problems.

SESSION V Coping with stressful life events

- EXERCISE - Imagine that the following situations happen to you
- Write down what you think you would do in these situations

YOU LOSE YOUR JOB.....

.....

YOU HAVE SOMEONE YOU DON'T LIKE LIVING WITH YOU.....

.....

SOMEONE YOU LOVE IS DEAD.....

.....

HUSBAND/WIFE IS UNFAITHFUL.....

.....

YOU HAVE A FINANCIAL PROBLEM.....

.....

SESSION VI

TOPIC: "Effective and Ineffective coping methods"

AIMS:

1. To learn what kind of coping methods are called effective
2. To examine our coping methods in terms of effectiveness and ineffectiveness

SESSION DETAILS:

Everybody faces a problem or problems; some people can cope effectively, but some cannot. When we say effective coping method, we refer to a method which is used appropriately in terms of the problem. There is no specific method which is effective to use in every situation. Thus we have to choose a method to fit with our specific problem rather than to stick to one method.

Effective coping methods have to fulfill the following functions:

1. They must be able to reduce disturbed emotions. This would seem to be the most important aim of a coping behaviour. Some coping methods, such as using tranquilizers, or being involved in other activities, may reduce stress to a tolerable limit but only temporarily. If we use any of them we have to use some other method at the same time.

2. They have to meet the demand of the problem situation as well as our own needs. Often, we have to do something just to please our parents or spouse, but it is not what we want to do. Such an action is likely to create inner conflicts for us. Furthermore, what we do must not be harmful to others.

When a difficult situation happens to us, most of the time we cannot solve it immediately. This is because our disturbed feelings reduce our coping ability by decreasing our ability to think clearly. To cope with one problem we may have to use many methods to cope effectively with it.

For example, people usually go through five steps in coping with their grief situation. Let us look at an example of a man whose wife has a cancer and she is very ill. When he first finds out that his wife has a cancer he denies the fact. He keeps saying that "It can't be true, the doctor must have made a wrong diagnosis!". After a while his wife is not better and he starts to be angry and says "Why has my wife got such an illness?". This stage of anger is a very

disturbed stage. Then he starts to make a bargain. Most bargains are made with God and are usually kept a secret. This stage is quite helpful but it does not last long. If the wife is still very ill, he will become depressed and guilt may accompany the depression. If he is given some help at this stage he may reach the final stage where he is able to accept his wife's illness. In this final stage he is neither depressed nor angry about his "fate".

If we are in this kind of situation we have to try to understand our behaviour and try to accept the fact. Whenever we can accept the fact then we can plan our actions to cope with the problem realistically.

We have to remember that whatever happens in our life which we cannot change as we want; we have to learn to cope with it and live with it. The more flexible we are, the better adjusted, more appropriate is our behaviour, and the better prepared we are to meet our demands of life.

At the time that we feel we cannot cope with our problem any longer, let us think of someone that can help us. Perhaps, others can see how to cope with the problem more clearly than we do.

EXERCISE:

"My coping behaviour."

This exercise will help you look at the ways you used to cope with your problems. Analyse your coping behaviour in terms of being effective or ineffective by using the knowledge you have learned from the teaching programme. If you think your coping behaviour is ineffective, write down the coping behaviour which you think will be effective. Then share with the group.

Session VI

What is "good coping behaviour"

Exercise

"My coping Behaviour"

'My coping Behaviour'

My stressful life events	My feeling towards them	My coping behaviour		Reason	Well adjusted person's coping behaviour	Reason
		Good	Bad			

Coping Behaviour Test

This exercise is designed to help you look at the way you deal with your problems.

After you have read each phrase write in the left hand column (Actual) the number which best describes how you feel. Then in the right hand column (Preferred) write the number which best describes the way you would like to be.

		Actual	Preferred
1. Things never bother me	1 2 3 4 5 6 7		
2. I know my problems	1 2 3 4 5 6 7		
3. I can cope with my problems	1 2 3 4 5 6 7		
4. Others can help me solve my problems	1 2 3 4 5 6 7		
5. I can understand my feelings	1 2 3 4 5 6 7		
6. I know how to cope with my problems	1 2 3 4 5 6 7		
7. I try to understand how other people feel	1 2 3 4 5 6 7		
8. When I fail to use one method to cope with my problems I always try another method	1 2 3 4 5 6 7		

EVALUATION OF THE TEACHING PROGRAMME

"What do you think of it?"

Appendix FINSTRUCTIONS FOR SCORING PATIENT AND NURSE UNIT*

1. SIMPLE SENTENCES: The simple sentence is the basic unit of scoring. The sentence contains a subject and predicate usually a verb and an object. Adverbs and adjectives may be present. The simple sentence is a simple English form with one major thought.

EXAMPLE: a) I'm afraid of losing my mind.
b) But I couldn't stand it.

2. INCOMPLETE SENTENCES: A statement may not be complete in itself and yet not be part of the previous sentence or following statement.

EXAMPLE: a) Very exciting over there.
b) Parked in the driveway.

3. SLIGHTLY COMPLEX SENTENCES:

EXAMPLE: a) I lied to you last week, last Tuesday.
b) God! I can't believe it.

4. RELATIONAL SENTENCES: These are sentences containing two parts which are related in some way such as showing cause and effect.

EXAMPLE: a) I just had to tell you that I lied because I'm not honorable at all.

The commonest words used in these sentences are: because, since, if, then, so, inspite of, therefore, when, before, after, etc.

5. CONJUNCTIVAL SENTENCES:

EXAMPLE: a) She was always nagging and shouting at me.

The conjunction may combine two sentences complete or nearly complete in themselves. There may be separate ideas or the same idea repeated. These sentences are scored as two or more units. However, a verb and a subject must be present in each section of the sentence to be scored as a separate unit.

EXAMPLE: a) I didn't know what you'd think / or what you'd say / or how you'd feel about it.

SENTENCES RELATED TO THE THERAPIST'S REMARKS: Although unit may be interrupted by the therapist but finished afterwards. The stroke is put at the end of the continuation.

EXAMPLE: Patient: .../They took her car as a getaway.../

Therapist: Oh, I see. MmmHm.

Patient: ...car./

Sometimes the patient will finish a sentence for the therapist. In this case the whole idea is scored as a patient unit.

EXAMPLE: Therapist: ...for something which just...

Patient: happened./

QUESTIONS AND QUOTES: All questions are scored as a unit if they are tacked on the end of a sentence.

EXAMPLE: a) Because its gone on too long./ Hasn't it?/

b) And I said "I don't know"./

c) And I said "I don't know/. I just have a guilt feeling."/

*Adapted from Murray, 1956

Appendix GCATEGORIES FOR PATIENTS

Category 1: PASSIVE LEARNING

Agreeing
Approving
Accepting

Category 2: ACTIVE LEARNING

Asking for general information
Asking/ clarifying the teaching material
Asking for help
Asking for support
Asking for reassurance
Sharing exercise
Reviewing the teaching content
Giving information

Category 3: EXPLORING FEELINGS/EXPERIENCES

Exploring own feelings
Sharing life experiences
Relating own experiences to another's
Relating own experiences to the concept teaching
Getting involved in others' problems

Category 4: GAINING INSIGHT

Confirming
Analysis of own problems or behaviour
Showing insight in the concept teaching or
life problems
Giving related examples

Category 5: PLANNING FOR ACTIONS (FUTURE PLANS)

Making a plan for future action
Discussing a plan for future action

Category 6: RESISTANCE TO LEARNING

Avoiding
Rejecting
Disapproving
Defending
Using denial
Challenging
Testing
Introducing unrelated topic
Disagreeing
Showing hostility
Refusing to respond
Giving wrong answers

Other UNSCORABLE

Appendix HCATEGORIES FOR THE NURSE

Category 1: ORIENTATING/INTRODUCING

 Giving general information
 Presenting knowledge
 Explaining general view
 Giving an example

Category 2: STIMULATING TO LEARN

 Approving
 Accepting
 Agreeing
 Demanding
 Summarizing
 Reviewing the concept teaching
 Giving support or help
 Offering general leads
 Giving reassurance
 Encouraging to participate
 Giving broad openings
 Offering help/self

Category 3: STIMULATING TO EXPLORE

 Sharing own experiences/or feelings
 Attempting to explore patients' feelings
 Comparing patients' experience to the concept
 teaching
 Comparing a patient's experience to another's

Category 4: STIMULATING TO GAIN INSIGHT

 Reflecting
 Restating
 Focusing

Category 5: STIMULATING TO FORMULATE PLANS

Encouraging formulation of a plan of action

Giving suggestions/advice in planning

Category 6: DISCOURAGING LEARNING

Disapproving

Rejecting

Agreeing

Defending

Testing

Challenging

Introducing unrelated topic

Belittling feelings expressed

Cut off

Sustaining unrelated topic from a patient

Other

UNSCORABLE

Appendix It-tests OF THE MPN TEST SCORES OF PATIENTS AND NON-PATIENTS

Key for Appendix I:

P1-10	photographs	1-10	in Category 1
P11-20	"	1-10	in Category 2
P21-30	"	1-10	in Category 3

Group 1 = Patients

Group 2 = Non-patients

VARIABLE	NUMBER OF CASES	MEAN	STANDARD DEVIATION	STANDARD ERROR	* POOLED VARIANCE ESTIMATE *					* SEPARATE VARIANCE ESTIMATE *				
					F VALUE	2-TAIL PROB.	T VALUE	DEGREES OF FREEDOM	2-TAIL PROB.	T VALUE	DEGREES OF FREEDOM	2-TAIL PROB.		
P1														
GROUP 1	19	4.9474	1.810	0.415										
GROUP 2	10	5.2000	1.033	0.327	3.07	0.091	-0.41	27	0.688	-0.48	26.71	0.636		
P2														
GROUP 1	19	4.9474	1.393	0.320										
GROUP 2	10	5.6000	0.843	0.267	2.73	0.127	-1.35	27	0.188	-1.57	26.30	0.129		
P3														
GROUP 1	19	5.1579	1.537	0.353										
GROUP 2	10	5.4000	0.966	0.306	2.53	0.157	-0.45	27	0.655	-0.52	25.94	0.608		
P4														
GROUP 1	19	4.9474	1.393	0.320										
GROUP 2	10	4.8000	1.687	0.533	1.47	0.468	0.25	27	0.803	0.24	15.62	0.816		
P5														
GROUP 1	19	4.5263	1.611	0.370										
GROUP 2	10	5.0000	1.944	0.615	1.45	0.475	-0.70	27	0.489	-0.66	15.66	0.518		
P6														
GROUP 1	19	4.3158	2.335	0.536										
GROUP 2	10	3.8000	2.394	0.757	1.05	0.880	0.56	27	0.580	0.56	18.01	0.585		
P7														
GROUP 1	19	3.7895	2.097	0.481										
GROUP 2	10	3.8000	1.476	0.467	2.02	0.281	-0.01	27	0.989	-0.02	24.47	0.988		
P8														
GROUP 1	19	4.2105	1.751	0.402										
GROUP 2	10	5.0000	1.414	0.447	1.53	0.520	-1.23	27	0.230	-1.31	22.16	0.203		
P9														
GROUP 1	19	4.4211	2.063	0.473										
GROUP 2	10	4.0000	2.494	0.789	1.46	0.470	0.49	27	0.631	0.46	15.64	0.653		
P10														
GROUP 1	19	4.3158	1.916	0.440										
GROUP 2	10	4.6000	1.897	0.600	1.02	1.000	-0.38	27	0.706	-0.38	18.58	0.707		

VARIABLE	NUMBER OF CASES	MEAN	STANDARD DEVIATION	STANDARD ERROR	* POOLED VARIANCE ESTIMATE *						* SEPARATE VARIANCE ESTIMATE *				
					F VALUE	2-TAIL PROB.	T VALUE	DEGREES OF FREEDOM	2-TAIL PROB.	T VALUE	DEGREES OF FREEDOM	2-TAIL PROB.			
P11	GROUP 1	19	1.0526	2.248	0.516	*	*	*	*	*	*	*	*	*	*
	GROUP 2	10	0.0000	0.000	0.000	*	*	*	*	*	*	*	*	*	*
						0.00	1.000	1.47	27	0.154	2.04	18.00	0.056		
P12	GROUP 1	19	5.0526	2.248	0.516	*	*	*	*	*	*	*	*	*	*
	GROUP 2	10	4.4000	2.633	0.833	*	*	*	*	*	*	*	*	*	*
						1.37	0.541	0.70	27	0.489	0.67	16.05	0.515		
P13	GROUP 1	19	3.4737	2.195	0.504	*	*	*	*	*	*	*	*	*	*
	GROUP 2	10	4.4000	2.066	0.653	*	*	*	*	*	*	*	*	*	*
						1.13	0.887	-1.10	27	0.280	-1.12	19.44	0.275		
P14	GROUP 1	19	2.8421	2.243	0.514	*	*	*	*	*	*	*	*	*	*
	GROUP 2	10	1.6000	2.271	0.718	*	*	*	*	*	*	*	*	*	*
						1.03	0.915	1.41	27	0.169	1.41	18.21	0.177		
P15	GROUP 1	19	3.1579	2.609	0.599	*	*	*	*	*	*	*	*	*	*
	GROUP 2	10	3.2000	2.860	0.904	*	*	*	*	*	*	*	*	*	*
						1.20	0.704	-0.04	27	0.968	-0.04	16.98	0.969		
P16	GROUP 1	19	1.1579	2.243	0.514	*	*	*	*	*	*	*	*	*	*
	GROUP 2	10	1.6000	2.633	0.833	*	*	*	*	*	*	*	*	*	*
						1.38	0.535	-0.48	27	0.638	-0.45	16.02	0.658		
P17	GROUP 1	19	1.5789	2.063	0.473	*	*	*	*	*	*	*	*	*	*
	GROUP 2	10	0.8000	1.398	0.442	*	*	*	*	*	*	*	*	*	*
						2.18	0.234	1.07	27	0.295	1.20	25.02	0.240		
P18	GROUP 1	19	4.2105	2.740	0.629	*	*	*	*	*	*	*	*	*	*
	GROUP 2	10	4.0000	2.828	0.894	*	*	*	*	*	*	*	*	*	*
						1.07	0.863	0.19	27	0.847	0.19	17.90	0.849		
P19	GROUP 1	19	0.8421	1.385	0.318	*	*	*	*	*	*	*	*	*	*
	GROUP 2	10	1.0000	1.944	0.615	*	*	*	*	*	*	*	*	*	*
						1.97	0.211	-0.25	27	0.802	-0.23	13.95	0.823		
P20	GROUP 1	19	0.3158	0.749	0.172	*	*	*	*	*	*	*	*	*	*
	GROUP 2	10	2.8000	3.011	0.952	*	*	*	*	*	*	*	*	*	*
						16.15	0.000	-3.45	27	0.002	-2.57	9.59	0.028		

VARIABLE	NUMBER OF CASES	MEAN	STANDARD DEVIATION	STANDARD ERROR	POOLED VARIANCE ESTIMATE						SEPARATE VARIANCE ESTIMATE			
					F VALUE	2-TAIL PROB.	T VALUE	DEGREES OF FREEDOM	2-TAIL PROB.	T VALUE	DEGREES OF FREEDOM	2-TAIL PROB.		
P21	GROUP 1	19	0.0000	0.000										
	GROUP 2	10	0.0000	0.000	0.00	1.000	0.00	27	1.000	0.00	0.00	0.500		
P22	GROUP 1	19	1.0526	2.147	0.492									
	GROUP 2	10	0.6000	1.350	0.427	2.53	0.157	0.60	27	0.551	0.69	25.93	0.494	
P23	GROUP 1	19	0.3150	1.003	0.230									
	GROUP 2	10	0.6000	1.350	0.427	1.81	0.270	-0.64	27	0.525	-0.59	14.38	0.567	
P24	GROUP 1	19	2.8421	3.078	0.706									
	GROUP 2	10	0.4000	1.265	0.400	5.92	0.011	2.39	27	0.024	3.01	26.04	0.006	
P25	GROUP 1	19	4.4211	2.545	0.584									
	GROUP 2	10	4.8000	2.530	0.800	1.01	1.000	-0.38	27	0.706	-0.38	18.52	0.706	
P26	GROUP 1	19	2.5263	3.044	0.698									
	GROUP 2	10	4.6000	2.503	0.792	1.48	0.558	-1.85	27	0.076	-1.96	21.84	0.062	
P27	GROUP 1	19	3.4737	2.816	0.646									
	GROUP 2	10	4.2000	2.201	0.696	1.64	0.454	-0.71	27	0.485	-0.76	22.75	0.452	
P28	GROUP 1	19	1.8947	2.865	0.657									
	GROUP 2	10	3.2000	2.860	0.904	1.00	1.000	-1.17	27	0.254	-1.17	16.45	0.256	
P29	GROUP 1	19	1.7895	2.097	0.481									
	GROUP 2	10	3.2000	2.348	0.742	1.25	0.651	-1.65	27	0.110	-1.59	16.68	0.129	
P30	GROUP 1	19	0.0000	0.000	0.000									
	GROUP 2	10	1.0000	2.160	0.683	0.00	1.000	-2.05	27	0.050	-1.46	9.00	0.177	

Appendix J

t-tests OF THE CONTENT ANALYSIS RESULTS OF GROUP A AND
GROUP B PATIENTS (for each category during each session)

Key for Appendix J:

c1-6	=	Categories 1 - 6	in session one
c7-12	=	" " " "	two
c13-18	=	" " " "	three
c19-24	=	" " " "	four
c25-30	=	" " " "	five
c31-36	=	" " " "	six

Group 1 = Group B

Group 2 = Group A

VARIABLE	NUMBER OF CASES	MEAN	STANDARD DEVIATION	STANDARD ERROR	* POOLED VARIANCE ESTIMATE *					* SEPARATE VARIANCE ESTIMATE *				
					F VALUE	2-TAIL PROB.	T VALUE	DEGREES OF FREEDOM	2-TAIL PROB.	T VALUE	DEGREES OF FREEDOM	2-TAIL PROB.		
C1	GROUP 1	5	2.8000	2.387	1.068	1.08	0.945	-0.40	8	0.696	-0.40	7.99	0.696	
	GROUP 2	5	3.4000	2.302	1.030									
C2	GROUP 1	5	14.4000	11.238	5.026	5.31	0.138	0.88	8	0.407	0.88	5.46	0.421	
	GROUP 2	5	9.6000	4.879	2.182									
C3	GROUP 1	5	3.4000	3.209	1.435	2.18	0.467	-1.41	8	0.197	-1.41	7.03	0.203	
	GROUP 2	5	7.0000	4.743	2.121									
C4	GROUP 1	5	1.8000	2.683	1.200	9.00	0.061	1.11	8	0.301	1.11	4.88	0.319	
	GROUP 2	5	0.4000	0.894	0.400									
C5	GROUP 1	5	0.0000	0.000	0.000	0.00	1.000	0.00	8	1.000	0.00	0.00	0.500	
	GROUP 2	5	0.0000	0.000	0.000									
C6	GROUP 1	5	16.0000	19.912	8.905	396.50	0.001	1.68	8	0.131	1.68	4.02	0.168	
	GROUP 2	5	1.0000	1.000	0.447									
C7	GROUP 1	5	0.0000	0.000	0.000	0.00	1.000	0.00	8	1.000	0.00	0.00	0.500	
	GROUP 2	5	0.0000	0.000	0.000									
C8	GROUP 1	5	12.0000	16.432	7.348	1.23	0.847	-1.62	8	0.145	-1.62	7.92	0.145	
	GROUP 2	5	28.0000	14.832	6.633									
C9	GROUP 1	5	35.6000	36.281	16.225	8.09	0.072	1.27	8	0.241	1.27	4.97	0.261	
	GROUP 2	5	13.8000	12.755	5.704									
C10	GROUP 1	5	18.0000	17.889	8.000	4.53	0.175	-1.70	8	0.127	-1.70	5.68	0.140	
	GROUP 2	5	50.0000	38.079	17.029									
C11	GROUP 1	5	2.0000	4.472	2.000	10.00	0.051	-1.21	8	0.262	-1.21	4.79	0.282	
	GROUP 2	5	10.0000	14.142	6.325									
C12	GROUP 1	5	0.2000	0.447	0.200	96.00	0.002	-1.02	8	0.340	-1.02	4.08	0.367	
	GROUP 2	5	2.2000	4.382	1.960									

VARIABLE	NUMBER OF CASES	MEAN	STANDARD DEVIATION	STANDARD ERROR	F VALUE	2-TAIL PROB.	POOLED VARIANCE ESTIMATE			SEPARATE VARIANCE ESTIMATE		
							T VALUE	DEGREES OF FREEDOM	2-TAIL PROB.	T VALUE	DEGREES OF FREEDOM	2-TAIL PROB.
C13	GROUP 1	5	6.0000	8.944	4.000	0.210	0.89	8	0.397	0.89	5.88	0.0406
	GROUP 2	5	2.0000	4.472	2.000							
C14	GROUP 1	5	3.4000	1.517	0.678		3.83	8	0.223	-0.13	8	0.897
	GROUP 2	5	3.6000	2.966	1.327					-0.13	5.96	0.898
C15	GROUP 1	5	13.8000	9.783	4.375		1.78	8	0.588	0.37	8	0.724
	GROUP 2	5	11.8000	7.328	3.277					0.37	7.41	0.725
C16	GROUP 1	5	8.0000	6.205	2.775		3.29	8	0.276	1.64	8	0.139
	GROUP 2	5	2.8000	3.421	1.530					1.64	6.23	0.0152
C17	GROUP 1	5	0.8000	0.837	0.374		1.00	8	1.000	0.00	8.00	1.000
	GROUP 2	5	0.8000	0.837	0.374					0.00	8.00	1.000
C18	GROUP 1	5	0.0000	0.000	0.000		0.00	8	1.000	0.00	8.00	1.000
	GROUP 2	5	0.0000	0.000	0.000					0.00	8.00	1.000
C19	GROUP 1	5	15.2000	22.264	9.957		291.59	8	0.001	1.30	8	0.229
	GROUP 2	5	2.2000	1.304	0.583					1.30	4.03	0.0202
C20	GROUP 1	5	0.4000	0.548	0.245		0.00	8	1.000	1.63	8	0.141
	GROUP 2	5	0.0000	0.000	0.000					1.63	4.00	0.178
C21	GROUP 1	5	36.4000	15.469	6.918		7.13	8	0.088	-0.91	8	0.388
	GROUP 2	5	54.4000	41.307	18.473					-0.91	5.10	0.403
C22	GROUP 1	5	38.8000	18.240	8.157		1.06	8	0.958	1.88	8	0.097
	GROUP 2	5	17.4000	17.743	7.935					1.88	7.99	0.007
C23	GROUP 1	5	38.0000	31.145	13.928		1.14	8	0.901	-0.63	8	0.547
	GROUP 2	5	50.0000	29.155	13.038					-0.63	7.97	0.547
C24	GROUP 1	5	0.0000	0.000	0.000		0.00	8	1.000	-1.63	8	0.141
	GROUP 2	5	4.0000	5.477	2.449					-1.63	4.00	0.178

VARIABLE	NUMBER OF CASES	MEAN	STANDARD DEVIATION	STANDARD ERROR	* POOLED VARIANCE ESTIMATE *			* SEPARATE VARIANCE ESTIMATE *				
					F VALUE	2-TAIL PROB.	T VALUE	DEGREES OF FREEDOM	2-TAIL PROB.	T VALUE	DEGREES OF FREEDOM	2-TAIL PROB.
C25	GROUP 1	5	1.0000	1.732	126.67	0.002	-1.49	8	0.176	-1.49	4.06	0.1212
	GROUP 2	5	14.0000	8.718								
C26	GROUP 1	5	24.0000	32.863	36.00	0.008	1.21	8	0.262	1.21	4.22	0.294
	GROUP 2	5	6.0000	5.477								
C27	GROUP 1	5	5.2000	4.550	1.43	0.737	-0.30	8	0.771	-0.30	7.76	0.771
	GROUP 2	5	6.0000	3.808								
C28	GROUP 1	5	11.8000	7.294	2.34	0.429	1.28	8	0.235	1.28	6.89	0.240
	GROUP 2	5	6.8000	4.764								
C29	GROUP 1	5	9.2000	4.919	1.56	0.677	0.28	8	0.783	0.28	7.64	0.783
	GROUP 2	5	8.2000	6.140								
C30	GROUP 1	5	0.2000	0.447	0.00	1.000	1.00	8	0.347	1.00	4.00	0.374
	GROUP 2	5	0.0000	0.000								
C31	GROUP 1	5	0.8000	1.304	0.00	1.000	1.37	8	0.207	1.37	4.00	0.242
	GROUP 2	5	0.0000	0.000								
C32	GROUP 1	5	10.8000	10.849	12.01	0.039	-1.43	8	0.192	-1.43	4.66	0.213
	GROUP 2	5	3.6000	3.130								
C33	GROUP 1	5	0.2000	0.447	0.00	1.000	1.00	8	0.347	1.00	4.00	0.374
	GROUP 2	5	0.0000	0.000								
C34	GROUP 1	5	34.4000	16.920	3.91	0.216	-1.57	8	0.154	-1.57	5.92	0.167
	GROUP 2	5	60.8000	33.477								
C35	GROUP 1	5	42.6000	16.349	1.55	0.681	1.71	8	0.125	1.71	7.65	0.125
	GROUP 2	5	22.6000	20.342								
C36	GROUP 1	5	42.0000	30.332	1.00	1.000	-0.52	8	0.616	-0.52	8.00	0.616
	GROUP 2	5	52.0000	30.332								

Appendix K

t-tests OF THE CONTENT ANALYSIS RESULTS OF GROUP A AND GROUP B
PATIENTS (for each category for combined sessions)

Key for Appendix K:

G6 = Categories 1-6

Group 1 = Group A

Group 2 = Group B

VARIABLE	NUMBER OF CASES	MEAN	STANDARD DEVIATION	STANDARD ERROR	F VALUE	2-TAIL PROB.	* POOLED VARIANCE ESTIMATE *			* SEPARATE VARIANCE ESTIMATE *			
							T VALUE	DEGREES OF FREEDOM	2-TAIL PROB.	T VALUE	DEGREES OF FREEDOM	2-TAIL PROB.	
C1	GROUP 1	6	22.6667	7.146	2.917								
	GROUP 2	6	21.3333	11.308	4.616	2.50	0.336	0.24	10	0.812	0.24	8.44	0.813
C2	GROUP 1	6	37.6667	19.232	7.851	1.21	0.839	-1.00	10	0.341	-1.00	9.91	0.341
	GROUP 2	6	49.3333	21.153	8.636								
C3	GROUP 1	6	59.3333	38.381	15.669	1.75	0.554	-0.30	10	0.774	-0.30	9.31	0.775
	GROUP 2	6	67.0000	50.742	20.716								
C4	GROUP 1	6	2.6667	1.751	0.715	10.10	0.027	-0.91	10	0.384	-0.91	5.98	0.398
	GROUP 2	6	4.8333	5.565	2.272								
C5	GROUP 1	6	1.3333	2.805	1.145	2.95	0.260	0.50	10	0.626	0.50	8.04	0.628
	GROUP 2	6	0.6667	1.633	0.667								
C6	GROUP 1	6	14.1667	11.957	4.881	7.15	0.053	-3.69	10	0.004	-3.69	6.37	0.010
	GROUP 2	6	65.6667	31.979	13.055								

Appendix Lt-tests OF THE CONTENT ANALYSIS RESULTS OF THE NURSE IN
GROUP A AND GROUP B

Key for Appendix L:

c1-6 = Categories 1 - 6

Group 1 = Group A

Group 2 = Group B

VARIABLE	NUMBER OF CASES	MEAN	STANDARD DEVIATION	STANDARD ERROR	* POOLED VARIANCE ESTIMATE * SEPARATE VARIANCE ESTIMATE									
					F VALUE	2-TAIL PROB.	T VALUE	DEGREES OF FREEDOM	2-TAIL PROB.	T VALUE	DEGREES OF FREEDOM	2-TAIL PROB.		
C1	GROUP 1	6	103.0000	34.246	13.981									
	GROUP 2	6	84.8333	33.600	13.717	1.04	0.968	0.93	10	0.376	0.93	10.00	0.376	
C2	GROUP 1	6	118.5000	27.682	11.301									
	GROUP 2	6	115.8333	40.902	16.698	2.18	0.411	0.13	10	0.897	0.13	8.79	0.898	
C3	GROUP 1	6	50.1667	28.625	11.686									
	GROUP 2	6	26.0000	15.192	6.202	3.55	0.192	1.68	10	0.125	1.68	7.61	0.132	
C4	GROUP 1	6	20.8333	11.071	4.520									
	GROUP 2	6	9.1667	4.622	1.887	5.74	0.081	2.38	10	<u>0.038</u>	2.38	6.69	0.049	
C5	GROUP 1	6	7.0000	15.232	6.218									
	GROUP 2	6	1.3333	3.266	1.333	21.75	0.006	0.89	10	0.394	0.89	5.46	0.414	
C6	GROUP 1	6	15.6667	10.152	4.145									
	GROUP 2	6	24.3333	13.186	5.383	1.69	0.579	-1.28	10	0.231	-1.28	9.39	0.234	

Appendix MWHITAKER AND LIEBERMAN'S THEORY OF GROUP DEVELOPMENT⁽¹⁾

No matter how long the group goes on, the patients are recurrently confronted with the basic issues of how to manage anger constructively, and how to manage personal relationships. At this point, Kemp (1970) calls it a state of disequilibrium when the patients experience uneasiness and dissatisfaction, and at this point they are most likely to change. Consequently the patients find methods of expressing their feelings through the current material, that is, their experiences with one another and therapists, their outside experiences, and aspects of the past brought into the group situation. The predominant methods used to express their feelings of the group are regarded as the group characteristics (culture of the group), and these change during the group's life.

Whitaker and Lieberman (1977) divide the group development into two phases:

I. Formative Phase

When the group begins, its behaviour reveals the patients' expectations of the group, the nature of the group situation and the composition of the group.

These three factors involve the initial conflict of the group, which is expressed in different ways because of the individual differences of group members. How soon the initial focal conflict⁽²⁾ is developed depends on how these expressions of feeling touch the other group members, that is, they may or may not be picked up. The therapist's style also has an impact on the initial conflict of the group.

Early reactive motives, the shared fears which emerge in the group, are likely to include fears of criticism or ridicule from the

(1) Adapted from Whitaker and Lieberman, 1977, p. 116-137.

(2) Refers to a sequence of diverse events which occur in the group and can be conceptualized as a common, covert conflict which consist of an impulse or wish (the disturbing motive) opposed by an associated fear (the reactive motive).

other patients; fear of hurting other patients or the therapist; fear of punishment, retaliation or harm from the therapist; and fear of intolerable guilt and anxiety. Such fears emerge in conjunction with specific disturbing motives or wishes. These include wishes to reveal one's problems in the group; to please the therapist by talking about ones-self; to have an exclusive special relationship with the therapist; to be angry at the therapist for not providing help; and to form intimate relationships with others in the group.

When disturbing and reactive motives appear, solutions may develop in order to alleviate anxiety and maintain the group, for example, discuss competitive feelings, agree that everyone has little problems or get one person to admit that he has problems, then attack him.

The solutions which develop during the early sessions are likely to be restrictive⁽³⁾ rather than enabling⁽⁴⁾ in character. This is because although the tension is reduced, the disturbing motive remains unsatisfied and inaccessible to exploration. Nevertheless, the patients are sufficiently comfortable to commit themselves to the group.

The close of the formative phase is marked by the establishment of successful solutions which cope with initial anxieties about criticism, ridicule, punishment by the therapist and so forth. The patients build hope for therapeutic gain so that they feel some commitment to the group. Furthermore, there is some feeling that the group now is a group, for it becomes meaningful to the patients. The exact time marking the end of the formative phase is clear in some groups and vague in others. The therapy group studied by Whitaker and Lieberman usually reached this point between the eighth and twelfth session.

II. Established Phase

The second phase continues until the group terminates. In this phase, old themes may recur, sometimes leading to the utilization of previously successful solutions, sometimes to the modification of the old solutions. Modified solutions permit patients to express impulses,

(3) Are those in which wishes are largely suppressed to protect the group from fear.

(4) Are those in which wishes may be more nearly gratified without danger.

wishes, and fears in new and usually more direct terms. The trend is toward the enabling solutions, with fewer restrictive solutions.

As the group proceeds, concise description of the group's behaviour becomes more difficult to understand.

When the group has achieved stable solution to basic focal conflicts, it is regarded as a mature group where further development is unlikely or unnecessary. However, a therapy group is unlike a work group, which is not believed to reach the state of ultimate maturity. A therapy group continues to work on recurring basic issues until the patients feel that each individual has accomplished enough from the group so that the termination of the group is appropriate.