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HELPLESSNESS OR SELF CARE?

A Study of Nursing Practice with Depressed Patients
in an In-care Setting

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

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1982

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ABSTRACT

This study was conducted to investigate the practice of nurses when working with depressed patients in an in care setting. A survey of the literature shows that the role commonly prescribed for nurses who work in psychiatric settings is one that emphasises a one-to-one relationship based on models of psychotherapy and focusses on individual illness, pathology, symptoms and psychodynamics. It is suggested that this is not a role which most nurses working in New Zealand psychiatric settings would be able to implement in practice.

Three perspectives of nursing practice were explored in the study: what nurses were seen to do in practice; what they thought they should do as evidenced in results of an exercise to rank different possible interventions; and what patients said were helpful nursing interventions. A framework was developed for the study which depicts the process of helplessness (depression) as the negative 'mirror-image' of the process of self care. Results were analysed within this framework to determine whether or not nurses tended to support behaviours which were indicative of movement towards helplessness or encourage those which indicated progress towards self care.

Results suggest that nurses in this study sample did not encourage progress towards self care by their interventions. There was little evidence of positive reinforcement for independent or coping behaviours with patients in the study sample. Further, the nursing practice

showed little relationship to the role prescribed in the literature. The nurses did demonstrate a warm, caring, friendly approach that seemed to stem from a more traditional 'succouring' or 'mothering' view of the nurse's role.

ACKNOWLEDGEMENTS

My thanks are offered to a number of people who have contributed in many ways to the process of completing this thesis.

Cheryl Woolley, my supervisor in the beginning stages assisted in the refinement of ideas, as did Victor Souterik, the Senior Psychologist in the unit where the study was done. Julie Boddy, who took over the supervisor role for the major part of the process provided support and sound advice. Norma Chick particularly, but also other staff of the Nursing Studies Unit at Massey University helped tremendously with their interest and suggestions.

The staff and patients involved in the study clearly made my task possible but more than that, they made it pleasant. Bill Steven, the nursing supervisor, has my special thanks for the efforts he made to ensure the observation study and patient interviews were possible.

The contribution made by Jan Kay and Glennis Anderson, the two nurse observers, was sincerely appreciated.

Heather Norrish assisted with clerical work. Sue Seed and Kathy Stephen also have my thanks for their sterling work in typing drafts and the final presentation.

AUTHOR'S NOTE

Recently the issue of "sexist" treatments of populations has assumed major importance. The feeling is that stereotypes are developed and maintained by the way in which information is presented. However, since there is a large body of information relating to nursing practice where a traditional use of language sees patients as 'he' and nurses as 'she', to maintain continuity for the reader these terms are retained in this study. In this context, both terms should be read to include both sexes. It is hoped that readers will accept the spirit in which these terms are used.

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GLOSSARY

ALIENATION — "A sense of the basic fragility and contingency of human life; the impotence of reason confronted with the depths of existence; the threat of nothingness; and the solitary and unsheltered condition of the individual before this threat" (Barrett, 1962).

AVAILABILITY — The process of using a problem-solving approach in interaction to determine if a patient has a need for help and then attempting to meet that need.

Ministrative Availability: Response to patient signals indicating need for help with attempt to minister to this need. "Although the word 'ministering' has the connotation of physical presence, a nurse can still be ministratively available to a patient when she is not physically at his side. If a nurse lets a patient know when she gives him care and information how he can summon her again, that she is aware of his needs-for-help, and that she will return, she is being ministratively available to him" (Schmidt, 1972, 1087).

Receptive Availability: Sensitivity and receptivity to the patient and his needs.

"BARS" — Behaviourally Anchored Rating Scales:- A procedure for constructing a performance scale that has unambiguous anchors (Smith and Kendall, 1963; Schwab, Heneman and DeCotiis, 1975).

CONSISTENCY OF CARE — Identification and implementation of a specific approach to providing care when patients exhibit certain behaviours.

DEPRESSION — For this study, patients were taken to be depressed if they exhibited on admission to hospital at least four of the following eight symptoms indicative of a

depressive episode (Kalkman and Davis, 1980, 266).

1. Appetite disturbance with gain or loss of weight.
2. Sleep disturbance with either too much or too little sleep
3. Loss of energy with fatigue or tiredness
4. Psychomotor disturbance with either agitation or retardation
5. Loss of interest and/or pleasure in activities and a decrease in sex drive
6. Self reproach and/or guilt
7. Decreased concentration and reported inability to think or make decisions
8. Recurrent suicidal thoughts including wishes to be dead and/or suicidal behaviour.

HELPLESSNESS — A condition where the subject sees the power to change his environmental contingencies as being outside his own control (Seligman, 1975).

LEARNED HELPLESSNESS — A condition characterised by symptoms such as passivity; difficulty in learning that responses produce relief; lack of aggression; weight loss; appetite loss; social and sexual deficits. The learned aspect denotes a conditioned response where the perceived locus of control shifts from the self to outside the self.

NURSING CARE — In this study, nursing care refers to the behaviours exhibited during unstructured time in the clinical setting by nursing staff in interaction with depressed patients who are receiving in-care treatment.

REINFORCEMENT — The consequences governing behaviour. This may be positive, as in a rewarding sense, or negative, as in a punishing sense.

SECONDARY GAIN	The additional gratification or extra attention gained because of care given in relation to a primary problem.
SELF CARE	The practice of learned activities that individuals initiate and perform on their own behalf in maintaining life, health and well being (Orem, 1980, 28).
SICK ROLE	Acceptance of being sick and temporarily withdrawing from adult responsibilities to concentrate on the problem of getting well (Lederer, 1952).
UNSTRUCTURED TIME	That time outside of the weekday daily programmed sessions of individual, group, occupational, or recreational therapy which occur from 8.00 a.m. to 5.00 p.m. in the clinical setting used in this study.

Chapter 1

INTRODUCTION

The Practice of Psychiatric Nursing [1]

Like all disciplines working with psychiatric patients, nursing has been influenced by the psychological theories and techniques of the 1930's, 40's and '50's. Much of the psychiatric nursing literature released since the early 1950's has emphasised the therapeutic nurse-patient relationship as the focus of psychiatric nursing (Peplau, 1952; Matheney and Topalis, 1961; Brown and Fowler, 1967; Kyes and Hofling, 1974; Kalkman and Davis, 1980). This relationship was based on individual therapy models derived from psychological theories of human behaviour, and still takes precedence in writing on psychiatric nursing today. A survey of New Zealand literature on psychiatric nursing in this country (New Zealand Nursing Journals 1909-1981) indicates a similar emphasis.

A "Nurse-Therapist" Role? [1]

Such a focus has fostered the development of the 'nurse-therapist' role, encouraging psychiatric nurses to become skilled in counselling, psychotherapy and milieu therapy with individual patients or small groups of patients in the same time-limited interaction approach used by other disciplines such as psychology and psychiatry. The continued focus on the psychotherapy model by leading nurse writers has emphasised individual illness, pathology, symptoms or psychodynamics and caused less attention to be paid to nursing care for individual health, strength and coping abilities

[1] These 2 sections are heavily based on the work of Dr. P.R. Underwood in her dissertation (UCSF 1978) NURSING CARE AS A DETERMINANT IN THE DEVELOPMENT OF SELF CARE BEHAVIOR BY HOSPITALISED ADULT SCHIZOPHRENICS.

in day to day living. What happens in the 'therapy' session seems to be viewed as more important than what happens with the patient throughout the day, with the result that psychotherapy is thought to require more knowledge and skill than nursing (Marks et al, 1977) and nursing knowledge and care becomes less valued. Lego's (1973) article "Nurse Psychotherapist: How Are We Different?" clearly illustrates this problem. The emphasis on the one-to-one approach may have hindered the development of better approaches to care in what is still a common role for psychiatric nurses - that of being responsible for and accountable to all patients hospitalised in the ward or unit in which they practice for an 8 hour shift. Nurses are the only professional group offering care in a hospital setting which covers 24 hours a day, 7 days a week.

Discrepancies between Prescribed Role and Nursing Practice

Johnson and Martin (1958, 373) defined the nurse's role in terms of instrumental and expressive functions: "We call actions which are directly related to moving the system toward its goal instrumental, and actions which are related to maintaining motivational equilibrium in the individuals composing the group expressive." They suggest that being expressive may be the specialised function of the nurse. This interpretation of the nurse's role implies that nursing practice would assist the patient to be receptive to treatments prescribed by others, and facilitate a ward environment conducive to optimal functioning of patients and staff. The view has merit when considering the reality of work situations for many psychiatric nurses in this country where statistics quoted by the Minister of Health indicate that there is a high proportion of untrained staff and

relatively few qualified nurses working with high density patient populations (Christchurch Star, 3 July 1981, see Appendix 1, p. 153).

Cormack (1976, 87-9), in comparing the observed practice and prescribed role of the psychiatric nurse found that "the observed nurses were not carrying out a role which was equivalent or even similar to that which was prescribed by many of the contributors to contemporary nursing literature." Further, he suggested that the ideology existing in the wards used in the study did not encourage the nurse to perform or be able to perform the prescribed psychotherapeutic role. Expectations in terms of constant availability and organisation of work prevented the prolonged individual patient contact such a role necessitates. However, he notes that "... while the contribution of the observed nurses did not conform to the very narrow definition of therapy as defined in much of the literature, it was clear that many patients saw the nurse as a positive contributor towards their achievement of mental health. ... The striking resemblance between what the patients perceived the nurse being, and what Rogers (1965) suggested as being the necessary conditions which must exist in order that client-centred psychotherapy be successful, is worthy of comment." Cormack suggests that psychiatric nurses were providing a form of unsystematic and unrecognised therapy, valuable in its genuineness, vitality and spontaneity within the context of daily living. He expresses concern that such nursing practice may continue to go unrecognised and the contribution of nurses continue to be undervalued.

A Multidimensional Role for the Psychiatric Nurse - The Reality?

The W.H.O. seminar (1957, 36) on the nurse in the psychiatric team, while recognising the importance of 'interpersonal skills' of the nurse concluded that the functions of the psychiatric nurse: " ... may conveniently be divided into technical, interpersonal and social skills, though in practice there is constant interpenetration of all these aspects of her work." In brief, technical skills were seen to include functions directly concerned with the physical care of the patient; interpersonal skills as those pertaining to the relationship between the nurse and her patient in their day to day contact with each other; and social skills as pertaining to group, rather than individual management - for example the maintenance of morale amongst patients and the creation of a democratic and co-operative social climate.

Articulating the "Nursing Dimensions of Practice"

Orem (1980, 14) notes the problem of how to look at people from a nursing perspective will not be resolved until nurses are able and willing to ask and answer the question - "when and why can people be helped through nursing as distinguished from other forms of health care?" She further states "The interest in nursing theories exhibited by nurses in the late 1970's is one indication that they may be approaching that stage of development where many more of them will become able to take an objective nursing approach toward the practice of nursing. For too long nurses have been unable to make the *nursing dimensions* of their practice explicit, ... More nurses have been able to perform discrete nursing tasks than to 'think

nursing' within particular situations of practice. Nurses will become able to make explicit the nursing dimensions of their practice as they conceptualise more and more fully the proper object of nursing in social groups and use their concepts in the practice of nursing".

The Problem in Context

Nursing care of depressed patients in hospital is a major component of the in-care professional service since nurses comprise the only professional group who have contact with patients over the whole day. Although there is a wealth of literature on theories of depression, treatment modes, and suggested nursing care, there is less literature involving clinical studies with in-patient populations. Most clinical studies seem to involve therapy on an outpatient basis or a one-to-one treatment approach and they do not relate specifically to nursing practice.

Aims of the Study

This study seeks to explore and describe the nursing dimensions of practice with patients who are depressed and receiving care as in-patients in a hospital setting. A further aim is to generate concepts and hypotheses which may contribute both to nursing knowledge in this area and to building nursing theory.

Structure of the Report

The discrepancy between the role prescribed for the psychiatric nurse in current literature and the practice of psychiatric nursing

as it commonly occurs in hospital settings has been introduced as the context for the present study. Nursing practice with depressed patients requiring in-care treatment has been identified as the focus for the study and the aims of this briefly outlined.

Since nursing exists for the benefit of people, or patients as we often label them, their opinions and views of the nursing contribution to care are explored. Chapter 2 reviews relevant literature in this area, including the importance of patient opinion in a 'consumer's era'; patients' views about what nurses offer in psychiatric settings; discussion of the 'professional' versus the 'people' approach; and the relevance of patient opinion as reported in the literature to nursing practice with depressed patients.

Current theories and therapies relevant to depression are discussed in Chapter 3, with an overview being given of four major perspectives: biological; psychoanalytic; social; and behavioural. Some implications for nursing practice are raised. Chapter 4 presents contemporary perspectives in nursing care of depressed patients, outlining the major concepts found in the literature and detailing those which are particularly relevant to this study. The separate processes leading to self care on the one hand and helplessness on the other are detailed in Chapter 5. Concepts common to both are then incorporated into a new model which provides the framework for later analysis of data.

Background information related to the study undertaken is presented in Chapter 6, and the methodology is described in Chapter 7 where the major research question identified is "DOES THE NURSING CARE OF DEPRESSED PATIENTS IN AN IN-CARE SETTING TEND TO SUPPORT BEHAVIOURS INDICATIVE OF PROGRESS TOWARDS HELPLESSNESS OR ENCOURAGE THOSE WHICH INDICATE PROGRESS TOWARDS SELF-CARE?" The chapter provides details of the setting, the sample and the procedure for gathering data from observations of nursing practice; from patient interviews, and for carrying out a scaling exercise to determine what nurses thought were effective and ineffective nursing interventions.

Results and discussion are presented in Chapter 8. Three separate sections reflect three views of nursing practice: what nurses were observed to do; what they thought should be done; and what patients said nurses did. Finally, chapter 9 presents conclusions drawn from the study and suggests implications for nursing education and for clinical practice. Areas which appear profitable for further research related to nursing practice with depressed patients are also outlined.

Chapter 2

PATIENTS' PERSPECTIVES OF THEIR CARE

Patients have opinions about the nursing care they receive in hospital and many of these are voiced to family, friends, fellow patients and, probably less frequently, to staff. The chances of the patient elaborating his opinions to care to nurses attending to his needs, as Marram (1973a, 322) notes, are extremely poor. It is implied by Marram that nurses do not provide opportunities for patients to verbalise these opinions, and she states that opportunities for patients to put comments in writing are infrequent. Mentioned also, is "a strong professional conviction that those who administer the service to the client are in a better position to judge what is good for the client than he is himself." This is in sharp contrast to an ideology of nursing which suggests that the nurse is, or should be, greatly influenced by the evaluations of patients and their families. Marram (1973a, 322) suggests such an ideology may be "just a pious professional cliché."

Is the Patient's Opinion Important?

A study was conducted by Marram (1973a) to determine, amongst other issues, the importance of patients' evaluations to nurses. It was found that nurses did say a patient's opinion of his care was important to them, but also that they perceived patients as having little power and influence in the hospital situation and this was as

it should be. Questions then raised were "Will nurses really allow their behaviour to be modified by what patients think, even though they give lip service to the importance of patients' evaluations? Do nurses just say they care about what the patient thinks, because this is part of their professional mystique or ideology? Or, taking the opposite stand, why should nurses be influenced by patients' evaluations at all?" No definitive answers are available here, but one might infer that the nurses in Marram's study do not see patients' opinions as having much worthwhile to contribute to nursing care - that nurses do not see themselves as accountable to patients for nursing care given.

The Consumer's Era?

Currently there is a growing awareness of the rights of consumers which has extended into the health services arena. The patient opinion survey conducted at Wellington Hospital in New Zealand in 1974 (N.Z. Dept. of Health, 1977) was one of the first of its kind in this country where there was no established tradition of consumer research in health services. In contrast to the implications of Marram's study it was nurses at this hospital who decided to seek an expression of patient opinion about nursing care in the hospital with the objective of gathering information which could be used in planning for improved patient care.

Hospital - An unknown Situation

Brown (1963) has noted that staff often take it for granted that patients think and feel much as they do about many matters, and

that this is an error with unfortunate consequences. They forget that they are not only accustomed to the hospital and have the knowledge requisite for predicting the probable outcome of disease, but also that they are well, fully occupied, often young, and generally interested in what they are doing. Brown suggests that these factors are such important determinants of staff attitudes and reactions that many experience difficulty in looking at situations from the point of view of patients and families whose orientation and experience are very different. As the Wellington survey (N.Z. Dept. of Health, 1977) indicates, many people want more information than they are given - they want to know what is happening to them and why. Anne Clark (1976) in her booklet Hospital Shock outlines some of the frustrations experienced by patients in a general hospital in New Zealand where even social norms are not necessarily those that apply in everyday life, and pleads for improved communications between patients and staff.

What Do Patients Consider Nurses Offer in Psychiatric Settings?

Nurses in in-care psychiatric settings usually work an eight hour shift and have continuous contact with psychiatric patients who are receiving in-patient care. A small study conducted by Sweeney (1978) was designed to provide information concerning psychiatric patients' perceptions of their individual treatment programme in an in-patient treatment facility with an established therapeutic milieu which incorporated a variety of treatment techniques. Most patients considered talking with nurses the most helpful treatment component, which supports the importance of the nurses's role in the provision

of treatment and care for psychiatric patients. This raises the issue that the availability of nursing staff is a primary factor in considering what nurses have to offer. To what extent such availability is used has not been well documented, and it seems an area which requires further study if optimal use is to be made of this feature of nursing.

Worth (1969), a psychiatric nurse who wrote from her own experience as a psychiatric patient, reflected upon the qualities in the nurse to which the patient responds. Tolerance and patience are seen as most important. "The nurse who possesses warmth, sensitivity, and an attitude of respect for others and who is able to communicate these characteristics really reaches the patient." A variety of nursing approaches which helped patients feel they were being treated as individuals have been identified by Connolly (1960) who interviewed patients after surgery. Desires for acceptance without judgements or false reassurances, for acceptance of the culture from which they came and for orientation by the nurse to allay anxiety about "floundering" were indicated. These points are relevant for nursing in any setting.

Zaslove (1966) found that patients rated psychiatric nursing care as "most helpful" as often as they rated individual psychotherapy as "most helpful." Patients' opinions were gathered just prior to their discharge when they were still actively engaged in daily contact with nursing staff. An interesting facet of this study is that, unlike the patients, nurses were less likely to rate nursing care as the most important aspect of the patient's hospital care,

and psychiatric resident physicians virtually never rated nursing care as the most helpful aspect of hospitalisation. A relevant question here is whether nurses recognise how important their care is to the patient.

As Chastko et al (1971) note, "There has been a gradual shift in in-patient psychiatric care from custodial to treatment-oriented approaches. The role of psychiatric nursing in particular has continued to develop and change, but there has been little systematic research in assessing the contribution of the psychiatric nurse to the hospitalised patient." They conducted a study which obtained former patients' views of their hospital stay after a period of time had elapsed, as they felt with greater distance from their hospital experience views might have changed as they saw their care in the context of other events in their life. Measures of perceived helpfulness of nurses were used and the relationships of these perceptions to measures of hospital and post-hospital outcomes explored. It was concluded that "the psychiatric nurse's role as therapeutic agent was highly valued by most patients; her helpfulness was conceived in different ways by different patients with supportiveness, availability, confrontation, and insight most commonly mentioned."

It is relevant to note that this study was carried out in the United State of America. However, Cormack (1976) presents a similar picture with results from a questionnaire and interview study involving 96 patients in a British psychiatric hospital and, in the absence of any contradictory data published in this country, it

seems reasonable to suggest a New Zealand view would not differ markedly. Cormack found that the personal and human qualities of the nurse were regarded as being highly important. Patients remarked that they were treated as people, not patients, by the nurses. Other positive comments offered included encouragement given by nurses who engendered a feeling of optimism in the patients; constant availability; willingness of the nurse to offer help; and creation of an atmosphere that made patients feel a positive attempt was being made to help them.

Professional Approach or People Approach - Is there a Difference?

A further aspect relevant to patient opinion and nursing care is that raised by Bellaby (in Shoenberg, Ed., 1972), who in 1972 was conducting a research project in a psychiatric hospital with a therapeutic community ideology. Data were gathered from relatively unstructured interviews asking patients, among other things, to whom they found it helpful to talk. She says, "The data have not been systematically analysed, but a fascinating sociometric pattern is emerging in the material so far. Certain staff are chosen by patients as having been helpful much more frequently than others and are described not just in enthusiastic terms as popular people, but are spoken about with long accounts of how they were therapeutic and what it was about them that was helpful. When the interviews of these staff are compared with the others, the interesting thing is that they conceive their work differently. Those quoted as being particularly helpful approach their work as people, while those not chosen answer more in terms of professional

roles. They speak as nurses, or social workers, not themselves."

One could speculate on the relationship between perceived professionalism and power retained by the patient. Therapeutic communication may be difficult to achieve when the nurse is perceived as dominant in the interaction with the patient in a dependent position (Argyle, 1975). Such a relationship seems incongruent with acceptance of the patient as a person with his own rights and feelings. Without any need to denigrate professionalism, it may be that for truly therapeutic communication to ensue, it is necessary for the professional to present a more integrated personal-professional approach. This would seem to require that the professional is at ease with herself as a person and able to respond as such while using professional skills. As Purtilo (1978, 147) notes, "If one views professionalism solely in a way that opposes it to a more casual or relaxed mode of interaction, the health professional is forced to assume two personalities - now being professional, now personal .... If such a dichotomy really exists, the health professional must commit herself or himself not only to playing two roles but also to becoming two wholly different selves. There must be a better way to demonstrate both professional competence and care for the patient than by becoming a split personality." This is an area requiring further research which necessarily includes patients' opinions of the care they receive and which has relevance for nursing care in terms of identifying ways in which nurse-patient communication can be improved.

Relevance of Patient Opinion to Nursing Practice with Depressed Patients

Marram (1973b, 153) reports a study in which she concluded that "the most powerful factor to affect the soundness of patient evaluation was visibility of tasks to the patient." It was revealed that nurses cared most about patients' evaluations of providing comfort and support and least about their evaluations of her ward management and record keeping tasks. Suggested is the assumption that patients may not possess enough professional skill and knowledge to elicit respect for their evaluations of some areas of nursing. While this point is debatable, there is no question that the visibility of nursing tasks to the patient can be varied, and nurses can take an active role in determining the percentage of highly visible functions in everyday work situations.

Marram's finding could also be useful in devising instruments for evaluation of nursing practice by patients. It seems necessary to determine fairly precisely what are the high visibility functions of nurses in specific situations and to concentrate initially on gathering data about patient opinion in these areas. For example, the nursing functions that depressed patients see as highly visible need to be identified. That information can then be used to improve prescriptions for nursing practice or the way in which it is performed. Such information could also provide a guide for patient evaluation of nursing practice. However, before taking discussion further into the nursing arena, theories and therapies relevant to depression will be presented, so that the treatment milieu within which nurses work is clear.

Chapter 3

DEPRESSION: THEORIES AND THERAPIES

The Label

Depressive disorders are among the most distressful and common maladies afflicting mankind. The label 'depression' covers many different forms of expression, and the dominance of the medical model in the last century resulted in efforts to distinguish between these. A major differentiation commonly used is between exogenous depressive reactions, which seem to be linked to the individual's life experiences, and endogenous reactions which have no obvious external cause. Other labels commonly used include involutional melancholia; manic-depressive psychoses - depressive type; reactive depressive psychosis; and depressive neurosis (W.H.O. International Classification, W.H.O., 1977).

While in many cases the differences between these are sufficient to permit agreement on one or other diagnosis, there are also cases in which classification is much less reliable (Rosen, Fox and Gregory, 1972; Sarason, 1976). However, the effect of classifying and labelling the different behaviours results in the patient being labelled as well as the illness. "The diagnosis made by the psychiatrist is regarded as 'official' not only for legal and statistical purposes, such as insurance claims, hospital records, and government reports, but also by other psychiatric professionals and paraprofessionals even though privately they may not concur." (Kalkman and Davis, 1980, 158).

Anderson (1978) suggests that reliance on diagnostic labels may preclude the use of observational data. In a study undertaken in a psychiatric facility in British Columbia to determine whether the diagnostic label influenced perceptions of health professionals in arriving at a patient's prognosis, it was found that if labels were removed, professionals based their interpretations on the patient's behaviour, but if present, they used the label rather than the behaviour.

Signs and Symptoms

Irrespective of the particular label applied, the person who is depressed commonly has signs and symptoms reflecting retardation in affective, physical, and cognitive areas, although these may be evident in varying degrees from extremely overt to very subtle forms of expression. Signs and symptoms reflecting retardation in affective function of the individual may include sadness; pessimism; unhappiness; feelings of hopelessness and worthlessness. Physical symptoms of depression may be expressed through fatigue; constipation; anorexia with subsequent weight loss, or excessive eating with weight gain; insomnia; dyspepsia; dry skin; and a variety of somatic complaints. Expression of cognitive dysfunction in depression may be through inability to concentrate and handle previous responsibilities; loss of interest; poverty of thought; ambivalence and indecisiveness.

Psychotic incapacity, with major impairment of perception of reality and ability to cope with daily problems of living, is seen in some

patients. Also a suicide attempt may grow out of such a mood disturbance. Depressed people may not stop with self-condemnation, but extend self-debasement and destruction from thoughts and words to overt acts, and often these constitute the presenting factor in the patient admitted for in-care (Drake and Price, 1975; Burgess, 1981).

Theoretical Perspectives and Resultant Therapies

A review of the literature on depression reflects a number of theoretical perspectives from which models have been derived, each representing a different conceptualisation of depression and therefore advocating different therapies. The most common are the biological, psychoanalytic, social, and behavioural perspectives. A factor clearly evident, but rarely expressed in the literature is that many of the clinical problems associated with depression have little acceptable experimental evidence regarding effective treatment. Despite a rigorous scientific approach in other branches of psychology, much of clinical psychology and psychiatry uses therapies based on belief systems in a manner not too dissimilar to that of the creationists in comparison to those who prefer evolutionary theory. This is not to suggest that either method is right or wrong. Rather, it is suggested that our ability to talk about, and to explain problems greatly exceeds our ability to show we can cure them (Azrin, 1977, 142). In contrast to nursing where care is the aim, by virtue of providing therapy, or being a 'therapist', there is a connotation of <u>cure</u> involved and expected.

In many instances, use of a particular therapy has effected a cure, or at least, the therapy is seen or believed to have done so. Otherwise therapies would hardly survive. The problem of lack of scientific evidence of effectiveness, however, is one that suggests fruitful possibilities for future studies.

The Biological Perspective (Medical Model)

This 'medical' model views depression as a disease, and emphasises aetiology, pathogenesis, signs and symptoms, differential diagnosis, treatment and prognosis (Copper, 1967; Goodwin and Bunney, 1971; Burgess, 1981). Concepts derived from the biological basis have provided for the development of anti-depressant medication; studies of genetic transmission of depression; and metabolic studies of depression, and there has been much progress in these areas since 1950. Schildkraut (1965) found that depression is associated with a deficiency of catecholamines, particularly norepinephrine, in the central nervous system. Baldessarini (1975) points out that single amine theories simply cannot account for the clinical diversity of depression, and the current accepted hypothesis appears to be a functional deficiency of two central neurotransmitters (both mono-amines - norepinephrine and serotinin) is important in depression (Hackett and Cassem, 1978, 219-220).

Therapy derived from this model centres on detecting and caring for somatic aspects of clients' health problems, including responses to drugs and other treatments such as sleep deprivation (Doyle, 1976). Electro-convulsive therapy (ECT) may be used particularly in treatment

of serious depression where drug therapy has failed or where treatment cannot wait for the onset of action of drugs (Burgess, 1981).

The Psychoanalytic Perspective

Psychoanalytic theory, which is also the basis for many other psychodynamic models, places little emphasis on the diagnosis or classification of the disorder, but stresses self-realisation and maturity of the total personality. Psychoanalytic therapy is based on the assumption that the symptoms arise from neurotic conflict. Depression is seen as an intrapsychic condition occurring when aggression or hostility is turned inwards. Freud (1950) sees this as resulting from loss of an ambivalently loved person, while Spitz (1952) and Bowlby (1960) focus on damage to the ego by introjection of hostility because of a reaction to separation from a significant object of attachment. More recently Bibring (1965) and Beck (1967), still working from a psychoanalytic base, have focused on helplessness, lowered self-esteem and negative cognitive set.

Therapy within a psychoanalytic framework consists of clarifying the psychological meaning of events, feelings and behaviours. The long-term therapist-patient relationship is the vital tool, since it is this therapeutic alliance that enables patients to remember forgotten events, re-experience them, and put them back into a perspective in which current situations can be seen realistically. Pathological use of defense mechanisms is replaced by a "corrective emotional experience" (Burgess, 1981, 119).

The Social Perspective

This view of psychiatric illness focuses on the way the individual functions in the social system. It is the type and quality of his 'connectedness' to the groups which make up his life space that is seen as important (Thomas and Berben, 1965; Bart, 1974). Much impetus was given this approach by Harry Stack Sullivan (1960) with his interpersonal theory of psychiatry. Although a sociological view may still define depression in terms of a response to loss, rather than viewing the problem as intrapsychic in origin, it is seen to originate at the interface of the individual and society (Bart, 1972; Weissman, in Burgess, 1981, 254). Symptoms are regarded as an index of social disorder.

Here, therapy will focus on the social matrix and try to reorganise either the patient's relationship to the social system or the social system itself, because the 'personality' is not seen as diseased nor in need of any restructuring. Work with the patient on recreational, occupational and social skills can also be part of the therapist's responsibilities when working from this perspective.

The Behavioural Perspective

Although a behavioural view of depression as extinction had been in place for years, it had been little studied until the "big explosion in the last ten years ... in cognitive and behavioural therapies." (Phillips and Bierman, 1981). Lazarus (1968) showed how learning theory can be related to the treatment of depression, and Burgess (in Ruben, 1969, 193-199) presents results demonstrating

success with this approach in modifying depressive behaviours.

Currently, different models offer some clearly competing formulations: "do depressed persons view actions and consequences as causally unrelated, as Seligman's helplessness model suggests, or do they overestimate their own causal responsibility for negative but not positive events, as Beck's scheme proposes ...; is the deficit in availability of reinforcement, as Lewisohn assumes, or in reinforcer effectiveness, according to Beck and others ...?" (Phillips and Bierman, 1981) Despite this seeming confusion, there is a common theme in that all of these models in one way or another emphasise deficit in positive reinforcement. Depression is seen as a set of maladaptive behavioural responses that are additionally maintained by the rewards of the "sick-role" (see glossary).

Since the overt symptoms (the learned behaviours) are the 'problem' and not the secondary manifestations of disease or the unconscious conflict, it is the symptoms that are treated. Therapy typically involves determining the behaviours to be modified and then identifying the relationship between depressive behaviours and the antecedent and consequent environmental events that precipitate and maintain the depression (Liberman and Raskin, 1971). Adaptive behaviours incompatible with depression are then positively reinforced and depressive behaviours are extinguished.

Implications for Nursing

As Akiskal and McKinney (1975) have noted, use of different models tends to be competitive rather than complementary. Nurses who care

for patients with depression may find they are required to manage patients quite differently according to the theoretical perspective of each patient's psychiatrist. Unless familiar with the theories involved, the nurses' practice can become detrimental to patient progress because nursing care is not congruent with the treatment of the psychiatrist. This is not to say it is not possible to use more than one model at once. A combination may be most beneficial if, for example, nursing staff maintain a supportive, sustaining relationship based on a social model while the primary therapist uses an intrapsychic model of individual psychotherapy. The success of such an approach, however, is dependent upon recognition of the contribution being made by each party and on ongoing discussion between them to ensure the goals are the same.

It is also possible that the moment the nurse moves from an ideological neutrality which can be adaptive in facilitating treatment goals ordained by other professionals, there is potential conflict in the care situation. The nurse has two moral commitments in an in-care setting; responsibility for the patient and his welfare and responsibility to facilitate treatment as prescribed by the primary therapist (- psychiatrist, psychologist or other professionals). Rushing (in Skipper and Leonard, Eds, 1965) poses the question - ".... what does the nurse do when these two principles are in conflict? For example, what does she do when she thinks the orders prescribed by the doctor are unsuitable for meeting the patient's needs?"

This issue has yet to be confronted and adequately resolved. As Grosskopf (1981, 32) notes, "Generally, conflict situations within the literature today are rare, if they exist at all. Something to

be concerned about is whether the lack of controversy and how to cope with it as portrayed in nursing literature leads students to believe controversies do not exist. Of even greater concern should be the kinds of impressions nurses form regarding the options available to them in problem solving and conflict resolutions."

An Integrated Model?

Although the models already mentioned have been presented under specific headings indicating a particular orientation, they are not in practice as discrete as seems apparent. Some models incorporate concepts from different perspectives as, for example, Seligman's (1975) helplessness theory which, while essentially a behavioural model, encompasses sociological, existential and cognitive concepts.

Akiskal and McKinney (1975, 299) have endeavoured to integrate ten conceptual models into a comprehensive clinical frame (Table 1, p.25). This allows a unified hypothesis for depression which is said to represent the feedback interactions of three sets of variables at chemical, experiential and behavioural levels - with the diencephalon serving as the field of action as shown in Figure 1 (p. 26).

The controversy about whether altered catecholamine metabolism is a cause or effect of depression is easily resolved since it can in fact be either. Depression is conceptualised as a psychobiological state which is "the final common pathway of various interlocking processes at chemical, experiential, and behavioural levels that, in the language of neurophysiology, translate into a functional impairment

TABLE 1 Ten Models of Depression
(Akiskal and McKinney, 1975, 299)

School	Model	Mechanism
Psychoanalytical	Aggression-turned-inward	Conversion of aggressive instinct into depressive affect
	Object loss	Separation: disruption of an attachment bond
	Loss of self-esteem	Helplessness in attaining goals of ego-ideal
	Negative cognitive set	Hopelessness
Behavioural	Learned helplessness	Uncontrollable aversive stimulation
	Loss of reinforcement	Rewards of "sick-role" substitute for lost sources of reinforcement
Sociological	Sociological	Loss of role status
Existential	Existential	Loss of meaning of existence
Biological	Biogenic amine	Impaired monoaminergic neuro-transmission
	Neurophysiological	Hyperarousal secondary to intra-neuronal sodium accumulation
		Cholinergic dominance
		Reversible functional derangement of diencephalic mechanisms of reinforcement

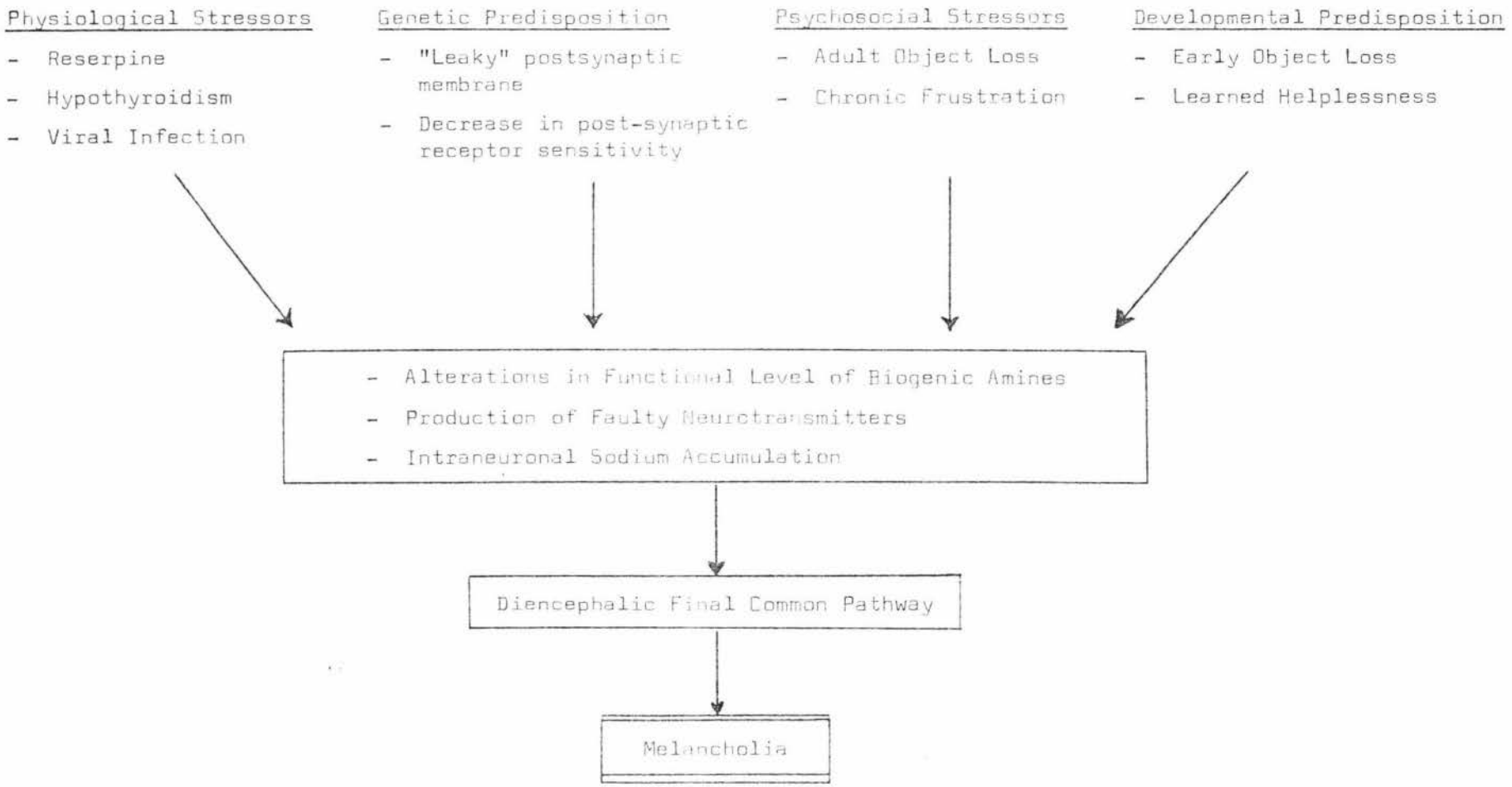

FIGURE 1 Melancholia as a Final Common Pathway
(adapted from Akiskal and McKinney, 1975, 300)

of the diencephalic centres of reinforcement." (Akiskal and McKinney, 1975, 299.) The model does not specify how each component is diagnosed nor which, if any, component predominates at any given time.

Akiskal and McKinney (1973; 1975) feel the model accounts for the shared clinical features seen in the heterogeneous group of depressive disorders, while the specific features of different types of depression can be explained by differences in pathogenetic factors and the multilevel interaction possible among them. Such a view does reflect a need for some means of organising current knowledge of the many facets of depression to ensure attention is not focused on only one possible cause of the condition. Treatment within this framework would necessitate assessment and possibly interventions at each of the chemical, experiential and behavioural levels, and this would offer a more integrated approach than currently occurs within any of the individual models or even schools of thought on depression.

Nurses may find this framework useful when attempting to articulate nursing dimensions of practice with depressed patients as distinct from contributions to care from other health professionals. Because they are involved with patients over prolonged periods of daily living, nurses could look particularly at the area of psycho-social stressors to identify specific interventions that would benefit the patient. It may be, for example, that the availability of nursing staff can help fulfill patient need based in the concept of adult object loss. A better understanding of this component might lead to more optimal use of such availability. Similarly, in the area

of developmental predisposition, the concept of learned helplessness seems particularly relevant for nurses to explore, since again the factor of the amount of time they spend with patients provides opportunities to assist the patient with developing and particularly maintaining new and less helpless behaviours.

Currently the nursing literature does not reflect these ideas in terms of possible specific nursing contributions to care since, as previously noted, the emphasis there reflects a role as a nurse-therapist.

Chapter 4

DEPRESSION: CONTEMPORARY PERSPECTIVES IN NURSING CARE

The literature on psychiatric nursing tends to advocate a role as 'therapist' for the nurse, particularly in clinical studies that have been reported. Psychiatric nursing texts, although tending to take a more eclectic view than is apparent in journal studies, also follow this trend. Burgess (1981) suggests psychiatric nurses either become adherents to one particular therapy model or they use bits of data from each model in a unsystematic way. Current writing on nursing practice with depressed patients supports this general rule.

This chapter provides a brief overview of suggested interventions for nursing depressed people. Emphasis is given to those concepts which are incorporated in the study that follows.

Observation and Assessment

For the patient who is depressed and has thoughts of suicide or self-mutilation, an important reason for the nurse to observe the patient is that she may anticipate his behaviour, and move to prevent him from injuring himself (Leonard 1975; Floyd, 1975; Rosenbaum, 1980). Close observation helps the nurse to understand the patient better and may thus facilitate a more productive relationship in terms of meeting nursing goals for him. Also, the nurse's observations offer many implications for the planning and evaluation of the patient's nursing care (Brown and Fowler, 1971). Because of the time spent with patients, particularly in relatively unstructured settings, the nurse is often able to furnish valuable data that no other worker has the opportunity to discover (Leavitt, 1975; Rosenbaum, 1980). Much is contributed to the total care of the patient if the nurse can communicate to others what she has observed in her relationship with the patient.

Determining what to select as relevant clinical data when observing and assessing can be somewhat confusing if one looks at the literature or at the practice of different skilled nurses when they are making assessments. As Burgess (1981, 110) notes "... the kind of assessment obtained, the meaning assigned to certain historical facts, and the treatment modalities most often chosen depend on which model or combination of models is employed." She suggests that at this stage of development psychiatric nursing can best be learned by making the available therapy models already in use explicit rather than implicit. Perhaps even more useful would be the use of a nursing model as the

base for nursing practice. This need not preclude use of knowledge of any or all of the 'therapy' models but would ensure that observations and assessments were relevant for treatment of symptoms.

Specific observations relevant to the patient who is depressed are related to changes in the patient's behaviour over time in the affective, physical and cognitive areas briefly described in the introduction on depression (p. 17). Some of the prescriptions for care outlined in the literature in each of these areas are now discussed.

Care in Relation to Physical Needs

Besides physical and psychological protection the severely depressed person also needs considerable nursing care to see that his basic biological needs are met. Such needs include sufficient sleep, adequate intake of food and fluids, some exercise, and attention to personal hygiene and general health. Patients with depressive illness may be indifferent to these needs and neglectful of caring for themselves. They may be physically ill as well as mentally ill, particularly if, as is often the case, they have been depressed for some time prior to admission for treatment. Malnourishment, dehydration, chronic constipation, neglect of infections and self-inflicted injury are just some of the physical problems the nurse may encounter in such persons (Kalkman and Davis, 1974).

The specific nursing care related to these problems is essentially the same as for any patient similarly affected and, probably for this reason, details of such care are often not given in psychiatric nursing literature. However, it seems generally recognised that because of

his inability or lack of desire to co-operate in his care, the patient who is depressed may pose greater difficulties for the nurse in providing such care.

Care in Relation to Affective Needs

In his book Therapeutic Communication, Reusch (1961, 87) states, "The ability to mutually correct the meaning of messages and to mutually influence each other's behaviour to each other's satisfaction is the result of successful communication. This is the only criterion we possess, and if we achieve such a state, it indicates mental health."

On this basis, the patient with depressive illness has a disturbance in his ability to communicate. Improvement will not be forthcoming or lasting without some motivation on the part of the patient. In an in-care setting, an ongoing nursing function is to provide positive reinforcement of any improved ways of communicating as well as to try and identify specific individual motivators that can be used to assist the patient to progress (Kalkman and Davis, 1980). Support from nurses is seen to sometimes be a decisive factor in ensuring the patient has the very necessary primary commitment - the desire to survive, without which no treatment is of much avail.

The expression of anger is suggested as being beneficial for depressed patients and many texts and articles, particularly those set within a psychoanalytic framework, cite encouragement of such expression in acceptable ways as a nursing function. Other suggested nursing interventions for dealing with feelings run the gamut from

encouraging physical activity (Knowles, 1981) to poetry therapy (Poole, 1981) to group psychotherapy (van Servellen and Dull, 1981). The range of interventions here reflects the variety of 'therapy' models in use.

Swanson (1975, 63) argues that the treatment of depression includes the use of one's self in communication, because it is through communication that the depressed person can see more clearly his withdrawal from life, and begin to make investments in new relationships. When one considers the time the in-patient has in contact with nursing staff compared with other staff, it is suggested that understanding of this concept is important for the nurse who wishes to make best use of that available time.

The person who is depressed greatly needs human company and communication, despite the lack of interest he may seem to have for either. Depressed persons are not the most comfortable people in the world to be around. Nurses may find, in the presence of a depressed person, that they suddenly feel low, irritable or somewhat hostile - all natural reactions (Rosenbaum, 1980). As Sullivan (in Swanson, 1975) has noted, depressed persons do not stimulate a zest for living, nor imbue a spirit of loving kindness towards others. In one sense, their communication is excellent: that is the efficiency with which messages of dejection or hopelessness get through to another. Here actions speak louder than words. Even in silence, a person cannot not communicate, (Wazlawick, 1967).

Touch can be a most important means of communication. If the patient

reacts favourably to touch, it can assist in improving self-image and in diminishing the isolation and sense of despondency that depressed persons commonly feel. A non-judgemental attitude is often mentioned in the literature as being vital for therapeutic communication and this is cited as a necessary co-requisite to touch to prevent the patient interpreting the nurse's behaviour as being smothering or patronising (Rosenbaum, 1980).

An overly sympathetic attitude could help sustain or even increase the patient's depressed mood, while open communication will help ensure appropriate nursing responses are made. Schmagin and Pearlmutter (1977) write of the secondary gains of depression in an article entitled "The Pursuit of Unhappiness." They say that only minor attention appears to have been given to these gains and present a number of instances of what could be interpreted as manipulative behaviour for secondary gain. A behavioural orientation is evident here.

Care in Relation to Cognitive Needs

Information on specific nursing interventions directly related to meeting patients' needs in the cognitive area is sparse. It appears that there is an underlying but unstated assumption that as problems in the affective area are overcome, so will improvement occur in the cognitive area. Depression will nearly always involve alteration in cognitive ability. Usually there is impaired concentration, and the literature infers that it is important that nursing care does not place unrealistic demands on the patient. For example, as Rosenbaum (1980, 65) notes, "Most depressed patients have difficulty making

decisions. A severely depressed patient might not be able to make even the smallest decisions."

Ayd (1961) says that depressed patients need and expect simple words of comfort and reassurance to be given repeatedly. Such patients get temporary relief from reassurance but they must be repeated as anxiety mounts again. The point is also made that some depressed patients may be confused to some extent, and many cannot remember all that is said to them.

Kalkman and Davis (1980) also emphasize this need for simple, direct information, especially regarding the practical aspects of his illness that cause the patient concern - effect of drugs, prognosis, electric shock treatment, possible loss of employment, home responsibilities and so on. The educative component is particularly relevant in relation to the concept of learned helplessness which identifies decision-making as a major difficulty for depressed patients. This would be worsened by a lack of information which limits the individual's feelings of control over his situation.

Availability and Alienation

It is suggested that availability is possibly one of the most important facets of nursing care when used as a recognised contribution. Availability is not often discussed in any detail in psychiatric nursing texts although it seems always inferred, yet in patient opinion surveys availability is often shown as a primary attribute appreciated by patients (Chastko et al, 1971; Cormack, 1976; Sweeney, 1978).

Schmidt (1972, 1087) identifies two aspects of nursing availability: receptive availability involves the nurse's "sensitivity and receptivity to the patient", while ministrative availability involves response to patient signals with an attempt to minister to the need identified. Schmidt goes on to present two further relevant points. Ministering does not necessarily hold the connotation of physical presence - "If a nurse lets a patient know when she gives him care and information how he can summon her when he needs her again, that she is aware of his needs-for-help, and that she will return, she is being ministratively available to him." This type of availability seems to fit the needs of a situation where the nurse does not wish to reinforce depressive behaviour by providing company at those times, whereas receptive availability seems appropriate for positively reinforcing non-depressive behaviours.

Schmidt's other point is that if nurses try to minister help but fail, or only partially succeed, they are seen as more available than if they had recognised a need but not tried to minister to it. The fear of many nurses new to the psychiatric setting of 'saying the wrong thing' (Sayre, 1978), and the fear of making mistakes seems pertinent to this point, since such fears may have resulted in no help being given at all.

Availability is a service: it implies giving a patient the opportunity to avail himself of the nurse's services, an opportunity to talk about what might be bothering him, or to ask for information. Of course, not all patients are ready for, or desirous of taking advantage of the available nursing. Patients who are depressed

may feel so worthless, for example, that they might not consider they have the right to use this service, or they may not trust enough to use it initially, resulting in alienation (see glossary, p.xiii). Repressed anger may also result in alienating behaviour, giving the nurse an arduous task in staying with the totality of the patient's experience.

As Carser and Doona (1978) note, some patients alienate themselves at a time when the most important therapy is another person. These authors present their experience of offering a class on their theory of alienation in which they invite students to share ideas and experiences of alienation so that as nurses they are able to stay 'available' to their patients and not defend against the patient's experience.

Alternatively, patients may not be alienating themselves, but may simply not know how to use the nurse's availability. Schmidt (1972, 1087) sums up concisely: "The effectiveness of a nurse-patient interaction varies concomitantly with the nurse's availability - the more available she is, the more adequately she can meet the patient's needs for help." Patients in in-care settings usually have fairly direct access at any time of particular need to a member of nursing staff, while because of the way in which their work is structured, such access is not usually possible to any of the other health professionals.

Permitting Depression

As Rosenbaum (1980, 66) notes, "Few nurses realise they can help

relieve depression simply by permitting it. Our society has put a stigma on depression. We're taught to think we should always feel young, alive, and bursting with energy. Of course these are unrealistic goals, but patients often feel depressed because they think feeling ill is 'bad'. And feeling depressed is unacceptable."

Consistency of Care

Consistency of care (see glossary) gives patients something they can count on and can therefore assist in increasing a patient's sense of security - thus alleviating some of the depression. (Rosenbaum, 1980). Again, this is a concept which often seems inferred in the nursing literature, but is less commonly made explicit.

Rehabilitation

An important facet of nursing care is preparation of the patient for discharge. In essence this begins from the time of admission with encouragement of as much independence as possible, and continues throughout the in-care stay with the patient being encouraged and supported in taking responsibility for his own health. As Kalkman and Davis (1974) state, "Self awareness and the responsibility for the direction of his own life are important goals for the patient in this phase. One way to help patients to achieve these goals is to help them with opportunities within the treatment setting to gain experience in making decisions which are realistic yet contain some degree of self-realisation and gratification." Such a view is congruent with Orem's (1971) self care approach to

nursing, and also fits within Seligman's (1975) learned helplessness theory of depression. Nursing staff can most frequently have opportunities to give this decision-making experience by reducing their own decision-making for the patient as he improves, and by creating situations where he has a choice. Thus the patient regains some feeling and perception of power over his own destiny.

A brief overview has been given of interventions commonly prescribed in the literature for nursing patients who are depressed. Some concepts which could have specific relevance for nursing practice in this particular situation were then explored. These were:

1. availability and alienation
2. permitting depression
3. consistency of care
4. rehabilitation

It could be suggested that availability would have therapeutic value when considered from the perspective of adult object loss. It would also be a vital requisite for providing the positive reinforcement important in a behavioural orientation, or for encouraging and supporting the patient in active responding and decision-making - important care components within the helplessness model.

Chapter 5

TOWARDS HELPLESSNESS OR SELF CARE? - TWO MODELS COMBINED

This study is about nursing practice with a particular patient population - the depressed. To provide a framework allowing systematic analysis of data presented, the models of learned helplessness and self-care have been combined.

The Self-Care Model

The core of Dorothea Orem's (1971; 1980) theory of nursing is the idea that nursing has as its special concern the individual's need for self-care action and the provision and management of it on a continuous basis in order to sustain life and health, recover from disease or injury, and cope with their effects. People can benefit from nursing because they are subject to health-related limitations that render them incapable of continuous self care. When this occurs a self care deficit exists, which validates or legitimates the existence of a requirement for nursing.

The central idea of self care is that it comprises LEARNED behaviours that purposely regulate human structural integrity, functioning, and human development. Self care is defined as "the practice of learned activities that individuals initiate and perform on their own behalf in maintaining life, health and well being" (Orem, 1980, 28).

The Self Care Process

Self care is purposeful action. The self care activities are learned relative to the beliefs, habits and practices that characterise the cultural way of life of the group to which the individual belongs. When self care is not maintained, illness, disease or death will occur. Figure 2 provides a schematic representation of the self care process.

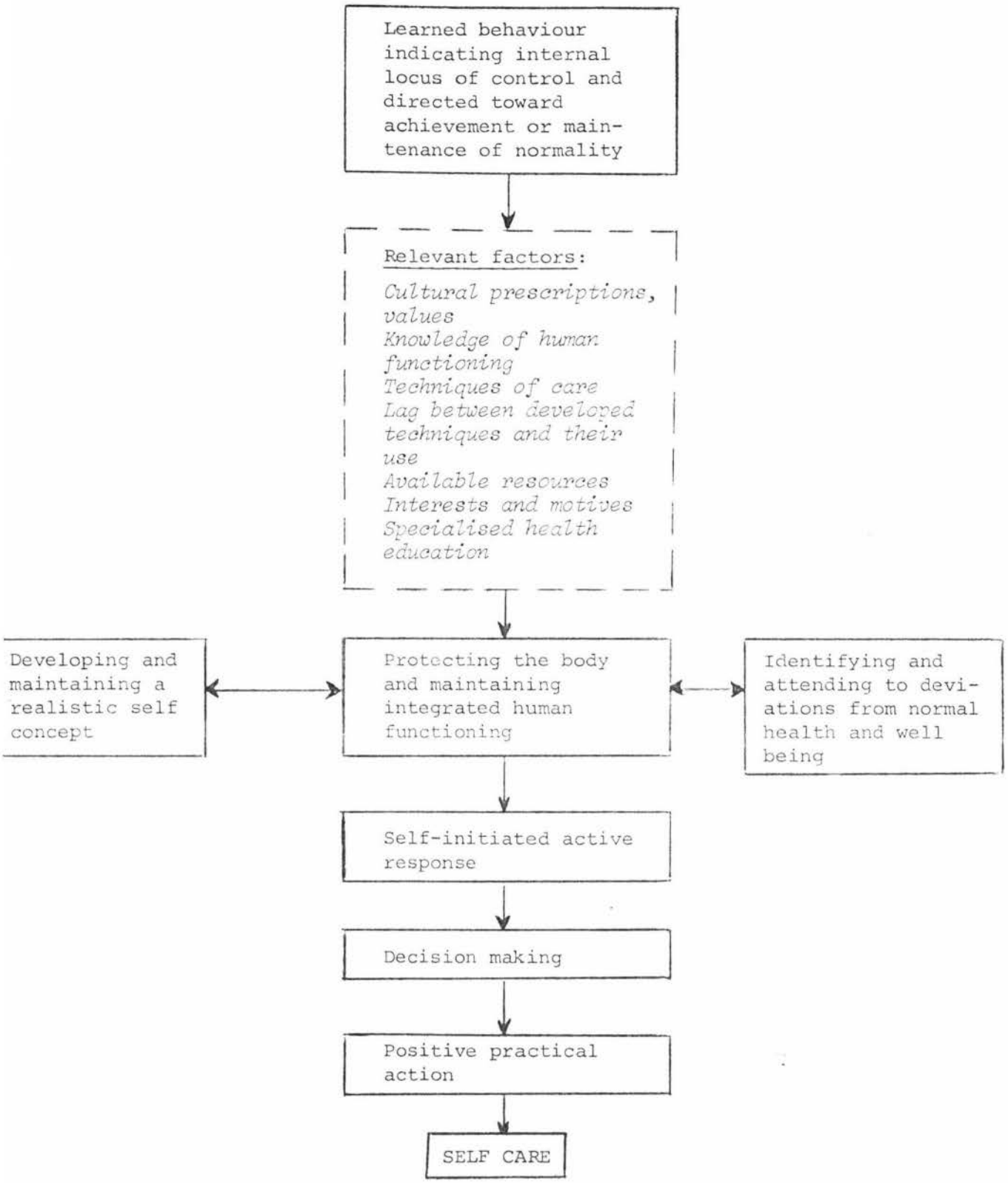

FIGURE 2 The Self Care Process

Figure 3, 'The parts of the nursing focus', illustrates what the nurse must consider in determining appropriate nursing actions to achieve the nursing goal of developing, maintaining, and promoting self care behaviour essential for daily living.

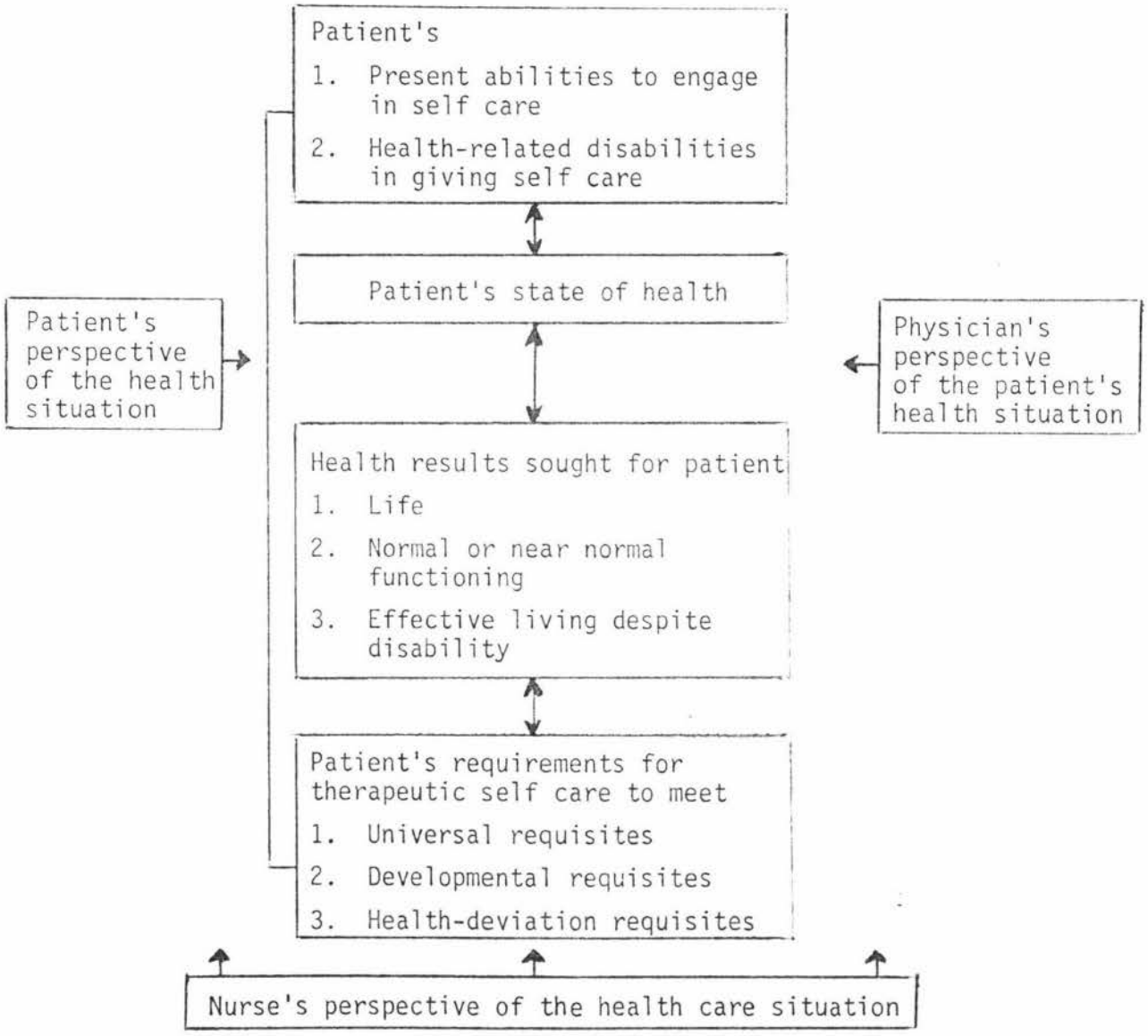

FIGURE 3 The Parts of a Nursing Focus
(Orem, D, 1980, 129)

The self care model for nursing practice has been chosen as a basis for this study for four main reasons:

1. The model provides a clear definition of the role of the nurse and an explanation of her function within a multi-disciplinary health team;
2. The model gives direction in determining therapeutic goals and asks for clear and measurable outcomes of care to be specified in health terms for the patient. In this way the nursing contribution can be clearly identified;
3. The model necessitates recognition and acceptance of the patient's point of view;
4. The model 'fits' current trends which show the emergence of what might be termed a social movement with the aim of increasing self care, - of increasing self-responsibility for one's own health and thus reducing dependence on professionals for health care (Levin et al, 1976; Hattinga Verschure, 1980).

Within this model, nursing practice is seen as valid when there is an imbalance in a situation where the nurse's abilities to manage and maintain therapeutic systems of self care for individuals exceed the abilities of those individuals or their families to do this. The model identifies three perspectives of a patient's health situation within a nursing focus: the patient's own perspective; the physician's perspective; and the nursing perspective. The nurse takes responsibility for melding these into a therapeutic approach to nursing care.

Although this study is about nursing practice, if the self care model is to provide a framework for analysis of data, the physician's perspective cannot be ignored. This term is interpreted to include other health professionals - psychologists, social workers, occupational therapists, dieticians, etc. To take an eclectic theoretical view within the nursing approach was not practical within the limits of the study. The theory of 'learned helplessness' (Seligman, 1975; Abramson, Seligman, Teasdale, 1978) has therefore been selected because it appears to reflect the'mirror image'of the self care process, as shown in Figure 5 (p. 52).

The Learned Helplessness Model

Helplessness is a condition where the subject sees the power to change his environmental contingencies as being outside his own control (Seligman, 1975). The learned aspect denotes a conditioned response where the perceived locus of control shifts from the self to outside the self. Learned helplessness is characterised by symptoms such as passivity; difficulty in learning that responses produce relief; lack of aggression; weight loss; appetite loss; social and sexual deficits (Seligman, 1975, 82). Table 2 summarises the features identified by Seligman as being common to learned helplessness and depression (p. 46).

TABLE 2 Summary of Features Common to Learned Helplessness and Depression (adapted from Seligman, 1975, 106)

	Learned Helplessness	Depression
Symptoms	Passivity Difficulty learning that responses produce relief Lack of aggression Weight loss, appetite loss, social and sexual deficits Norepinephrine depletion and cholinergic activity Ulcers and stress	Passivity Negative cognitive set Introjected hostility Weight loss, appetite loss, social and sexual deficits Norepinephrine depletion and cholinergic activity Ulcers Feelings of helplessness
Cause	Learning that responding and reinforcement are independent	Belief that responding is useless
Cure	Directive therapy: forced exposure to responses that produce reinforcement Electroconvulsive shock Time Anticholinergics; norepinephrine stimulants	Recovery of belief that responding produces reinforcement Electroconvulsive shock Time Norepinephrine;stimulants; anticholinergics
Prevention	Immunization by mastery over reinforcement	

The Learned Helplessness model has excited much discussion and research - so much so that a whole issue of the Journal of Abnormal Psychology (87:1, 1978) was taken to present different views on the adequacy of learned helplessness as a model for depression in humans. Although there was no clear consensus amongst authors, one could suggest a trend toward a view of depression emphasising the cognitive reactions of persons to certain learning experiences (Huesmann, 1978).

A critique and reformulation of the learned helplessness model (Abramson, Seligman, Teasdale, 1978) identified two major problems in the original hypothesis when applied to humans: a lack of distinction between universal and personal helplessness and a lack of explanation of when helplessness is general and when specific, or when chronic and when acute. According to the reformulation (p. 49) " ... once people perceive noncontingency, they attribute their helplessness to a cause. This cause can be stable or unstable, global or specific, and internal or external. The attribution chosen influences whether expectation of future helplessness will be chronic or acute, broad or narrow, and whether helplessness will lower self-esteem or not."

The inclusion in the model of an extensive amount of cognitive processing leading to attributions about the cause of outcomes necessitates a more complex statement about depression, and the reformulation is made explicit thus:

"1. Depression consists of four classes of deficits: motivational, cognitive, self-esteem, and affective.
2. When highly desired outcomes are believed improbable or

highly aversive outcomes are believed probable, and the individual expects that no response in his repertoire will change their likelihood, (helplessness) depression results.

3. The generality of the depressive deficits will depend on the globality of the attribution for helplessness; the chronicity of the depression deficits will depend on the stability of the attribution for helplessness; and whether self-esteem is lowered will depend on the internality of the attribution for helplessness.
4. The intensity of the deficits depends on the strengths or certainty of the expectation of uncontrollability and, in the case of the affective and self-esteem deficits, on the importance of the outcome" (Abramson, Seligman, Teasdale, 1978, 68).

Treatment strategies suggested include environmental manipulation to reduce the likelihood of aversive outcomes and increase that of desired outcomes; reducing the aversiveness of unrelievable outcomes or the desirability of unobtainable outcomes by altering the cognitions about these; changing expectations from uncontrollable to controllable when outcomes are attainable either by training in appropriate skills or modifying distorted expectations; and changing unrealistic attributions for failure towards external, unstable, specific factors and unrealistic attributions for success towards internal, stable, global factors.

Studies using this model with clinical populations are not numerous, and this has been criticised (Depue and Monroe, 1978), as has the

type of study commonly done. Price, Tryon and Raps (1978), for example, used a noise, no-noise treatment followed by an anagram-solving task with a group of clinical depressives and state they were able to replicate the learned helplessness phenomenon and support Seligman's model of depression. However, Buchwald, Coyne and Cole (1978) suggest what is needed are studies of clinical depressives that look at their symptoms and other characteristics so that these can be carefully compared to the laboratory phenomena. This certainly seems necessary before any further reformulations take place.

The Helplessness Process

For the purpose of this study, the usefulness of the learned helplessness model lies in its similarity of process to that identified for self care (p. 42). If the basic behaviours inherent in the process leading to helplessness are specified, a flow chart as shown in Figure 4 can be derived.

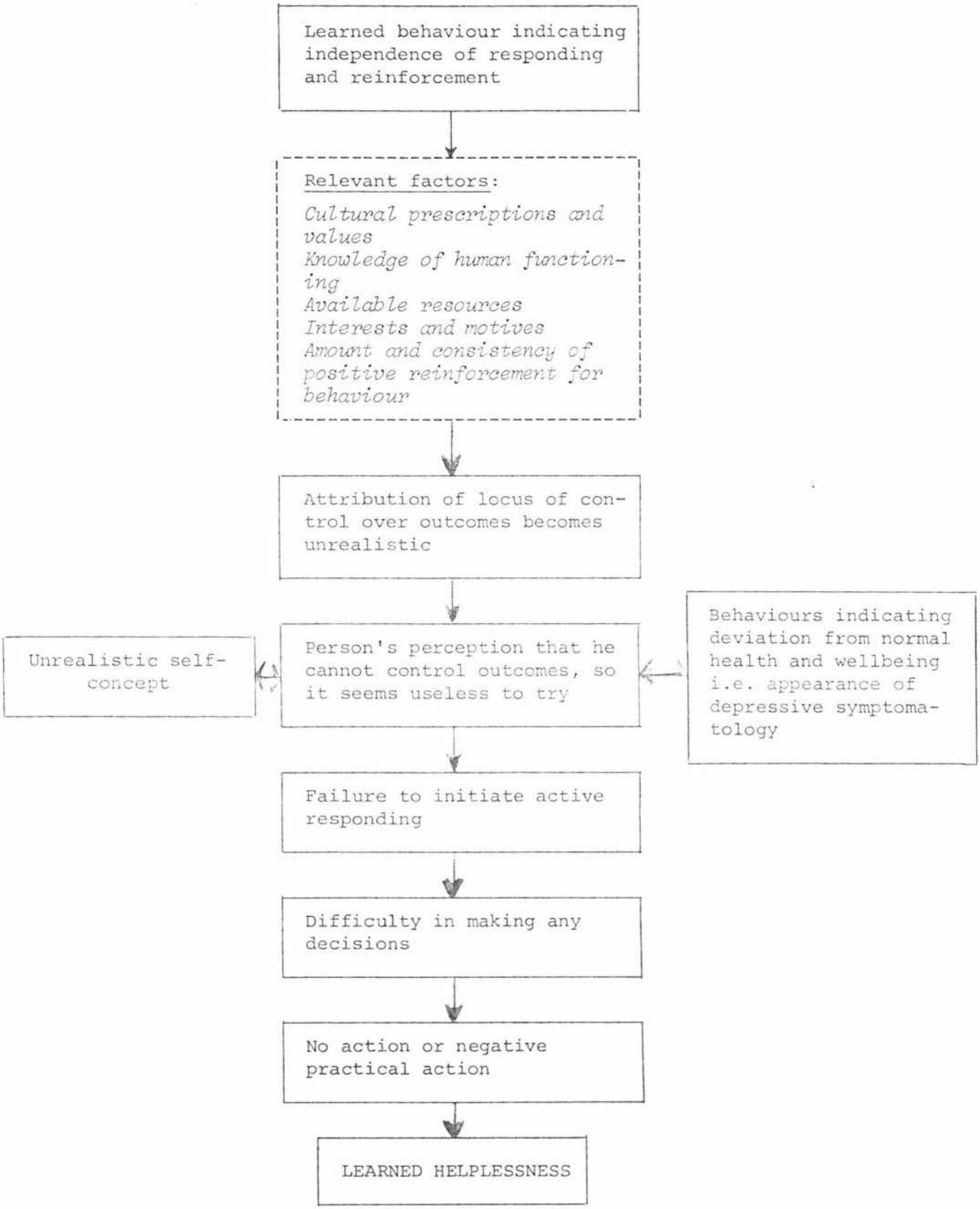

FIGURE 4 The Helplessness Process

A Framework for Analysis of Data

The behaviour in the process leading to helplessness or depression appears to be the negative side of the process which leads to self-care. Thus, the two can be 'mirrored' as shown in Figure 5 (p. 52).

Factors which determine which way a person will move in terms of these processes include cultural prescriptions and values; individual knowledge and beliefs about human functioning; individual interest and motives; available resources; amount and consistency of reinforcement for behaviour; and specialised health education and health care. It is suggested that movement through each separate process follows a 'pendulum-like' swing and if there has been movement towards the helplessness side, it will be necessary to go back and work at changing the learned behaviours before progress through the steps to self-care can occur. The dotted arrows back to the pivot of the 'pendulum' indicate that the learning process is ongoing and continually evolving throughout life. Neither self-care nor helplessness are states which, once achieved, can be maintained without effort. The readiness for and maintenance of healthy self-care will always depend on the continual changes taking place in the factors identified as affecting what the individual learns.

Of course, there are limitations in the simplistic approach taken here, but these seem outweighed by the need for some practical, systematic and meaningful frame of reference within which data can be analysed - a major consideration in designing the study which follows.

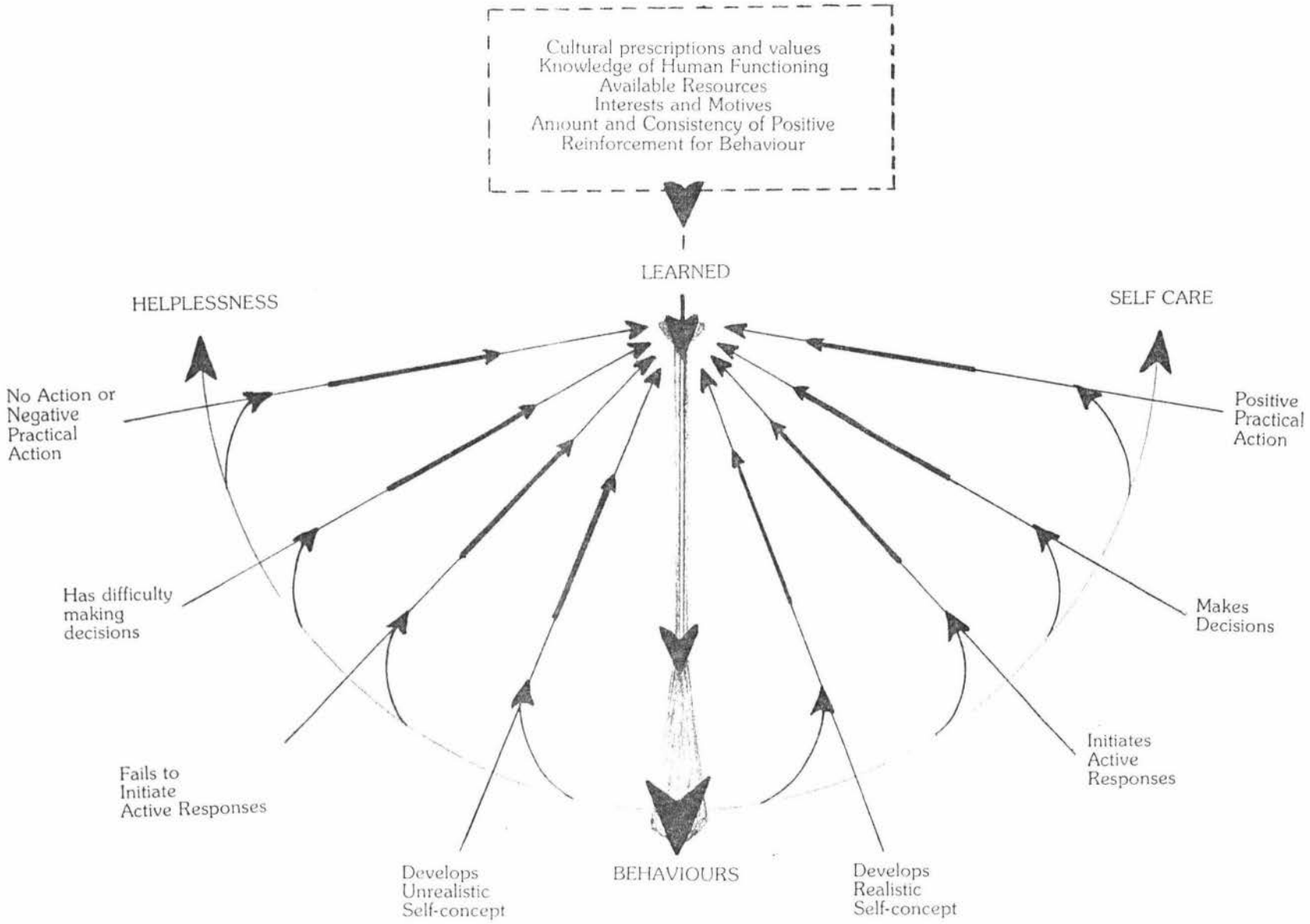

FIGURE 5 Two Processes Combined: Helplessness and Self Care

Chapter 6

BACKGROUND TO THE STUDY

Nursing care of patients admitted to hospital because of depressive illness is generally recognised as an important feature of their in-care programme. This is seen as facilitative of, and additional to the care given by other health professionals. Although there is a wealth of literature on theories of depression, treatment modes, and on specific nursing care, there is less literature involving CLINICAL studies in the latter area. There is a need for clinical nursing research to provide a base of information about this patient population and the nursing care it receives so the nursing contribution can be defined and more definitive guides for the improvement of nursing practice can be derived. This section sets out the preliminary work entailed in setting up a practicable study in the area.

Assumptions and Definitions

An early difficulty encountered was that of defining depression. As has been noted (p.16), medical diagnoses can lack reliability, and deciding which of the different classifications of depression should be accepted as sample criteria was an added problem. Also many patients who have diagnoses other than depression may still be depressed. It seemed unsatisfactory to exclude such patients from the sample when they would require nursing in relation to the specific self care deficits arising from that depression. The criteria eventually used were those detailed by Kalkman and Davis

(1980) for defining a depressive episode (see p. 68). In this way, the individual patient and his behaviour is the focus of attention before any specific illness label that might be applied to him. The patient is seen as a person with highly individual needs, concerns, strengths and weaknesses, who has a right to expect respect from those giving care.

An assumption is made that the patient-nurse relationship is the essential vehicle for nursing care. Nursing care in this study refers to the behaviours exhibited during unstructured time in the clinical setting by nursing staff in interaction with depressed patients who are receiving in-care treatment. Unstructured time is that time outside of the weekday daily programmed sessions of individual, group, occupational, or recreational therapy which occur from 8.00 a.m. to 5.00 p.m. in the clinical setting used in this study. It is assumed that the aim of nursing care is to facilitate treatment to relieve depression and to assist in achieving an improved health status for the patient; that nursing is a purposeful activity; that, along with other health professionals, the care that nurses give affects the outcome of the patient's illness and influences his future health status; and that validation with patients of their needs and goals is important.

It was envisaged that three separate data sources would be useful within the clinical setting to provide different perspectives in trying to answer the first identified research question, "DOES NURSING CARE OF DEPRESSED PATIENTS TEND TO SUPPORT BEHAVIOURS INDICATIVE OF PROGRESS TOWARDS HELPLESSNESS OR ENCOURAGE THOSE WHICH INDICATE PROGRESS

TOWARDS SELF CARE?" The sources were

1. Data from nursing notes and patient identification information.

   A retrospective study of the admission forms which give personal data and of the nursing notes of the patients in the sample would be carried out, and recorded information described in terms of a patient 'profile' and process-outcome relationships.

2. Observational Data

   Observed behaviours of the patients under study and of nursing staff who interact with each patient would be recorded by two observers during specified time intervals.

3. Data from Patients

   Semi-structured interview techniques would be used to gather information just prior to discharge to describe what the patients in the sample perceived as helpful or effective nursing interventions and what indicators they used to identify progress.

The Nursing Notes

A pilot study was undertaken on the nursing records of thirty patients treated for depression in a psychiatric unit of a general hospital (unpublished study, Butterfield, 1979) to describe the patient population and to determine process-outcome measures and relationships. Results indicated that further study of the notes would not prove fruitful, since very little information of this nature

is recorded, and the system used for nursing records in the particular setting has not changed since 1979. For example, the most common descriptors of patients' psychosocial behaviour were 'quiet, bright, settled, anxious, cheerful'. Very little was recorded in nursing notes about communications: for 9 of a sample of 30 patients, nothing was recorded that related to this aspect specifically. Similarly, little was recorded in relation to cognitive function, 21 patient files having no comment on this aspect. Although there were comments about 'socialising', there was little to indicate how this was being done, on whose initiative, and nothing to give a clear indication of change over time. Comment on physical state was related mostly to exercise, eliminatory function and sleep. Very few nursing interventions were recorded and those that were reflected care such as giving of medication, enemata, or fluids. The lack of behavioural data made it difficult to determine what indicators nurses use to denote progress other than the relatively meaningless statements like brightness or quietness.

If one were to make judgements on the nursing care given from the nursing notes alone, it would appear that it is custodial in nature rather than being actively or knowingly therapeutic. It was felt, though, that there were perhaps other reasons for the lack of useful recorded data and that the notes could not be taken to infer what nursing care had in fact been given. The question of the value assigned these notes in comparison to those written by a psychiatrist or a therapist may be relevant, and it is possible that nurses just do not write down what they do. A study by Santara and Willer (1975; in Stuart

and Sundeen, 1979) suggests that this can be so, and the plethora of literature on writing care plans and improving nursing records implies that this is not an uncommon problem. It may well be that much more is done by nurses than their notes suggest, and that such information is transmitted verbally. However, as Stuart and Sundeen (1979) state, "Nursing goals and actions that are not documented in writing tend to remain vague and negate the opportunity for continuity of care."

Since the nursing notes did not indicate that nurses did what the literature suggests should or could be done with depressed patients, it seemed a reasonable next step to determine if they agreed about what were effective and ineffective nursing interventions. What was sought was a technique which would give a clear discrimination between these actions while reducing the possibility of semantic ambiguity.

Initially the behaviourally anchored rating scale (Smith and Kendall, 1963) seemed most useful, until it was recognised that the purpose of "BARS" was to devise an instrument for evaluating performance - to determine who are the 'good' and 'bad' workers. This was far beyond the purpose of this study, so Thurstone's method of equal appearing intervals (Thurstone, 1929, in Krech, Crutchfield and Ballachey, 1962) has been selected instead.

Devised for the measurement of attitudes, this technique could well be the basis from which BARS has developed, although this is not recognised in the literature, where generally Flanagan's (1954)

'Critical Incident Technique' is cited as the precursor. It allows for a wide range of actions to be considered and sorted on a scale by a large sample of nurse 'judges' so that measures of central tendency, standard deviations and range for each statement of an action can be computed and items with wide disagreement discarded. Items remaining will have high agreement among the nurse judges as to their effectiveness or ineffectiveness according to their scale value. Although Thurstone (op cit) included a final step of selecting a small number of items spread along the continuum to measure the attitude, for this study this step is not necessary, since it is the discriminatory portion of the technique that is so useful here.

The Observation Study

In trying to clarify the method for the observation study, difficulties were encountered in determining what to observe - given that the observers required specific guidelines to know what to record. Use of video equipment as a means was discarded because of the impracticability in the situation available, and space precluded having more than one observer at any one time unless only a specified area, e.g. lounge, dining room, was used for the study.

Goodrich (1959; in Lindzey and Aronson, 1968, p. 231) reported that when observations are made in treatment centres, observers can heighten paranoia, serve as objects for displacement, or deprive people of privacy with predictable effects on behaviour. This problem, particularly in relation to privacy, was recognised in determining the design for the observation study and is a major reason

for the observation with each patient being kept to one three-hour period on two separate days. On balance, it was deemed more was gained by having one person observing who could move with a patient in a relatively passive and non-participating role than was lost by lack of control for 'observer bias'. Each patient would be 'shadowed' within the fourth, fifth or sixth day following admission. This condition was imposed to attempt to get patients at a similar stage of illness, given that admission is taken as the point of crisis from which active treatment begins, irrespective of whether or not this admission is a patient's first in-care stay.

There are many sources of error that can occur in observing behaviour. Inadequate content sampling; chance response tendencies; changes in the environment and changes in the person comprise four of these. An ideal observational study would assess reliability in several ways to ensure a stable phenomenon is being recorded. However, the methodology required to implement all of these different measures was not practicable in this instance in terms of time, space, or maintenance of good relationships with people involved. Inter-observer agreement of a single event seemed most important because without this, there is no assurance that any distinct phenomenon is being preserved in the record (Weick, in Lindzey and Aronson, 1968, p. 404). Given that it was not possible to have two observers in situ at once because of lack of space and intrusion of privacy, it was seen as imperative in terms of design that the recording chart constructed provide an explicit and well defined category system to reduce to a minimum the amount of inference about behaviour required of the observer. It was also recognised that there is a limit to the

detail one can reliably observe and that more was required than a record of manifest verbal content. The problem was to devise a method of observing that ensured appropriate and reliable data were gathered while ensuring that the amount of error was reduced as far as possible

The Recording Chart

A recording chart based on the work of Bales (1950) was devised first but discarded because not only was it difficult to get observer reliability in recording, but the information obtained was not easily analysed in terms of the helplessness/self care framework. Since an appropriate and reliable observation tool was not found in the literature, an attempt was made to devise one using the nursing literature on depressives as a guide to what nursing behaviours one could expect to find and creating a check list of these. An objective here was to observe for a wide range of behaviours and analyse the findings from the perspective of nursing for self care rather than impose the theoretical framework first and derive the instrument from it, as it was felt the latter method might unduly limit what was observed. However, this proved impractical as behaviours were mostly complex, creating difficulty where a portion of the specified behaviour only was observed, and because more inference was required than was acceptable to maintain any reliability. Also, there was too much required of the observer in the amount of recorded detail, so that again reliability was reduced, and lack of contextual information tended to render the information gained less useful in the light of the specific question about helplessness being asked.

It was then decided to go back to the theoretical framework and identify the major simple behavioural acts which it suggested would or should occur. This limits the scope of observations, but it has the advantage of creating a practical observation chart (Appendix 2) and one which provides information that is directly relevant to the research question.

Some difficulty was encountered in defining an interaction. There was no problem with the beginning, since each interaction began when either a patient spoke or otherwise communicated with a nurse or vice versa. After some trials it was decided that the most practicable solution was that the ending would be taken as the first major natural pause in conversation or activity.

Time sampling also posed problems. Given that it is not possible economically or in terms of the time required to cover the whole range of the unstructured time with which this study is concerned, a selection of observation times were identified as being as representative as possible.

Patient Interviews

In general, patient opinion studies show that patients are most reluctant to criticise those providing nursing care. Most are grateful for the care they receive and tend to praise those who care for them. Despite the fact that they have legitimate grievances, patients often hesitate to complain, and comment is often suspect because of halo effect. A number of studies have attempted to get some expression of negative comment, but this has proved difficult

perhaps because of fear of reprisals. Nehring and Geach (1973) suggest a solution in taped interviews. They state, "Patients had seemed more conscious of contradictions when using a questionnaire, so that if they had marked one desirable item as having been given frequently, they tended to check that ALL desirable items had been given frequently." It was noted that a tape recorder would pick up qualifying remarks following an initial answer which would then be available for later analysis.

With the less formal interview, patients seemed more able to say that in certain respects their care had been excellent, but in others it had not been as good. Evasion was common, as in responses such as "I wouldn't expect that, but others might;" in mentioning failures in nursing care for roommates; or in shifting responsibility to themselves by stating they hadn't asked for something. Noted, too, was a great deal of explicit anxiety about being seen as "picky" or complaining. Since all statements were recorded in their entirety, some evidence of patients' doubts, misgivings, or reasons behind a judgement was gained.

After writing some open-ended questions to provide a structure for this section of the study three pilot interviews were conducted. The questions were then reduced to four which seemed to allow maximum elaboration, and these were written onto a card so the patient could be shown them when permission to interview was requested (Appendix 3). It was hoped this would reduce the anxiety evident in the first two pilot interviews where the patients said afterwards they had been worried about what might be asked.

Research Approvals

Having achieved a practicable study design, a research proposal was submitted and defended before the Massey University Social Science Faculty Ethics committee. With approval from this committee, the proposal was sent to the Ethics committee of the Hospital Board in whose unit the study was to take place. Their reply (Appendix 7) provides some support for the view expressed in this thesis: that nursing care during unstructured time is not valued. The letter states "It was noted that it was proposed to carry out the study at such times during the day when the nurses most involved with the patients would not be included, it was felt that this could limit the scope of the study." The particular unit employed nurses as "therapists" during the hours of 8.00 a.m. to 5.00 p.m., and presumably it was felt that these therapy sessions were what should have been observed.

Chapter 7

METHODOLOGY

This descriptive study uses a model depicting helplessness as a negative "mirror-image" of self care to look at nursing practice with patients who are depressed in one psychiatric in-care setting. The major research question is

> DOES THE NURSING CARE OF DEPRESSED PATIENTS IN AN IN-CARE SETTING TEND TO SUPPORT BEHAVIOURS INDICATIVE OF PROGRESS TOWARDS HELPLESSNESS OR ENCOURAGE THOSE WHICH INDICATE PROGRESS TOWARDS SELF CARE?

To gain a broad view in researching this question, specific questions reflecting three separate perspectives were identified:

1. (a) Does nursing care of adult patients with depression as observed in practice in the unit indicate any 'fit' with the helplessness/self care model described?
   (b) If there is a 'fit', does such observed nursing care tend to facilitate progress from helplessness towards self care?

2. (a) Is there any agreement among registered nurses working in the unit about what are effective and ineffective nursing actions with patients who are depressed?
   (b) Does their view of effective nursing practice 'fit' with promoting progress towards self care?

3. (a) How do patients recognise they are making positive progress, and do the behavioural changes fit with progress as the helplessness/self care model would predict?

   (b) What do patients see as helpful or effective nursing actions and do these 'fit' with the helplessness/self care model?

The Setting

The setting used for the study is an acute psychiatric unit within a general hospital. It has 20 in-care beds, with facilities also for one family to stay. A floor plan is shown below. (Figure 6)

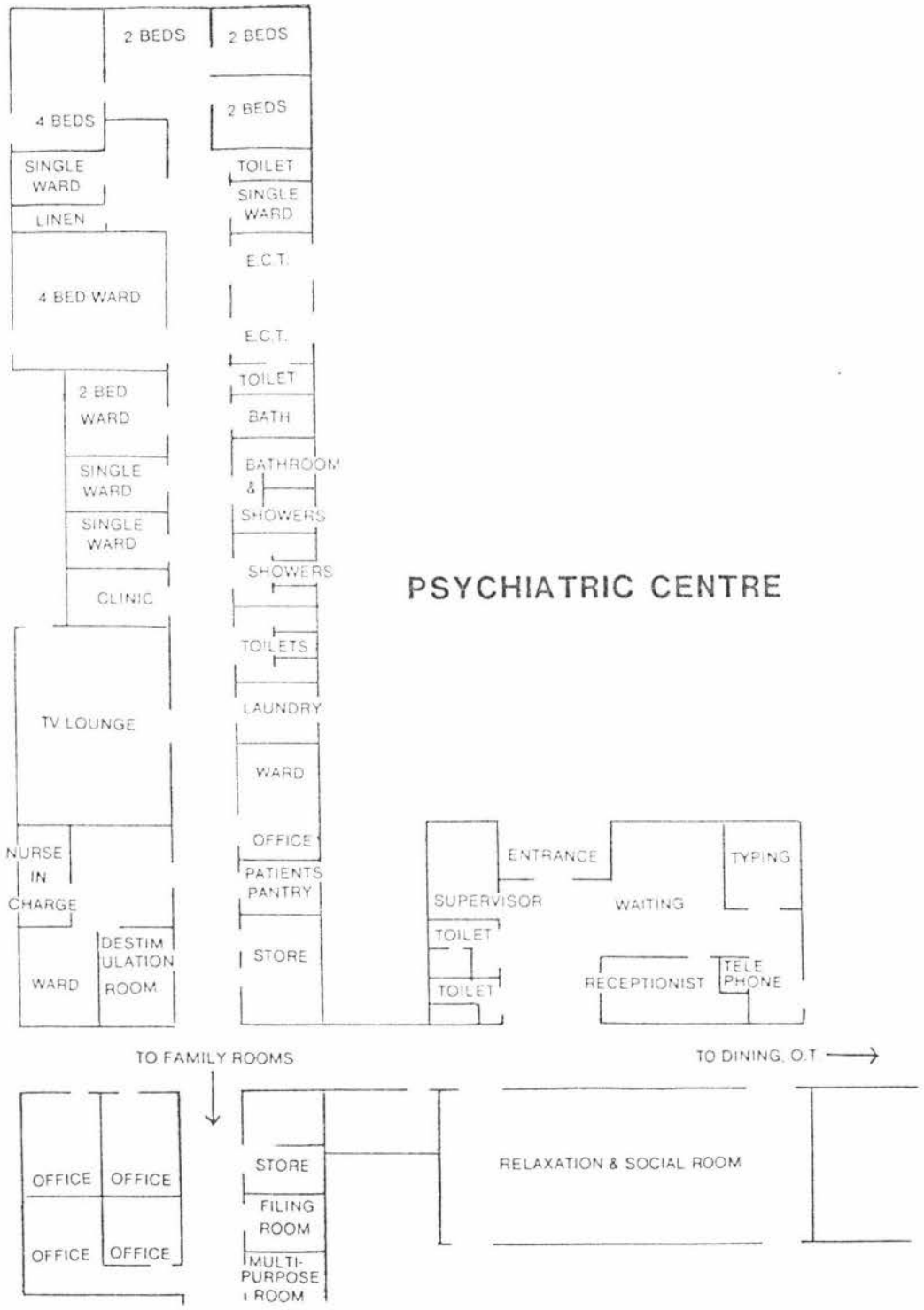

FIGURE 6 Floor Plan of Unit used in Study

Apart from its in-care service, the unit provides a large day and out-patient service, and patients 'on the books' of the latter two services may come to the unit for support as required without being admitted. Although new patients normally come to the unit via a general practitioner or Accident and Emergency Department, patients who are in crisis and are known to the unit can come direct. Telephone counselling is another service offered patients 'on the books'.

On weekdays, patients are expected to be up, washed and breakfasted ready for the day's 'structured' programme which begins at 8.00 a.m. and goes through till 5.00 p.m. with group and individual therapy sessions; recreation and rest. Tea is served at 5.00 p.m. and time from then is usually unstructured. At weekends, patients are usually left to wake at leisure and breakfast is kept until 9.30 a.m., with people getting it when they desire. Everyone is expected to be up by 10.00 - 11.00 a.m., but the day apart from meal times and visiting times is relatively unstructured.

Staffing during unstructured time (see glossary, p. xv) usually comprises 2-3 registered nurses and one or two nurse aids working under the direction of the registered staff. Some have psychiatric registration; some general; while others have comprehensive registration. Most of these staff work on a part-time basis, working from 1-5 shifts a week. There is always a consultant psychiatrist on call. Shifts worked are 7.00 - 3.30 p.m.; 2.30 - 11.00 p.m.; 11.00 p.m. - 7.30 a.m.;

Nursing staff do not wear uniform and christian names are commonly used by both staff and patients. Patients can use kitchen, bathroom and laundry facilities when they wish, and they have free access to games room and lounge with television. There is a minibus available to take patients on outings. Although the unit is cleaned commercially, patients who are capable are expected to maintain their bedrooms in reasonable tidiness. They are also encouraged to contribute towards making morning and afternoon tea and supper.

SAMPLE

(a) ALL nursing staff employed in the unit during the period of the study: N = 28 Registered Staff
10 Nurse Aids.

(b) ALL patients aged 18 and over

(i) who were admitted to the unit from 17 August 1981 to 30 November 1981

(ii) AND who, as determined by the Nursing Supervisor or person delegated by him, exhibited on admission at least four of the following eight symptoms indicative of a depressive episode:

1. appetite disturbance with gain or loss of weight
2. sleep disturbance with either too much or too little sleep
3. loss of energy with fatigue or tiredness
4. psychomotor disturbance with either agitation or retardation
5. loss of interest and/or pleasure in activities and a decrease in sex drive
6. self reproach and/or guilt

7. decreased concentration and reported inability to think or make decisions

8. recurrent suicidal thoughts including wishes to be dead and/or suicidal behaviour

(from Kalkman and Davis, 1980, 266)

(iii) AND who agreed at the request of the Nursing Supervisor his delegate to being 'shadowed' as part of this study: N = 13.

Time Span

The observation study was conducted over a 15 week period from 17 August to 30 November 1981. Interactions within 2 3-hour periods with each patient were observed, giving a total of 74 HOURS OF OBSERVATIONS.

The scaling exercise was completed by all staff between 1-7 December 1981, while patient interviews were conducted within 2 weeks of discharge from in-care.

Procedure

(a) Observations of patient-nurse interactions in an in-care setting

The sequence of events leading to observation by one of two trained people observing was:

1. The Nursing Supervisor or his delegate identified the patients who fitted the criteria outlined under "SAMPLE" and recorded which of the criteria were met.
2. The Nursing Supervisor or his delegate explained to the

patients on their third day following admission that there was a study being done in the unit to obtain information about the nursing care being given to try to find any ways in which it could be improved. Their help would be very much appreciated. Would they agree to have an observer stay with them for three hours, on two consecutive evenings (or for a Saturday and Sunday from 7.00 a.m. until 11.00 a.m. one day and 11.00 a.m. until 2.00 p.m. the next) - not to talk to them, but just to keep by at a short distance so that she could record what care the nurses gave over that time period.

3. If the answer was "NO", there was no further action. If "YES" the Supervisor or delegate telephoned one of the observers to let her know there was a patient willing to participate who reached fourth day the following day. The observer then decided which evening or weekend days observations would take place.

   The observers were, in their preparations, asked to always

   1. introduce themselves to staff and the patient concerned before commencing observations
   2. thank both staff and patient for their assistance before they left
   3. explain that any questions should be directed to the nurse researcher.

ALL nursing staff on the shifts covered were individually told by the researcher that a study was being carried out on depressed patients and their care; that further information at this stage

might affect their behaviour and therefore the patient's behaviour, so their forbearance was asked not to question further. The mechanics of the study in terms of sample size and hours of observation were explained and they were told that the study would be fully discussed when the observations of all the patients were over. While observations were taking place, staff were asked to please

1. accept the observer as 'part of the furniture' as far as possible - not talk to her nor ask what she is recording
2. not talk to the patients about the study other than to say it is good that we get this kind of information (patients have been told it is nursing care we are looking at to try to improve it)
3. continue in their work as normal.
4. Each patient was 'shadowed' only twice on the fourth and fifth or fifth and sixth day after admission at the following times:

   Evenings: 5.00 - 8.00 p.m. and
   8.00 - 11.00 p.m.

   Days: Saturday, Sunday OR Public Holiday — 7.00 - 11.00 a.m. and 11.00 a.m. - 2.00 p.m.

5. A data sheet (see Appendix 2) was provided for the observer to use in making observations, and recording continued for the three or four hour period.

Preparation of observers and staff

Two observers, both registered nurses, were orientated to the unit and then trained to use the chart provided by observing and recording a series of videotaped interactions. This was done to ensure that in the field experiment the observers would mark categories on the observation chart in a similar way. Problems were clarified as they arose, and some adjustments were made to the chart at this stage to improve ease of recording. After this training, observers watched a further series of video interactions so that a reliability coefficient could be calculated for their recordings.

The Pearson correlation coefficient calculated was 0.913 ($p<.001$). This is well over the value of 0.8 which is accepted in the testing literature for reliability coefficients (Anastasi, 1976). The result of an F test on the same data was insignificant with a probability of $<.75$, indicating that there was no constant difference between the recordings of the two observers accounting for the high correlation.

(b) Nurse Perceptions of Effective and Ineffective Nursing Interventions

A procedure based on the scale devised by Thurstone (1929 in Krech, Crutchfield and Ballachey, 1962) was used to determine what nurses thought were effective and ineffective nursing interventions. Using the recent literature on nursing patients who

exhibit depressive symptoms, a number of statements of possible nursing actions were generated. A study of nursing notes (unpublished study, Butterfield, 1979) provided a further source for statements. Since the total number of statements was high, only those which could be observed in practice without too much inference by observers were retained.

Statements were then sorted by registered nursing staff who were asked to rate each on a scale from 1 to 8 indicating least effective actions to most effective actions. Since each statement was on a separate card, it was easy for nurses to shift these around as they ranked other statements and wished to re-rank a previously sorted statement. Statement cards had been shuffled prior to placement in an envelope ready for use, so that they were not presented in numerical order. No rankings were recorded until all sorting was completed. (For full instructions and list of statements used, see Appendix 4).

Measures of central tendency and a frequency distribution were computed for each statement across the sample (N = 21), using the procedure "FREQUENCIES" from the Statistical Package for the Social Sciences (SPSS) (Nie et al, 1975). Results were examined to determine which statements showed consistently that they were either effective or ineffective. Consistency was inferred where the following criteria were met:

1. mean, median and mode were all either 7 or 8, indicating very effective interventions OR 1 or 2, indicating ineffective interventions

2. standard deviation was less than 1.5
3. range was not more than 4.

Trends were identified in some other statements where results showed high agreement but lacked the consistency outlined above. Relationships between nurse perceptions as indicated by results or rankings and the helplessness/self care model were then explored and some comparisons made with results of other studies in the area.

(c) Patient interviews

After they were discharged, patients from the identified sample were interviewed about their perceptions of their progress and their care. The four questions asked were:

1. What are the greatest differences you feel in yourself from when you came into hospital compared with the way you feel now?
2. What kinds of things let you know in yourself that you were making progress - that you were getting better?
3. Think of the person on the nursing staff who helped you most (no need to mention names). How was that person able to help you?
4. Was there anything nurses could have done that would have helped you more?

Information gathered from these interviews was examined for possible relationships with the helplessness/self care model and was compared with the results of other studies of patients' perceptions of their care.

Chapter 8

RESULTS AND DISCUSSION

This study sought to provide descriptive data relevant to the question "Does nursing care of depressed patients in an in-care setting tend to support behaviour indicative of progress towards learned helplessness, or does it tend to encourage behaviours which indicate progress towards self-care?"

Research results are presented in three sections, with discussion reflecting three views of nursing practice. The first section details what nurses were observed to do during patient-nurse interactions in an in-care setting. Nurse perceptions as shown in results of a scaling exercise to determine effective and ineffective nursing interventions then provide information on what nurses in the sample thought should be done in practice. Finally, patients' views of their progress and care provide the third perspective.

OBSERVATIONS OF PATIENT-NURSE INTERACTIONS IN AN IN-CARE SETTING

Observations of 186 interactions were carried out in 3 hour periods over 74 hours within a 15 week period. (For one patient who became acutely disturbed while being observed, the period was reduced to 2 hours). The behaviour of 13 depressed patients and that of the nursing staff who interacted with them was recorded. None of the patients were observed on weekend days, since the granting of weekend leave when practicable for in-care patients precluded this. 3 patients had to be dropped from the sample because their 4th - 6th days fell over the weekend and they were granted leave. Each of these patients had been in the unit as in-patients before.

Eight patients refused to participate in the study, and one reason suggested to account for this was that most of these patients were more depressed than whose who agreed to being 'shadowed', - that perhaps these patients might have agreed to participate at a later stage of their in-care stay. However, the restriction of observations to between 4th and 6th days was adhered to, since it had been set as a practicable, albeit not infallible method of attempting to have patients at a similar stage of illness. The refusals, in the final analysis, may in fact have been a factor which determined this just as much as the arbitrary decision of x days after admission.

It was noted by the nursing supervisor that 20 - 25 patients also met the criteria but could not be included because they were grossly

psychotic and he felt it would not have been therapeutic to have an observer with them, nor could they have given informed consent for observations.

Biographical Data

It is the INTERACTIONS which are the focus of this study, not the patients. However, brief biographical and contextual data are important to provide some feeling for the milieu in which interactions took place.

Nurses: Biographical details of the registered nursing staff were as follows: 7 staff were male and 14 female.

Of the 12 staff who held a psychiatric qualification, 7 had psychiatric registration and 5 a comprehensive registration. 9 staff were registered general nurses who had no psychiatric qualification.

5 staff had registered since 1975, 1 between 1970 and 1974, and 12 prior to 1969. (Missing data = 3).

15 staff had worked in a psychiatric setting for more than five years, 3 of these for more than twenty years.

Nurse aids were included in this portion of the study since they form part of the nursing staff and work under the direction of registered staff. Like the registered staff who became involved in the observation section of the study by virtue of being rostered on

evening or weekend shifts, most of the aids worked part-time, one or two evenings a week. Many were concurrently studying at university, most commonly within the social science faculty. N = 10: - 6 female, and 4 male.

Patients: Of the 13 patients 'shadowed', 2 were male and 11 female, with ages ranging from 19 - 65. 3 patients were single and 10 married.

4 patients were cited as having no religion, 4 Roman Catholic, 2 Presbyterian, 1 Anglican, and 2 "other" with no further information given.

1 of the sample was Maori and 12 European, - this reasonably reflecting the statistical proportions for the urban area involved as shown in the 1976 New Zealand census information, where Moaris comprised 4.3% of the total population.

6 patients had received previous psychiatric care at the unit with 4 being admitted from current outpatient status. 7 had been admitted for the first time for psychiatric care.

3 patients were given Electro-convulsive therapy (ECT) during their in-care stay.

Admission Data:

To become part of the sample, patients had to exhibit on admission at least 4 out of 8 criterion behaviours identified as typifying

a depressive episode by Kalkman and Davis (1980, 266). Table 3 shows how many patients in the sample exhibited each of these behaviours.

TABLE 3 Numbers of Patients exhibiting specific Criterion Behaviours on Admission (N = 13)

Criterion Behaviours	No. of Patients
Appetite Disturbance with weight change	8
Sleep Disturbance	10
Loss of Energy with fatigue	7
Psychomotor Disturbance	8
Loss of Interest/Pleasure in activities/sex	11
Self reproach and/or Guilt	5
Decereased concentration and inability to make decisions	13
Recurrent suicidal thoughts and/or behaviour	10

Only one patient exhibited all 8 criterion behaviours on admission, and the mode was 5 behaviours.

The only criterion behaviour exhibited by all patients in the sample is the decreased concentration and inability to make decisions. This provides an indication of 'fit' with the helplessness process (p. 50) since it is the one criterion that relates specifically to the learned helplessness model. Others do relate, of course, but not to any greater extent than they do to, for example, a biochemical or psychoanalytic model.

This sample was selected on the basis of behaviours observed, not according to diagnostic labels. However, the diagnoses assigned each patient were noted as is shown in Table 4. (The patient with Tardive Dyskinesia was also diagnosed as having Psychotic Depression).

TABLE 4 Provisional Diagnoses given Patients in the Sample (N = 13)

Diagnosis	No. of Patients
Manic-depressive Illness: Circular type	1
Bipolar Affective Disorder	1
Psychotic Depression	3
Tardive Dyskinesia	1
Agitated Depression	1
Depression	5
Schizophrenia	1
Personality Disorder with Depression	1

The low number of patients with a diagnosis other than some form of Depression as defined in the WHO International Classification (WHO, 1977) is, perhaps, surprising. Patients who are given a diagnosis of schizophrenia, for example, not uncommonly exhibit depressive behaviours. Since the criteria for admission to the sample were behavioural, it was thought that a wider range of diagnoses could have been included. However, the 20 - 25 psychotic patients earlier mentioned as being omitted from the sample for ethical and

therapeutic reasons probably account for the lack of such diagnoses in the sample.

Duration of In-care Stay and Follow-up Arrangements

The range of the time spent in in-care was from 9 days to 79 days. Four patients were discharged within 3 weeks and a further four within 7 weeks. Two patients were in hospital longer than 9 weeks.

It could be inferred that some patients were more seriously ill than others and that this would account for the discrepancy in length of in-care stays. However, from information gained on the unit, it seems likely that other factors such as geographic distance of home from the unit; the home background and available support for the patient on discharge; and the ideology of the particular psychiatrist treating that patient were largely responsible.

The fact that 6 of the patients in the sample were discharged to outpatient care, 3 to day-patient care, and 1 to the halfway house operated by the unit indicates that most patients were being discharged probably as soon as acute symptoms subsided and functioning improved to the point at which they no longer required 24 hour care. One patient who was observed early in the study was discharged to day-care but had to be readmitted 3 weeks later, when she was again observed for this study as another admission. Another patient also in the study sample was readmitted within the time span of the study but was not eligible for observations the second time round because she went on weekend leave at the time when observations would have taken place. These examples support the idea of 24 hour in-care

status mostly being reserved for crisis care. Only 3 patients were discharged back to the care of their usual General Practitioner.

The Context

The 'pace' of the unit fluctuates. As previously mentioned (p. 67) when describing the setting for this study, there are usually 4 - 5 staff on during the evenings and weekends (2 - 3 registered staff and 1 or 2 nurse aids). Catering for the whole range of acute psychiatric care means that at any one time the patient load may include anorexic patients on behavioural programmes requiring very consistent and time consuming management, as well as psychotic patients, any one of whom may suddenly need total commitment from one staff member for a period of time. Additional to this are the variable demands placed upon staff by the provision of a telephone counselling service for patients, not currently in in-care but known to the unit, who may be suffering some crisis; who require information about effects of medication; or who have concerned relatives not knowing what to do to help. Such patients can also visit the unit if in need of social or emotional support or medication.

Outside of 8.00 a.m. to 5.00 p.m., a record is kept of telephone work and visits by patients to the unit and a survey of this book over the time span of the observation study indicated that, on average, 4 - 5 patients or their relatives had been given counsel over the telephone each day. 12 calls were recorded on 3 occasions - these calls all being over and above normal enquiry work. Since there is no receptionist outside of 8.00 a.m. to 5.00 p.m., nursing

staff must cope with this work as well. In contrast, on some occasions only 1 or 2 calls were recorded.

Outpatients coming in to the unit for medications, support or socialisation outside 8.00 - 5.00 p.m. numbered 3 - 5 on average on weekdays, but increased to up to 16 on some weekend days. Not all of these people would have required much nursing time, but the extra demands must reduce the availability of staff to in-patients.

This information is supported by comments from both observers who spoke of the greatly fluctuating nature of the patient care needs. On busy nights they felt patients who were not overtly distressed got less attention. Unless patients sought help, staff tended to leave them alone although on some occasions the observers felt patients' behaviour indicated they needed attention. However, the demands of other patients were highly visible to all, and both observers and patients commented that sometimes the nurses just had so much to do it was not possible to spend time with everyone.

One of the areas of intervention identified in the chapter on nursing care was that of observation and assessment (p. 30). These concepts are basic to nursing in any situation and in this instance it would have been useful to know what kind of observations were being made and how priorities were assessed. However, any such judgements by the observers could only be inferred from observation and because asking the nurses what they were observing and what assessments they were making would have confounded the rest of the study, this area has

not been included in this study. Its importance would suggest that a separate study relating to observation and assessment alone would yield profitable information.

Overall, observers commented very positively on the ward atmosphere. It 'felt' very friendly and warm. Staff seemed easy to approach and appeared mostly to be fairly readily available. It was suggested that the times when they appeared least available were when the unit was not so busy and there was a tendency for staff to gather in the office to chat. This was also mentioned by a number of patients who commented that they found it more difficult to approach staff when there was more than one and they were talking together.

The support and help given by fellow patients was said by the observers to be tremendous. They were in a position as 'part of the furniture' to hear patients talk about their problems to other patients. Often it was after such a talk that a patient would approach a nurse about the problem just discussed, - sometimes at the direct suggestion of the other patient, e.g. "You should tell the nurse about that." It was noted that, in general, the nursing staff were highly spoken of amongst the patients.

Patient Activities Observed

Although the focus of observations was on interactions between patient and nursing staff, patient behaviours between interactions were also recorded to provide contextual information.

13 patients were observed, but of these 1 exhibited increasingly disturbed behaviour to the extent that it was felt necessary to discontinue observations in her interests after 2 hours. All others were observed for 2 3-hour periods: one from 5.00 - 8.00 p.m., the other from 8.00 - 11.00 p.m.

The evening meal was served at 5.00 p.m., and in most instances, patients were in the dining room at least until 5.15 p.m. Visiting hours were from 7.00 p.m. to 8.00 p.m., and of the 13 patients observed, 8 had visitors for that hour on the night of observation. All were left with their visitors for that time, but there was contact with staff as visitors came and went. Contrary to what nurses indicated they believed was effective nursing action (p.106) they did not talk with patients and their visitors together.

Television watching was the most common patient activity recorded, with only 2 patients not spending time in this manner. These same 2 patients were also recorded, along with 3 others, as having spent some time alone (i.e. more than 20 minutes) during the evening. One of the 2 spent most of the evening in bed, and the second had retired to bed by 9.00 p.m. Other activities included playing scrabble, cards, or pool; sitting chatting with other patients; or assisting with making supper and odd drinks. 6 of the patients had retired to bed to sleep by 9.00 p.m. and only 3 were still up when observations ceased by 11.00 p.m. From this information it seems hardly surprising that early morning waking is a common symptom of depression.

All patients attended to their own physical needs and these activites were performed alone without interaction with staff. This contrasts somewhat with the earlier suggestion of the unit being used for 'crisis care', since on that basis, one would expect patients to be having difficulty in these areas so soon after admission. Again, the suggested reason for this is that the more depressed patients did not become part of the sample, either because they could not or would not consent to participating in the study.

INTERACTIONS OBSERVED

A total of 186 interactions were observed to occur between the patients being 'shadowed' and a member of nursing staff over the 74 hours. Recordings were discontinued after 2 hours with one patient who became overtly disturbed. The length of interactions varied from a few seconds to 12 minutes.

Registered staff interacted with patients in 146 (78.5%) of the total interactions observed. 33 recordings (18%) showed interactions with nurse aids, while in 7 instances (3.5%) it was not recorded which category of staff was involved. Relevant to this was the comment of one observer that the aids seemed to spend a lot of time with the anorexic patients and in activities with the more active patients. One reason suggested to account for this was that aids could be given specific instructions as to what they should do with the anorexic patients since their care was always clearly specified, and with the more active patients they could easily spend time profitably. It is not known whether aids were instructed to spend

their time with specific patients, in which case registered staff may have chosen to care for the overtly less well patients themselves.

Place: A majority of interactions (36%) took place in the lounge. A further 28% were recorded as happening in the patient's bedroom, and most interactions where feelings were discussed took place there. This seems reasonable when one considers the functions of each place and the relative privacy of each.

As would be expected, a number of interactions occurred in the dining room during the evening meal (13%). The corridor was the place where 16% of interactions occurred - most of them social chat in passing.

Posture: The posture of the nurse in relation to that of the patient was seen as relevant to determine whether patient and nurse are often on 'equal terms' when interactions take place. As noted (p. 14) therapeutic communication may be difficult to achieve when the nurse is perceived as dominant in the interaction. Observers therefore recorded whether nurses maintained a 'dominant' posture by standing while the patient sat or lay down, or if the reverse occurred. Table 5 shows the basic posture held by nurses and patients during interactions.

TABLE 5 Basic Posture Held by Nurses and Patients in Interactions As a Percentage of Total Interactions N = 186

POSTURE	% of INTERACTIONS (rounded to nearest whole No.)
Nurse and Patient both standing or sitting	59
Patient stands while Nurse sits	6
Nurse stands while Patient sits or lies down	35
	100

It was also recorded that nurse or patient changed posture during the interaction in 6.75% of instances when they were not on "equal" terms at the beginning. In well over half of the interactions observed, then, patient and nurse appeared to be in a position where body posture would indicate that neither party in the interaction was dominant. Of course, many other factors contribute to the dimension of dominance - tone of voice, attitudes, values, gestures for example, but aside from these issues, it would be difficult to even begin to talk as 'partners' if a dominant body posture were to set the tone of the interaction from the start.

Touch: Touch has been recognised in much of the literature as being therapeutic for the depressed, (e.g. Stuart and Sundeen, 1979; Burgess, 1981) and it seems relevant in relation to patient self-image in terms of being "untouchable." While it was not possible with the other demands upon the observer to ask for more than whether or not there was any action resulting in physical contact between

patient and nurse, it was felt that it would be worthwhile to establish the number of times touch was recorded in relation to the total number of interactions. At least it is an indicator of proximity in interaction, particularly where there is no task involving physical contact between patient and nurse.

Touch was noted to occur in 12% of total interactions in this study. Of this figure, one patient accounted for 9.5% of the instances of touch occurring.

Both observers commented independently on what they felt was a lack of physical contact by nurses with patients being shadowed where, in their opinion, patients could have considerably benefited from this. It was also noted that with the one patient who was touched, it was one particular staff member who did the touching, and that the patient responded positively to this, seeming to relax and calm after being touched, even briefly. Comments from observers indicated that, with a few exceptions, staff generally did not get physically close to other patients either. They did not think that the patients being 'shadowed' were treated any differently from other patients in the ward.

Availability

Throughout this thesis the concept of availability has been given prominence as a vital component of nursing care (pp. 35-37). Over the 74 hours of observations with 13 patients, a total of 186 interactions between staff and the patients being shadowed were recorded. Many of these were of short duration, - some only seconds. Despite the

perceived approachability of the staff by both observers and patients, such a small number of interactions over the time span involved does not indicate that these particular patients had much personal contact with nursing staff, and this calls staff availability into question. The presence of the observer may have inhibited interactions but it is felt that this alone does not satisfactorily account for the low contact. Other factors which would affect this included visitors, and the time the patient went to sleep, but even taking these into account, it is suggested that despite comments indicating staff were approachable, they often were not available. The adequacy of staff:patient ratios would also have to be considered here.

Patients in this study appreciated nurses spending time with them when they felt down (p. 123), and the nurses in the sample believe it is a good thing to do so (p. 107). When observed in practice it was found that nurses did spend time with patients when they were exhibiting depressive behaviours. 10% of total interactions observed (N = 186) involved just such situations. Further, every instance (100%) of overt depressive behaviour such as crying resulted in attracting nurse time. On only one occasion (0.5%) did the nurse stay briefly, but tell the patient when she would return, and this occurred when the unit was very busy with the nurse being required to man the office for telephone calls, visitors etc. It could not, therefore, be suggested that such "ministrative availability" (Schmidt, 1972, see glossary) was knowingly used as it could be in such situations.

Nursing Approach

The kind of nursing approach could affect patient self-image by indicating that the patient was, for example, incapable of performing tasks or not able to make decisions, and could certainly assist in identifying when self-image was unrealistic. Necessarily the approach will affect the course of the interaction and thus the patient-nurse relationship and its therapeutic value.

Categories recorded to give information about the kind of nursing approach used included

1. whether the nurse performed a task for the patient during the interaction
2. who initiated conversation and whether this involved information about personal or non-personal things; or about feelings
3. the kinds of questions nurses used - open or closed.

Tasks: In 13% of total interactions (N = 186) nurses performed a task for the patient. These ranged from taking blood pressures to giving medications. Interactions were not prolonged after the task was completed.

Conversation: The range of content of conversation in interaction observed in this study covered much social chat related to dining, television, or other activity in which either patient or nurse were engaged; some sharing of information about home, family, animals, garden etc; and occasionally some conversation about the patient's feelings. Nurses' feelings were never discussed. 53% of interactions

involved conversation about non-personal things.

Conversation was initiated by nurses in 61% of interactions; by patients in 31%; and in 8% another patient initiated but drew in both the patient being "shadowed" and a nurse.

Information: Nurses gave information in 32% of interactions, whereas they asked the patient for information in 68%. Of the questions asked by nurses, (N = 127) 63% were 'closed' thus reducing the likely answer to a "Yes" or "No" or at best a very short reply. In 18% of these instances nurses continued to question further within the same interaction, still using closed questions. These do not encourage any elaboration and are considered less helpful in establishing the rapport necessary for development of a therapeutic relationship than are 'open' questions.

Asking open questions suggests that the questioner is really interested in the reply: the question has been asked in such a way that more than a brief reply is expected. This assists in leading to the sharing of information, ideas, opinions and feelings (Sorensen and Luckmann, 1979). Nurses in this study used open questions in 37% of interactions.

Powell (1969) has suggested that there are five levels of communication: (1) cliché conversation, (2) reporting facts, (3) sharing personal ideas and judgements, (4) sharing feelings, and (5) peak communication. Parkinson (in Sorensen and Luckmann, 1979, 39),

elaborates on the relevance of these for nurse-patient relationships and suggests that cliché conversation may be employed to help establish trust. However, it is really only at the third level where some sharing of self is taking place that it can be assumed some trust has been developed in the relationship. Interpersonal trust and security are necessary conditions for the sharing of feelings to occur and the nurse can help build such a climate by (a) being a real person herself (genuineness); (b) caring warmly for the patient (non-possessive warmth); and (c) attempting to understand him accurately (accurate empathy). Peak communication, or a sense of 'oneness' is achieved by few and even then for only short periods of time.

Feelings: Feelings were discussed in 21% of total interactions and, as noted previously, these were always those of the patient. Nurses did not discuss their own feelings with the patients. Neither Powell nor Parkinson clarify whether the sharing they speak of should include only the patient's feelings. Ujhely (1968, 762) infers that in most instances this is appropriate - "A nurse is entitled to have feelings, regardless of what nature, toward a patient. We are not necessarily entitled, however, to express these feelings openly to him." Saupe (1974), however, is explicit in her belief that although a nurse may not be comfortable expressing her feelings to a patient, both patient and nurse can grow from the experience if she does.

Validating feelings is very important if the nurse is not to make unwarranted and possibly inaccurate assumptions, and in 45% of instances where feelings were discussed in this study, these conversations ensued

because nursing staff had checked out with the patient what they thought he might be feeling.

Patient Response to the Nursing Approach: Content of patient conversations in interactions comprised 21% about their feelings; 16.5% about themselves as people; and a large component, 62.5%, about topics that were entirely impersonal. These results, combined with detail on the records, indicate that most communication was occurring at Powell's (1969) levels of cliche conversation and reporting facts. There was little to suggest much development of patient-nurse relationships based on the concepts of nurse genuineness, non-possessive warmth and accurate empathy, - all of which depend basically on the prior concept of availability.

Patient-initiated Activity: One of the factors identified in the helplessness process is the failure to initiate active responding, while the opposite is true of the self care process. As already noted, patients initiated conversation in 31% of interactions. All patients 'shadowed' cared for themselves in relation to personal needs for hygiene, sleep, food etc. indicating that the level of depression across the sample was not extreme. Aside from such personal activities, recordings indicated a low level of patient-initiated activity unless one classed watching television in this category. The feeling of observers was that in many instances this was very passive, - sometimes even just a 'front' to appear occupied until the patient went to bed. Patient-initiated activity within interactions with nursing staff occurred in 6.5% of total interactions.

These activities included reading; completing a jigsaw; and preparing drinks or food for supper.

Nurse Response: It was noted that in 50% of the interactions within which patients initiated activity nurses did not comment at all or seem to acknowledge this fact. In 33%, there was acknowledgement, but in only 16.5% was positive comment made.

The lack of positive reinforcement to patients in the study given by nurses was commented on by both observers. One said she often wished she had been 'shadowing' an anorexic patient as then she could have recorded plenty of instances of positive reinforcement being given. When asked if it was felt that the observers themselves were the inhibitors in relation to patients in the study, the opinion of observers was that this was doubtful. Certainly their presence in the lounge, for example, did not inhibit positive reinforcement being given the anorexic patients in that room, nor did they feel the patients they 'shadowed' were treated any differently from the majority of other patients. Anorexic patients in the unit are all on behaviour modification programmes, with nursing actions and responses to specific behaviours being clearly specified, and this results in positive reinforcement being given consistently. Despite the need for consistent positive reinforcement in the care of depressives, there was no indication of such an approach with this group.

Motivation and Goal Setting

Nurse behaviours relevant to supporting patient motivation and goal setting were very few. It has been noted (Kalkman and Davis, 1980) that individual motivators can be used to assist the patient to progress. In this study, in 1.67% of interactions, nurses tried to assist patients to identify things they liked or that tended to result in their behaving in specific ways. In 0.5% of interactions, a nurse used a known patient motivator to assist a patient to participate in a specific activity.

Goal setting, too, is noted in Kalkman and Davis (1980, 279) to be of value to patients in specifying the expectations they have for themselves, and in providing a sense of achievement and pride at having met the requirements set. "Feelings of control and security are fostered when individuals take an active role in formulating their plans for the immediate future and when they know what is expected of them by others in the environment."

In 1% of interactions, nurses assisted patients with goal setting - in both instances very short-term and easily achievable goals for which positive reinforcement was given when they were met. Nurses set goals for the patients in 1.5% of interactions. These goals were not met. The number of instances here is too small to generalise, but it would be interesting at a later stage to develop a study in this area to determine what percentage of goal achievement occurs when goals are set <u>with</u> the patient or <u>by</u> the patient compared with goals being set by the nurse.

Decision Making

Difficulty in making any decision is an identified step in the helplessness model while decision-making is a crucial factor in self-care. Good decision making is based on adequate information and 17% of interactions comprised patients seeking information from nursing staff, indicating that even though active decision making behaviours were low (3%) patients were at a stage in their recovery where the prerequisite behaviours were becoming apparent. In 3% of interactions nurses set up decisions for patients to make, and on each occasion the patient did so. However, in 2% of interactions, nurses made decisions for the patient without any discussion or input from the patient.

Summary

Observations of 186 interactions between depressed patients and nursing staff were recorded over 74 hours. Conversation in interactions with staff tended to most commonly reflect impersonal topics. Patients' feelings were discussed with them by staff who did try to validate what they thought patients might be feeling. The feelings of staff were never mentioned and the question of whether or not this would be appropriate was raised. Touch between patients and staff was rarely observed.

Gross body posture observed during interactions did not suggest that nurses took dominant positions in these. However, results indicate that nursing care observed in this study in relation to motivation, goal setting and decision making could be serving to reinforce

patients' beliefs that they have no control over outcomes. Such a nursing approach conflicts with that which a self care model would prescribe, since the nurse is taking on greater compensatory responsibilities than are required, thus tending to reinforce helpless behaviours.

Positive action by patients themselves gained very little recognition from nursing staff who were not observed to spend time with patients who were exhibiting occasional independent and coping behaviours. There was, therefore, little evidence of positive reinforcement for non-depressive behaviours. It was noted that time WAS spent with patients who were clearly coping well, although none of these were in this study sample. It was suggested to observers that possibly patients in the sample tended to alienate themselves (see glossary, p.xiii) as Carser and Doona (1978) note depressed people may. However, the observers did not support this suggestion and neither did their records of patients' behaviour, unless one interprets retiring early to bed as an example of alienating behaviour.

In contrast to care given some other patients, notably those who were anorexic, little consistency was noted in the approach of staff to patients in the sample. The fluctuating pace of the unit, and the highly visible demands of some other patients were noted to affect the access patients had to staff. In general, the atmosphere was felt to be warm and pleasant and staff were said by observers to appear very approachable. However, the small number of interactions recorded over the 74 hours of observations does suggest that staff may not be as available as they seem.

NURSE PERCEPTIONS OF EFFECTIVE AND INEFFECTIVE NURSING INTERVENTIONS

21 Registered staff of a total 28 working in the unit agreed to complete the scaling exercise, details of which are given in Appendix 4, (pp.157-9). Biographical details of staff have been detailed on p. 77). The sample represents 75% of the total registered staff on the unit (N = 21).

Statistical Analysis

Descriptive statistics of the responses to each statement are given in Appendix 5 (p.163). 8 statements fell within the criteria identified as inferring consistency. These were that

1. mean, median and mode were all either 7 or 8, indicating very effective interventions OR 1 or 2, indicating ineffective interventions.
2. standard deviation was less than 1.5.
3. range was not more than 4.

Statement 33

GIVES SIMPLE, DIRECT INFORMATION ABOUT THE EFFECT OF DRUGS OR ECT

Table 6 present statistics describing responses by registered staff to this statement.

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TABLE 6 Frequency Distribution of Responses to Statement 33 given by Registered Staff (N = 21)

Rank	Absolute Frequency	Cumulative Adjusted Frequency
6	3	14.3
7	7	47.6
8	11	100
Total	21	

The mode for this statement was 8, the mean 7.38 and the median 7.54. Standard deviation was 0.74 and the range 2.

Responses here demonstrate that these staff believe it is important for the patient to have information about the effect of drugs and electro-convulsive therapy (ECT) and that they see it as a nursing function to provide such information.

Kalkman and Davis (1980), emphasise a need for simple, direct information, especially regarding the practical aspects of his illness that cause the patient concern - not just relating to the effect of drugs or ECT, but also regarding expectations of his behaviour; prognosis, possible loss of employment, home responsibilities and so on.

In this study, each of these kinds of information was put in a separate statement (statements 30 - 34) and results indicate a clear trend towards all of them being seen as effective actions (see Table 7),

although these other statements did not demonstrate the amount of consistency seen in statement 33. It is suggested that some kinds of information are seen as more important for the nurse to discuss with the patient. The effects of drugs and ECT and expectations of patient behaviour gain the most consistent high rankings, with talking about home responsibilities being ranked as less effective. The range of results for statements 30; 32 and 34 indicates that some staff have differing views of the effectiveness of these particular interventions.

TABLE 7 Statistics describing Responses by Registered Staff to Statements 30 - 34. (N = 21)

Statement	Mean	Median	Mode	Std. Dev.	Range
Gives simple, direct information about					
30 Home Responsibilities	5.45	5.50	6.0	1.84	7.0
31 Expectations of his behaviour	6.38	6.62	8.0	1.53	4.0
32 Patient's Prognosis	5.76	5.87	8.0	1.97	6.0
34 Employment Prospects	5.50	5.70	6.0	1.73	5.0

As noted (p. 92), nurses observed were seen to offer such information, and patients state they appreciated having it (p.125). In this instance, then, this study demonstrates support for what is suggested in the literature. In relation to the helplessness/self care model, such information would be seen as vital to the learning process and subsequent decision making which are identified as key components.

Statement 97

DISPLAYS CALM CONFIDENCE IN INTERACTION WITH PATIENT

TABLE 8 Frequency Distribution of Responses to Statement 97 given by Registered Staff (N = 21)

Rank	Absolute Frequency	Cumulative Adjusted Frequency
6	3	14.3
7	4	33.3
8	14	100.0
Total	21	

The mode for this statement was 8, the mean 7.52 and the median 7.75. Standard deviation was 0.75 and the range 2.

As Kalkman and Davis (1980, 278) note "Only a calm person can effectively assist an anxious patient." Anxiety is not at all uncommon in depressed patients and it seems nurses in this sample are in agreement with the need identified in the literature for a calm, confident approach.

Statement 82

ASSISTS PATIENT TO SET REALISTIC SHORT-TERM GOALS FOR HIM/HERSELF

TABLE 9 Frequency Distribution of Responses to Statement 82 given by Registered Staff (N = 21)

Rank	Absolute Frequency	Cumulative Adjusted Frequency
5	1	4.8
6	3	19.0
7	7	52.4
8	10	100.0
Total	21	

The mode for this statement was 8, the mean 7.23 and the median 7.42. Standard deviation was 0.88 and the range 3.

"Goals that are impossible to achieve before discharge are discouraging to both patients and nursing staff. Including individuals in planning their nursing care is an educational experience that increases their sense of personal responsibility and self-esteem." (Kalkman and Davis, 1980, 277).

Support for this view is clear from the responses of staff in the unit used in this study. However, as has been noted (p.96) examples of this kind of nursing behaviour during the period of observation in the unit were very few. Although the staff clearly believe this is a good thing to do, there was little evidence of their carrying it out in practice.

Statement 78

GIVES REALITY FEEDBACK

TABLE 10 Frequency Distribution of Responses to Statement 78 given by Registered Staff (N = 21)

Rank	Absolute Frequency	Cumulative Adjusted Frequency
5	2	9.5
6	3	23.8
7	4	42.9
8	12	100.00
Total	21	

The mode for this statement was 8, the mean 7.23 and the median 7.62. Standard deviation was 1.04 and the range 3.

Most depressed patients have a disturbed sense of self-esteem and the following are among the interventions described by Kalkman and Davis (1980, 280) to meet the nursing objective of increasing the patient's self-esteem.

> "When individuals make derogatory comments about themselves or unrealistically positive praises of themselves, point this behaviour out and explain that the tendency serves to block communication.
>
> Place limitations upon individuals' conversation regarding failures. Suggest that they talk further with their therapist regarding these issues. Focus the nursing interaction upon events of the here and now.

Provide honest, objective feedback about the patients' present appraisal of their feelings and behaviour."

Although scaling would have to be done for each of these statements, the simple principle "Gives reality feedback" is inherent in each, and again support for this concept as being basic to good nursing intervention with depressed patients is evidenced in results from the study sample. These results are also consistent with those of Gardner and Wheeler (1981) who found that nurses in their sample believed that "pointing out reality to patient" was important in medical, surgical and psychiatric areas.

Statement 62

TALKS WITH PATIENT AND VISITORS

TABLE 11 Frequency Distribution of Responses to Statement 62 given by Registered Staff (N = 21)

Rank	Absolute Frequency	Cumulative Adjusted Frequency
5	4	19.0
7	9	61.9
8	8	100.0
Total	21	

The mode for this statement was 7, the mean 7.0 and the median 7.22 Standard deviation was 1.09 and range was 3.

Leavitt (1975, 37) conducted a study of 16 families of psychiatric patients immediately prior to discharge in which she sought to gain information about their feelings and knowledge about the impending discharge of their relative. When asked what would have been helpful, "they responded that they needed guidelines, ways to cope with the illness of their relative, people to count on in time of trouble (professional especially) and a way to get in touch with resource personnel. They needed understanding, support, education, and someone to talk to."

If one is to treat visitors as often being significant others irrespective of blood ties, then it seems important that nurses do talk with patients and their visitors. As is mentioned in the section on patients' views (p.128) "Sometimes your visitors get told more than you do and that doesn't help." The intent in the statement above is determined by the word 'with', inferring that patient and visitors are one group. Responses from the study sample indicate these nurses perceive this as being important. However, from patient comment, and observations (p.85) it is questionable whether this is done in practice.

Statement 60

SPENDS TIME WITH PATIENT WHEN EXHIBITING DEPRESSIVE BEHAVIOURS, E.G. ISOLATING, CRYING, PHYSICAL COMPLAINTS, FEARFUL, WITHDRAWN ...

TABLE 12 Frequency Distribution of Responses to Statement 60 given by Registered Staff (N = 21)

Rank	Absolute Frequency	Cumulative Adjusted Frequency
4	1	4.8
5	2	14.3
6	2	23.8
7	3	38.1
8	13	100.0
Total	21	

The mode for this statement was 8, the mean 7.19 and the median 7.69. Standard deviation was 1.25 and the range 4.

Patients in this study appreciated nurses staying with them when they were 'upset' or 'really down' (p.123) and, as noted (p. 90) nurses in this study were observed to spend time with patients who were exhibiting depressive behaviours. Results here indicate that nurses in this sample perceive spending time with the patient on these occasions to be a good or effective action and these findings support those of Gardner and Wheeler (1981) who found that nurses in their study identified the item 'stay with patient when he is upset' as being important.

An alternative intervention for coping with patients who were overtly distressed was offered in statement 75:
WHEN PATIENT IS UPSET, STAYS WITH HIM UNIL HE FEELS CALM BUT THEN LEAVES, AND COMES BACK TO SPEND MORE TIME WITH HIM WHEN HE IS FEELING BETTER.

Responses to this statement did not meet the criteria for consistency. The mode was 6; the mean 5.9; the median 6.4; and the range 7. The literature would tend to suggest that this is in fact the better way to intervene in such instances since the dependent or depressive behaviours are given less reinforcement than those which indicate coping independent functioning.

Statement 39

ENCOURAGES PATIENT TO TALK ABOUT FEELINGS

TABLE 13 Frequency Distribution of Responses to Statement 39 given by Registered Staff (N = 21)

Rank	Absolute Frequency	Cumulative Adjusted Frequency
4	2	9.5
5	2	19.0
6	1	23.8
7	5	47.6
8	11	100.00
Total	21	

The mode for this statement was 8, the mean 7.0 and the median 7.54. Standard deviation was 1.37 and range 4.

As would be expected from what the literature suggests, nurses in this sample perceive it is important to encourage patients to talk about their feelings.

Statement 42

MENTIONS ONLY ENVIRONMENTAL TOPICS, (FLOWERS, WEATHER, ETC.)
NOT PATIENT-RELATED TOPICS IN INTERACTION

TABLE 14 Frequency Distribution of Responses to Statement 42 given by Registered Staff (N = 21)

Rank	Absolute Frequency	Cumulative Adjusted Frequency
1	8	38.1
2	10	85.7
3	2	95.2
4	1	100.0
Total	21	

The mode for this statement was 2, the mean 1.81 and the median 1.75. Standard deviation was 0.81 and the range 3.

Although the literature abounds with suggestions about helpful and effective nursing interventions, there is little information on the relative effectiveness of each and virtually none on what constitutes poor or ineffective nursing. To obtain a wide variety of statements, some 'negative' actions were formulated from the suggested effective actions in the literature, of which this statement was one example. It is unlikely that the opposites of all statements of effective nursing actions are necessarily equally negative or ineffective. Therefore, it seems important to distinguish which actions do fall into this category and which fall into an in-between category where it is an effective nursing action when it IS performed, but it is

relatively inconsequential when not performed.

Results here indicate that nurses in this sample agree with what is inferred in the literature since they rated this statement as being at the ineffective end of the scale.

Definite Trends

By relaxing the criteria for consistency to include statements where the standard deviation is less than 2.0 and range ignored, but mean, median and mode are still within 7 or 8, OR 1 or 2, 11 further statements show definite trends.

At the effective end of the scale is statement 13 -

ASSISTS PATIENT TO IDENTIFY ALTERNATIVE BEHAVIOURS FROM SUICIDAL THREAT TO GET ASSISTANCE AND SUPPORT

The importance of learning and the role of the nurse in assisting patients in their learning process is inherent in this statement. Certainly such a nursing action would be predicted to be effective in helping a patient to move from helplessness towards self care and most nurses in this unit perceive such action as effective as indicated in their rankings (see Appendix 5 , p.163 for descriptive statistics).

Most statements in this less rigorously defined category were rated at the 'ineffective' or 'poor nursing' end of the scale. These are listed and grouped for brief discussion below. Descriptive

statsitics for each statement can be found in Appendix 5.

Statements 80: MAKES DECISION FOR PATIENT

81: DOES SOMETHING FOR PATIENT WHICH HE COULD PERHAPS HAVE DONE FOR HIMSELF

85: ALLOWS PATIENT TO OPT OUT OF DECISION MAKING

The views underlying these statements are consistent with the practice prescribed in the literature on nursing depressives and support the concepts comprising the helplessness/self care model (p.52).

Statements 59: KEEPS PHYSICALLY DISTANT FROM PATIENT WHEN TOUCH MIGHT BE APPROPRIATE

114: LEAVES PATIENT WITHOUT ANY STRUCTURE TO HIS EVENING

These two statements are interesting not so much for their congruence with what the literature on nursing depressed patients would suggest, but because when the nurses in this sample were observed in practice, records indicate that they did both of these things. It could be argued that television provides some structure, or that after a structured day patients need to be able to relax in the evening. However, from their ranking of this statement, these nurses thought it was NOT a good thing to leave patients without structure. Why, then, do they not provide some structure in practice. Similarly, why do they not touch patients when they appear to be seeking it? Again, observations showed they did not generally do this (p. 89), yet they know or feel that touching is often therapeutic. It may be

that knowing what should be done is not enough. Perhaps education and practice in HOW to do these things is required. Touching also requires a degree of comfort about physical closeness on the part of the nurse which no nursing text can impart.

Statements 90: DOES NOT CHECK MEDICATION IS SWALLOWED BY PATIENT
95: ENCOURAGES ACTIVITY REQUIRING PROLONGED CONCENTRATION
105: TELLS PATIENT TO GO FOR A WALK
112: ASSISTS PATIENT TO SUPPRESS ANGER
113: AVOIDS TALKING ABOUT THE FUTURE

This group of statements completes the list of those meeting reasonable criteria for consistency. They are all 'negatives' formed from positive statements in the nursing literature and it is therefore not surprising to find that nurses have ranked them ineffective nursing actions. Nurses do appear to agree with what the literature would suggest in these instances.

Reinforcement

Another group of statements, none of which met the criteria for consistency of ranking across the sample, were those related to feedback or reinforcement given patients. Six statements specifically related to this factor:

Statements 19: HELPS PATIENT TO 'LOOK GOOD' (E.G. SHAVE, USE OF MAKE-UP) AND COMMENTS POSITIVELY ON THE RESULT

20: GIVES POSITIVE FEEDBACK WHEN PATIENT MAKES EFFORT WITH HYGIENE AND GROOMING

28: COMMENTS POSITIVELY TO PATIENT WHEN ACTIVITY IS INCREASED

52: PROVIDES POSITIVE FEEDBACK FOR ANY PATIENT INITIATED ACTIVITY

53: NO COMMENT OR INTERACTION FROM STAFF ABOUT PATIENT INITIATED ACTIVITY

54: ACCEPTS UNREALISTIC COMMENT FROM PATIENT WITHOUT INDICATING WHAT THE REALITY IS

Feedback and positive reinforcement do not appear to be seen by nurses in this sample as being as influential in patient progress as the literature would suggest. The lack of emphasis given these factors is evident also from observations of nurses in practice (p. 95). Reasons for this discrepancy between prescriptions for practice from the literature and apparent beliefs about practice held by the nurses are not clear.

Summary

This section of the study has identified some effective and ineffective nursing interventions with depressed patients which are clearly accepted as such by unit staff. Their rankings are noted to be very similar to those of another larger sample of 58 registered staff working in psychiatric settings throughout New Zealand who completed the same scaling exercise (unpublished study, Butterfield 1981). A summary of these results is given in Appendix 6.

Nurses in this sample agreed that the following interventions are effective when nursing depressed patients:

- Gives simple, direct information about drugs or ECT
- Displays calm confidence in interaction with patient
- Assists patient to set realistic short-term goals for him/herself
- Gives reality feedback
- Spends time with patient when exhibiting depressive behaviours, e.g. isolating, crying, physical complaints, fearful, withdrawn ...
- Encourages patient to talk about feelings
- Assists patient to identify alternative behaviours from suicidal threat to get assistance and support.

They also agree that the following interventions are ineffective when nursing depressed patients:

- Mentions only environmental topics (flowers, weather, etc.), not patient related topics in interaction
- Makes decision for patient
- Does something for patient which he could perhaps have done himself
- Allows patient to opt out of decision making
- Keeps physically distant from patient when touch might be appropriate
- Leaves patient without any structure to his/her evening
- Does not check medication is swallowed by patient
- Encourages activity requiring prolonged concentration
- Tells patient to go for a walk
- Assists patient to suppress anger
- Avoids talking about the future.

Many statements have not been ranked at extremes of the scale but, apart from those about reinforcement, most statements that relate specifically to the helplessness/self care model (p. 52) have been ranked at one end or the other, indicating that some concepts involved in the model may already be accepted in practice.

PATIENTS' VIEWS OF THEIR PROGRESS AND CARE

Of the 13 patients observed in the in-care setting, 2 refused to be interviewed by the researcher. One of these was readmitted within the span of the observation study and readily consented to being 'shadowed' again, but again refused to be interviewed after discharge, thereby accounting for 2 refusals. Contact was lost with one who moved out of the region and hence the eventual sample size for this section of the study was 9.

Patients were given the option as to where they were interviewed after one near refusal was avoided only by accepting a telephone interview. 5 patients were interviewed at home, 3 by telephone and 1 was interviewed at the unit after her first outpatient appointment. A tape recorder was accepted and used for 2 of the home visits, and when the telephone was used, a tape recorder playing at the same time recorded interviewer conversation so that immediately following the interview, notes of patient conversation were 'fitted' to this context and the best possible record of the total conversation was put onto a dictaphone. In this way maximum possible recall was effected. On the other occasions, notes were taken and the dictaphone used immediately following the interview to record as much detail as could be recalled.

Patterns of behaviour on Admission and Indicators of Progress

Examination of the transcripts revealed some similarity in the patterns of behaviour as the patients remembered them at the time of their admission to hospital. Two patients said they really couldn't remember what they were like, but knew they were 'down'. The descriptions of feelings included terms such as hopeless; couldn't function; lonely; frightened; desperate; down; no interest in anything; out of control; no confidence; heavy; tight; useless; in blackness; or just wanting to die. Such descriptors are congruent with the symptoms described in the literature on depression (p. 17), but also reflect the individual manner in which each person feels and describes these.

With supportive comment and time, the patients were well able to detail changes from their 'pre-illness' pattern of behaviour to the time of admission. The individual descriptions reflected a wide variety of interests and daily living patterns, but commonalities were found, as the literature would predict (p. 17) in severely reduced social contact; not eating; poor sleep; difficulty in concentrating; and generally sitting around or lying down - not DOING anything. One example was "I couldn't cope with people. My husband got very angry because I wouldn't go out, and we were having no social life, and then it got worse when I couldn't even cope with the family. I couldn't cope with running the home, I couldn't eat, couldn't do anything."

If one word were to be used to sum up the information gained from all the interviews, it would be 'couldn't'. Every patient said that when they were admitted they 'couldn't' something, and the most common way they described their progress was to say "Now I can ..., but before, I couldn't."

One patient talked of cutting herself. She "always used clean razor blades and cut where no-one would see" - upper arms; abdomen etc. This helped to relieve the guilt she felt. She talked also of not being able to make even minor decisions, and of 'freaking out' when faced with a choice. This patient knew she was recovering as the need to cut subsided; as she was able to complete small tasks; as she started to make decisions again; and as she felt she had some control over herself.

Another example was a patient who, just prior to her being admitted, spent all day lying on her bed, managing only to get up and go to the toilet of her own volition. She would not eat; would drink only when encouraged; did not get dressed; and wouldn't wash. She talked of starting sentences but seeming to forget half-way through what she had already said so she would 'give-up' on the conversation. She had no interest in anything. By the time she was discharged, she was looking after herself completely; and she wanted and sought company. Like most of the patients she also recognised progress by jobs being completed - "I made a pie to bring home for our lunch" the day she was discharged. For most, even simple tasks were recognised as milestones if they were completed, - "When I made the supper it felt better"; "I finished knitting a pair of booties for ..."

(the grandchild in whom this patient had been totally disinterested at the time of admission).

Feelings of being 'scared' or a 'bit shaky' were voiced by three patients in relation to their progress, and this seemed to relate not just to coping as they returned to health, but also to fear of 'sinking' again.

Suicidal thoughts losing their power, feeling more confident, sleeping better and just generally feeling better were the indicators described by one patient, while another described her progress in terms of the effort required to do anything. At the time of admission it took a tremendous effort to do anything. When interviewed, some things could be done with less effort, and others without any. Feeling 'light' again was a sure sign of return to health for one patient who had felt a dreadful 'heaviness' and 'pressure all around' her when admitted. Another patient summed up "The difference is life is worth living now."

Many of these descriptions fit well with the 'helplessness process' illustrated on p. 50 . Examples include low self-esteem and unrealistic self-concept; the perception that the patient cannot control outcomes so it is useless to try; and the appearance of depressive symptomatology. From these, a locus of control external to the patient can be inferred, resulting in behaviour indicating independence of responding and reinforcement. The lack of initiating of active responses and difficulty in decision making which the model (p. 52) shows lead finally to helplessness are clearly illustrated. The

concepts of self care being a positive 'mirror image' of the helplessness process gains some support from the indicators patients use to identify for themselves that they are returning to health. Their descriptions of their recovery are entirely congruent with movement through the steps of the self care process (p. 42).

What did Patients Think were Helpful Nursing Interventions?

All patients felt their hospital stay had helped their recovery and all felt that nurses had contributed to this. Some felt nurses had helped more than anything. "When you come in you feel like nothing on earth and the nurses just act like people but they know how to help." A different view was "No uniforms helped. Nurses come across as people, not starched bosses."

The idea that the nurses were seen as people rather than just professionals came through strongly with four of the patients. In no way were they devaluing the professionalism of the nurses but they felt that they could respond as to people rather than worry about what was the expected response from the professional.

Cormack (1976) used both a questionnaire and a semi-structured interview with 96 psychiatric patients in Scottish hospitals to find how they viewed the nursing care given them. "Nurses were described as being friendly, accepting, non-judgemental, discreet, cheerful, kind, considerate and sympathetic, the most frequently used term being 'friendly'. Thus the personal and human qualities of the nurse were regarded as being highly important. The reference to friendship

and comradeship was frequent, and patients remarked that they were treated as people, not patients, by the nurses. Similarly, some patients regarded the nurses more as people and friends than as nurses." This 'personal versus professional' approach has been discussed (pp.13-14) and the view taken that professionals need to be at ease with themselves and able to respond as such while using professional skills. Discussion with patients interviewed in this study supports Cormack's results and also demonstrates appreciation for the skilled but personal approach.

Patients generally talked about nurses as a group. Some would talk about specific nurses being particularly helpful to them, but in most instances would immediately qualify their statement with a comment like "But they were all kind", "But everyone tried to help" or "But I didn't have much to do with the others."

Without exception, the first response to the question, "How were nurses able to help you most?" was to indicate that the nurses were kind and friendly. "You could talk to the nurses" was a comment made by five patients, each of whom said they found this helpful. As one said "We had more time to get to know the nurses." Two patients commented that "You could trust the nurses." In contrast, one patient mentioned the fear that when she saw the nurses writing in the report book, she was scared they were putting down everything she'd said and that made her really angry but she never felt she could do anything about it. All of the patients said they found some nurses easier to talk to than others, but only one felt she had "never really got on with any of them." Although the word trust was

used by only two patients, it seemed inferred in many instances as a very positive trait attributed to the nurses as a group.

Acceptance was mentioned as being very important by 3 patients. As one said "They let me be down and it was such a relief to let go." Rosenbaum's (1980) suggestion that nurses can help relieve depression simply by permitting it (p. 37) gains support here. For another, it was "They didn't try to make me different"; while for a third, "They accepted me as I was."

Trying to describe HOW nurses helped proved difficult at first for nearly all of the patients. "Just being themselves" was one suggestion but this was followed by recognition of the fact that such an observation might not be helpful in trying to improve nursing care. Staying with the problem, this patient eventually decided that "When I was right down, they kept me moving; they kept me functioning." This 'functioning' was identified as being vital to her knowing she could survive at a time when she felt there was no hope.

Quiet support is illustrated in this example: "I had this fear of being mad. I would go up to staff and say 'I'm not mad - I'm only depressed' and they'd say 'That's right, you're not mad'. The way the staff handled it - just treating me as I was - I mean I was being absurd but I was frightened, and they would just quietly say 'That's right, you're not mad' no matter how many times I bothered them."

Smiling proved to be very important for one patient. "The nurses

smiled at me and made me feel I could approach them." "The nurse smiled, so I knew it was alright."

Six of the patients commented about the presence of the nurse being important to them. "Just her being there helped"; "They stayed with me"; "They didn't leave me alone"; "You could talk to them anytime and they'd spend time with you"; "When I couldn't stop crying the nurse stayed with me." Although expressed in different words, appreciation of having someone available and 'with' them was the feeling implied. One said "The nurses knew how I was feeling": that they accepted this and still stayed gave her great comfort.

Some of these comments are in direct contrast to what behavioural theorists would suggest is helpful to the patient in that, according to reinforcement theory (Mikulic, 1971) the optimal nursing intervention would be to indicate acceptance of the patient's feelings but NOT to stay and provide comfort and reassurance since this will serve only to reinforce the depressive behaviour. Rather the nurse should use her time to stay with the patient when non-depressive behaviours can be reinforced. However, much of the behavioural literature citing success with reinforcement of non-depressive behaviours seems to have been done with patients who are at home, (e.g. Burgess, 1969; Liberman, 1970; Liberman and Raskin, 1971). Possibly, when patients have to be admitted to an in-care setting, they are often so depressed that to get them to a stage where one could begin a programme of reinforcement of non-depressive behaviours it is necessary to provide support and comfort initially. The dilemma for nursing staff then is to recognise when it is no longer appropriate

to provide that kind of support and to be able to change their approach.

As has been noted, (p. 107) nurses in this study thought they should stay with patients when they were exhibiting depressive behaviours and in practice this was what they did.

Encouragement was mentioned by all patients in one form or another. "They gave me confidence that I COULD do things."; "They helped me do things - didn't leave me to do them alone."; "They sort of helped you, you know - by telling you how different you looked or ..."; "They set things for you to do so you couldn't just sit". Important here was the concept of doing 'with' rather than 'for'. Four patients mentioned this specifically - that they knew they had to 'do things' for themselves but, left to themselves, they would not have done them. However it would have been "worse if the nurse had done them for me because then I'd have felt even more guilty." They stated that nurses helped a lot by sharing activites. The following description illustrates this: "She would ask 'Would you like a game of dominoes?' and would quietly manoeuvre it so we had our game of dominoes and there'd be no-one else around. And it didn't matter how long it took me to sort out what I was doing or how many times she had to say 'It's a green one' - you know - that sort of thing. Things that I myself would expect of a child in the infant room - and that even while she was fixing up my mistakes I knew she didn't blame me, - that she wasn't passing judgement on me."

Gardner and Wheeler (1981, 112-3) in describing supportive nursing behaviours found that the three items ranked as most important by the patients in descending order of importance were:

"1. nurse helped me to feel confident that adequate care was being provided
2. nurse was friendly
3. nurse showed interest in me"

Patients in medical, surgical and psychiatric care were included in the sample, and while there was no significant difference in the opinions of patients across the groups for the items mentioned above, providing patients with moral support was perceived as more important by psychiatric patients than by the others. Also, "The nurses sharing feelings and thoughts, assisting them to gain control over their behaviour, and helping them to solve their problems was perceived as relatively more important by psychiatric patients than medical and surgical patients."

In this study, one patient talked at some length about how helpful nursing staff were in providing information about medications so that "you knew why you were taking different things. It wasn't just because Dr ... said you had to, but because it would help. And they would explain things like the side effects, so you didn't have to panic if your vision went funny or something. You could go and ask if it's the pills doing that. It meant you could sort of keep control better, because you knew what was going on."

Assistance with gaining control over behaviour and with problem-solving are two areas of nursing intervention that would be suggested

if one were to try to reverse the helplessness process earlier described (p. 50). Results of this study indicate some support of Gardner and Wheeler's (1981, 113) findings and together they provide some support for use of the helplessness/self care model in nursing practice. It does seem that patients use the steps of the helplessness/self care process in recognising that they are making progress although, of course, they have individual ways of expressing this. Further, they articulate their perceptions of how nurses were able to help in terms that can be readily identified with the model.

How Could Nurses Have Helped More?

Constructive comment in this area proved less easy to obtain, since understandably and predictably, patients were loathe to offer what could be construed as criticism. The reason for asking the question was stressed so that patients understood that only if nurses were to find out from patients how they thought they could better be helped could any changes be made. In some instances, suggesting that "some other patients had found X difficult' or "we nurses often wonder whether this would be better than that" proved successful strategies in getting the patients to offer comment. However, despite these approaches, three patients said they felt nurses could not have done anything more to help. When it was suggested that maybe some things could have been different, they responded that they didn't think so. At that stage, the issue was left.

Three patients commented that they found the weekends dreadful.

Without a structured programme they felt totally lost. One felt nursing staff were not strict enough in making them get up and do something. None of the other patients voluntarily mentioned weekends as being a problem, and when specifically asked, they stated there was no problem. One enjoyed the freedom of the unstructured day, and others mentioned visitors; outings; or they had been on weekend leave.

Two patients felt that some nurses were too kind and ended up doing things for them that they should have, and sometimes would have, done themselves. They described feelings of being 'a hopeless case' and 'useless' resulting. These responses could have been predicted from the helplessness/self care model (p. 52).

Another two patients specifically mentioned how difficult it was to approach staff when they were talking as a group together. "If a nurse was even reading a book in the lounge, it would be easy to ask something. Even if there are two together it's nearly impossible to talk to them - you see, you think because they're staff, what they're talking about is important so you mustn't interrupt." Clearly nurses are not necessarily perceived as being available as often as they might be.

A suggestion was made that using non-stereotyped phrases in greeting instead of the common "How are you?" would be helpful. The explanation given was that the normal response to "How are you?" is "Fine thank you." This patient said "When the nurse comes along gaily and says 'Hi, How are you?' you know she doesn't really mean it and you get so

angry you either blast her when it's not her fault or fob it off and get angrier."

One patient felt some of the staff had been 'fed-up' with her and that "they thought I should have been at home." She contrasted the hopeless feelings resulting from this with the relief in being able to 'let go' with some staff who accepted her as she was. When asked if she had checked out whether the staff she mentioned as feeling negative about her being depressed did in fact feel so, she answered she had not.

More comment on progress being made was mentioned by three patients as being helpful. "You know, you forget so quickly how bad you were before and you need reminding just how much better you are"; and "Sometimes you think you'll never make it, and if the nurses would keep telling you you will, it helps somehow" and "They don't let you know how you're getting on. Sometimes your visitors get told more than you do and that doesn't help." A felt need for positive reinforcement can be identified as the basis of these statements.

Again, the ideas and opinions reported here can be identified as fitting within a helplessness/self care model. The expressed need for structure; and the need for patients to be able to do things themselves and make their own decisions could be predicted.

Summary

The indicators which patients use to denote progress towards recovery have been found to 'fit' with those which the helplessness/self care

model would predict. These included the ability to complete tasks; feelings of regaining control; and being able to make decisions.

A clear feature of responses related to the question "How did nurses help you most?" was appreciation of their personal approach to patients. This was often contrasted with the 'professional' approach of some other staff. Patients felt nurses accepted them even though they were depressed whereas with doctor or therapist, for example, patients perceived that each time they saw these people they were expected to have improved, and if they felt they had not, the encounter was not easy. In relation to caring for depressed people, then, one highly visible nursing function seems to be to foster 'normalcy' in the patients' lives. The comments made by patients during interviews give some support for Cormack's (1976) suggestion that nurses provide an unsystematic and unrecognised therapy which is valuable in its genuineness, vitality and spontaneity within the context of daily living. It is questionable, though, whether nurses realise how important this care is to patients and accept this as being a valid comment on their practice (see p. 12).

Another feature of this section was the appreciation demonstrated for nurses staying with patients when they felt low. Patients felt they gained support and motivation from this assistance and that this was one of their major needs on admission. The possibility of nurses providing such support for too long with resultant reinforcement of patients' depressive and dependent behaviours was raised.

Two main areas of concern were noted from responses to the question "How could nurses have helped more?". These were that more feedback on their progress to patients would have helped, and that on some occasions nurses tended to do things for patients which they could have done themselves and this left them feeling helpless. The provision of encouragement and being available to do things with patients can therefore be identified as further nursing functions which are visible to patients. Given that they were reported even in their absence in this study, it is suggested that to patients they are probably very important.

Chapter 9

CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

The aim of this study was to examine the nursing dimensions of practice with patients who are depressed and receiving care as in-patients in a hospital setting. This chapter summarises conclusions drawn from the information gathered, identifies the implications for clinical practice and for nursing education, and presents some recommendations for further action and research.

The Research Question Answered

The major research question identified for this study was

> Does the nursing care of depressed patients in an in-care setting tend to support behaviours indicative of progress towards helplessness or encourage those which indicate progress towards self care?

Three separate perspectives were explored to provide a broad view in researching this question. These were (1) what nurses were seen to do in practice; (2) what they thought they should do as shown in results of a scaling exercise; and (3) what patients said nurses did when they were interviewed after discharge. The specific research questions identified in each of these areas will therefore be addressed before any conclusions regarding the major question are drawn.

1. (a) Does nursing care of adult patients with depression as observed in practice in the unit indicate any 'fit' with the helplessness/self care model described?

   (b) If there is a 'fit', does such observed nursing care tend to facilitate progress from helplessness towards self care?

Reports of observations of nursing practice with depressed patients over 74 hours in an in-care setting provided little evidence to suggest a 'fit' with this model. Some of the behaviours recorded were opposite to those which the model would prescribe. Results indicated that nursing care observed in this study in relation to motivation, goal setting and decision making could be serving to reinforce patients' beliefs that they have no control over outcomes. Instances of nurses asking for information from the patient were numerous and questions were mostly closed, thus reducing opportunity for discussion. Instances of nurses providing information were less, and there was little follow-up to these usually brief and mostly 'one-way' conversations. Observations showed few attempts to determine the degree of understanding and/or acceptance of information by patients.

A warm and caring attitude was inferred in the kind, friendly approach of nurses as it was perceived by patients. Patients in overt distress were always given prompt attention in a manner which seemed to effect an improvement in the way the patient was feeling at the time. It is suggested that the nursing care observed reflected a traditional 'succouring' view of the nurse's role with the nurse

acting as the 'provider' of care, rather than the self care orientation of a 'partner' in care

2 (a) Is there any agreement among registered nurses working in the unit about what are effective and ineffective nursing actions with patients who are depressed?

(b) Does their view of effective nursing practice 'fit' with promoting progress towards self care?

Results of the scaling exercise (see summary, p. 114) demonstrate that there is some agreement about effective nursing practice with depressed patients. However, there were a large number of statements which did not meet the criteria used to indicate agreement. This may have been due to ambiguity in the statements but if this were not so, there is cause for concern about maintaining consistency of care for depressed patients over the period of their in-care stay when nurses have such divergent views about the relative effectiveness of various nursing actions.

If patients are to be supported and assisted to progress towards self care, the Helplessness/Self care model dictates that it is necessary to focus on what the patients are learning, since this is the ongoing process which affects their behaviour (p. 51). However, results suggest that nurses in this sample either did not understand or did not accept the principles of learning theory in general or reinforcement theory in particular. They did not consistently rank interventions based on these principles as effective.

3. (a) How do patients recognise they are making positive progress, and do the behavioural changes fit with progress as the helplessness/self care model would predict?

   (b) What do patients see as helpful or effective nursing actions and do these 'fit' with the helplessness/self care model?

Patients' views of their progress showed a similar pattern of recovery over all patients in the sample, and one which could readily be identified in terms of movement from a state of helplessness (p. 45) towards that of self care (p. 40). All patients evidenced some behvaiours indicative of helplessness on admission. From interviews undertaken shortly after their discharge, patients' descriptions of their individual recoveries demonstrated movement from that state towards one of improved self esteem and more realistic self concept; ability to initiate and complete tasks; ability to make decisions; and feeling in control of themselves and their lives. There had been a swing from the inevitable "I can't" at the end of the process of helplessness through to the "I can" which is indicative of self care. For some patients though, the process had taken a very long time, and some were still 'swinging'.

Nursing actions perceived by patients to be most helpful were those that indicated nurses accepted them even with their depression, and those which resulted in nurses spending time with them when they felt really low. The first of these 'fits' with the helplessness/

self care model since a realistic and positive self-image is basic to self care, and patients could learn from the attitudes of nurses that they were 'worth' attention and care. The second action could be said to be encouraging further depressive behaviour and therefore be opposite to what the model would prescribe. However, it may be that at some stages of depression the need for the patient to know he is not alone takes precedence over avoiding the possibility of 'secondary gain' (see glossary). At this stage, such nursing actions could be seen to assist in promoting a more positive self-concept, - an interpretation which would 'fit' with the helplessness/self care model if nurses were aware of what they were doing and why.

Provision of encouragement, doing things 'with' rather than 'for'; and direct information about how the nurses saw they were progressing were other nursing actions identified by patients as being helpful and these each 'fit' with the care the helplessness/self care model would prescribe.

To return to the major research question, using the helplessness/ self care model as the basis for analysis, many of the nursing behaviours reported in this study were not conducive to enhancing recovery of the patient, since they did not encourage movement towards self care, but rather maintained a situation where nurses provided care for the patient.

General Conclusions

Results in relation to both nurse perceptions of effective care and observations of nursing practice indicate that nurses in this sample do recognise some concepts inherent in the helplessness/self care model. However, there was no evidence to show acceptance of the basic principles involved.

A behavioural formulation of depression emphasises objective observation of the individual's behaviour in relation to the preceding and consequential events in the interpersonal environment. This approach is basic to the helplessness/self care model in which cognitions and feelings related to the behaviours identified are also recognised as important in the learning process which effects change in behaviour.

Liberman and Raskin (1971, 517) argue "the acknowledgement and attention given to a patient for 'sick' behaviour serves to make that behaviour likely to occur in the future." For the depressed patient, professionals cannot overlook the possibility of secondary gain to the patient who succeeds in attracting staff time and support with depressive behaviours. Schmagin and Pearlmutter (1977, 64) note "By insisting they are unloved, depressed persons almost force others around them to contradict these sentiments and refute their accusations." Further, "The secondary gains of depression may be minor, or they may reach such proportions as to outweigh the original emotional problem and become an obstacle to the therapist in treating the patient's original depression."

Liberman (1970) reports clinical success with the application of reinforcement contingencies for the modification of depressive behaviours. Burgess (1969) also reports success with six depressed patients using methods based on reinforcement of 'performing' behaviours (i.e. active, task oriented behaviours) and extinguishing depressive behaviours.

Mikulic (1972, 164) conducted a study to determine the incidence of independent and dependent patient behaviours and the nature of the reinforcement afforded those behaviours by nursing personnel over 28 hours of observations in an extended care facility, where it was acknowledged that the nursing needs of patients were the primary concern of staff. "The findings ... indicated that nursing personnel more consistently provided positive reinforcement for dependent patient behaviours than for independent behaviours. If one accepts the tenents of the operant approach to behaviour analysis, the behaviours of the nursing personnel studied can be viewed as contributing to an increase in the incidence of dependent patient behaviours."

Mikulic (1972) found that independent behaviours received less positive reinforcement than dependent behaviours. This finding is reflected in the lack of positive reinforcement noted in observations in this study (p. 98). Nurses in this sample tended to recognise that providing positive reinforcement is a reasonably effective nursing action (p. 112) but their actions belied such recognition in practice.

A traditional succouring or mothering role of the nurse is evident in practice in both Mikulic's (1972) study and this one. If nurses do not learn to be discriminating in their reponse to patient behaviours and provide the opportunity for patients to learn independent and non-depressive behaviours, they may in fact be working against the patient's recovery as the helplessness/self care model would predict.

It may be that with depressed patients, a major reason for admission to in-care is the absence or low rate of coping behaviours. Possibly it is necessary for nurses to use their availability to stay with the patient when exhibiting depressive behaviours until some rapport and trust are established and some coping behaviours exist for reinforcement to be given. However, one wonders if nurses are able to forsake their traditional succouring role when patients have reached this state. Certainly, it is unlikely that this will occur if the importance of non-reinforcement of depressive behaviour is not recognised or accepted.

A Teaching Strategy for Classroom or Inservice Session

The scaling technique used in this study can be used as an effective teaching strategy in a number of ways. Students or staff can be asked to create their own lists of statements or these can be provided. The exercise can be undertaken exactly as detailed in this study or a more limited list of statements used. Results for the group of participants can be compiled so that subsequent discussion and role plays about statements where there is wide

divergence of opinion can assist in clarifying basic principles. Participants can be asked to justify their own beliefs and also be given opportunity for rehearsal of new approaches to care. Discrepancies between beliefs and what is suggested in the literature can be identified and students can be encouraged to assess their own performance in relation to the interventions agreed upon as effective. If used within one particular setting, such a strategy could contribute much to achieving better consistency in the nursing approach to care. Two recommendations are therefore made:

The scaling technique should be developed and marketed as a teaching strategy.

Nursing staff working within a specific setting should be encouraged to use strategies such as the scaling technique to identify different beliefs and approaches to care amongst the group and then to try to diminish differences so that patients receive a more consistent approach to care.

Recommendations for Future Research

One factor that was clear from this study was the discrepancy between what nurses said they should do and what they did in practice. Had the scaling exercise alone been used, for example, and an assumption made that nurses do as they say, the results would have reflected a most inaccurate answer to the research question. It is suggested that future research relating to nursing practice should similarly involve observations of that practice

despite the inherent difficulties of observation studies. Only in this way will tools which have predictive ability be developed.

This study has provided some clear directions for immediate action in the areas of clinical practice and nursing education. In relation to future research, profit would seem to be gained from extending the scaling exercise to construct a behaviourally anchored rating scale. The major purpose of such scales is for staff appraisal and they would be useful in this area for assessment both by self and others. Most scales thus far constructed have related to a specific area of practice rather than to meeting the needs of a specific patient population, and evaluative tools in this latter area could assist in clarifying when different nursing approaches are necessary. The major advantage of such measures as BARS (see glossary) is that the evaluator is cast more in the role of observer/recorder and less in the role of judge. Inference is reduced because of the emphasis on behaviours, and the instrument developed therefore should have higher reliability and validity than many staff appraisal tools used currently.

In this study, only two extremes of effectiveness and ineffectiveness were identified, but as previously noted, (p. 109) it does not always follow that because one intervention is effective, its opposite is necessarily ineffective or poor nursing. Results of constructing a Behaviourally Anchored Rating Scale would be of value to both clinical practice and nursing education in that necessarily the scale would articulate nursing dimensions of practice.

A further benefit of constructing such scales lies in the ability to then use these not only for individual performance appraisal but also for conducting a nursing audit to determine the standards of care given in a particular setting. Although not cited in the literature as a method of using the scales, there seems little problem in extending their use into this field. They might also help to demonstrate more clearly when and why people can be helped through nursing as distinct from other forms of health care. The following actions are recommended:

Further clinical research needs to be undertaken to observe nursing practice so that valid tools for practice which have predictive ability can be developed.

The scaling exercise used in this study should be extended to construct a Behaviourally Anchored Rating Scale to measure nursing performance in providing care in an in-care psychiatric setting. This scale would be used for

1. Staff Appraisal
2. Contributing to ward or unit audit
3. Assisting in articulating nursing dimensions of practice.

Nursing Exists for the Benefit of People

A premise basic to this thesis is that nursing is a service, and as such it exists for the benefit of society. In helping human beings, nursing has as its special concern "the individual's need for self care action and the provision and management of it on a

continuous basis in order to sustain life and health; recover from disease or injury; and cope with their effects " (Orem, 1980, 6).

The Prescribed Role for the Psychiatric Nurse is Challenged

In this study, patients' opinions of their needs for care and of care they received provide support for a nursing role which emphasises a personal, non-judgemental approach that is therapeutic in its 'normalcy' (p. 129). This is in contrast to the role prescribed in much of the literature which, as has been argued (p. 1), emphasises a 'therapist' approach to care based on theoretical models of mental illness and resultant therapies. This trend has led to a devaluation of nursing care, and if it continues, nurses may opt to become 'therapists' in the same time-limited interaction approach as other health professionals, while untrained staff provide the nursing care because it seems to require little knowledge or skill. In fact, the difference between the role of the nurse and that of the therapist is in the FOCUS of knowledge and skill, not in the knowledge and skill per se.

Availability - A Concept Basic to Nursing Practice

The concept of availability (see glossary p.xiii) has been presented as being basic to nursing (p. 35). In practice, nurses comprise the one professional group who have a unique opportunity to translate the concept into action, particularly in being receptive to needs-for-help in relation to daily living and being able to minister to these needs. For example, an "effective way of preparing the

patient for discharge is to review pre-treatment patterns of living to see in what respect they have been faulty" (Kalkman and Davis, 1974, 328). Nursing staff generally have far more time available to gently discuss such things and this is directly beneficial for the patient as he can then review his life pattern in its totality. Valuable information may also be gained for the primary therapist who can then work more specifically with the patient on revising the pattern if necessary so that it will be better balanced and more satisfying to him in the future. However, nurses are not likely to make themselves available or to support patient progress towards recovery through optimal use of staff availability if the concept is not understood and the resultant practice specified and valued.

The Discrepancy between Role Perceptions and Practice

Results have indicated that there are some discrepancies between what nurses in this sample said were effective or ineffective interventions with depressed patients and what they did in practice. Despite opportunities to do so, on many occasions they did not DO as they said. Reasons for this failure to practice as they say they should are not readily apparent and are doubtless multiple. Perhaps nurses do not feel their care is valued by other staff or by patients and therefore there is less effort to provide the best possible care or to critically evaluate what they are doing. Further, if they believe the effective professional input comes from the 'therapy' sessions, they may feel cautious about providing anything other than basic supportive care.

It could be that the effectiveness of the patients' communication of gloom was a factor affecting the practice of nurses in the sample, since it is well recognised (p. 33) that depressed patients are not the most comfortable people with whom one can spend time. One wonders, too, if nurses recognise and accept the importance patients feel the care given by nurses has to them, or if patients' opinions are not felt important enough to justify valuing the nurse's role.

Nurses need to articulate and practice from a nursing perspective if a nursing role is to be maintained in the field of psychiatric nursing, and this will require a shift in focus from emphasis on individual illness, pathology, symptoms and psychodynamics to one concerned with individual health, strengths, and capabilities within daily living. The use of a nursing model as a base for practice could correct the current dissonance between prescribed role and practice. Such a model would force specification of the nursing dimensions and clearly demonstrate the validity of the nursing contribution to care. To assist in achieving this aim, the following actions are recommended:

A 'therapist' role, as prescribed for the psychiatric nurse in much of the literature, should be challenged.

A nursing role clearly based on a nursing model should be prescribed for nurses working in the psychiatric field.

The concept of availability should be given greater prominence as a core concept of nursing so that it can be profitably used in practice to promote better nursing care.

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APPENDICES

THE CHRISTCHURCH STAR
(CHRISTCHURCH)
Canterbury Province
Circulation approx. 64,000

- 3 JUL 1981
Chongs Press Cutting Bureau
Box 68143, Auckland, N.Z.

NEWS TODAY

Improvement in nurse ratios Minister says

WELLINGTON (PA). — The ratio of qualified to unqualified nurses is improving in psychiatric and psychopedic hospitals, according to the Minister of Health (Mr Gair).

He said the Government would welcome representations from the Public Service Association on hospital staffing.

Psychiatric and psychopedic bed occupancy fell from an average of 7167.3 beds last year to 7121.4 beds last March and the number of available beds fell from 8412 to 8280.

"For the year ended March 31, 1980, there were 1672.3 full-time equivalent qualified nurses in the psychiatric and psychopedic area. There were also 1629 unqualified staff and 789 students," Mr Gair said.

"For the year ended March 31, 1981, the number of qualified staff had risen by 65.5 fulltime equivalents to 1738. The number of unqualified staff rose by seven and the number of hospital-trained students declined by 52 to 737."

He said that although hospital-trained students showed a decline, nurses trained at technical institutes were also qualified to work in this area.

Last year 84 technical institute-trained comprehensive nurses were employed in psychiatric hospitals and eight in psychopedic hospitals.

"I must also point out that while I have the power to control intakes to schools of nursing no directions have been given on the number of psychiatric or psychopedic nurses which hospital boards can train.

"With regard to the dispensing of medicines, the administration of drugs is the responsibility of registered nurses. If unqualified nurses are involved they are working under the supervision of a registered nurse."

Exaggeration

Mr Gair said some of the psychiatric and psychopedic hospital buildings were getting old and some would have to be replaced, but it was an exaggeration to say that they were "falling to bits."

He said he was heartened by the PSA's assurance that industrial action which might be contemplated by the nurses would not affect patient care.

"I would certainly hope they would approach me for discussions before taking any further action."

Meanwhile, psychiatric nurses held a stopwork meeting at Cherry Farm, Dunedin, yesterday and approved a programme of direct action that could have a serious effect on staffing at the hospital.

The meeting was held as part of a nationwide programme of stop work meetings by psychiatric subgroups of the PSA.

Staff shortage grievances were discussed and at a local level concerns were aggravated by the Otago Hospital Board's intention to cancel the September student intake.

The nurses have agreed to withdraw their services from all non-nursing duties such as laundry, clerical work, driving, kitchen duties, non-patient cleaning and housekeeping duties.

They also decided to withdraw their services in any situation where a nurse or registered nurse is required to fill or is effectively left in, a position of responsibility beyond the level paid at.

A number of moves also have been approved to ensure the law is strictly adhered to in all cases of drug handling and dispensing.

The nurses claim the law relating to the handling of controlled drugs is not adhered to. By insisting on this they will effectively force the board to have registered nurses on duty at all times drugs are used.

The chairman of the Otago branch of the PSA (Mr I. Paterson) said when the national office has approved the action, 14 days notice will be served on the board and action will follow this.

The chairman of the Cherry Farm sub-group (Mr A. Hewson) said it is expected all groups throughout the country will approve the action. But even if they do not, the Cherry Farm sub-group will go ahead "because the shortages apply here."

Meanwhile phychiatric nurses at Porirua Hospital will take action from Monday against "illegal practices" they say they are forced to carry out because of a lack of trained staff.

Yesterday's stopwork meeting at the hospital voted overwhelmingly for direct action.

The chairman of the hospital's PSA sub-group (Mr B. Lavery) said: "The hospital board and Health Department say there are no problems at Porirua.

"It's lies. I am happy to go through the wards with anyone and show them. Last night out of 40 nurses on duty only 10 were registered."

Wards with 40 to 50 beds were being left in the care of one unqualified nurse.

The hospital was given two weeks notice of the action yesterday.

From Monday, nurses would follow the "letter of the law" on controlled drugs, and no drugs of any kind would be dispensed without the direct supervision of a registered nurse.

INTER-ACTION NO.	TIME	TOOK PLACE IN	POSTURE PATIENT	POSTURE NURSE	TOUCH	INFORMATION	CONVERSATION	TASKS	PATIENT ACTIVITY
			Standing Sitting Lying	Standing Sitting	Yes No	Nurse gives Asks for - open - closed	Nurse initiated Validates feelings Asks about feelings Talks about non-personal things	Nurse Performs task No task Checks medications are swallowed Does not check meds swallowed	Patient initiated - inappropriate Nurse comments positively comments negatively no comments acknowledges
			Standing Sitting Lying	Standing Sitting	Yes No	Repeated questioning			
			Standing Sitting Lying	Standing Sitting	Yes No	Patient gives Asks for Patient responds No response Repeated questioning	Patient Initiated Talks about self Talks about feelings Talks about other topics	Patient Initiates physical care	

PATIENT BEHAVIOUR:

MOTIVATION	GOAL SETTING	AVAILABILITY
Nurse encourages Pt to identify things that motivate him Nurse uses pt likes to motivate him	Nurse assists pt to set realistic short-term goals for himself Nurse sets goals for pt	Spends time with pt when exhibiting depressive behaviour Stays briefly in above situation but then leaves, giving time of return or place where nse can be found

COMMENTS:

DECISION MAKING

Nurse sets up decision for pt to make

Pt has difficulty
Pt presents problems requiring decision
Pt makes
Nurse makes

CODE FOR RECORDING ON OBSERVATION CHART

An interaction is defined as a unit which begins when either patient approaches nurse or nurse approaches patient and ends at the first natural pause in conversation or activity. Time to be recorded at beginning and end of each interaction.

Bedroom	BR
Bathroom	Bt
Lounge	L
Kitchen	K
Dining Room	DR
Corridor	C
Games Room	GR
Outside	OS

Touch - Any action which results in patient and nurse touching each other.

Questions - Open - Phrase or sentence structured in such a way as to encourage expression of opinion, feelings etc.

Closed - Phrase or sentence structured to get an explicit yes/no type answer.

Tasks - Include any action that involve 'doing for' the patient: giving meds, making bed.

Activity - Any activity not related to meeting physical needs.

- Any activity that is related to fulfilling needs for solitude and social interaction, for creactivity, for cognitive functioning.

Comment - Comments should be of a general nature, briefly describing content of interaction or patient activity.

QUESTIONS FOR PATIENT INTERVIEW

AND EXPLANATION GIVEN

EXPLANATION TO PATIENT

Given verbally after permission obtained from unit Nursing Supervisor, the explanation would be similar to the following:

"I'm doing a project to find out how we nurses can help patients most and I would like your help. I have just got four questions I would like to ask and to talk about with you. It will take about five or ten minutes unless you want to spend longer. No names will be mentioned when I write the project up so anything you say is confidential.

If you are agreeable, to save time and to save me taking notes I'd like to record our conversation to help me write it up accurately later. The tape will be wiped when I've done that. MAY I RECORD? (If no, may I take notes?)

Do you have any questions before we begin?

Now, I have just one explanation. In the four questions you have there (the patient has a copy), I am asking about nurses and nursing staff. I want you to think only about those who work in the evenings and at weekends and on night-duty - NOT the day staff or therapists. Is that clear? Then let's start with question 1.

1. What are the greatest differences you feel in yourself from when you came into hospital compared with the way you feel now?

2. What kinds of things let you know in yourself that you were making progress - that you were getting better?

3. Was there any person on the nursing staff who helped you a lot? (No need to mention names.) How was that person able to help you most?

4. Was there anything nurses could have done that would have helped you more?

INSTRUCTIONS FOR SCALING EXERCISE

The purpose of this exercise is to determine what NURSES think are examples of EFFECTIVE nursing actions in caring for patients hospitalised in an acute-care setting with DEPRESSION.

PLEASE WORK THROUGH THE FOLLOWING STEPS ALONE. Do not discuss your ideas with anyone else.

1. Fill in the biographical information on the sheet provided.

2. You have 8 numerically labelled cards in the packet provided. Please ensure these are set out at the top of your workspace with "1" at the left through to "8" at the right. These numbers constitute a scale on which you can rate different nursing actions. You should remember that "1" is the least effective and "8" is the most effective end of this scale. In other words, "8" is the good nursing end and "1" indicates poor nursing.

3. You also have a bundle of numbered statements of nursing actions which could be relevant for depressed patients. Your job now is to sort these statements, placing each under the number on the scale you feel is most appropriate to indicate the level of effectiveness of that particular action.

   For example, statement no. 8 might read: "encourage patient to drink". If you think this is an effective action with a depressed patient, you would place it under the letter 7 or 8, but if you think it is not effective, you would place it under 1 or 2. Or maybe it would end up rather more neutral, under 4 or 5.

   You may shift statements as you sort and find that you review your initial thinking, but you should not dwell on these decisions too long. There are many instances where a statement may be a less effective intervention in one circumstance than another, depending upon the patient's state at the time. We are not at present concerned with this. The aim is to see what, in general terms, nurses think would be effective nursing actions with depressed patients. It is necessary, however, to ensure after your sorting that you have at least ONE statement in each category.

4. When you have finished sorting, record the rating you have given each action. There is now no statement for the numbers marked "X".

5. On the back of your recording sheet please answer the questions indicated there.

THANK YOU FOR YOUR CO-OPERATION

RECORDING CHART FOR SCALING STATEMENTS

PLEASE FILL IN THE BLANKS TO PROVIDE THE FOLLOWING INFORMATION:

Sex: MALE/FEMALE (delete one)

Please circle the nursing qualification(s) that you hold and state the year of registration/qualification for each in the space provided:

R.G. & O.N. _____ R.P.N. _____ R.Pd.N. _____

R.Comp.N. _____ Other: _____ _____

_____ _____ _____

How long have you worked in a psychiatric setting? _____

How much of this time has been in a large psychiatric institution? _____

How much of this time has been in a psychiatric unit within a general hospital? _____

Are you currently working in an acute or long-stay area? _____

NURSING INTERVENTIONS WITH HOSPITALISED DEPRESSED PATIENTS

PUT YOUR RATING AGAINST EACH STATEMENT NUMBER

1	X
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3	X
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ALL REGISTERED STAFF AT UNIT PAGE 7

01/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR31

MEAN	6.381	MEDIAN	6.625	MODE	8.000
STD DEV	1.532	RANGE	4.000	MINIMUM	4.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR32

MEAN	5.762	MEDIAN	5.875	MODE	8.000
STD DEV	1.972	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR33

MEAN	7.381	MEDIAN	7.545	MODE	8.000
STD DEV	0.740	RANGE	2.000	MINIMUM	6.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR34

MEAN	5.500	MEDIAN	5.700	MODE	6.000
STD DEV	1.732	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				

VALID CASES 20 MISSING CASES 1

VAR35

MEAN	5.333	MEDIAN	5.250	MODE	5.000
STD DEV	1.560	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

Appendix 4(c)

LIST OF STATEMENTS FOR SCALING EXERCISE

1. Observes and records patient's major moods
2. Observes and records patient's span of concentration
3. Observes and records patient's activities
4. Observes and records patient's physical state
5. Observes and records comparisons to indicate progress
6. Observes and records interaction patterns
7. Asks if patient feels suicidal
8. Asks if patient has plans for suicide
9. Contract with suicidal patient regarding behavioural limitations
10. Reminds patient that behavioural contract requires that he practise self-control rather than expecting staff to take responsibility for his behaviour
11. When a patient verbalises fear, discusses the worst possible outcome and then assists to problem solve to deal with his fear
12. Instructs a patient in relaxation techniques
13. Assists patient to identify alternative behaviours from suicidal threat to get assistance and support
14. Gives positive reinforcement for maintenance of self-control
15. Allows patient to miss a meal
16. Encourages patient to drink
17. Encourages patient to eat appropriately for good nutrition
18. Assists patient with personal hygiene
19. Helps patient to look 'good" (e.g. shave, use of make-up) and comments positively on the result
20. Gives positive feedback when patient makes effort with hygiene and grooming
21. Deals with problems relating to elimination supportively, but does not dwell on them
22. Reports on type of movement - slow, normal, sluggish, etc.
23. Comments on way patient is moving to patient
24. Allows patient to settle for sleep earlier than 9.00 p.m.
25. Assists patient with relaxation technique to cope with restlessness
26. Encourages patient with physical activity
27. Assists patient with relaxation technique to encourage sleep
28. Comments positively to patient when activity is increased
29. Goes for walk with patient
30. Gives simple direct information about home responsibilities

31. Gives simple direct information about expectations of his behaviour
32. Gives simple direct information about patient's prognosis
33. Gives simple direct information about effect of drugs or ECT
34. Gives simple direct information about employment prospects
35. Repeats words of comfort and reassurance
36. Encourages activity requiring concentration for limited time
37. Comments to patient on increased ability to concentrate
38. Maintains eye contact (without staring) with patient while talking to him
39. Encourages patient to talk about his feelings
40. Does not allow patient to remain alone for more than 20 minutes

41. Assists/interacts with patient in a structured activity
42. Mentions only environmental (flowers, weather, etc.) topics, not patient-related topics in interaction
43. Validates with patient what nurse thinks he/she is saying/ feeling
44. Tells patient he/she CAN do something
45. Encourages patient to talk of the past
46. Sets tasks for patient to do alone
47. Provides support doing things WITH but not FOR the patient
48. Listens with concern to repetitive complaints
49. Provides honest, objective feedback about patient's present appraisal of his feelings and behaviours
50. Talks to patient who cannot sleep

51. Listens to complaints but when repetition occurs assists patient to get on with some activity
52. Provides positive feedback for any patient-initiated activity
53. No comment or interaction from staff about patient-initiated activity
54. Accepts unrealistic comment from patient without indicating what the reality is
55. Points out when patient makes unrealistic (e.g. derogatory, guilt) comment about himself and explains that this tends to block communication
56. Focuses interaction on here and now
57. Leaves patient alone but tells him/her where he/she can find a staff member, or gives a time when nurse will return
58. Uses touch in interaction with patient
59. Keeps physically distant from patient when touch might be appropriate
60. Spends time with patient when exhibiting depressive behaviours, e.g. isolating, crying, physical complaints, fearful, withdrawn . . .

61. Encourages overt expression of anger or aggression
62. Talks with patient and visitors
63. Talks with patient's visitors
64. Encourages patient to go on outing
65. Tries to identify individual motivators
66. Encourages patient to identify things that motivate him
67. Uses motivators that patient likes to encourage non-depressive behaviour
68. Shows interest in patient's description of his symptoms
69. Limits patient's conversation about failures
70. Talks about pattern of living prior to admission

71. Reviews pre-admission patterns of living to see if they have been faulty
72. Asks about present relationships and contrasts them with previously normal levels
73. Reviews pre-admission pattern of living with patient and talks over possible changes for future
74. Talks with patient about being home again
75. When patient is upset, stays with him until he feels calm but then leaves, and comes back to spend more time with him when he is feeling better
76. Comments positively about increasing independence
77. Talks with patient about his/her future
78. Gives reality feedback
79. Assists to draw up a plan for the shift and gives positive reinforcement for sticking to it
80. Makes decision for patient

81. Does something for patient which he could perhaps have done for himself
82. Assists patient to set realistic short-term goals for himself
83. When patient leaves nurse to make a decision for him, points this out and encourages to act for himself
84. Provides suggestions of solutions to problems for patient
85. Allows patient to opt out of decision making
86. Points out when patient sets up personal failure and assists in identifying alternative behaviours
87. Encourages creative or mildly competitive activities that provide some degree of success
88. Refuses to repeat statements of reassurance or comfort
89. Complies with suicidal patient's request for cigarettes and matches
90. Does not check that medication is swallowed by patient

91. Suggests medication will help him feel better
92. Enquires at discharge if patient feels he can cope with past anxieties
93. Points out contradictions in patient's communications immediately
94. Provides simple jobs for patient to do
95. Encourages activity requiring prolonged concentration
96. Checks that patient is adequately clothed for warmth
97. Displays calm confidence in interaction with patient
98. Tells suicidal patient that his life is his own responsibility
99. Makes assumptions about patient's feelings
100. Tells suicidal patient that his family will be upset by his wanting to end his life

101. Stays with suicidal patient all the time
102. Allows patient to eat alone
103. Gives light hearted reassurance
104. Demonstrates sympathetic approach
105. Tells patient to go for a walk
106. Encourages patient to verbalise his failures
107. Comments to patient on lack of ability to concentrate
108. Baths and dresses patient while he feels low
109. Tells patient when his hygiene care is inadequate
110. Encourages patient to go to bed early to ensure a good sleep

111. Is cheerful and optimistic in approach to patient
112. Assists patient to suppress anger
113. Avoids talking about the future
114. Leaves patient without any structure to his evening
115. Tells patient he cannot expect staff to take responsibility for his actions

ALL REGISTERED STAFF AT UNIT PAGE 2

01/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR1

VALID CASES 0 MISSING CASES 21

VAR2

VALID CASES 0 MISSING CASES 21

VAR3

VALID CASES 0 MISSING CASES 21

VAR4

VALID CASES 0 MISSING CASES 21

VAR5

VALID CASES 0 MISSING CASES 21

VAR6

VALID CASES 0 MISSING CASES 21

VAR7

MEAN	5.571	MEDIAN	6.125	MODE	8.000
STD DEV	2.481	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR8

MEAN	5.238	MEDIAN	6.000	MODE	8.000
STD DEV	2.700	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

ALL REGISTERED STAFF AT UNIT PAGE 3

01/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR9

MEAN	6.190	MEDIAN	6.583	MODE	7.000
STD DEV	1.750	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR10

MEAN	4.650	MEDIAN	4.833	MODE	5.000
STD DEV	1.843	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	20	MISSING CASES	1		

VAR11

MEAN	5.952	MEDIAN	6.556	MODE	7.000
STD DEV	1.564	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR12

MEAN	6.000	MEDIAN	6.188	MODE	6.000
STD DEV	1.378	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR13

MEAN	7.095	MEDIAN	7.313	MODE	8.000
STD DEV	1.179	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR14

MEAN	5.857	MEDIAN	6.083	MODE	7.000
STD DEV	1.352	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR15

MEAN	4.000	MEDIAN	4.000	MODE	4.000
STD DEV	1.643	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR16

MEAN	5.190	MEDIAN	5.571	MODE	6.000
STD DEV	1.965	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR17

MEAN	6.381	MEDIAN	6.417	MODE	6.000
STD DEV	1.431	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR18

MEAN	5.190	MEDIAN	5.125	MODE	3.000
STD DEV	1.861	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

ALL REGISTERED STAFF AT UNIT PAGE 5

01/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR19

MEAN	5.952	MEDIAN	6.200	MODE	6.000
STD DEV	1.802	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR20

MEAN	6.762	MEDIAN	7.000	MODE	8.000
STD DEV	1.446	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR21

MEAN	6.429	MEDIAN	6.583	MODE	7.000
STD DEV	1.287	RANGE	4.000	MINIMUM	4.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR22

VALID CASES	0	MISSING CASES	21

VAR23

MEAN	3.810	MEDIAN	3.417	MODE	3.000
STD DEV	1.887	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				
VALID CASES	21	MISSING CASES	0		

VAR24

MEAN	3.952	MEDIAN	4.375	MODE	5.000
STD DEV	2.061	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

ALL REGISTERED STAFF AT UNIT PAGE 6

01/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR25

MEAN	6.333	MEDIAN	6.583	MODE	7.000
STD DEV	1.390	RANGE	4.000	MINIMUM	4.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR26

MEAN	6.429	MEDIAN	6.313	MODE	6.000
STD DEV	1.028	RANGE	3.000	MINIMUM	5.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR27

VALID CASES	0	MISSING CASES	21

VAR28

MEAN	6.619	MEDIAN	6.778	MODE	7.000
STD DEV	1.071	RANGE	4.000	MINIMUM	4.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR29

MEAN	6.381	MEDIAN	6.188	MODE	6.000
STD DEV	1.117	RANGE	3.000	MINIMUM	5.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR30

MEAN	5.450	MEDIAN	5.500	MODE	6.000
STD DEV	1.849	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	20	MISSING CASES	1		

11/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR36

MEAN	6.381	MEDIAN	6.688	MODE	7.000
STD DEV	1.359	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR37

MEAN	6.300	MEDIAN	6.500	MODE	7.000
STD DEV	1.302	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				

VALID CASES 20 MISSING CASES 1

VAR38

MEAN	6.905	MEDIAN	7.045	MODE	8.000
STD DEV	1.609	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR39

MEAN	7.000	MEDIAN	7.545	MODE	8.000
STD DEV	1.378	RANGE	4.000	MINIMUM	4.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR40

MEAN	4.048	MEDIAN	3.800	MODE	3.000
STD DEV	1.746	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				

VALID CASES 21 MISSING CASES 0

ALL REGISTERED STAFF AT UNIT PAGE 9

01/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR41

MEAN	6.429	MEDIAN	6.813	MODE	7.000
STD DEV	1.399	RANGE	4.000	MINIMUM	4.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR42

MEAN	1.810	MEDIAN	1.750	MODE	2.000
STD DEV	0.814	RANGE	3.000	MINIMUM	1.000
MAXIMUM	4.000				
VALID CASES	21	MISSING CASES	0		

VAR43

MEAN	6.857	MEDIAN	7.400	MODE	8.000
STD DEV	1.558	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR44

MEAN	5.143	MEDIAN	5.200	MODE	5.000
STD DEV	2.032	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR45

MEAN	3.905	MEDIAN	4.000	MODE	2.000
STD DEV	1.841	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

ALL REGISTERED STAFF AT UNIT PAGE 10

01/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR46

MEAN	4.810	MEDIAN	4.667	MODE	3.000
STD DEV	2.112	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR47

MEAN	6.667	MEDIAN	6.667	MODE	7.000
STD DEV	0.796	RANGE	3.000	MINIMUM	5.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR48

MEAN	3.476	MEDIAN	3.250	MODE	1.000
STD DEV	2.205	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				
VALID CASES	21	MISSING CASES	0		

VAR49

MEAN	6.667	MEDIAN	7.333	MODE	8.000
STD DEV	1.623	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR50

MEAN	4.619	MEDIAN	4.625	MODE	4.000
STD DEV	1.687	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

ALL REGISTERED STAFF AT UNIT PAGE 11

01/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR51

MEAN	6.571	MEDIAN	6.778	MODE	7.000
STD DEV	1.165	RANGE	4.000	MINIMUM	4.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR52

MEAN	6.476	MEDIAN	7.000	MODE	7.000
STD DEV	1.806	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR53

MEAN	2.524	MEDIAN	1.583	MODE	1.000
STD DEV	2.205	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR54

MEAN	2.524	MEDIAN	1.800	MODE	1.000
STD DEV	2.015	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR55

MEAN	5.800	MEDIAN	5.833	MODE	5.000
STD DEV	1.704	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	20	MISSING CASES	1		

ALL REGISTERED STAFF AT UNIT PAGE 12

01/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR56

MEAN	5.286	MEDIAN	5.375	MODE	5.000
STD DEV	2.148	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR57

MEAN	5.810	MEDIAN	6.083	MODE	6.000
STD DEV	1.806	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR58

MEAN	5.476	MEDIAN	5.500	MODE	3.000
STD DEV	2.294	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR59

MEAN	2.190	MEDIAN	1.714	MODE	1.000
STD DEV	1.778	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR60

MEAN	7.190	MEDIAN	7.692	MODE	8.000
STD DEV	1.250	RANGE	4.000	MINIMUM	4.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

11/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR61

MEAN	4.500	MEDIAN	4.500	MODE	2.000
STD DEV	2.188	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 20 MISSING CASES 1

VAR62

MEAN	7.000	MEDIAN	7.222	MODE	7.000
STD DEV	1.095	RANGE	3.000	MINIMUM	5.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR63

VALID CASES 0 MISSING CASES 21

VAR64

MEAN	5.095	MEDIAN	5.571	MODE	6.000
STD DEV	1.921	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR65

VALID CASES 0 MISSING CASES 21

VAR66

MEAN	6.810	MEDIAN	7.000	MODE	7.000
STD DEV	1.167	RANGE	4.000	MINIMUM	4.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

11/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR67

MEAN	5.905	MEDIAN	6.429	MODE	6.000
STD DEV	2.234	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR68

VALID CASES 0 MISSING CASES 21

VAR69

MEAN	5.238	MEDIAN	5.714	MODE	6.000
STD DEV	1.786	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR70

MEAN	5.381	MEDIAN	5.571	MODE	6.000
STD DEV	1.656	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR71

MEAN	4.762	MEDIAN	5.200	MODE	6.000
STD DEV	1.841	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR72

MEAN	4.857	MEDIAN	5.000	MODE	6.000
STD DEV	1.740	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

01/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR73

MEAN	6.619	MEDIAN	6.667	MODE	7.000
STD DEV	0.865	RANGE	3.000	MINIMUM	5.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR74

MEAN	5.750	MEDIAN	5.900	MODE	6.000
STD DEV	1.517	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	20	MISSING CASES	1		

VAR75

MEAN	5.905	MEDIAN	6.417	MODE	6.000
STD DEV	2.022	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

MEAN	6.714	MEDIAN	6.889	MODE	7.000
STD DEV	1.169	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR77

MEAN	6.143	MEDIAN	6.375	MODE	7.000
STD DEV	1.424	RANGE	4.000	MINIMUM	4.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

01/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR78

MEAN	7.238	MEDIAN	7.625	MODE	8.000
STD DEV	1.044	RANGE	3.000	MINIMUM	5.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR79

MEAN	6.095	MEDIAN	6.125	MODE	8.000
STD DEV	1.841	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR80

MEAN	2.333	MEDIAN	1.667	MODE	1.000
STD DEV	1.592	RANGE	5.000	MINIMUM	1.000
MAXIMUM	6.000				
VALID CASES	21	MISSING CASES	0		

VAR81

MEAN	1.857	MEDIAN	1.308	MODE	1.000
STD DEV	1.459	RANGE	5.000	MINIMUM	1.000
MAXIMUM	6.000				
VALID CASES	21	MISSING CASES	0		

VAR82

MEAN	7.238	MEDIAN	7.429	MODE	8.000
STD DEV	0.889	RANGE	3.000	MINIMUM	5.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

ALL REGISTERED STAFF AT UNIT PAGE 17

01/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR83

MEAN	6.810	MEDIAN	7.000	MODE	7.000
STD DEV	1.250	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR84

MEAN	4.381	MEDIAN	4.625	MODE	5.000
STD DEV	2.109	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR85

MEAN	2.952	MEDIAN	2.375	MODE	1.000
STD DEV	1.962	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				
VALID CASES	21	MISSING CASES	0		

VAR86

MEAN	6.286	MEDIAN	6.417	MODE	6.000
STD DEV	1.454	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR87

MEAN	6.000	MEDIAN	6.400	MODE	7.000
STD DEV	1.817	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

01/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR88

MEAN	2.714	MEDIAN	1.750	MODE	1.000
STD DEV	2.101	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				

VALID CASES 21 MISSING CASES 0

VAR89

MEAN	4.000	MEDIAN	4.375	MODE	1.000
STD DEV	2.214	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				

VALID CASES 21 MISSING CASES 0

VAR90

MEAN	1.952	MEDIAN	1.250	MODE	1.000
STD DEV	1.627	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				

VALID CASES 21 MISSING CASES 0

VAR91

MEAN	5.905	MEDIAN	6.250	MODE	6.000
STD DEV	1.670	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR92

MEAN	3.857	MEDIAN	3.333	MODE	1.000
STD DEV	2.393	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

01/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR93

MEAN	4.476	MEDIAN	4.250	MODE	4.000
STD DEV	2.182	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR94

MEAN	5.714	MEDIAN	5.000	MODE	4.000
STD DEV	1.521	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR95

MEAN	2.000	MEDIAN	1.000	MODE	1.000
STD DEV	1.342	RANGE	5.000	MINIMUM	1.000
MAXIMUM	6.000				
VALID CASES	21	MISSING CASES	0		

VAR96

MEAN	5.238	MEDIAN	5.000	MODE	4.000
STD DEV	1.972	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR97

MEAN	7.524	MEDIAN	7.750	MODE	8.000
STD DEV	0.750	RANGE	2.000	MINIMUM	6.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

31/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR98

MEAN	3.762	MEDIAN	3.667	MODE	6.000
STD DEV	2.095	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR99

VALID CASES 0 MISSING CASES 21

VAR100

MEAN	2.905	MEDIAN	2.857	MODE	3.000
STD DEV	1.708	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				

VALID CASES 21 MISSING CASES 0

VAR101

MEAN	6.429	MEDIAN	7.333	MODE	8.000
STD DEV	2.014	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR102

MEAN	3.048	MEDIAN	2.429	MODE	2.000
STD DEV	1.857	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR103

MEAN	3.429	MEDIAN	2.875	MODE	2.000
STD DEV	1.938	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				

VALID CASES 21 MISSING CASES 0

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01/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR104

MEAN	6.238	MEDIAN	6.417	MODE	8.000
STD DEV	1.814	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR105

MEAN	2.619	MEDIAN	2.286	MODE	2.000
STD DEV	1.431	RANGE	5.000	MINIMUM	1.000
MAXIMUM	6.000				

VALID CASES 21 MISSING CASES 0

VAR106

MEAN	3.333	MEDIAN	2.875	MODE	2.000
STD DEV	2.008	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				

VALID CASES 21 MISSING CASES 0

VAR107

MEAN	3.952	MEDIAN	3.800	MODE	2.000
STD DEV	1.687	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

VAR108

MEAN	3.714	MEDIAN	3.400	MODE	3.000
STD DEV	1.978	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 21 MISSING CASES 0

11/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR109

MEAN	5.143	MEDIAN	5.250	MODE	5.000
STD DEV	1.558	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR110

MEAN	4.238	MEDIAN	4.083	MODE	4.000
STD DEV	2.119	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				
VALID CASES	21	MISSING CASES	0		

VAR111

MEAN	5.810	MEDIAN	6.000	MODE	6.000
STD DEV	1.806	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	21	MISSING CASES	0		

VAR112

MEAN	2.286	MEDIAN	1.938	MODE	2.000
STD DEV	1.521	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				
VALID CASES	21	MISSING CASES	0		

VAR113

MEAN	2.333	MEDIAN	1.813	MODE	1.000
STD DEV	1.798	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				
VALID CASES	21	MISSING CASES	0		

01/26/82 FILE - - CREATED 12/08/81

SUBFILE NONAME

VAR114

MEAN	2.810	MEDIAN	2.400	MODE	1.000
STD DEV	1.721	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				
VALID CASES	21	MISSING CASES	0		

VAR115

MEAN	3.762	MEDIAN	3.917	MODE	4.000
STD DEV	1.578	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				
VALID CASES	21	MISSING CASES	0		

LARGER SAMPLE OF REGISTERED STAFF PAGE 2

31/26/82 FILE - - CREATED 01/26/82

SUBFILE NONAME

VAR1

MEAN	6.300	MEDIAN	6.100	MODE	6.000
STD DEV	1.337	RANGE	4.000	MINIMUM	4.000
MAXIMUM	8.000				

VALID CASES 10 MISSING CASES 48

VAR2

MEAN	5.900	MEDIAN	6.000	MODE	5.000
STD DEV	1.663	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				

VALID CASES 10 MISSING CASES 48

VAR3

MEAN	5.400	MEDIAN	5.500	MODE	5.000
STD DEV	2.011	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				

VALID CASES 10 MISSING CASES 48

VAR4

MEAN	6.400	MEDIAN	6.700	MODE	7.000
STD DEV	1.174	RANGE	4.000	MINIMUM	4.000
MAXIMUM	8.000				

VALID CASES 10 MISSING CASES 48

VAR5

MEAN	6.000	MEDIAN	6.000	MODE	6.000
STD DEV	1.700	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				

VALID CASES 10 MISSING CASES 48

LARGER SAMPLE OF REGISTERED STAFF PAGE 3

01/26/82 FILE - - CREATED 01/26/82

SUBFILE NONAME

VAR6

MEAN	6.200	MEDIAN	7.000	MODE	8.000
STD DEV	1.989	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				

VALID CASES 10 MISSING CASES 48

VAR7

MEAN	5.561	MEDIAN	6.050	MODE	8.000
STD DEV	2.299	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 57 MISSING CASES 1

VAR8

MEAN	5.754	MEDIAN	6.313	MODE	8.000
STD DEV	2.378	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 57 MISSING CASES 1

VAR9

MEAN	5.310	MEDIAN	5.929	MODE	8.000
STD DEV	2.393	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 58 MISSING CASES 0

VAR10

MEAN	4.569	MEDIAN	4.773	MODE	5.000
STD DEV	2.177	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 58 MISSING CASES 0

LARGER SAMPLE OF REGISTERED STAFF PAGE 4

01/26/82 FILE - - CREATED 01/26/82

SUBFILE NONAME

VAR11

MEAN	5.614	MEDIAN	6.531	MODE	7.000
STD DEV	2.226	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR12

MEAN	5.614	MEDIAN	5.909	MODE	7.000
STD DEV	1.868	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR13

MEAN	6.596	MEDIAN	6.923	MODE	8.000
STD DEV	1.602	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR14

MEAN	5.724	MEDIAN	6.115	MODE	6.000
STD DEV	1.963	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR15

MEAN	3.684	MEDIAN	3.778	MODE	5.000
STD DEV	1.974	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

01/26/82 FILE - - CREATED 01/26/82

SUBFILE NONAME

VAR16

MEAN	6.053	MEDIAN	6.550	MODE	8.000
STD DEV	1.922	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				

VALID CASES 57 MISSING CASES 1

VAR17

MEAN	6.071	MEDIAN	6.357	MODE	6.000
STD DEV	1.715	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 56 MISSING CASES 2

VAR18

MEAN	5.621	MEDIAN	5.767	MODE	6.000
STD DEV	1.674	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				

VALID CASES 58 MISSING CASES 0

VAR19

MEAN	6.070	MEDIAN	6.600	MODE	7.000
STD DEV	1.898	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 57 MISSING CASES 1

VAR20

MEAN	6.862	MEDIAN	7.313	MODE	8.000
STD DEV	1.538	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				

VALID CASES 58 MISSING CASES 0

)1/26/82 FILE - - CREATED 01/26/82

SUBFILE NONAME

VAR21

MEAN	5.946	MEDIAN	6.063	MODE	6.000
STD DEV	1.494	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	56	MISSING CASES	2		

VAR22

MEAN	5.000	MEDIAN	5.167	MODE	5.000
STD DEV	2.494	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	10	MISSING CASES	48		

VAR23

MEAN	4.017	MEDIAN	4.125	MODE	5.000
STD DEV	2.132	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR24

MEAN	3.228	MEDIAN	3.042	MODE	1.000
STD DEV	1.852	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR25

MEAN	6.070	MEDIAN	6.321	MODE	6.000
STD DEV	1.699	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

LARGER SAMPLE OF REGISTERED STAFF PAGE 7

01/26/82 FILE - - CREATED 01/26/82

SUBFILE NONAME

VAR26

MEAN	5.655	MEDIAN	5.900	MODE	6.000
STD DEV	1.722	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR27

MEAN	5.000	MEDIAN	4.500	MODE	4.000
STD DEV	1.563	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				
VALID CASES	10	MISSING CASES	48		

VAR28

MEAN	6.193	MEDIAN	6.750	MODE	8.000
STD DEV	1.941	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR29

MEAN	5.025	MEDIAN	6.133	MODE	6.000
STD DEV	1.956	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR30

MEAN	4.776	MEDIAN	5.000	MODE	6.000
STD DEV	2.271	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

LARGER SAMPLE OF REGISTERED STAFF PAGE 8

01/26/82 FILE - - CREATED 01/26/82

SUBFILE NONAME

VAR31

MEAN	5.845	MEDIAN	6.409	MODE	8.000
STD DEV	2.134	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR32

MEAN	4.897	MEDIAN	5.071	MODE	8.000
STD DEV	2.299	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR33

MEAN	5.107	MEDIAN	7.134	MODE	8.000
STD DEV	1.723	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	56	MISSING CASES	2		

VAR34

MEAN	4.571	MEDIAN	4.188	MODE	3.000
STD DEV	2.179	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	49	MISSING CASES	9		

VAR35

MEAN	5.293	MEDIAN	5.417	MODE	5.000
STD DEV	2.009	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

LARGER SAMPLE OF REGISTERED STAFF PAGE 9

01/26/82 FILE - - CREATED 01/26/82

SUBFILE NONAME

VAR36

MEAN	6.088	MEDIAN	6.281	MODE	6.000
STD DEV	1.479	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR37

MEAN	6.321	MEDIAN	6.833	MODE	8.000
STD DEV	1.800	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	56	MISSING CASES	2		

VAR38

MEAN	6.737	MEDIAN	7.267	MODE	8.000
STD DEV	1.631	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR39

MEAN	6.914	MEDIAN	7.533	MODE	8.000
STD DEV	1.548	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR40

MEAN	4.404	MEDIAN	4.273	MODE	4.000
STD DEV	2.103	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

LARGER SAMPLE OF REGISTERED STAFF PAGE 10

01/26/82 FILE - - CREATED 01/26/82

SUBFILE NONAME

VAR41

MEAN	6.052	MEDIAN	6.088	MODE	6.000
STD DEV	1.503	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR42

MEAN	2.200	MEDIAN	1.842	MODE	1.000
STD DEV	1.366	RANGE	5.000	MINIMUM	1.000
MAXIMUM	6.000				
VALID CASES	55	MISSING CASES	3		

VAR43

MEAN	6.140	MEDIAN	7.184	MODE	7.000
STD DEV	2.022	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR44

MEAN	4.630	MEDIAN	4.611	MODE	4.000
STD DEV	1.926	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	54	MISSING CASES	4		

VAR45

MEAN	3.982	MEDIAN	3.923	MODE	4.000
STD DEV	1.557	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	55	MISSING CASES	3		

LARGER SAMPLE OF REGISTERED STAFF PAGE 11

01/26/82 FILE - - CREATED 01/26/82

SUBFILE NONAME

VAR46

MEAN	3.845	MEDIAN	4.000	MODE	6.000
STD DEV	1.862	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				
VALID CASES	58	MISSING CASES	0		

VAR47

MEAN	6.544	MEDIAN	7.028	MODE	8.000
STD DEV	1.753	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR48

MEAN	3.474	MEDIAN	3.067	MODE	3.000
STD DEV	1.974	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR49

MEAN	6.897	MEDIAN	7.300	MODE	8.000
STD DEV	1.347	RANGE	5.000	MINIMUM	3.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR50

MEAN	5.439	MEDIAN	5.650	MODE	7.000
STD DEV	1.890	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

LARGER SAMPLE OF REGISTERED STAFF PAGE 12

01/26/82 FILE - - CREATED 01/26/82

SUBFILE NONAME

VAR51

MEAN	5.491	MEDIAN	5.692	MODE	6.000
STD DEV	1.713	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR52

MEAN	6.672	MEDIAN	7.233	MODE	8.000
STD DEV	1.771	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR53

MEAN	1.512	MEDIAN	1.337	MODE	1.000
STD DEV	1.527	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				
VALID CASES	57	MISSING CASES	1		

VAR54

MEAN	2.293	MEDIAN	1.786	MODE	1.000
STD DEV	1.633	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				
VALID CASES	58	MISSING CASES	0		

VAR55

MEAN	6.190	MEDIAN	6.556	MODE	7.000
STD DEV	1.638	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

LARGER SAMPLE OF REGISTERED STAFF PAGE 13

01/26/82 FILE - - CREATED 01/26/82

SUBFILE NONAME

VAR56

MEAN	6.621	MEDIAN	7.100	MODE	8.000
STD DEV	1.642	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR57

MEAN	4.776	MEDIAN	5.200	MODE	6.000
STD DEV	2.128	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR58

MEAN	5.931	MEDIAN	6.250	MODE	8.000
STD DEV	1.872	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR59

MEAN	2.224	MEDIAN	1.406	MODE	1.000
STD DEV	1.855	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR60

MEAN	6.897	MEDIAN	7.438	MODE	8.000
STD DEV	1.619	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

LARGER SAMPLE OF REGISTERED STAFF PAGE 14

01/26/82 FILE - - CREATED 01/26/82

SUBFILE NONAME

VAR61

MEAN	4.857	MEDIAN	4.944	MODE	6.000
STD DEV	2.084	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	56	MISSING CASES	2		

VAR62

MEAN	6.224	MEDIAN	6.654	MODE	8.000
STD DEV	1.826	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR63

MEAN	5.222	MEDIAN	6.000	MODE	7.000
STD DEV	1.986	RANGE	5.000	MINIMUM	2.000
MAXIMUM	7.000				
VALID CASES	9	MISSING CASES	49		

VAR64

MEAN	5.281	MEDIAN	5.632	MODE	6.000
STD DEV	1.849	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR65

MEAN	4.900	MEDIAN	4.833	MODE	4.000
STD DEV	1.197	RANGE	4.000	MINIMUM	3.000
MAXIMUM	7.000				
VALID CASES	10	MISSING CASES	48		

LARGER SAMPLE OF REGISTERED STAFF PAGE 15

01/26/82 FILE - - CREATED 01/26/82

SUBFILE NONAME

VAR66

MEAN	6.621	MEDIAN	6.900	MODE	7.000
STD DEV	1.400	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR67

MEAN	6.123	MEDIAN	6.455	MODE	8.000
STD DEV	1.702	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR68

MEAN	4.200	MEDIAN	4.167	MODE	4.000
STD DEV	1.619	RANGE	5.000	MINIMUM	2.000
MAXIMUM	7.000				
VALID CASES	10	MISSING CASES	48		

VAR69

MEAN	5.421	MEDIAN	5.538	MODE	5.000
STD DEV	1.700	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR70

MEAN	5.414	MEDIAN	5.500	MODE	6.000
STD DEV	1.707	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

01/26/82 FILE - - CREATED 01/26/82

SUBFILE NONAME

VAR71

MEAN	5.579	MEDIAN	5.571	MODE	5.000
STD DEV	1.822	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR72

MEAN	5.310	MEDIAN	5.167	MODE	4.000
STD DEV	1.719	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR73

MEAN	5.158	MEDIAN	5.469	MODE	6.000
STD DEV	1.699	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR74

MEAN	4.891	MEDIAN	5.000	MODE	5.000
STD DEV	2.025	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	55	MISSING CASES	3		

VAR75

MEAN	5.579	MEDIAN	6.091	MODE	7.000
STD DEV	2.095	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

LARGER SAMPLE OF REGISTERED STAFF PAGE 17

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SUBFILE NONAME

VAR76

MEAN	6.362	MEDIAN	6.962	MODE	8.000
STD DEV	1.907	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR77

MEAN	5.818	MEDIAN	6.091	MODE	7.000
STD DEV	1.816	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	55	MISSING CASES	3		

VAR78

MEAN	6.241	MEDIAN	6.611	MODE	8.000
STD DEV	1.829	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR79

MEAN	5.754	MEDIAN	6.385	MODE	7.000
STD DEV	2.029	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR80

MEAN	2.241	MEDIAN	1.786	MODE	1.000
STD DEV	1.571	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

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SUBFILE NONAME

VAR81

MEAN	2.035	MEDIAN	1.419	MODE	1.000
STD DEV	1.625	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 57 MISSING CASES 1

VAR82

MEAN	7.172	MEDIAN	7.671	MODE	8.000
STD DEV	1.523	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 58 MISSING CASES 0

VAR83

MEAN	5.414	MEDIAN	6.722	MODE	7.000
STD DEV	1.499	RANGE	6.000	MINIMUM	2.000
MAXIMUM	8.000				

VALID CASES 58 MISSING CASES 0

VAR84

MEAN	4.091	MEDIAN	3.850	MODE	3.000
STD DEV	1.788	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				

VALID CASES 55 MISSING CASES 3

VAR85

MEAN	2.054	MEDIAN	1.786	MODE	1.000
STD DEV	1.299	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				

VALID CASES 56 MISSING CASES 2

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SUBFILE NCNAME

VAR86

MEAN	6.138	MEDIAN	6.625	MODE	7.000
STD DEV	1.840	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 58 MISSING CASES 0

VAR87

MEAN	5.793	MEDIAN	5.944	MODE	5.000
STD DEV	1.775	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 58 MISSING CASES 0

VAR88

MEAN	2.414	MEDIAN	1.808	MODE	1.000
STD DEV	1.797	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 58 MISSING CASES 0

VAR89

MEAN	3.018	MEDIAN	2.375	MODE	1.000
STD DEV	2.013	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 57 MISSING CASES 1

VAR90

MEAN	1.596	MEDIAN	1.179	MODE	1.000
STD DEV	1.486	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 57 MISSING CASES 1

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SUBFILE NONAME

VAR91

MEAN	4.948	MEDIAN	5.300	MODE	7.000
STD DEV	2.139	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR92

MEAN	4.182	MEDIAN	4.000	MODE	1.000
STD DEV	2.404	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	55	MISSING CASES	3		

VAR93

MEAN	4.439	MEDIAN	3.875	MODE	2.000
STD DEV	2.275	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	56	MISSING CASES	2		

VAR94

MEAN	5.828	MEDIAN	6.192	MODE	7.000
STD DEV	1.788	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR95

MEAN	2.579	MEDIAN	2.350	MODE	1.000
STD DEV	1.569	RANGE	5.000	MINIMUM	1.000
MAXIMUM	6.000				
VALID CASES	57	MISSING CASES	1		

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SUBFILE NONAME

VAR96

MEAN	5.702	MEDIAN	6.000	MODE	6.000
STD DEV	1.832	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR97

MEAN	6.965	MEDIAN	7.464	MODE	8.000
STD DEV	1.426	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR98

MEAN	3.661	MEDIAN	3.333	MODE	1.000
STD DEV	2.306	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	56	MISSING CASES	2		

VAR99

MEAN	2.222	MEDIAN	2.000	MODE	1.000
STD DEV	1.302	RANGE	3.000	MINIMUM	1.000
MAXIMUM	4.000				
VALID CASES	9	MISSING CASES	49		

VAR100

MEAN	3.053	MEDIAN	2.571	MODE	1.000
STD DEV	2.082	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

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SUBFILE NONAME

VAR101

MEAN	6.218	MEDIAN	6.909	MODE	8.000
STD DEV	2.061	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 55 MISSING CASES 3

VAR102

MEAN	2.473	MEDIAN	1.727	MODE	1.000
STD DEV	1.824	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 55 MISSING CASES 3

VAR103

MEAN	2.431	MEDIAN	1.944	MODE	1.000
STD DEV	1.748	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 58 MISSING CASES 0

VAR104

MEAN	5.000	MEDIAN	5.500	MODE	8.000
STD DEV	2.397	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 56 MISSING CASES 2

VAR105

MEAN	2.161	MEDIAN	1.466	MODE	1.000
STD DEV	1.766	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 56 MISSING CASES 2

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SUBFILE NONAME

VAR106

MEAN	4.316	MEDIAN	4.286	MODE	3.000
STD DEV	2.139	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR107

MEAN	3.431	MEDIAN	3.409	MODE	4.000
STD DEV	1.677	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR108

MEAN	4.155	MEDIAN	3.750	MODE	3.000
STD DEV	2.262	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	58	MISSING CASES	0		

VAR109

MEAN	4.596	MEDIAN	5.000	MODE	6.000
STD DEV	1.944	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

VAR110

MEAN	3.246	MEDIAN	2.813	MODE	2.000
STD DEV	1.845	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				
VALID CASES	57	MISSING CASES	1		

01/26/82 FILE - - CREATED 01/26/82

SUBFILE NONAME

VAR111

MEAN	4.931	MEDIAN	4.433	MODE	4.000
STD DEV	2.076	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 58 MISSING CASES 0

VAR112

MEAN	2.268	MEDIAN	1.433	MODE	1.000
STD DEV	1.863	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 56 MISSING CASES 2

VAR113

MEAN	2.554	MEDIAN	1.972	MODE	1.000
STD DEV	1.826	RANGE	6.000	MINIMUM	1.000
MAXIMUM	7.000				

VALID CASES 57 MISSING CASES 1

VAR114

MEAN	2.649	MEDIAN	2.219	MODE	1.000
STD DEV	1.768	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 57 MISSING CASES 1

VAR115

MEAN	4.042	MEDIAN	3.929	MODE	3.000
STD DEV	2.021	RANGE	7.000	MINIMUM	1.000
MAXIMUM	8.000				

VALID CASES 48 MISSING CASES 10

COMBINED MEDICAL STAFF

Address reply to officer whose official title appears below signature.

22 July 1981

Ms Shona Butterfield
[redacted]

Dear Ms Butterfield

The Ethical Committee discussed your proposed study entitled "Towards Helplessness or Self Care" at their meeting held on Thursday 16 July 1981.

The Committee of the project subject to the following provisos:

1) Patients who were unable to give informed consent were to be excluded, on this point the discretion will remain with the senior nurse.

2) The instructions to patients are to be revised to indicate that the study is connected with Massey University and not part of the routine hospital procedure.

3) No clinical notes are to be examined by the participants.

It was noted that it was proposed to carry out the study at such times during the day when the nurses most involved with the patients would not be included, it was felt that this could limit the value of the study.

Yours sincerely

Honorary Secretary