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SOCIAL WITHDRAWAL AMONG ELDERLY PATIENTS IN A LONG-STAY PSYCHIATRIC WARD

A thesis presented in partial fulfilment
of the requirements for the degree of
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ABSTRACT

Following a review of theories of aging it is argued that social interaction, as it occurs between nurse and patient, may be modified to decrease the withdrawn and apathetic behaviour commonly observed among the elderly patients of long-stay institutions. This presupposes that quality of patient care is closely related to the nature and extent of nurse-patient interaction.

The study is designed to demonstrate the presence of social withdrawal in long-stay wards for elderly patients and the effect of an activation group, or programmed recreation, on the degree of withdrawal. It is predicted that following exposure to increased opportunity for social interaction in an activation group there will be measurable changes in behaviour for those directly involved.

Measuring instruments have been adapted from an observation schedule described by Mooresand Grant (1976), a verbal code developed by Paton and Stirling (1974) and a study by Quilitch (1974). In the study non-participant observation has been used to record the dayroom behaviour and activity of male patients in two long-stay psychiatric wards during three periods of observation. An activation group for 12 selected patients supplemented the ongoing routine of the experimental ward between the first two periods of observation for social withdrawal. Behaviour ratings for group members were obtained using scales presented by Robinson (1974) and Gibson (1967).

It is shown that in two psychiatric wards for long-stay patients (mean ages 65.5 and 71.48 years respectively) the degree of social withdrawal of the patients in a dayroom setting varies over time, and variations in social withdrawal are linked with variations in nurse-patient interaction. The hypothesis that increased opportunity for interaction for a section of the patient population of a ward results in an overall increase of interaction in that ward, is partially supported. Participation in a planned group programme is associated with measurable changes in a variety of behaviours identified on selected rating scales, but the results are not statistically significant.

Various factors relating to the implementation and conduct of an activation group by nurses in a long-stay ward are identified and discussed. A model of nursing care for the elderly is presented which incorporates interaction as a crucial component within a systems model.

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CONTENTS

CHAPTER		Page
	ABSTRACT	ii
	ACKNOWLEDGEMENTS	iv
	CONTENTS	v
	LIST OF FIGURES	vii
	LIST OF TABLES	viii
	INTRODUCTION	1
1.	AGING	3
	Biological Aging	4
	Psychological Aging	6
	Psycho-social Theories of Aging	9
	Implications for Nursing Practice	15
2.	ASSESSMENT OF ELDERLY PATIENTS	17
	Becoming a Patient	17
	Assessment Scales	21
3.	NURSING PRACTICE IN THE CARE OF THE AGED	26
	Selected Research Reports of Therapeutic Interventions	28
	Activation of Patients	30
4.	BACKGROUND TO THE PRESENT STUDY	34
	Pilot Study	35
	Measurement of Social Withdrawal	36
5.	THE PRESENT STUDY	39
	Hypotheses	40
	Definitions	41
6.	METHOD	43
	Setting	46
	Selection and Pretesting of Instruments	46
	Selection of Group Subjects	51
	The Activity Group Sessions	52
	Methods Used for Analysis of Data	53
7.	RESULTS RELATED TO SOCIAL WITHDRAWAL	56
	Type I Observations	56
	Type II Observations	71

CHAPTER		Page
8.	INDIVIDUAL BEHAVIOUR OF GROUP MEMBERS	72
	Sketches of Group Members	75
	General Comments	82
9.	ANALYSIS OF THE GROUP	87
	Programme Outline for the Group Sessions	88
	Overview of the Group Process	89
	Analysis of Content	94
	Discussion	97
10.	APPARENT INFLUENCES ON NURSE AND PATIENT INTERACTION	100
	Nurse Factors	100
	Patient Factors	104
	Organisation Factors	105
	Non-nursing Staff Factors	106
	Patterns of Interaction	107
11.	DISCUSSION	110
	Analysis of Data	110
	Hypotheses	117
12.	A SYSTEMS MODEL PERSPECTIVE OF NURSING	119
	Interactional Component of the Model	120
13.	SUMMARY AND IMPLICATIONS FOR NURSING	125
	APPENDICES	131
	REFERENCES	157

LIST OF FIGURES

FIGURE		Page
6.1	Plan of the Experimental Ward Dayroom	47
6.2	Plan of the Control Ward Dayroom	47
7.1	Percentage of Observed Purposeful and Simple Activity by Patients in the Experimental Ward	57
7.2	Percentage of Observed Purposeful and Simple Activity by Patients in the Control Ward	57
7.3	Percentage of Interactions Initiated by Nurses and Patients in the Experimental Ward	60
7.4	Percentage of Interactions Initiated by Nurses and Patients in the Control Ward	60
7.5	Percentage of Observations in Each Verbal Category by Nurses and Patients in the Experimental Ward	63
7.6	Percentage of Observations in Each Verbal Category by Nurses and Patients in the Control Ward	63
7.7	Percentage of Observations in Each Activity Category by Patients in the Experimental Ward	68
7.8	Percentage of Observations in Each Activity Category by Patients in the Control Ward	68
12.1	The Process of Aging	122
12.2	Core of the Model	122
12.3	State of Responsiveness of Outer Permeable Membrane to External Stimuli	122

LIST OF TABLES

TABLE		Page
I	Timetable of the Study	44
II	Sequence of Data Collection Using Two Observation Schedules	45
III	Differences Between Type I Observation Periods for Purposeful and Simple Activity by Patients in the Experimental Ward	58
IV	Differences Between Type I Observation Periods for Purposeful and Simple Activity by Patients in the Control Ward	58
V	Differences Between Type I Observation Periods for Interactions Initiated by Nurses and Patients in the Experimental Ward	61
VI	Differences Between Type I Observation Periods for Interactions Initiated by Nurses and Patients in the Control Ward	61
VII	Differences Between Type I Observation Periods for Verbal Categories by Nurses and Patients in the Experimental Ward	64
VIII	Differences Between Type I Observation Periods for Verbal Categories by Nurses and Patients in the Control Ward	65
IX	Differences Between Type I Observation Periods for Activity Categories by Patients in the Experimental Ward	69
X	Differences Between Type I Observation Periods for Activity Categories by Patients in the Control Ward	70
XI	Differences From Use of Schedules in Type II Observations with Equivalent Days in Type I Observation Periods	71
XII	Scores on the Crichton Geriatric Behavioural Rating Scale by Group Subjects Before and Following Group Sessions	72
XIII	Range and Modal Scores for Performance in Group by Subjects for Number and Sessions Attended	73

TABLE		Page
XIV	Number and Percentage of Interactions by Group Subjects during Type I Observation Periods	74
XV	Comparison of Comment on Group Subject Suitability by Charge Nurse Pregroup and Group Leader Postgroup	82
XVI	Comment on Group Subject Suitability by a Charge Nurse during Group Sessions	83
XVII	Group Subjects as Rated by Two Charge Nurses on a Selection Scale Before and During Group Sessions	84
XVIII	Proportion of Patient to Nurse Verbal Units as Analysed from Group Sessions	94
XIX	Number, Rank and Percentage of Interactions by each Patient in Group Sessions	96
XX	Number of Nurses in Different Categories Observed in the Dayrooms of the Experimental and Control Wards	101
XXI	Percentage of Interactions of Various Durations in the Experimental and Control Wards	108

INTRODUCTION

A current, major challenge in Western style societies is care of the aged. In New Zealand, according to the Special Report Series No. 46 (1976), 8.5% of the population are in the 65 years and over category and this is an aged population in terms of the United Nations Office of Population Studies. The projected figure for 1986 is 9.17% and may under-estimate the actual flow of aging. The same document reports no evidence of a trend away from provision of institutional care and towards community services for the elderly. Therefore many elderly persons are likely to end their days in an institution.

Where an elderly person requires long-stay care and the main presenting features are physical in origin, the individual may be admitted to the geriatric ward of a general hospital, or to a geriatric hospital. Where the presenting features are psycho-social in nature and expressed in behavioural terms then admission may be to a long-stay ward of a psychiatric hospital. It is characteristic of these settings that much of the present nursing care is undertaken by enrolled or student nurses and hospital aides, rather than by registered nurses.

Among elderly patients in institutions signs of social withdrawal frequently usurp characteristics of individuality, resourcefulness and independence. Social withdrawal tends to be accepted as an inevitable consequence of aging and is predictable on the basis of disengagement theory. Yet the process of aging is not responsible for all the deterioration in behaviour which is seen, and there is evidence that functional levels rise with "greater opportunity and increased expectancy for performance" (Filer & O'Connell, 1964, p. 364). It therefore appears that the process of social withdrawal can be arrested, slowed, or reversed by appropriate intervention on the part of those caring for the aged person.

There is now an extensive range of literature which suggests that programmes of rehabilitation, resocialisation, remotivation and such-like lessen the level of social withdrawal among patients in long-stay institutions. Many New Zealand nurses recognise a need for activation of patients, and interest in activating patients for physical and

diversional purposes is increasing. However there are as yet no reports of group programmes for the elderly by nurses, such as those in North America reported by Burnside (1976). Consequently in this study, as well as investigating the effects on patient behaviour of providing an activation programme focusing on social interaction, there is interest in identifying variables which affect the implementation and maintenance of a series of group sessions for elderly patients in a long-stay psychiatric ward.

CHAPTER 1

AGING

Not only can the process of aging be viewed positively as growth and attainment of wisdom or negatively as decline and loss (Moses, 1970), but the age of the assessor will influence the perspective. For complete appraisal of an individual's adaptation to aging all perspectives must be considered. Within the community many aged are unable to remain self-sufficient without supportive services such as meals on wheels or domiciliary nursing supervision. Others lead active and productive lives with apparent successful adjustment to the developmental tasks of later life. These tasks include retirement, lowered economic standards, and death of spouse and friends (Havighurst, 1952).

Aging is a natural phenomenon (Birren, 1964) with both broad scientific and profound personal implications for each individual. There can be optimal growth and adaptation throughout the life cycle when the strengths and potentials of an individual are recognised, reinforced and encouraged by his environment (Butler & Lewis, 1977). Murphy (1971) used the concept of periodicity when explaining man's dependence upon his external environment and the consequent implication of the theory of adaptation for nursing.

For the individual, psychological, biological and social time need not be identical (Birren, 1964), and elapsed time is probably not registered at the same time in all organs or sub-systems of the body. Parts of the body occasionally have different directions in time (Birren, 1964) and function or structure may for an interval reverse its trend, as during regeneration.

The numerous and still emerging theories of aging are variously classified according to the orientation of the researcher. Everitt (1974) classified theories from a biological perspective into divisions of error and control theories. A more inclusive classification including both the traditional scientific and the newer behavioural science approaches to aging is stated by Birren (1964). Three groups into which most theories of biological, psychological and social aging

can be divided are named as genetic, counterpart (adult changes regarded as counterparts of earlier development), and accident or wear-and-tear theories (adult characterisitics viewed as an accumulation of the effects of random events or accidents).

Kimmel (1974) described gerontology as not able to decide if aging results from evolutionary necessity, the accumulated effects of "wear and tear" or natural process of physiological change. From an over-view of theories including physiological, hereditary and external factors of the aging process, it is proposed that none entirely explain, but each makes a highly valuable contribution towards understanding the process. Kimmel (1974) concluded that there is generally a growing inability of the organism to adapt to the environment and therefore survive in aging.

For the purposes of this thesis theories of aging are presented from biological, psychological and psycho-social perspectives according to the dominant and usually accepted interpretation of the theory. Man is understood as a complex bio-psycho-social being with inter-relationships and dependencies between the stated perspectives.

Biological Aging

Biological and chronological age are derived from different sets of measurements, and therefore not identical. Biological age is indicative of present position relative to potential lifespan. Butler (1977) has reminded that life's potential can be lengthened and enhanced but aging and death are an expected part of human experience.

Theories of cell aging described by Lansing (1959) have been summarised by Chown (1972). The categories are accumulation of metabolic waste products, increase in proportion of cytoplasm to nuclear material, and wearing out of protoplasm. Possible causes of the foregoing are each identified respectively as diseases in cellular permeability and changes in metabolism of calcium, increase in differentiation within the cell with time, and decreasing ability of the cell to synthesize itself and changes in DNA/RNA mechanisms.

These underlying processes are recognised by Chown (1972) as not mutually exclusive, and that mechanisms for most have not been investigated.

Experimental biologists have established that cell death occurs in many of the critical organs of the body with age. One explanation is lack of, or defective production of DNA, the critical genetic material of a cell. Everitt (1974) described somatic mutations as cumulative with only a certain number and type of errors tolerated by genetic apparatus before cessation of normal functions. Difficulty of studying cross-linkage in DNA in the cell has resulted in more literature on collagen aging as the latter is extracellular (Everitt, 1974).

Age changes within cells vary depending upon the type of cell involved (Chown, 1972). There is strong indication that aging may be a special characteristic of highly differentiated cells, those that have lost their potential for further division and remain fixed post-mitotic cells (Birren, 1964). For example, the number of basic functioning units of neurones declines about age 25, and is associated with decreased capacity for nerve impulse conduction to and from the brain (Kart, Metress & Metress, 1978). As conduction velocity decreases, motor movements become slower and reflex time for skeletal muscles is increased (Kart et al., 1978).

Everitt (1974) described age changes of cells in error accumulations, cross-linkage and immunological theories as controlled by genetic and environmental factors, and aging and longevity as genetically determined. Aging, in physiological terms, is defined by Boshier (1974) as "the progressive inability of the organism to maintain the milieu interieur within the narrow limits compatible with life" (p.10). The process of aging is an integral part of normal developmental growth.

Increased possibility of pathological change and disease occur with age. Boshier (1974) outlined aging in different organ systems (principally the neuromuscular) with the underlying themes of decreasing ability of humans to maintain physiological body control with age, and the non-synchronous aging of body systems.

Patterns of illness among the aging in relation to body systems are discussed by Kart et al. (1978). Their aim with reference to the cardio-pulmonary system was identification of anatomic and physiologic changes that reduce cardiac function plus information on dominant causes of heart disease in old age. Factors associated with differences in physiological age are genetics, life style, prior medical history and sex (Boshier, 1974).

The dual role nutrition appears to play in major theories of biologic aging is commented on by Kart et al. (1978). These may be factors in the physiologic and anatomic changes causing cell destruction and limiting cell regeneration, or the important role of diet in degenerative diseases associated with aging. They interpret these theories in terms of flaws in the mechanism of protein synthesis, reaction of molecular fragments (free radicals) with polyunsaturated fatty acids in the cell membranes from peroxidation products, and immunologic process gradual breakdown.

Butler and Lewis (1973) described neurones, multiplying and connective tissue cells as those of concern in current theories of aging. Cell anatomy and physiology are interdependent. As cells age, and are not regenerated, changes in physical appearance such as greying of hair, loss of teeth, subcutaneous fat loss, skin wrinkling, loss of vision and hearing, and postural changes are manifested. Although the elderly may be more prone to illness old age can still be an emotionally healthy and satisfying period with only a minimum of physical and mental impairment (Butler & Lewis 1977).

Psychological Aging

Birren (1964) described a behavioural theory of aging as concerned with systematic explanation of age differences in behaviour and capacities of adult organisms. Explanations have, and are being sought, for age differences in sensory and perceptual function, psychomotor skills, learning and memory, thinking and problem-solving, motivation and personality.

Psychological age refers to the adaptive capacities of individuals as observed from their behaviour, and to subjective reactions or self-awareness. It is related to both chronological and biological age, but is not fully described by their combination (Birren, 1964). However biologic changes affect the psychologic state of being, just as psychologic and psychosocial changes may affect biologic functioning (Kart et al., 1978).

With aging there is reduction of sensory acuity from sources such as injury, disease or neuronal change. There is a trend to psychomotor slowness, to which the individual adapts or compensates. For many elderly the decline of sensory and perceptual processes does not seriously hamper behaviour until after age 70. In general there is discrimination among stimuli of lower intensity than when younger. The level of excitation to the nervous sytem may thus be lowered and thereby lessen the activity level (Birren, 1964).
Thus psychomotor performance is limited by capacities of various parts of the system (Atchley, 1972) and the rise in sensory threshhold is the most serious limitation.

According to Atchley (1972) increase in reaction time with aging is very slight for simple tasks, but greater with increasing complexity and "the more complex the task, the better older people tend to look in relation to the young" (Atchley, 1972, p.59). The same author stated that the slower reactions of older people are a fact but the reason far from clear. For example, some slowness could be attributed to the difference between the time required for accuracy and that required for certainty. Birren and Riegel (1962) reported age differences and speed of response as not limited to the simple motor aspects of tasks, but involving the associative processes as well.

It is suggested that age related decrements in psychomotor performance reflect changes in cerebral cortex functioning, rather than decreased loss of ability to move (Kart et al. 1978), and that without pressures of time older people are as capable of performing psychomotor skills as their younger counterparts.

With the aged person, as for any other, individual variables such as practice at a task, and motivation, may affect reaction time and performance.

Research evidence does not totally support the view that all types of memory decline with age. Many persons retain sound memory regardless of age (Atchley, 1972) and "memory decline" more aptly describes more persons as they age. Separation of memory and learning skills is difficult because most tests of learning involve memories, and memories nearly always involve learning. Those who exercise their memories tend not to lose remote and recent memory (Atchley, 1972) and with age, retention of things heard becomes increasingly superior to retention of things seen.

Age related change in learning ability appears to be small, even when the keenness of senses is declining (Kart et al., 1978), and any impairment in learning can be due to a physiological cause such as arteriosclerosis (Kart et al., 1978). Atchley (1972) described learning performance as tending to decline with age but not noticeably until past middle age, and older people being able to learn as much as others given more time. He said error numbers in solving problems rise steadily with age and studies of creativity indicate gradual decline following a peak in the thirties.

The assumption that aging is associated with decline in intelligence has identified problems associated with methodology of testing. The Weschler Adult Intelligence Scale has been criticised for measuring mental skills and abilities emphasised by the educational system, and as appropriate for determining intelligence of younger people (Kart et al., 1978). Environmental features may constrain intellectual functioning. Atchley (1972, p. 64) emphasizes that "at least a part of what appears to be the decline in intelligence of older people is actually a change in the skills that are being emphasised by the culture".

Generally, personality traits are more variable over the adult years than mental abilities (Birren, 1964). Studies of personality traits in relation to age and intelligence indicate age is less important than intelligence in the personality adaptations over adult life. Literature

on rigidity is immense. Chown (1972) stated her results as indicating most age-related data concerning rigidity of thought are better regarded as intelligence related data.

Certain adaptive techniques often appearing characteristic of old age are stated by Butler and Lewis (1977). These include denial, fixation, regression, displacement, counterphobia, idealisation and rigidity. Defensive behaviour adaptations include selective memory, selective sensory reception, exploitation of age and disability, restitution, replacement or compensating behaviour, use of activity or busyness, and insight as an adaptive technique. The tendency towards self-reflection and review of one's life, is presented as a general phenomenon in the aged.

Physical factors are increasingly recognised for their functional consequences in older persons, and not only in depressive affect (which may lead to suicide), but also for precipitating mental disorder (Birren, 1964). More emphasis is currently placed on mixed aetiology and complete diagnostic evaluation for elderly persons presenting with medical conditions, and there is less tendency for symptoms to be regarded categorically as either functional or organic in origin.

Many of the disorders which affect the aged are irreversible, but symptoms can be alleviated. When rehabilitative techniques are applied they can be as successful as for the young disabled. Much of the more negative emotional aspects of aging are the result of disease states (Butler & Lewis, 1973).

Psycho-social Theories of Aging

Age is an important factor in determining how individuals behave in relation to one another (Birren, 1964), and is not completely defined by chronological, biological, and psychological age. Social age refers to the social habits and roles of the individual relative to the expectations of his group and society. There appears general consensus that behaviour, activities, nature and extent of social relationships change with age.

From studies in the United States there has been consistent support, apart from the work of Cumming and Henry (1961), for the hypotheses "that, among the elderly, maintenance of contact with the social environment is a condition of maintaining a sense of life satisfaction" (Maddox, 1966, p.181).

Activity or Implicit Theory

This theory has been summarised by Havighurst (1968) as viewing the decreasing social interaction characteristic of old age resulting from withdrawal by society from the aging person as a decrease in interaction which proceeds against the desires of most aging men and women. Thus the individual who remains active, and is able to adapt to the changing nature of his world and find substitutes for his losses, ages optimally.

Some of the assumptions stated by Cumming and Henry (1961) as indicative of an implicit theory of the aging process in the literature include: the misleading use of "aged" as if "old" is meant; the idea that every man ages alone in respect of age severing him from others; successful aging consisting of retention of middle-age characteristics as far as possible; the quality of interpersonal relationships among the aged remaining unchanged, and while older people of high morals have outgoing, rich and satisfying relationships these are entirely free from sexuality.

Kart et al. (1978) named the activity theory as the implicit theory from its emergence in much gerontological research. They describe the theory as a positive relationship between activity and life satisfaction, with psychologic and social needs remaining essentially unchanged despite the inevitable changes which confront elderly persons from physiological, anatomical and health status. Lemon, Bengston, and Peterson (1972) indicated that personality should be included as a variable in any revision of the activity theory, following a formal and explicit test of the theory, using a sample of 411 potential in-movers to a southern Californian retirement community.

Social Disengagement Theory

As proposed by Cumming and Henry (1961), this theory describes normal aging as "an inevitable withdrawal or disengagement resulting in decreased interaction between the aging person and others in the social systems he belongs to" (p.14). In the process of disengagement many of the relationships between a person and others are severed and those which remain are altered in quality. There is stress on the mutuality of withdrawal by both society and the aging person (Havighurst, 1968).

In 1963 Cumming noted the theory's need for greater rigour as the original form was concerned with the modal, and neglected the non-modal American case such as late retirement. Combining biological and sociological variables within the theory's framework is suggested as enabling more interactional styles to be described such as the "impinging mode" and the "selecting mode".

Intrinsic or developmental qualities as well as responsive ones are suggested in the person's withdrawal (Havighurst, Neugarten, & Tobin, 1963). As the withdrawal is either accompanied or preceded by an increased preoccupation with the self, and a decreased emotional interest in persons and objects in the environment, then disengagement can be seen as a natural rather than an imposed process (Havighurst, 1968). When disengagement is complete, the equilibrium of middle life between the individual and society, has been replaced by another characterised by both greater distance, and a changed basis for solidarity (Cumming, 1963).

Personality and Life Satisfaction Theory

Data from Kansas City and other studies support both the activity and disengagement theories of optimal aging (Havighurst, 1968). Neither theory deals adequately with the issue of personality differences, nor with aging in cultural settings where the aged are more respected and/or revered than in America. Relationships between activity levels and life satisfaction appear influenced by personality type and especially by the individual's ability to retain integration of emotional and rational elements of the personality (Havighurst, 1968).

From data available on activity, satisfaction and personality, Havighurst (1972) concluded that "personality seems to be the pivotal dimension in describing patterns of aging and in predicting relationships between level of activity and life satisfaction" (p.309).

Further research for a personality dimension from the Kansas City Study of Adult Life revealed emergent groups named by Havighurst (1968) as: the reorganisers, the focused , the successfully disengaged, the holding-pattern, the constricted, the succorance-seeking, the apathetic and the disorganised. He suggests these patterns of aging are established and predictable by middle age.

Several writers (Havighurst, 1968, Kart, et al., 1978) refer to a study reported by Reichard, Livson, and Petersen (1962) of 87 elderly working men in San Francisco in which a variety of behavioural adjustments to aging are revealed. Some achieved successful aging through disengagement and others through activity. Those identified as the "mature", "rocking-chair", and "armoured" were judged as successful in aging; and the "angry" and "self-haters" as unsuccessful.

Havighurst, Neugarten, and Tobin (1963) distinguished between disengagement as a process and a theory of optimum aging. Evidence was presented to support the first but not the second. That is, although social and psychological changes which occur with aging are described by disengagement, social engagement is usually related to psychological well-being.

The life satisfaction theory has developed from the personality theory and successful aging is defined in terms of inner satisfaction rather than external adjustment (Atchley, 1972).

The Continuity Theory

This is named by Atchley (1972) as the third major theory in social gerontology of recent years and described as follows:

> Continuity theory holds that the individual's reaction to aging can be explained by examining the complex inter-relationships among biological and psychological changes; the person's habits, preferences, and associations; situational opportunities for continuity; and actual experience. The person's life-long

> experience thus creates in him certain predispositions that he will maintain if at all possible. (p.36)

Continuity theory therefore permits, as disengagement and activity theories do not, adaptation in any one of a number of directions.

Interactionist Theory

Symbolic-interactionist concepts have been advocated by Rose (1964) using social psychology terms such as adjustment, role changes and changing self-concept. The interactionist theoretical orientation is the interpretation of the facts of aging in terms of interactions among the aging themselves and between the aging and others in society. The facts of social life in reference to aging are stated as "too complicated and varied to be encompassed in any notion of equilibrium" (Rose 1964, p.189).

Whereas the disengagement and personality theorists place emphasis on intrinsic processes, with some acknowledgement of social interaction, the interactionists tend not to acknowledge the possibility of individual personality differences (Schooler & Estes, 1966). The degree of engagement is largely explained by Neugarten, Henry and others using concepts of ego development and by Rose and his associates with concepts of role theory and group identification (Schooler & Estes, 1966).

Rose (1964) considered much research in social gerontology to be guided explicitly or implicitly by broad conceptions of interactionist theory, with the major exception of work by Cumming and her collaborators.

A Socioenvironmental Approach

Anomalies for explanation of morale with use of both the disengagement and activity theories are stated by Gubrium (1972). He noted an accumulation of thinking and evidence in the gerontological literature directed at understanding the relationship between activity and morale through combining environmental and personal concepts. References cited include Blau, 1956, 1961;

Bultena and Marshall, 1969; Carp, 1967; Rose, 1965; Rosow, 1967 and Townsend, 1957. Data analyses from a Detroit study is said to corroborate the unity of combining both social and individual contexts, as in his proposed socioenvironmental model.

Social Reconstruction Theory

Kuypers and Bengston (1973) argued that current perspectives on aging do not adequately specify mechanisms by which personal adaptive changes are contingent upon social-system changes, and in general, aging assumes a pathological quality due to the nature of environmental changes. Adjustment to aging is presented as an ongoing process of interaction which occurs as a vicious or benign cycle between the individual and his social environment. The former, the Social Breakdown Syndrome, is a cycle of increasing incompetence. From a precondition or susceptibility to psychological breakdown, social labelling of the individual as deficient or incompetent, occurs. This is followed by the onset of a sick or dependent role with atrophy of previous skills, and leads to self-identification as sick or inadequate. The social reconstruction is a benign cycle which has increasing competence through social inputs (Bengston 1973) such as improvement of conditions relating to housing, health and nutrition. The social-breakdown syndrome is presented as a model which enables interventions for social reconstruction, by providing positive input from the external system to the aging person.

Other Theories

Theories of aging abound and continue to increase. It is probable that no one theory will in the immediate future adequately explain the total and interrelated features of aging.

Among theories mentioned by Atchley (1972) are older people as a minority group (Streib, 1965), identity crisis theory (Miller, 1965), personal action system (Williams & Wirths, 1965) and the developmental theory of Clark and Anderson (1967). The latter is presented as probably holding the greatest promise for eventual understanding of success and failure in adjustment to aging (Atchley, 1972).

IMPLICATIONS FOR NURSING PRACTICE

Only one fundamental difference between the developmental tasks of later maturity and other ages is perceived by Havighurst (1952). That is, of a defensive strategy of holding on to life rather than of seizing more of it. Overall, in determining the energies and adaptive capacities of the elderly a critical role is played by the general physical health of the body (Butler & Lewis, 1977).

If given time an older person can do about as well as someone younger in situations where reaction time, speed and accuracy of movement, and organisation of complex performance are important (Atchley, 1972). Atchley (1972) described psychological functioning for older people as being relatively positive, but suggested an environment which permits constant exercise of the mental faculties as the most important element in maintaining mental skills. Thus psychological and sociological approaches indicate the inclusion of environmental features in any consideration of aging.

Without adequate tissue functioning death of an organism must occur. Any theory which excludes physiological functioning cannot be considered a comprehensive theory of aging. Biological aging does not happen independently of psychological and social aging. Most workers agree aging occurs from multiple causes (Birren 1968) and is a combination of programmed and unprogrammed events (Everitt, 1974). Continuing research at molecular, cellular and organismic levels, and the level of behavioural and social characteristics is therefore advocated by Birren (1968).

Miller and Schooler (1972) commented on the need for social scientists to include the influence of biological explanation on the sociological and psychological processes they utilise for explaining aging, but without becoming unduly concerned with biological mechanisms. Kastenbaum's (1965) suggestion of documenting and describing the association between physiological and social processes of aging as an eventual goal for social gerontology is cited. They, Miller and Schooler (1972) considered a more plausible, initial goal to be the inclusion of the psychological and sociological dimensions of aging in some statement of the social processes.

From the extensive literature relating to aging and the aging process there is much of immediate theoretical and clinical relevance for nursing practice. The later social theories incorporate concepts largely ignored in the original theories of disengagement and activity such as personality, environmental influences and the continuity of a person's lifelong experience. Such variables cannot be ignored for full bio-psycho-social assessment to enable development of individualised nursing care plans.

CHAPTER 2

ASSESSMENT OF ELDERLY PATIENTS

Geriatrics is defined by Breen (1970, p.6) as "the medical treatment of older persons" and gerontology as "the study of old persons and the aging process". Recognition of geriatrics as a medical speciality is occurring. Assessment centres are on the increase in general and psychiatric hospitals in New Zealand. As more medical practitioners are appointed geriatricians to Hospital Boards, a move from the traditional model of care is possible.

Labels such as geriatric and senile are frequently applied indiscriminately to patients over 65 years. As Barker reminded in the Special Report Series No. 46 (1976) "over half the population of over 80 are in no way disabled and four out of five are not blind, very deaf, mentally disturbed or otherwise severely disabled" (foreword).

Patient status is usually associated with admission to hospital. Wu (1973, p.62) defined hospitalisation as "confinement of a person to an institution with separation from one's immediate family for a protracted period of time for the purposes of diagnosis, care and/or cure". Three phases are suggested as associated with hospitalisation. The first period occurs from the time the individual knows admission to hospital is necessary until orientated to ward staff and hospital policies. The second phase is the period of treatment and/or confinement, and the final phase is that of discharge. For many elderly patients discharge equates with death.

Becoming a Patient

Although every hospital has its inherent tradition, policies, and personnel and is therefore unique, there are certain consistencies in structure, process and outcome. Consistencies stem from the normative expectations of hospital goals, functions and purposes by the citizen, national policy makers and health planners.

Associated with hospitalisation are the routines, policies and sets of expectations of staff and patients. An individual is socialised to the patient role from experiences past and present. Patients bring to hospital a "presenting culture", that is, a set of beliefs, attitudes, values and social relationships in addition to belongings, reputation or status and deference (Goffman, 1961).

Admission to a long-stay ward is frequently a desocialising process. Features of a presenting culture may be swept away, for example, choice of clothing from private belongings may not be permitted. Coe (1970) described control of resources such as authority and privilege concentrated in staff hands as an institutional attempt to control behaviour through restricting mobility of patients.

Wu (1973), in summarising a patient's perception of a hospital, referred to the denotable features such as the physical and social environment; the phenomenalistic features such as sound, sight and odours, and the varying routines and expectations associated with hospitals. Hospitalisation for the long-term patient is accurately depicted as an endless waiting, with slow passage of time and productivity, plus feelings of aimlessness and sameness day in and day out. Reactions of the patient to the physical environment is suggested by Sommer (1963) as almost exclusively left to the architect and the interior designer.

Possible modes of adjustment to hospital described by Coe (1970) are withdrawal,aggression, integration and acquiesence. Withdrawal is considered as more likely in association with long-term hospitalisation and poor prognosis for recovery. Aggression is manifested as an overt resistance to the rules and regulations which are imposed on patients. Integration enables conformity with some institutional rules, and also participation with other persons in like situation. Acquiescence results in compliance with institutional demands and regulations. This latter is suggested as the most likely mode of adjustment. For purposes of this thesis the emphasis is on withdrawal of patients, but acquiescence is considered as a possible component of withdrawal.

Mental hospitals have been described by Erving Goffman (1961) as a particular type of total institution.

> First, all aspects of life are conducted in the same place and under the same single authority. Second, each phase of the member's daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. Third, all phases of the day's activities are tightly scheduled, with one activity leading at a prearranged time to the next, the whole sequence of activities being imposed from above by a system of explicit formal rulings and a body of officials. Finally, the various enforced activities are brought together into a single rational plan, purportedly designed to fulfil the official aims of the institution. (p.17)

That forced inactivity would seem more characteristic of mental hospitals than tightly scheduled activity is suggested by Coe (1970). This idea is valid for some long-stay psychiatric wards in New Zealand. But, where Goffman's statements are applicable to long-term psychiatric wards for example, "all phases of the day's activities are tightly scheduled" they appear from my observations equally pertinent and relevant to many geriatric wards in other institutions.

Coe (1970) likens the mental hospital to the medical prototype of a total institution, and general hospitals as a very mild form. In general hospitals, unlike total institutions, there is said to be status differentiation among the patients according to variables such as type of illness, type of accommodation and age of the patient (Coe 1970). Such differentiation also occurs in the large New Zealand psychiatric hospitals which have both acute and long-stay facilities. However, in long-stay facilities there does tend to be homogeneity regarding age, reason for admission, diagnosis, accommodation and so on.

Individuals adjust variously to the patient experience. Perucci (1974) describes ideal-type social adjustments made by patients in mental hospitals. The withdrawal mode is essentially flight

from the situation. The accommodation mode occurs where patients conform with the expectations of both staff and other patients. The conversion mode of adaptation is apparent where patients indicate a strong identification with staff. Resistance is seen in behaviour ranging from a quiet questioning of hospital procedures and facilities to complete rejection of the authority, and competence of ward personnel. Adaptations such as withdrawal and conforming could be viewed as disengaging from the situation and thus promoting a dependency state.

Models of patient care described by Coe (1970) are those of custodial, classical (acute) and rehabilitative care. Care of the elderly patient in New Zealand ranges along a continuum from custodial to rehabilitative care. The compared stated goals of these two dimensions range from comfort to restoration; disease process assumptions from incurable to mutable; therapy from sporadic to supplementary, and sick role from permanent to intermittent; patient motivation from obedience to institutional rules to collaboration with staff to achieve mastery of any disability, and the resulting institutional model from total institution to rehabilitation centre (Coe, 1970).

The experience of becoming a patient can be represented by different models. As abstractions of reality, models permit broad distinctions of individuals and groups. Regardless of the model stated a theme of loss of independence for a majority of those being socialised to the patient role emerges.

Ebersole (1974) made reference to workers in institutions who wonder about apathy and resignation onset in admissions to long-care facilities, even where there has been an initial protest from the patient. She explained this behaviour as not necessarily related to the institution as such, but rather to the compounded message of society which is to go away and stay out of sight because he/she is no longer productive.

Tobin (1969) cited Goldfarb's (1965) definition of dependency as characterising the behaviour of the institutionally dependent. He says dependency is "the behaviour, either implicit or overt, of a person who believes himself to be weak or is weak and in need of help, in relation to one who is or is believed to be strong, capable of helping him, and likely to do so if properly signalled, invoked, appealed to, or controlled" (in Kalish 1969, p.85). If a person believes himself to be weak and in need of help this dependence on others will grow. Results of the process are recognisable in many institutions which care for the aged.

Assessment Scales

The development of dependency in many elderly patients lessens their prospect of rehabilitation and discharge to the community. Where patients are not encouraged to undertake self-care this produces reliance on others for fulfilment of physical and psycho-social needs. Unless the caring personnel recognise the process of increasing dependence it may be reinforced by their attitudes to patients. Accurate assessment of elderly persons on admission would assist accuracy of diagnosis and treatment plan, and possibly decrease the number becoming dependent and requiring long-term institutional care.

Lawton (1971) presented the case for evaluational techniques of the elderly as ensuring that: all areas of functioning are considered in treating a patient; a more complete picture of the living, functioning person can be drawn; there is some objective evidence for clinical impression; communication is facilitated as between members of a treatment team; results of treatment are more easily assessed, and formalised assessment helps the practitioner to monitor his own professional techniques.

Meer and Baker (1966) suggested the rapid development of the behavioural rating scale as an adjunct to the interview, because it enables utilisation of nurse observations of patients in psychiatric wards which occur in the routine course of their work. All patients may be evaluated regardless of anxiety level, degree of regression or mania, whereas an interview requires some co-operation from the patient.

The interview also requires special procedures and trained professionals. Robinson (1974) advocated behavioural scales for careful and continuing patient observation including those varying situations where the traditional doctor-patient interview may not indicate variability of patient performance. Craig (1970) obtained data indicating that nursing staff can effectively rate psychiatric patients during testing of the Nursing Observation of Behaviour Scales (NOBS). Results showed that ward staff may be better able to observe and report neurotic behaviour than an office interviewer.

Many long-term institutions appear to develop their own behavioural rating scales. First, the search for an appropriate, reliable and valid rating scale can be time consuming and non-productive. Secondly, the objectives of assessment, and the nature of patient and staff population differ in each institution. For example, the level of expertise of available staff to undertake scoring is a consideration when selecting a rating scale.

A selection of behavioural scales seemingly appropriate for use with elderly patients in psychiatric hospitals for physical, psycho-social and ward behaviour scores is presented in that order, to illustrate the range of instruments being used.

Scales of Physical and Psychological Measurement

Lawton (1971) concluded there is no satisfactory global index of physical health and that many researchers measure disability as an easier task. The "activities of daily living schedule" is used in many rehabilitation centres for objectively rating the independence and adequacy of a patient in aspects of health care such as grooming and toileting. These instruments vary widely regarding psychometric sophistication (Lawton, 1971).

Standard assessment instruments of inner psychological state are often unsuitable for elderly patients due to length and the comprehension required for completion, for example, the Minnesota Multiphasic Personality Inventory, the Edwards Preference Schedule, and the Maudsley Personality Inventory (Lawton, 1971). The Weschler Adult Intelligence Scale (WAIS) is a standardised traditional test recognised as the most satisfactory measure of mental status. It has provisions which eliminate many elderly subjects although an age correlation factor is built into the WAIS score. Kart et al. (1978)

view the WAIS as a more appropriate tool for determining the intelligence of younger people.

Kahn, Pollack,and Goldfarb designed the ten item Mental Status Questionnaire (MSQ) for use where there are deficiencies in language, sensory reception, attention and/or motivation (Lawton, 1971). The ten items are simple, for example, "Where are we now?" and, "Where is this place?" Lawton (1971) says the examiner can compensate for subject deficiencies in language, sensory reception, attention or motivation by mechanisms such as speaking loudly, using repetition and by translating.

The Kutner Morale Scale is recognised by Lawton (1971) as an admirable instrument for brief assessment but criticised for its limited content, ponderous language and brevity which prevents accurate measurement of a complex concept. For instance, the third item is "How much do you regret the chances you missed during your life to do a better job of living - not at all, somewhat, or a good deal?"

The Philadelphia-Geriatric-Center Morale Scale, a self-report scale, was developed by Lawton (1971). Items are phrased simply, and require an either/or format response for the 21 items. Sample items include: "Things keep getting worse as I get older" and, "I get upset easily". Diverse aspects of morale such as loneliness, anxiety and pessimistic outlook are said to be measured successfully. The PGC is reported as easier of comprehension for many subjects, of suitable length, and of greater reliability than many shorter scales. The validity coefficient between the scale and criterion is stated as only moderate.

Farina, Arenberg and Guskin (1957) developed the Minimal Social Behaviour Scale on the assumption that inappropriate interpersonal behaviours are an important facet of serious psychiatric illness. Appropriateness of responses to a number of basic social stimuli are scored. The test stimuli include a greeting, an invitation to be seated, a chance to do a favour, and so on. Few rating scales have its advantage of quick administration and no requirement of previous acquaintance with the patient.

The Nurses' Observation for Inpatient Evaluation Scale (NOSIE-30) of mental patients is described as a treatment sensitive ward behaviour scale which has scores in social competence, social interest, personal neatness, irritability, manifest psychosis and retardation. It was developed for assessing relatively higher levels of functioning than the MSBS (Lentz, Paul and Calhoun, 1971).

Scales for Measuring Ward Behaviour

A Ward Behavioural Rating Scale for mental hospital patients (Burdock, Hardesty, and Hakarem and Zubin, 1960) consisting of 150 dichotomous items was designed to measure severity of illness and as an index of treatment response by mental patients. Previous work such as The Behaviour Chart by Adolph Meyer, The Rating Scheme for Conduct, and the Wittenborn Psychiatric Rating Scales were utilised. The scale has been criticised by Meer and Baker (1966) for employing a scale used for younger patients and therefore not sensitive to certain problems unique to geriatric patients, although enabling differentiation of the more from the less impaired patients.

Lawton (1971) described the Stockton Geriatric Rating Scale, developed by Meer and Baker (1966) as one of the better ward behavioural rating scales. The scale was designed for assessing the level of impairment with prediction of improvement for hospital and nursing home patients 65 years and over. Scores relate to areas of physical disability, apathy, communication failure and socially irritating behaviour. It is reported that nurses using the scale became more aware and alert to patient behaviour (Meer & Baker, 1966). The author had similar results when attempting construction and testing of a behaviour scale with nurses in a ward situation.

The Crichton Geriatric Behavioural Rating Scale was devised for appraisal of elderly patients of all diagnostic categories (Robinson, 1971). The 10 items include mobility, orientation and sleep (see Appendix D). Robinson (1971) described mobility for example, as a conjugation of diverse entities such as skeletomuscular function, cardio-vascular state, vision, liability to fall, and volition. The first nine headings relate to behaviours mainly seen in brain-damaged patients, and the mood rating classifications are based on the effective changes in melancholia and therefore are not totally appropriate to the organic case.

Lentz, Paul and Calhoun (1971) stated that for institutionalised patients an adequate compromise for comparative assessment of global level of functioning is provided by standardised rating scales. It has been found (as common sense would indicate) that many psychological tests are not practical where patients are unable or unwilling to participate in self-report or performance activities.

Deficiencies of rating scales include: inappropriate length, that is, too long or too short; time consuming for completion and the amount of relevant information obtained; inadaptability for use with a particular population; unavailability of personnel to collect the information, or requirement of special preparation for implementation of the scale.

A chosen scale must be appropriate for the intended measurement, and for effective assessment should accurately measure the appropriate characteristic. The scale should be valid and reliable. The form of measurement should be relevant to the behavioural milieu of the subject and to the range of capacities of the subject population (Lawton, 1967). From the writer's own experiences and observations the existence of patient dependency among the elderly (physical and pyschosocial), is almost an accepted fact of life by many nurses.

To counteract features such as withdrawal, and decreasing independence, a number of nursing studies have been directed toward assessment of individualised care of patients (Thomas, 1967; Brown, 1969; Kyes, 1969) and reveal that dependency effects in institutions can be counteracted by the approach of the nurse. The growing awareness of dependency, in association with aging and admission to long-stay hospitals, has produced interest in accurate behavioural assessment of the elderly as well as therapeutic programmes to combat its development. The advent of reliable and valid measuring scales will enable more research determining the effectiveness of nursing programmes in arresting the processes of dependency and social withdrawal for elderly patients.

CHAPTER 3

NURSING PRACTICE IN THE CARE OF THE AGED

The Professional Services Committee of the New Zealand Nurses' Association has proposed standards for nursing services and guidelines for implementation closely modelled on *Standards for Nursing Services* prepared by the Commission on Nursing Services of the American Nurses' Association. In 1967 the Executive Committee of the Division of Geriatric Nursing Practice of the ANA appointed a committee to formulate Standards of Practice for Geriatric Nursing. In 1976 a revision of these standards was produced as Standards of Gerontological Nursing Practice to be used in conjunction with the generic standards for all areas of nursing practice. Such standards have been discussed and examined by at least one group of New Zealand nurses interested in promoting quality care for elderly persons.

Gerontological nursing has replaced the term geriatric nursing by the ANA so that the scope of nursing practice regarding care of the older adult can be better described. Thus, "Gerontological nursing is concerned with assessment of the health needs of older adults, planning and implementing health care to meet these needs, and evaluating the effectiveness of such care. Emphasis is placed on maximising independence in the activities of every day living and promoting, maintaining and restoring health" (1976, p.3).

Changes in the 1976 definition included replacement of "nursing needs" by "health needs" and an emphasis on maximising independence rather than on achieving and maintaining a level of wellness consistent with limitations imposed by the aging process.

Eight primary factors are noted as specific to the nursing care of older persons (ANA, 1976), and are valid for the older patient in New Zealand. Examples include: the effects of the aging process; the inter-relationship between social, economic, psychological and biological factors; the frequently atypical response of the aged to disease and its treatment; cultural values associated with aging, and social attitudes to such persons.

Nursing gerontology, the scientific study of nursing care of the elderly, is characterised as an applied science "since its aim is to use knowledge of the aging processes to design nursing care and services

which best provide for health, longevity and independence - or highest level of functioning possible - in the aging and aged" (Gunter & Miller, 1977, p.208).

Regardless of the chosen nomenclature nursing practice may be approached from different theoretical perspectives (such as systems, adaptation and interaction) and in conjunction with standards selected for provision of quality care. The problem-solving approach of the nursing process, although unrecognised as such, has probably been used by many nurses in New Zealand as an implicit component of nursing practice.

Many studies relate to the welfare of patients experiencing long-term care. For example, in England Norton received a research grant in 1964 from the trustees of the Nuffield Foundation. This was to enable finding of solutions for the practical problems of long-term patients and thereby contribute to their comfort and welfare, plus enhancing knowledge and skills in the basic art of nursing. Aims of the investigation were to improve nursing techniques, provide greater comfort for the patient, increase patient independence, and reduce nurse work load in time and effort (Norton, 1967).

Growing interest in geriatric nursing in New Zealand has resulted in the formation of a Geriatric Special Interest Group under the auspices of the New Zealand Nurses' Association. After the first year of functioning the Auckland Geriatric Nursing Special Interest Section, stated in the New Zealand Nursing Journal (May, 1978) that valuable exchange of information was occurring about hospital, residential and community-based care of the aged which would assist in future research programmes and seminars.

A survey in England, (Hardie, 1975) required a personal evaluation by nurses of the most important elements in the care of old people and resulted as care which was ; patient centred (42%), skill centred (27%), interaction centred (20%), professionally/socially centred (4%), while 3% thought everything is important. The results may or may not, reflect New Zealand nurses' views and no data are available for comparison.

In New Zealand the need for extending therapeutic programmes aimed at specific groups was recognised by the Commission of Inquiry into Psychiatric Services at Oakley Hospital (1971). It was recommended that as ward facilities and staffing permitted, attempts to develop such programmes should be made. It is not clear whether such therapeutic programmes were to include long-stay and elderly patients as well as the acute admission.

Many nurses would endorse the statement that "the challenge of geriatric primary care is more than medical or nursing care of the disease. Rather it must involve the relationship between physical and psycho-social factors" (Anderson, 1974, p.193). Gorton (1973) stated that nurse educators and nursing service personnel are devoting much time and attention to the behavioural components of gerontological nursing. This follows from a recognised need for re-evaluation of professional nurses' concepts and attitudes toward the aged for achievement of effective nurse-patient relationships.

Promotion of social interaction and effective communication of the older adult is recognised as an integral, although formerly neglected area, of nursing practice. For patients not to become increasingly dependent on staff,more than physical rehabilitative measures are required.

Nurses are the most appropriate health professionals to produce positive change in geriatric care (Anderson, 1974). They, of health care professionals are with the patient for continuing periods of time.

Selected Research Reports of Therapeutic Interventions

Various therapeutic interventions to stimulate interaction and/or activity among elderly patients are reported in the literature. Such studies produce findings which may be utilised by nurses to promote social interaction as in rehabilitation and remotivation programmes.

Among studies which stress promotion of interaction Birkett and Boltuch (1973) found remotivation therapy depends less than other forms of therapy on the patient's capacity for rational thought and verbal expression, and revealed that the widespread use of this therapy may

be partly attributed to the fact that the talking is done by the therapists. Brook, Degun and Mather (1975) found reality orientation was effective only where the therapists actively participated. Browne and Ritter (1972) reported concomitant improvements in dressing, eating and personal behaviour from the use of reality therapy based on principles of consistency and positive reinforcement. Abrams (1974) used transferable tokens to increase social interaction as in token economy programmes patients were generally unable to reinforce each other's behaviour with tokens. Beard and Bidus (1968) found that remotivation techniques were most effective for subjects over 60.2 years who had been hospitalised for long periods, and especially in terms of social interest and competence.

Among studies which stress promotion of activity Powell (1974) reported analysis of results of exercise therapy upon cognitive and behavioural characteristics which showed two of three cognitive tests as improving significantly but no significant difference in either of the two behavioural scales used. Clark (1973) investigated effects of a systematic programme of physical activity upon the total daily activity level and self-care personal neatness. Dewdney (1973) modified the Denver technique for art therapy programmes. Wagner and Lerner (1968) reported increased use of painting, drawing and other forms of art therapy as outlets of self-expression. Shapiro (1969) stated possible outcomes of music therapy from conducting as providing exercise for the larger arm muscles, encouraging leadership and self-confidence, and relieving tension, and through ear training improvement of the patient's memory and concentration. Sachs (1975) studied application of operant behavioural techniques in three studies to study walking, social interaction and oral hygiene. Hayer, Mishara, and Riebel (1975) suggested that the operant view is useful for conceptualising and treating many problem behaviours after review of research on the efficacy of operant techniques for programming individualised, group based, and ward wide therapeutic intervention. Kazdin (1974) presented a review of research on token economy systems and emphasised their effectiveness in dealing with symptomatic behaviours. Page, Caron, and Yates (1975) discussed use of behaviour modification techniques in mental hospitals to enforce hospital policy rather than to promote patient growth and suggested that most institutionally valued behaviours are considered to have limited transfer value to the larger society.

Other studies have utilised a combination of therapeutic or goal approaches so that differentiation of goals as directed toward interaction and/or activity blur. Reichenfeld, Csapo, Carriere and Gardner (1973) evaluated an activity programme described as a group-orientated programme including group discussions, art classes, exercise programmes and recreational activities in which patients in the experimental ward had higher discharge rates, less hostility and less evident behaviour deterioration. In another study de Lerma Salter and Salter (1975) combined reality orientation, activities of daily living, recreational activities and environmental stimulation. Those patients with the motivation to participate in the activities increased significantly from 14% to 76% in just four months. A variety of motivation techniques and socialisation methods based on an educational model to aid patients form a positive attitude and encourage more appropriate functioning are described by Lewis (1975).

Although mention is made of difficulties in working with regressed patient groups few studies mention the patience and persistence required to conduct a group, nor the long-term benefits for staff. Rodstein (1975) posited that through promotion of activity programmes, appropriate exercise, and participation in self-government mechanisms the institutional aged would be happier and healthier. Although such programmes demand constant effort on staff time and patience, since short-term goals may be easily lost, the staff are compensated by having their frequent feelings of hopelessness and boredom relieved. Too often, feelings of hopelessness and boredom are prevalent among staff caring for the long-stay patient.

Activation of Patients

Various therapies utilised to counteract the effects of long-term institutional care,for example, remotivation and reality-orientation have been cited. Nomenclature of approach is less important than an underlying concern with improvement of the quality of life for the patient, and lessening or preventing the growth of dependence. Gorton (1973) stated that when interacting with an aged person nurses should remember that reality is a fact when life situations have meaning and the individual participates in an effective relationship.

The use of groups improves the level of social functioning for many elderly yet few groups are conducted by nurses. Implementation and maintenance of groups requires due recognition of features of the processes of aging such as poor vision, deafness, lessened agility, and common adaptations to aging and institutionalisation.

Burnside has written extensively on group work with the aged (1969, 1973). In 1976 she edited *Nursing and the Aged* which contains articles on different types of group work with the aged such as group psychotherapy by Ebersole, music by Hennessey, and reality orientation by Taulbee. Types of groups listed by Burnside (1976) are: discussion, reality orientation, remotivation, bereavement, self-help (for example, stroke victims), instruction (for example, persons with malignant hypertension), psychotherapy for psychotic or disturbed individuals, self-image and social groups.

Differences between reality therapy, resocialisation and remotivation groups are highlighted by Burnside (1976). Each has emphasis on "appreciation of the work of the world" but from the perspectives of constantly reminding the patient who he is, why, and what is expected of him; reliving happy experiences, and stimulating the desire to return and function in society respectively.

Butler and Lewis (1977) described reality orientation programmes as having classes of four patients, Ebersole (1976) four to five, and Burnside (1976) three to five patients. Basic personal and current information is reiterated to the patient by the instructor beginning with his name, where he is and date. Therapy is directed towards use of the portion of the mind still intact (Burnside 1976).

The reality orientation group includes establishing the correct position or relation of the group members with the existing situation in a community. The group has structure, and is best organised as a short meeting (about thirty minutes) occurring daily at the same time and place. The emphasis is on time, place and person orientation (Burnside 1976). Refreshments may be served for purposes of identification. Reality orientation groups are ideally conducted where personnel are able to follow through with patients, and thus reinforce information received in the group, in the ward situation (Ebersole, 1976).

A resocialisation group fulfils a social function and not a therapeutic need. In contrast to remotivation and reality orientation groups, it is unstructured. Member numbers range from five to seventeen, and meetings occur three times weekly for half an hour to one hour. Emphasis is on memories and experiences and any topic may be discussed.

Remotivation programme guidelines include a definite structure, no refreshments, and from five to twelve patients, a meeting once or twice weekly for half an hour to one hour, and no discussion of religion, politics or death (Burnside, 1976). Butler and Lewis (1977) stated that remotivation must be followed by activities which lead toward rehabilitation, and mentioned occupational and recreational therapy, industrial programmes, and eventually vocational and social rehabilitation. In connection with rehabilitation programmes the same authors referred to activities including daily exercise (morning exercises to music), dance therapy (an expressive medium for self-recognition, communication, release of tension and socialisation), and bibliotherapy (the healing that lies in the written word).

Butler and Lewis (1977) stated that reminiscence in the aged is part of the normal life review process brought about by realisation of approaching dissolution and death. Forms of the life review include mild nostalgia, mild regret, a tendency to reminisce, story telling, and so on. This is likened to a therapeutic situation in which a person reviews his life in order to understand present circumstances. Ebersole (1974) found that a group of aged participants can recapitulate psychic development.

Davis (1967) suggested that activity therapy should make use of increasing levels of complexity to stimulate growth. A "weaning" process is advocated for the patient beginning with reducing the dependency relationship and reliance upon direction toward development of independence and self-reliance. Distinguishing features related to activity therapy in a geriatric setting are stated as: dependence upon the basic need for adaptation, production and performance rather than the need for rest, repose and nurturance; making use of a vivid and stimulating environment; using the concept of challenge associated with reward as a motivational tool, and being carried out in a social context with other people (Davis, 1967).

Among health professionals, the nurse has the most sustained contact with patients. His/her knowledge of the patient as an individual should therefore enable co-ordination of various aspects of patient care and so prevent the emergence of dependence and social withdrawal. From socialisation theory Brown (1968) postulated that therapeutic communication in aged patient-nurse interaction has socialisation goals and that continued socialisation is a part of the rehabilitative process of nursing. This makes the role of socialisation an appropriate one for the nurse.

CHAPTER 4

BACKGROUND TO THE PRESENT STUDY

Nursing care of the elderly (from the author's experience), focuses on meeting the physical needs of the patient and maintaining a controlled and orderly environment. Provision of quality care for physical needs is the primary concern. Too often nurse-patient interactions are confined to those occasions when treatments are being undertaken. Frequently casual and fleeting comments are given by nurses to patients without adequate time for patient reply.

The undertaking of nursing routines is usually adhered to strictly. An action research project reported by staff on a geriatric ward is cited by Towell (1975). Staff found that their concentration on completing rigidly scheduled routines meant there was little change in the nature of work accomplished during any shift, irrespective of the number of staff on duty. This finding prompted consideration of more flexible patterns of patient-centred care focused on development of more than physical care of patients.

Leisure time pursuits for patients arranged by nurses in psychiatric hospitals are limited in range, for example, bus trips, walks in the grounds, television viewing, housie, card games and so on. Many of these activities do not encourage verbal interaction between nurses and patients. In some institutions the paramedical staff (for example, recreational officers, occupational therapists, and physiotherapists) are morelikely to introduce activities which will stimulate cerebral functioning such as quizzes, discussion of news items, and presentation of readings than many nurses.

For nursing care of elderly patients which combats the development of dependency, more than efficient and effective care of physical needs is necessary. Programmes to increase and/or sustain general interaction is a possible extension of the nurse's role as a socialisation agent. Greater utilisation of group work to encourage interaction is an appropriate but infrequently used means of countering patient withdrawal. The use of groups has the advantage over one-to-one relationships, as occur in games of draughts and ludo, of enabling

participation by more patients at one time. It is therefore a more economical approach (Ebersole, 1976), although it should not be considered as a replacement for individual therapy.

Pilot Study

In 1975 the author conducted a social group for 12 elderly male patients in a long-stay psychiatric ward. The mean age of these subjects was 67.4 years, and age range 62-74 years. Subjects were selected from the ward population of 46 patients, age range 43-89 years, and mean age 69 years.

A guidebook on remotivation by Gibson (1967) was used as the authoritative source for selection of subjects, conduct of the group, arrangement of programme and evaluation of results.

Selection of the subjects was undertaken by the leader and co-leader (psychiatric nurses) using Gibson's criteria of four alert, four moderately alert, and four withdrawn patients (refer Appendix B). Verbose patients were excluded to prevent monopolisation of conversation by such persons. However, inclusion of more talkative patients would have stimulated more patient-initiated conversation. Recognition that certain types of patients increase the work of the group leader, that is, the depressed, withdrawn, and agitated (Burnside, 1976) became apparent.

Suggestions for organising content were obtained from Gibson's guidebook (1967), but with less emphasis on conduct of a remotivation group. This resulted in a social group for promotion of interaction through discussion and participation in general activities. The programme was varied, but focused eventually on activities such as games periods graded for different patient abilities, examination of objects including a motorcycle, viewing travel slides and housie. The conversational ability of patients was limited but opportunity and encouragement to speak were provided within the group. The patients' reactions were varied, and many appeared uncertain of their expected role.

Several ward staff attempted development of a rating scale for before and after measures of behavioural change of group subjects in the areas of physical dependency and psycho-social (or adaptive)

functioning. A major problem in using the scale was inter-rater reliability. For various reasons, including the factor of time, the rating scale was not completed. A range of difficulties was encountered in conducting the group. These included roster changes of the leader (which interfered with continuity of leadership), and sick leave absence for the co-leader. A concurrent although unrelated increase in patient dependency of the ward patients occurred without compensatory increase in staffing levels. Some peers passed comments such as "Well, you can't do much harm to those old boys, anyway". This statement can be interpreted as reflecting a need for education of many nurses as to the potential of group work for the elderly, as benefits both patients and staff. This "go ahead, you won't hurt anything" attitude was described by Burnside (1976).

There were no marked changes in the patients during the group sessions but an unscheduled three week break in programme continuity probably influenced results. Therefore, despite the lack of conforming evidence during the pilot study, the belief that groups for elderly patients in long-stay wards should create greater interactional opportunities (and concomitant reduction in social withdrawal) persisted. It was noted that the less withdrawn of the group members attended regularly, and appeared to enjoy the change of routine. Burnside (1976) referred to the aged as being so under-stimulated that they are conscientious about group attendance.

Measurement of Social Withdrawal

The existence of social withdrawal by patients was apparent in the ward of the pilot study, but no attempt was made to measure its extent. For purposes of the main study, an indication of the degree of social withdrawal in the ward was necessary to highlight the effect of introducing an activation group in the form of programmed recreation for selected patients. From research studies by Moores and Grant (1976), Paton and Stirling (1974), and Quilitch (1974) an indication of an approach for measuring social withdrawal emerged.

Moores and Grant (1976) undertook a study on the "Nature and Incidence of Staff-Patient Interactions in Hospitals for the Mentally Handicapped". As they indicated, most empirical studies of the nursing process, particularly in the general field, have concentrated either

on the patient as the recipient of care, or the nurse as the provider of care. Other interactional studies between the nurse and patient in the psychiatric hospital include Hargreaves (1969); Hargreaves and Runyon (1969); Cohler and Shapiro (1964); Behymer (1953); Kandler and Behymer (1952); Nakagawa and Hudziak (1963), and Altschul (1972).

A schedule for data collection was devised by Moores and Grant (1976) enabling categorisation of staff-patient interactions in mental hospitals, but specifically for the mentally handicapped. Their initial attempt to identify the key characteristics of interactions concisely and meaningfully was coded according to the originator of the interaction (nurse or patient), to the verbalisation (verbal or non-verbal) the nature of the interaction (functional, educational or social) and the urgency of the interaction (routine, voluntary or crisis).

The eventual Staff-Patient Interaction Schedule (SPIS) arose from modification during a pilot study. The modified verbalisation code list used items of commands, instructs/teaches, converses, encourages, enquiries/transacts and discourages, but from the nurse perspective only. For example, enquiries/transacts was defined as seeking information from the patient. The non-verbal code used items of performing other tasks, encourages, discourages, and ignores, hence discourages was defined as making negative gestures towards patient. The activity code list identified ten items as functional or activity related to patient's basic physical needs, nine items as social or activity related to leisure and social pursuits of patients, eight items as supervisory or patient surveillance activity, seven items as training or teaching activity of any type, and six items as relating to servicing or servicing activity needs of patients without giving directed training. Inter-observer reliability coefficients for staff-patient interaction categories were tested.

Paton and Stirling (1974) undertook research with mentally sub-normals to identify verbal-interaction categories in order that the therapeutic goal of improving verbal coding abilities of such patients could ensue. Their selected categories from a pilot study were nurse comment, nurse instruction, nurse question and nurse-initiated conversations. Patient responses to the four nurse initiated categories were classified as verbal or non-verbal (which included no response).

Quilitch (1974) investigated increase of purposeful activity in a geriatric ward through programmed recreation. Definitions of simple activity (for example, finger tapping) and purposeful activity (for example, letter writing) were made. The study showed that when supervised recreational materials were supplied in the experimental ward the level of purposeful activity increased.

As there are similarities of withdrawn and regressed behaviour among mentally retarded and elderly patients pretesting of the SPIS (Moores and Grant 1976) appeared appropriate for this study with long-stay patients. The observations focused on features of interaction such as its initiation levels which can be indicative of degrees of social withdrawal. Paton and Stirling's (1974) verbal code seemed a possible alternative if that of the SPIS was unsuitable. To supplement features of social withdrawal obtainable from the above, Quilitch's (1974) method of obtaining baseline data approximated the type of methodology required for before and after measure in association with conduct of an activation group.

CHAPTER 5

THE PRESENT STUDY

For purposes of this study it is assumed that behaviour is partially shaped by environmental influences and constraints, and that social interaction increases when conditions are conducive for facilitating communication. From review of group work with the institutionalised aged as reported in the literature, group therapy appears to improve behaviour and contribute to more appropriate expression of emotion. Ebersole (1976) suggests also that staff interest and attitudes are stimulated.

Individuals, regardless of age, react and respond to events occurring about them. Proshansky, Ittelson, and Rivlin (1970) have stated from the perspective of environmental psychology that human interaction in any given social setting and for any purpose occurs as a response "to another person, engaged in a specific activity in a specific place for a specific purpose" and that physical settings - evoke "responses in the form of feelings, attitudes, values, expectancies, and desires"(p.28).

Studies have shown that not all of the deterioration of behaviour seen in institutions is the result of the aging process. Where persons are exposed "to greater opportunity and increased expectancy for performance and increased attention and knowledge of approval or disapproval of the staff, functional levels rise" (Filer & O'Connell, 1964, p.364).

Schwartz and Will (1953) have described social process within a psychiatric ward "as a pattern of patterns integrated by the ward participants into a stable equilibrium" (p.582). Therefore, patterns of behaviour which relate to more or less interaction between nurses and patients may be discerned from observations in an environmental setting. Observations which focus on nurse-patient interaction and patient behaviour in selected settings may be indicative of social withdrawal in a selected setting such as a dayroom.

For purposes of this thesis it is assumed that the presence of social withdrawal exists in long-stay wards for elderly patients, although degrees of withdrawal may fluctuate. If patient behaviour is to some extent dependent on influences and constraints in the environment, then a change of behaviour can be produced by a change of routine.

A method for investigating these assumptions is the introduction of an activation group, or programmed recreation, for selected patients into an ongoing ward routine. An activation group modelled on remotivation groups as proposed by Gibson (1967) and the introduction of programmed recreation as mentioned by Quilitch (1974) is proposed as a suitable medium for producing behavioural change in selected group members. Activation of patients is a term which has been used by New Zealand nurses in preference to socialisation, resocialisation, or remotivation.

It is further proposed that the initiation and conduct of an activation group (or programmed recreation) can arrest or decrease the level of social withdrawal of the participants in the group situation, and indirectly decrease the level of social withdrawal in another ward setting such as the dayroom. If the group sessions are discontinued then the degree of social withdrawal will be less in the dayroom immediately following the group sessions, but gradually increase without the introduction of replacement activity(ies) to supplement the usual ward routine.

Hypotheses

For long-stay elderly patients in two psychiatric wards it can be shown that:

1. the degree of social withdrawal of the patients in a dayroom setting varies over time.
2. variations in social withdrawal of patients in a dayroom setting are linked with variations in nurse-patient interaction.
3. increased opportunity for interaction for a section of the patient population of a ward in an activation group results in an overall increase of interaction among patients in the dayroom of that ward.

4. participation in a continuing planned group programme will result in measurable changes in a variety of behaviours identified on selected rating scales for the participants.

Definitions

For purposes of this study definitions are as follows:

Elderly patients are those experiencing the process of aging in a long-stay psychiatric ward where the mean age is 65 years and above.

A long-stay psychiatric ward has a stable population of patients with few changes apart from internal hospital transfer of patients, transfer to general hospital, or death.

Patient behaviour refers to those actions which may be identified during periods of observation and include physical, social, and/or communicative utterances or actions.

An interaction occurs as an interrelationship or participative behaviour between two or more persons and may, or may not, include verbalisation by one or more persons. Interactions may be described in terms of whether:

1. the interaction is initiated by nurse to patient, patient to nurse, or patient to patient.
2. the categories of the associated ongoing activity are functional, social, expressive, learning or servicing activity as related to the patient.
3. the form of the accompanying verbalisation is nurse and/or patient comment, instruction, question or initiation of a conversation.

Purposeful activity is an act or action which may be observed. Actions include reading, writing, walking, talking, listening and ready response to external stimuli. In contrast, simple activity refers to apparent unconcern and non-reaction to external stimuli by a patient as in daydreaming, dozing or sleeping.

Social withdrawal is exhibited by patients as lack of purposeful behaviour, for example, as frequently dozing rather than engaging in an activity such as walking, talking or playing cards. Lack of interaction (as defined for this study) occurs. Orientation to time, place, and person of socially withdrawn patients may not be impaired.

Degree of social withdrawal refers to the extent the majority of patients in a particular setting are involved in interaction with others, or in purposeful activity.

An activation group (or programmed recreation) consists of a series of group sessions conducted to lessen social withdrawal in the dayroom through promoting individual and/or group interaction and/or activity.

CHAPTER 6

METHOD

This study is designed to demonstrate the presence of social withdrawal in elderly patients, and the effect of an activation group (or programmed recreation) on the degree of withdrawal.

First, selection and pre-testing of instruments was undertaken to enable collection of base-line data relating to the degree of social withdrawal demonstrated by patients in both the control and experimental ward. Subjects for an activation group programme were selected by the Charge nurse of the experimental ward from stated criteria (refer Appendix B), and rated on a behavioural rating scale (refer Appendix D) before and following conduct of the group. It was decided that the researcher lead the proposed 12 session activation group with assistance from a ward nurse each session. Suitable times for conduct of the group did not enable continuity of leadership by a ward nurse. For the timetable of observations during the 16 week period of the study refer to Table I.

Type I observations for social withdrawal in the control and experimental wards using the NPIS (Nurse-Patient Interaction Schedule), and PAS (Purposeful Activity Schedule), were undertaken in three blocks of five days observation in each ward. These observations were undertaken in the experimental ward during the second, twelfth and sixteenth weeks of the study, and in the control ward during the first, thirteenth and fifteenth weeks. Observations described as Type II were undertaken in the experimental ward on a random day in the fifth week, and on the Thursdays of the ninth, tenth and eleventh weeks. These latter random days corresponded with the final three Thursdays of the group sessions. Thursday was selected as Tuesdays and Fridays were group session days, and other days were inconvenient for the researcher.

For one observer to undertake the data collection it was vital for the researcher to be fully conversant with the names of patients and staff in both wards, as well as the codes to be used. It was also necessary that staff and patients accept the presence of the observer in the dayroom as a natural occurrence. To enable these processes data collected on the first of each five day period of Type I observations, and one day of Type II observation during the

TABLE I

Timetable of the Study

Ward	Type of observation	Week of observation 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Control	I	✓												✓		✓	
Experimental	I		✓				←	Activation group period				→	✓				✓
Experimental	II									x	x	x					
		Period I											Period 2			Period 3	

✓ Type I observation (i.e. four consecutive days of observation in one week)

x Type II observation (i.e. one random day of observation for three weeks)

Period 1 First period of Type I observation (i.e. pregroup phase)

Period 2 Second period of Type I observation (i.e. immediate postgroup phase)

Period 3 Third period of Type I observation (i.e. final postgroup phase)

fifth week were discarded. The observer knew the names of many nurses and patients from a previous work experience at the hospital.

The observer remained constantly in the dayroom from 9.20 a.m. to 2.30 p.m. apart from 12.20 p.m. - 12.50 p.m. when patients were usually in the dining room. For sequence of data collection refer to Table II. The observation schedule for nurse-patient interactions (NPIS) was used for 15 minute periods of recording. These periods were preceded and followed by 5 minute recording periods using the observation schedule for purposeful activity (PAS). A routine vantage point for purposes of observation was chosen and maintained throughout the observation periods. When more than one event occurred simultaneously in the dayroom the priority order for observation was first those interactions initiated by a nurse to a patient, then those initiated by a patient to a nurse and finally patient to patient initiated interaction. The latter group was therefore subject to incomplete data collection.

TABLE II

Sequence of Data Collection using Two Observation Schedules

Schedule for Purposeful Activity	Schedule for Nurse-patient Interaction	Schedule for Purposeful Activity
9.15 - 9.20 a.m.	9.20 - 9.35 a.m.	9.35 - 9.40 a.m.
9.55 - 10.00 a.m.	10.00-10.15 a.m.	10.15-10.20 a.m.
10.35-10.40 a.m.	10.40-10.55 a.m.	10.55-11.00 a.m.

The twelve group sessions were conducted for approximately three-quarters of an hour twice weekly from the sixth week. A three week period following the Period I Type I observations was set aside to enable preparation of any nurse wishing to act as leader of the group.

Setting

The study was undertaken in two long-stay wards of a psychiatric hospital. A series of group sessions for activating selected patients was conducted in the experimental ward. Observations for degrees of social withdrawal were undertaken in the dayroom settings of both wards.

In the experimental ward there were 47 male patients, mean age 71.48 years and range 46-89 years. During the study five patients were transferred to other wards but three transferred back, several transferred to general hospital, one discharged and readmitted, and four died. Several patients were confined to wheelchairs and eight to ten were incontinent. Any physically ill male patients were nursed in the ward.

In the control ward there were 42 patients, mean age 65.5 years, and range 23-86 years. The six patients under 60 required similar nursing care to the older patients. All were able to climb stairs to the sleeping quarters. During the study four patients were transferred to other wards, including two to the experimental ward (for physical illness), and four transfers received. The control ward patients were less physically dependant than those in the experimental ward.

For the physical layout and immediate surrounds of the experimental and control wards see Figures 6.1 and 6.2 respectively. The dayrooms were approximately equal in size, contained a colour television set and a radio, and had armchairs ranged round the periphery of the room. The control ward dayroom also contained a pool table. The experimental ward had a communicating door to the room used for the activation group meetings. About 14 people, including a patient in a wheelchair, could be comfortably accommodated in this room.

Selection and Pre-testing of Instruments

Observation-schedule for Nurse-patient Interaction

Initially the observation schedule for staff-patient interaction (SPIS) as devised by Moores and Grant (1976) was tested by the investigator in an admission ward of the psychatric hospital. Four patients categorised by a staff nurse as alert (1), moderately alert (2) and withdrawn (1) as in Gibson's criteria for group membership,

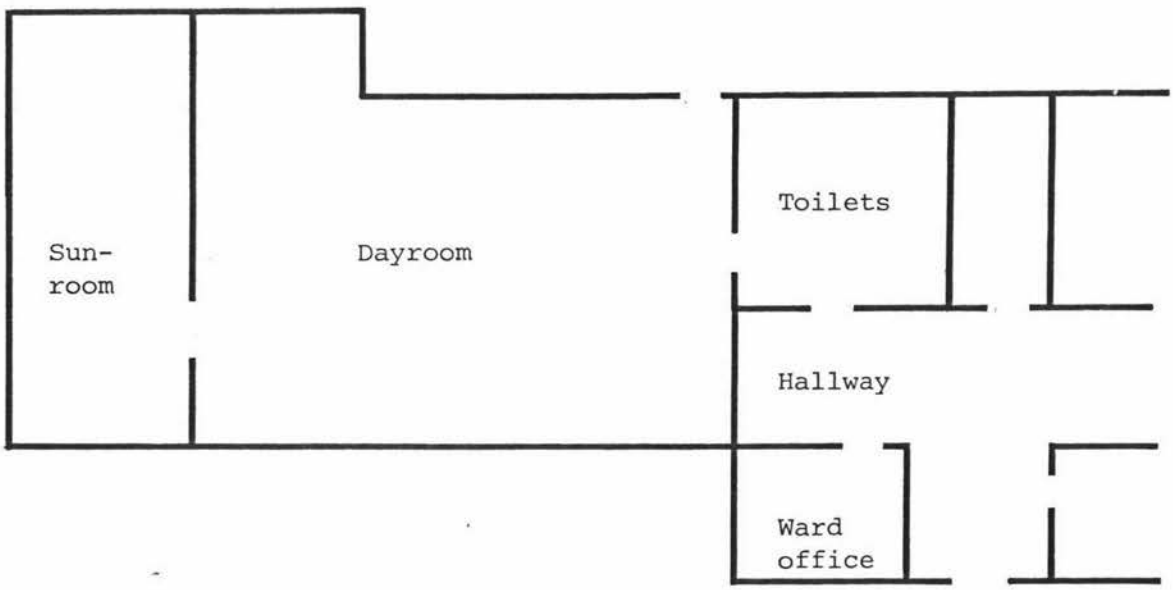

Figure 6.1. Plan of the Experimental Ward Dayroom

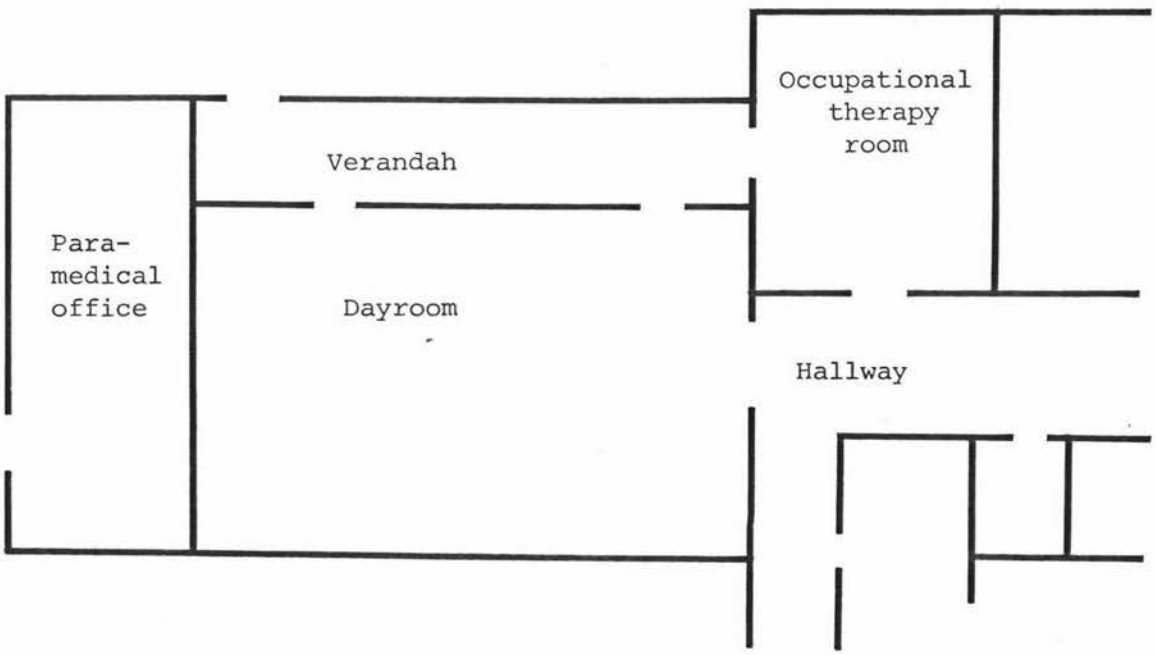

Figure 6.2. Plan of the Control Ward Dayroom

were observed intermittently from 9 a.m. to 4 p.m. for one day. The location for observation was selected as the place where the majority of the four were during any given observation period. Moores and Grant (1976) observed no more than four patients at a time, and where a patient was not fully observed on a particular day replaced that day by another of full observations.

It was found possible to observe four patients as selected when they all remained at one location. Dyadic interactions were more readily coded than others. The instrument could not have been used reliably for more than four patients at a time in the dayroom of the admission ward. Too many nurse and patient, and other interactions occurred at sporadic intervals during the times of observation. Also, a number of patients tended to speak to the observer and distracted attention from the observation process.

For familiarisation and adaptation of the instrument for use with elderly patients, four days of observation over nine days were undertaken with a sample of seven elderly females in the dayroom of a long-stay ward for female patients. The brief duration of many interactions was readily apparent. A symbol was devised to indicate those events initiated by a nurse in which he/she rapidly attended to a number of patients. As one nurse was involved in an ongoing activity this was counted as one episode for the data collection, but the appropriate number of individual nurse-patient interactions from such a sequence could be determined from the manner of coding. That is, for ease of data collection if a nurse gave out 10 cups of tea in rapid succession this scored as one episode, but 10 interactions as 10 patients were given and received a cup of tea. As the event was scored as one episode, only one activity, verbalisation form, and length of duration were charted.

Modification of Moores and Grant's (1976) observation of four patients occurred. It was found that more patients could be observed in a long-stay ward if the observer had a clear vantage point for data collection. Such a procedure was not suitable where much movement of patients occurred, or where there were young and active patients as in the admission ward.

During pre-testing no suitable code for non-verbal aspects of interaction was found nor adequately devised. Codes tested were time consuming and slowed up observation of other events. Therefore a non-verbal code was not used in conjunction with the observation schedule for nurse-patient interaction.

The verbal code of Stirling and Paton (1974) was found preferable to that of Moores and Grant (1976) for coding items. Less choice of items enabled quicker coding. The initiation of conversation item in this coding enabled classification of an ongoing activity and chitchat, as in a card game, as one episode of interaction. The codes of comment, instruction, question and initiation of conversation were utilised for both nurse and patient utterances. The definitions as adapted from Paton and Stirling (1974) were comment as any statement, that is, remark or suggestion passed; instruction as an authoritarian type of utterance for example, Sit down!; question as any sentence or phrase in question form, and initiated conversation as any utterances directly solicitous of an extended verbal response(s) from another.

During pre-testing adaptations were made to the SPIS and included change of name to Schedule for Nurse-Patient Interaction (NPIS). Other changes were inclusion of patient-patient interactions as well as nurse-patient, and patient-nurse as initiators of interaction. The non-verbal code was deleted as unnecessary to the study and the concepts not readily identifiable by an observer. There was change of focus from the nurse to the patient for the activity items. The two category titles altered were from supervisory to expressive, and from training to learning. Altered activity code definitions were expressive as activity related to overt behaviour indicating assertiveness; learning as activity related to being taught, doing, or working at task or skill, and servicing as activity related to servicing another's, or having activity needs serviced. For the adapted code refer to Appendix F and the NPIS refer Appendix G.

The SPIS (Moores & Grant, 1976) appeared more appropriate for adaptation for the present study, than other interaction scales such as Bales Interaction Process Analysis used by Conant, 1965.

Observation Schedule for Purposeful Activity (PAS)

Pretesting of Quilitch's (1974) method of collecting purposeful and simple activity data was undertaken in a male long-stay ward. The movement of the observer through the ward to collect data altered the level of patient activity. It was therefore decided to collect similar data, but from the same constant vantage point as for the NPIS. For the observation schedule for purposeful activity devised to collect data relating to the apparent level of awareness of patients in the data collection area refer Appendix H. The term purposeful activity was retained to include observable acts such as reading, writing and talking, and simple activity for use where the patient appeared unresponsive to external stimuli as when daydreaming.

This information was collected to supplement the use of the data from NPIS.

Behavioural Rating Scale

The Crichton Geriatric Behavioural Rating Scale (refer Chapter 2 p.24 and Appendix D) appeared the most appropriate for determination of any before and after group member behaviour change. This scale had been observed in use at a New Zealand psycho-geriatric assessment unit to measure improvement in patient behaviour on, and following admission. The patient population of the study was similar in age and behaviour range to many of the assessment unit's patients. The scale does not require co-operation of the patient for accurate assessment, and can be ably completed by nursing staff who have knowledge of the patient's behaviour. For instruction sheet as presented to raters refer Appendix C.

Robinson (1971) described the scale as devised for appraisal of elderly patients of all diagnostic categories. The sum of scores from each of the ten items are stated as giving a useful index of performance and capacity. Thus a score of less than 20 is said to be consistent with mild, 20-30 with moderate, and over 30 with severe dementia (Robinson, 1971). Ten items including mobility, orientation, sleep and so on are ranked one to five for each category, but an intermediate score such as 2.5 could be used to indicate other fluctuation or indication of disagreement between raters.

Rating Scale for Group Performance

For evaluation of individual performance within the group session the format used by Gibson (1967) as in Appendix I was used. Five sections of three choices enabled group member classification of numbers of sessions attended, state of grooming, ease of understanding by another, spontaneity of contributions, and relevance of ideas. Scores are classified as good, fair or poor.

The scale was selected following its use during the pilot study. An advantage was its simplicity and brevity, although choices were limited.

Social Behaviour Rating Scale

The Minimal Social Behaviour Rating Scale (Farina et al., 1957; Lawton, 1971) was tested for effectiveness and ease of use. It was administered to four elderly male patients selected because each had a vacant seat beside him at the time of testing. Lawton (1971) reported that social behaviour on a very low level can be measured fairly accurately from her adaptation of the scale. Of the four randomly selected patients two wandered off, another asked questions continuously and the fourth had one of his exercises completed by another patient.

It is possible that an interview room is necessary for conducting the test. The scale appeared as simple, but time consuming for one researcher to undertake with many patients. The author became frustrated during pilot testing and decided not to use the scale.

Selection of Group Subjects

Twelve subjects were chosen by the experimental ward Charge nurse for inclusion in the activation programme from criteria suggested by Gibson (1967). That is, four very alert patients oriented to time, place and identity, will respond when spoken to and volunteer information; four moderately alert patients who are oriented, and will participate in conversation and activity when stimulated, and four withdrawn patients who do not participate readily in conversation or activities. For the selection and selection form instructions used by the Charge nurse refer Appendices B and E.

The selected subjects had a mean age 69.5 years and age range 58-83 years. The four alert patients were coded as K, C, D and J; the four moderately alert as H, E, F and L and the four withdrawn as A, B, L and G respectively. Two subjects, A and I, had been in the pilot study.

For productive discussions ten to twelve patients is an acceptable number. Selection of twelve persons enabled adequate numbers for a functioning group irrespective of non-attenders or ill-chosen subjects. Yalom (1968) found the maximum number to be twelve with the optimum range eight to ten members. Burnside (1976) recommended six to eight members where there are elderly, regressed or disturbed patients, but warned that less than six to eight members puts too much stress of group action on all members, including the leader. A larger group may permit the leader to reach more persons, but limits level of participation through the greater membership.

The Activity Group Sessions

An open letter about the proposed group was given to the experimental ward nursing staff (refer Appendix A), and invited participation by interested nurses as leader or co-leader. Timing for continuity of group leadership by ward nurses clashed with imminent staffing changes, and the investigator assumed the role of group leader by default. Time allotted for preparation of prospective group leaders during the third to fifth weeks was therefore not utilised.

It was proposed that 12 sessions of the group be held twice weekly, or twice in six days (where there was a six day roster), and to last approximately 45 minutes. Suitable times for ward staff emerged as twice weekly meetings conducted between 1.45 p.m. and 2.30 p.m. for six weeks.

The following programme format (not strictly followed in actuality) was given to the ward staff in conjunction with the open letter.

An individual greeting to each patient on arrival.
A short recapitulation of the main features of the previous session.
A poem, newspaper reading or similar (preferably relating to the theme for the meeting) presented by a group member.
Discussion or activity(ies).
Concluding remarks.

The aim was provision of an environment for a selected number of patients to meet regularly for promotion of discussion, activity or both, according to the apparent needs and wishes of the group members. Reminiscing by patients was permissable, and if possible reminiscences were to be used as a theme(s). The emphasis was not on rehabilitation or recovery but on increasing interaction. The reality orientation approach of using the "here and now" seemed particularly appropriate for inclusion within the eclectic framework selected for conducting the group.

Group members were rated, using the Crichton Geriatric Behavioural Rating Scale, by the Charge nurse before and following the group. Patients who attended the group sessions were rated on the evaluation scale (Gibson, 1967) by the group leader. Group sessions were taped to enable analysis of the content.

Methods Used for Analysis of Data

In this exploratory study, undertaken in a natural setting, non-parametric statistics have been used. Levels of significance which are and are not acceptable within a discipline are of relevance to research. In nursing Fox (1970) observed that the 5% level of significance has typically been used.

NPIS and PAS

Two types of observation period using the NPIS and PAS were used to analyse data. The Type I period of observation refers to three intermittent periods of observation (i.e. 1, 2, or 3) undertaken in the experimental and control wards. In the experimental ward one of these periods preceded, and two followed the conduct of the activation group. Type II period of observation refers to a weekly random day of observation occurring during the latter half of the group sessions in the experimental ward only.

From the Type I observations comparisons were made between periods 1 and 2, 2 and 3, and 1 and 3 for the experimental and control ward situations. Comparisons between the totals for each ward, and trends which occurred within each ward, could therefore be identified. From the Type II observations undertaken in the experimental ward, comparisons with the corresponding random day from each of the Type I observation periods was possible. This enabled comparison of observation days when the group was progressing with one day preceding, and two days following completion of the group.

Content analysis

Fox (1970) defined content analysis "as a procedure for the categorization of verbal or behavioural data, for purposes of classification, summarization and tabulation" (p.262) and described the appropriate tests as principally chi-square.

For content analysis of the taped group material a number was used as the identifying term of the item(s) and thus for measurement purposes, the appropriate scale is at the nominal level (Carney, 1972).

The unit of analysis was the sentence where sentence structure was apparent or implied. Where there was no structural sentence the phrase or flow of words instead of a sentence was the unit. Where an interjection from another interrupted the flow of speech as taped, then any phrase which meaningfully completed or complemented the initial speech became a unit.

Units were coded as comment, instruction, question or initiation of conversation for the co-leader and patient members of the group. This coding corresponded with that used for the verbal categories of the NPIS.

Comment: any remark or suggestion not stated as an order, or question for example, ""That's right, Michael".

Question: any phrase or sentence in customary question form, for example, "How are you?"

Initiated conversation: any utterances directly solicitous of response from another group member and which can be analysed as initiating conversation with another, or changing the theme of the conversation. It might take the form of a question or series of questions, or be a combination of comment, question or instruction.

Inferential Statistics

Chi square technique is an "overall test of the significance of the differences in the total pattern of data in the contingency table" (Fox, 1970 p.129).

Conditions of use for chi square tests include data which is at least nominal, of two or more mutually exclusive and exhaustive categories, of more than one sample, independent observations, certain restrictions to ensure approximation fits, and predictions about distribution of frequencies across the categories derived either from theory or from knowledge of the population.

Wilcoxon matched-pairs signed-ranks test utilises information about the direction and magnitude of differences between pairs (Siegel, 1965). The test is used for matched pairs where the differences between the two scores can be ranked across cases (Willemsen, 1974). This test was used for analysis of group subjects' ratings on the Crichton Geriatric Behavioural Rating Scale (Robinson, 1974). The conditions for use of the test are ordinal date which is at least continuously discrete and two related samples. There are two problems with ties, that is, when they occur in rank of differences, and zero difference when there are ties between scores of different groups.

Number of Dayroom Subjects

The number of subjects in the dayrooms of the experimental and control wards was calculated by obtaining the average number of patients in the dayroom during use of the PAS in Type I observation periods. This resulted in an average number of 32 and 21 subjects in the experimental and control wards respectively. The average number of patients for periods 1, 2, and 3 in the experimental ward was 33, 32 and 30, and in the control ward, 21.

CHAPTER 7

RESULTS RELATED TO SOCIAL WITHDRAWAL

The phenomenon of social withdrawal by aging patients in long-stay institutions has been presented through discussion of psycho-social theories of aging and the citing of studies using different therapies to investigate or counteract such a process. Social withdrawal is a concept common to the first three hypotheses of the present study, and aspects of it will be presented in the first and subsequent chapters of the result section. Evidence related to the fourth hypothesis is presented in Chapter 8.

This chapter examines results of Type I and Type II observations from using the PAS and NPIS in the dayrooms of the control and experimental wards. In the next two chapters the presentation and discussion of results relates to the selected members of the activation group. The first includes their performance on rating scales used, analysis of interactions in the dayroom setting of the experimental ward, individual behavioural sketches and the apparent suitability of their selection for group membership: the second includes analysis of the process and content of the group sessions. Chapter 10 contains discussion of apparent influences on nurse and patient interaction identified in the dayrooms of the study during periods of Type I and II observation and precedes a general discussion chapter.

In Chapter XI the author presents a systems model with an interactional component for nursing care of the elderly which was developed from general observation during the study.

Type I Observations

Purposeful Activity Schedule Results

The percentage distribution of activity classified as purposeful or simple activity is shown for the experimental and control ward dayroom populations in Figures 7.1 and 7.2. (For raw score totals see Tables III and IV and further details Appendix J, Tables A and C.) In the experimental ward a steady increase in percentage of purposeful activity with a corresponding decrease in simple activity

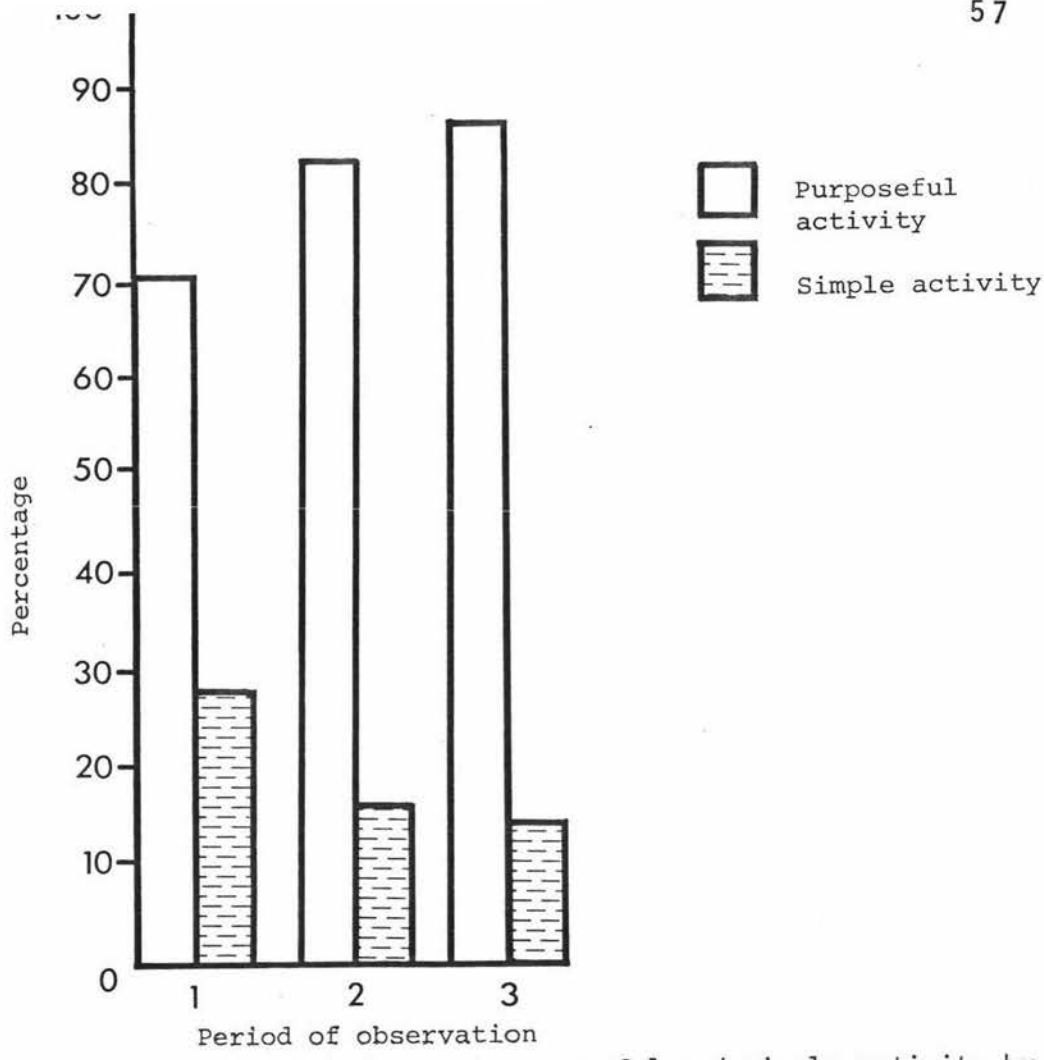

Figure 7.1. Percentage of observed purposeful and simple activity by patients in the experimental ward

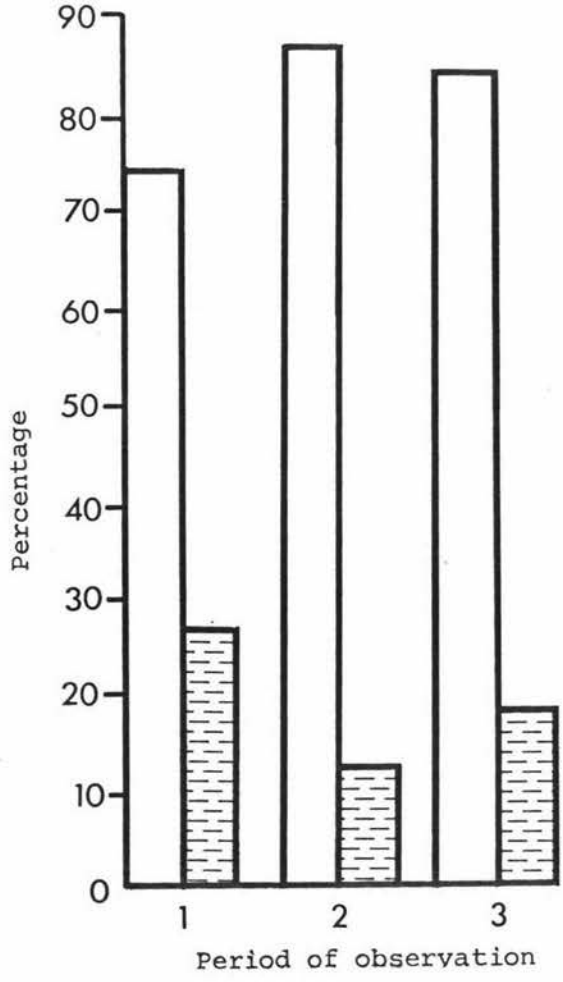

Figure 7.2. Percentage of observed purposeful and simple activity by patients in the control ward

is apparent and particularly between the first and second periods of observation. In the control ward there are fluctuating levels of purposeful activity during the periods of observation. In both settings less than 30% of the items for each observation period show as simple activity.

In Tables III and IV are shown the differences between purposeful and simple activity during each period of Type I observation in the experimental and control wards respectively.

Table III

Differences Between Type I Observation Periods for Purposeful and Simple Activity by Patients in the Experimental Ward

Observation period	Purposeful activity	Simple activity	χ^2
Period 1	1,512	598	$\chi^2=87.65$, $df=1, p<.001$
Period 2	1,701	329	
Period 1	1,512	598	$\chi^2=142.56, df=1, p<.001$
Period 3	1,654	246	
Period 2	1,701	329	$\chi^2= 8.35$, $df=1, p<.01$
Period 3	1,654	246	

N = 32

Table IV

Differences Between Type I Observation Periods for Purposeful and Simple Activity by Patients in the Control Ward

Observation period	Purposeful activity	Simple activity	χ^2
Period 1	987	349	$\chi^2=81.79, df=1, p=<.001$
Period 2	1,157	162	
Period 1	987	349	$\chi^2=36.42, df=1, p=<.001$
Period 3	1,131	225	
Period 2	1,157	162	$\chi^2=10.04, df=1, p=<.01$
Period 3	1,131	225	

N = 21

In the experimental ward the trend of result is indicative of the effects of a variable such as the introduction and withdrawal of an activation group into an ongoing ward routine. That is, statistical differences occur between the period before and each period following the group ($p<.001$) and between the two periods following the group ($p<.01$). A similar trend is apparent for the control ward data where no change in the ongoing ward routine was introduced to the author's knowledge.

There is no significant difference between the overall incidence of purposeful and simple activity by patients in both wards. Each ward has long-stay male patients with psychiatric conditions. Daily routines for procedures such as bathing, meals and so on are similar although the level of physical dependency is higher in the experimental ward.

The number of nurses in the dayroom and able to engage in activating patients may influence data collection for degree of purposeful activity in both wards. In the experimental ward activation of patients occurred mainly in the morning and in the control ward sporadically throughout the hours of observation.

Nurse-patient Interaction Schedule Results

Presentation of results occurs in sections relating to the initiator of an interaction, the nature of any ongoing patient activity, and the applicable verbal category of any interaction.

Initiator of an interaction

For the initiator of an interaction as nurse to patient, patient to nurse, or patient to patient in the dayroom settings of the experimental and control wards in percentage distributions refer to Figures 7.3 and 7.4 respectively. (For raw score totals see Tables V and VI and for details Appendix J, Tables D and F.) In the experimental ward an increase occurs in the percentage of patient to patient initiated interactions, and the patient to nurse category remains relatively constant. In the control ward the trend is for an increase in the percentage of interactions initiated by patient to patient and a corresponding decrease in nurse to patient initiated interactions.

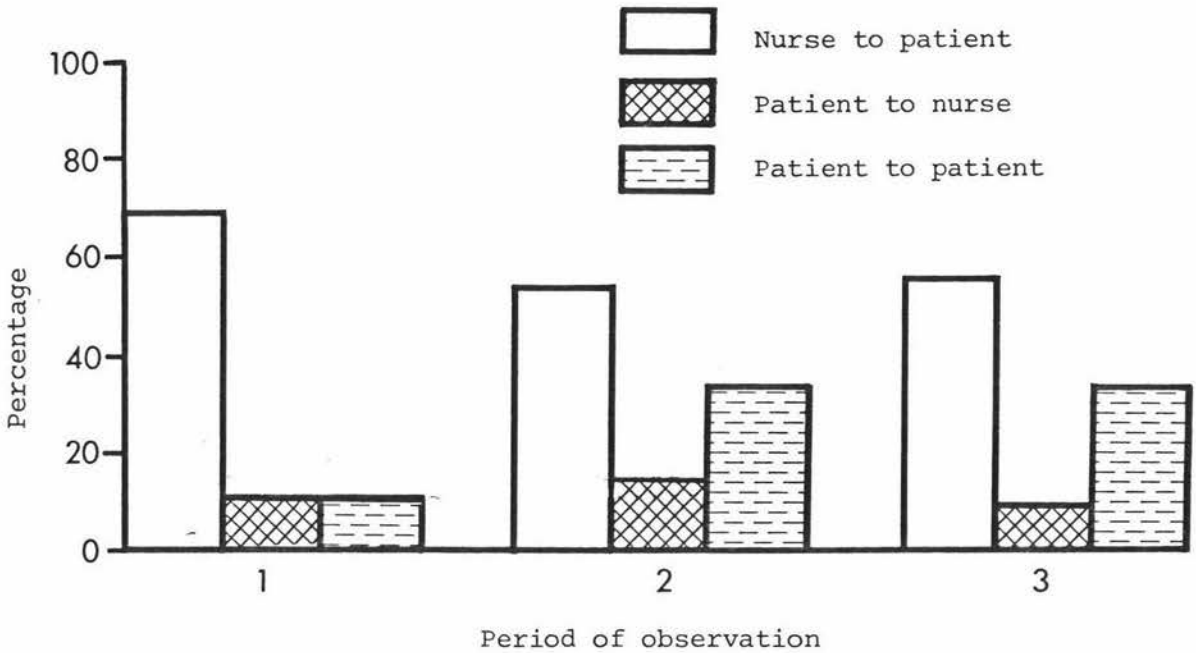

Figure 7.3. Percentage of interactions initiated by nurses and patients in the experimental ward

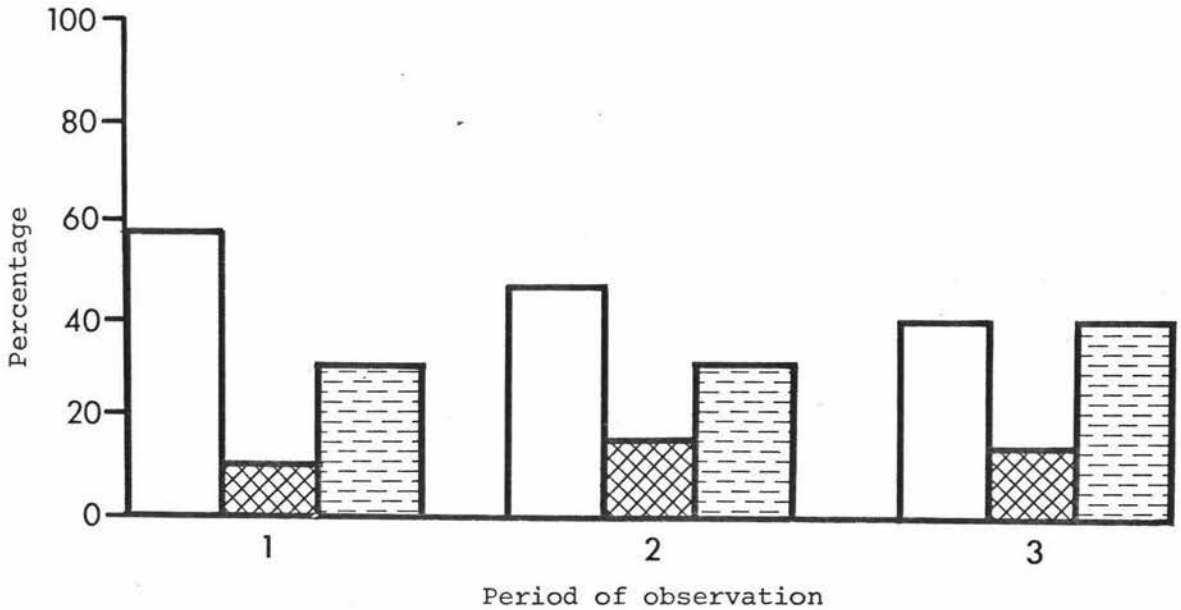

Figure 7.4. Percentage of interactions initiated by nurses and patients in the control ward

In Tables V and VI are shown the differences for initiation of activity by nurses and by patients between the periods of Type I observation undertaken in the experimental and control wards respectively.

Table V

Differences Between Type I Observation Periods for Interactions Initiated by Nurses and Patients in the Experimental Ward

Observation period	Interactions initiated by Nurse to patient	Patient to nurse	Patient to patient	χ^2
Period 1	220	46	46	$\chi^2=24.33, df=2, p<.001$
Period 2	210	66	114	
Period 1	220	46	46	$\chi^2=31.83, df=2, p<.001$
Period 3	199	35	121	
Period 2	210	66	114	$\chi^2=8.4, df=2, p<.05$
Period 3	199	35	121	

N = 32

Table VI

Differences Between Type I Observation Periods for Interactions Initiated by Nurses and Patients in the Control Ward

Observation period	Interactions initiated by Nurse to patient	Patient to nurse	Patient to patient	χ^2
Period 1	97	21	50	ns
Period 2	99	35	75	
Period 1	97	21	50	$\chi^2=10.22, df=2, p<.01$
Period 3	106	41	106	
Period 2	99	35	75	ns
Period 3	106	41	106	

N = 21

In the experimental ward the level of probability is least between the two periods of observation following the group, that is between periods 2 and 3. In the control ward there is a significant difference between periods of observation 1 and 3 ($p<.05$) and this corresponds with that for periods 2 and 3 in the experimental ward.

The control ward has the higher overall percentage of patient initiated interaction (see Appendix J, Tables D and F). The total number of interactions in the experimental ward is larger, and may correspond with the higher patient numbers usually in the dayroom. There is a significant difference between the two wards for initiation of interaction by nurses and by patients with $\chi^2=23.4$, $df=2, p<.001$).

Verbal categories

For the percentage distribution of verbal categories coded as comment, instruction, question or initiation of conversation by nurses and patients in the experimental and control wards refer to Figures 7.5 and 7.6 respectively. (For the raw score totals of the experimental and control wards refer to Tables VII and VIII and further details Appendix J, Tables G and I respectively.) For both wards the comment category is considerably greater for both nurses and patients, and greater for patients than nurses. In the experimental ward the percentage of patient comment increases and there is a decrease in nurse comment, but in the control ward an increase in nurse comment. In both wards conversations are more likely to be initiated and maintained by nurses. A gradual increase in the percentage of patient instructional items occurs during the study in the experimental ward.

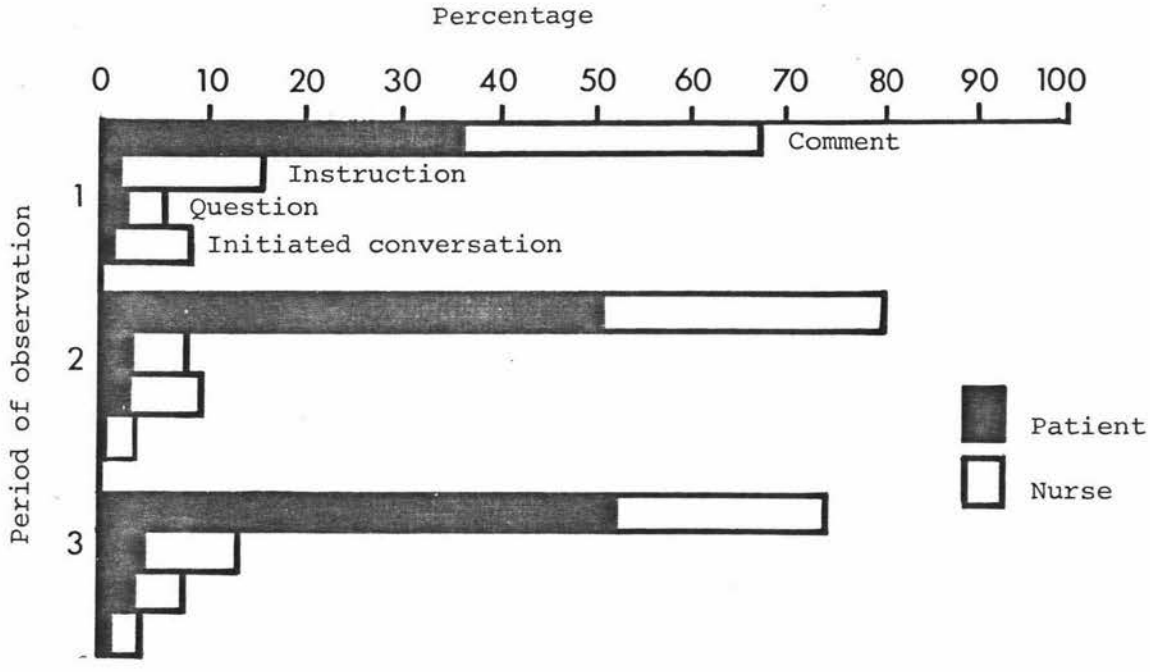

Figure 7.5. Percentage of observations in each verbal category by nurses and patients in the experimental ward

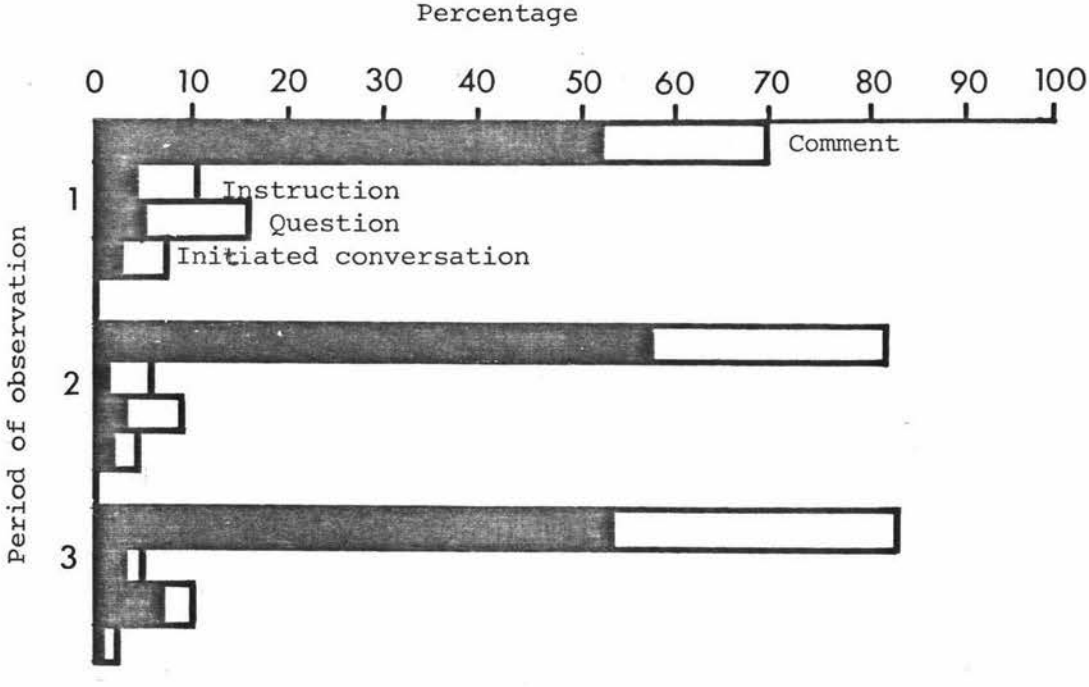

Figure 7.6. Percentage of observations in each verbal category by nurses and patients in the control ward

Table VII

Differences Between Type I Observation Periods for Verbal Categories by Nurses and Patients in the Experimental Ward

Observation period	Verbal categories 1	2	3	4	5	6	7	8	χ^2
Period 1	152	8	10	2	131	59	17	36	$\chi^2=76.98, df=7, p<.001$
Period 2	298	19	19	5	171	22	42	10	
Period 1	152	8	10	2	131	59	17	36	$\chi^2=57.42, df=7, p<.001$
Period 3	308	27	21	7	133	52	31	12	
Period 2	298	19	19	5	171	22	42	10	$\chi^2=20.73, df=7, p<.01$
Period 3	308	27	21	7	133	52	31	12	

* as analysed from interactions in Table V
N = 32

Key:

Patient		Nurse	
comment	1	comment	5
instruction	2	instruction	6
question	3	question	7
initiated conversation	4	initiated conversation	8

Table VIII

Differences Between Type I Observation Periods for Verbal Categories by Nurses and Patients in the Control Ward

Observation period	Verbal categories 1	2	3	4	5	6	7	8	χ^2
Period 1	131	10	11	3	42	16	30	12	$\chi^2=22.56, df=7, p<.01$
Period 2	191	2	11	5	79	15	18	9	
Period 1	131	10	11	3	42	16	30	12	$\chi^2=53.38, df=7, p<.001$
Period 3	203	11	28	2	117	6	12	3	
Period 2	191	2	11	5	79	15	18	9	$\chi^2=27.08, df=7, p<.001$
Period 3	203	11	28	2	117	6	12	3	

* as analysed from interactions in Table VI

N = 21

Key:

Patient		Nurse	
comment	1	comment	5
instruction	2	instruction	6
question	3	question	7
initiated conversation	4	initiated conversation	8

In Tables VII and VIII are shown the differences for verbal categories by nurses and patients in the experimental and control wards. In the experimental ward the lowest level of probability ($p<.01$) occurs between periods 2 and 3, that is, the observation periods following the activation group. In the control ward the lowest level of probability ($p<.01$) occurs between periods 1 and 2, that is, between the periods with the longest time lapse.

In the experimental ward more open supervision of patients, and especially of some restless patients, was seen by the observer in periods 1 and 3 and is highlighted by the higher number of instructional items by nurses in these periods. Patient instructional items increase in period 3 when a patient who readily expressed dissatisfaction with nurses and patients was more consistently in the dayroom following a physical illness. In period 2 one of the restless patients had a fractured femur, another was confined to bed, and a third had been transferred from the ward. No patients were observed as unduly restless, or requiring extra care for physical needs at this time. The dayroom atmosphere was calmer than in periods 1 and 3 and had the highest score for social activity of the three periods (see Figure 7.7). It was observed, and substantiated in casual comment by domestic staff, that the ward had a more relaxed atmosphere in the second than first observation period.

In the control ward the main trend during the observations is a gradual increase in frequency of nurse and patient comment. The increase in patient questions in period 3 relates to increased patient requests for cigarettes to be lit and the increased interactions tend to be among the smokers. The wall cigarette lighter acted temperamentally during period 2 and became nonfunctional during period 3. There were less staff for ongoing activation purposes in period 3 and this is seen as decrease of nurse-initiated conversation, often indicative of an ongoing event such as cards.

There is a significant difference between the overall incidence of verbal categories used by nurses and patients in both wards with $\chi^2 = 37.03$, $df=7, p<.001$. There are greater totals for verbal categories by nurses and by patients in the experimental ward, and especially for the nurse instruction category. The number of patient questions is

constant for each ward although 3.14% and 5.17% of totals in the experimental and control wards respectively.

Patient activity

For the percentage distribution of activity associated categories (that is, functional, social, expressive, learning and servicing) during the observed episodes of interaction in the experimental and control wards refer to Figures 7.7 and 7.8. (For raw score totals see Tables IX and X and further details Appendix J, Tables J and L.) In the experimental ward the percentage of functional activity remains constant, that of social activity fluctuates but is slightly higher than the functional, and the category of expressive activity shows most variation. In the control ward for each of the three periods the percentage of social activity is highest, but decreases from period 1 to period 3, while that of functional activity is fairly constant, and the servicing activity steadily increases.

In Tables IX and X are shown the differences for the activity categories by patients in the experimental and control ward. In the experimental ward a significant difference ($p < .001$) occurs between periods 1 and 2, that is, before and immediately following the activation group sessions. There is a significant difference ($p<.05$) between periods 2 and 3 but not between periods 1 and 3. Differences occur in number of items observed in the social and expressive activity categories. In the control ward significant differences occur between periods 2 and 3 ($p <.01$). The trend is for an increase of items observed in the servicing, and also the expressive categories.

There is a significant difference for the overall incidence of activity categories by patients between the two wards with $\chi^2=92.3$, $df=4, p<.001$. The trend is for more emphasis on the functional category of activity in the experimental ward and social activity in the control ward.

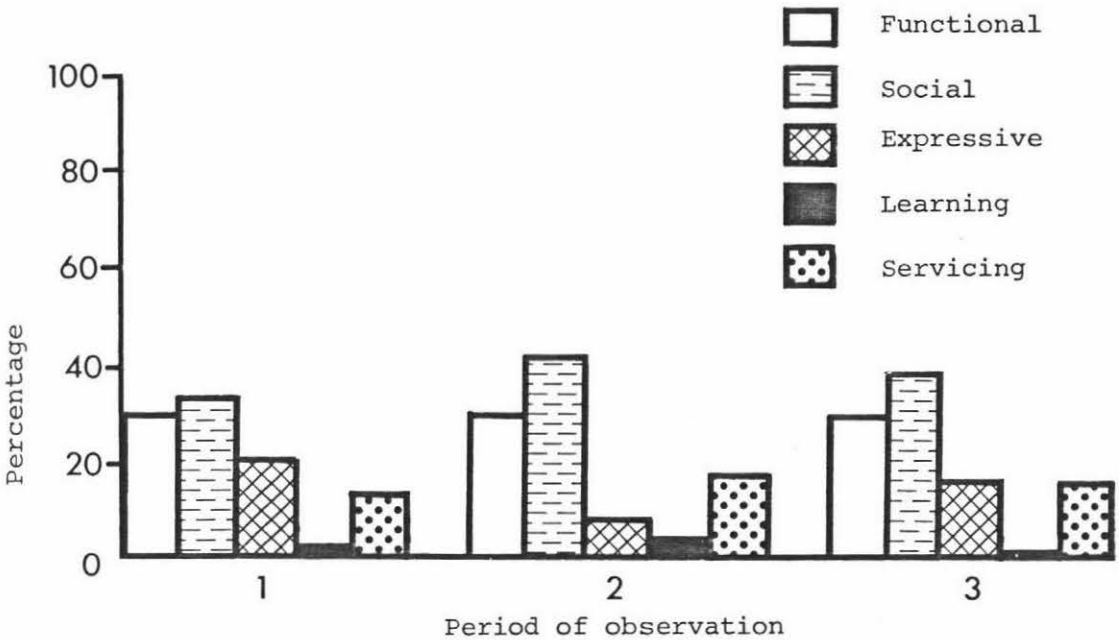

Figure 7.7. Percentage of observations in each activity category by patients in the experimental ward

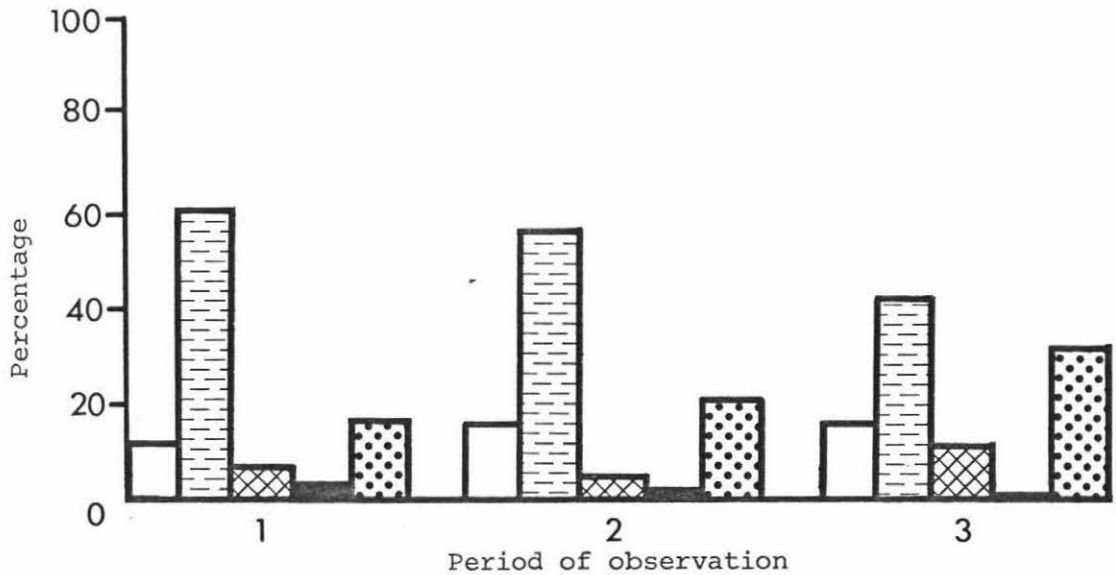

Figure 7.8. Percentage of observations in each activity category by patients in the control ward

Table IX

Differences Between Type I Observation Periods for Activity Categories by Patients in the Experimental Ward

Observation period	Activity categories Functional	Social	Expressive	Learning	Servicing	χ^2
Period 1	94	103	65	7	43	$\chi^2=25.43, df=4, p<.001$
Period 2	112	153	29	14	57	
Period 1	94	103	65	7	43	n.s.
Period 3	104	135	54	9	53	
Period 2	112	153	29	14	57	$\chi^2=10.07, df=4, p<.05$
Period 3	104	135	54	9	53	

* as analysed from interactions in Table V

N = 32

Table X

Differences Between Type I Observation Periods for Activity Categories by Patients in the Control Ward

Observation period	Activity categories Functional	Social	Expressive	Learning	Servicing	χ^2
Period 1	21	104	13	3	27	n.s.
Period 2	34	121	9	3	42	
Period 1	21	104	13	3	27	χ^2=19.09, df=4, p<.001
Period 3	39	107	26	2	79	
Period 2	34	121	9	3	42	χ^2=16.93, df=4, p<.01
Period 3	39	107	26	2	79	

* as analysed from interactions in Table VI

N = 21

Type II Observations

In Table XI are shown the differences from comparison of results using the PAS and NPIS on a random day during the final three weeks of the group sessions and the corresponding day (that is, Thursday) of the Type I observation periods in the experimental ward. For inspection of the totals refer to Appendix J, Tables B,E,H and K for the former, and Tables A,D,G and J for the latter. The average number of patients in the dayroom during the times of observation are 31 and 32 respectively.

Table XI

Differences From Use of Schedules in Type II Observations with Equivalent Days in Type I Observation Periods

Schedule	χ^2
PAS	$\chi^2 = 5.61, df=1, p<.05$
NPIS	
Initiator of an interaction	$\chi^2 = 18.62, df=2, p<.001$
Verbal category	$\chi^2 = 30.93, df=7, p<.001$
Activity category	n s

There is a significant difference between purposeful and simple activity on the contrasted days of observation. A difference of 35 in the number of actions recorded occurs but there is a greater proportion of purposeful than simple activity on the Thursdays of the Type I observation periods. This is associated with less patient initiated interaction. The lesser number of interactions may reflect the exodus of approximately 30 patients on a bus trip during the final hour of each of the Type II observation periods. Associated with the lesser number of interactions is the significant difference found in the verbal category. There are less verbal items by patients, except for the initiation of seven more conversations, but an increase in nurse categories. That no significant difference is found in the activity category reflects the trend for certain patients, such as the feeble, to be excluded from bus trips. Also, the main activities during the last hour of observation in the experimental ward appeared to be sitting quietly (an after-dinner nap time), or watching television.

CHAPTER 8

INDIVIDUAL BEHAVIOUR OF GROUP MEMBERS

Sketches of individual group member behaviour are preceded by results obtained on the rating scales and analysis of their dayroom interactions. The chapter concludes with general discussion related to suitability of selected patients for group membership.

Behavioural Rating Scale

For the Crichton Geriatric Behavioural Rating Scale scores for group subjects as completed by the Charge nurse of the ward before and following group sessions are in Table XII. For the behavioural scale used see Appendix D.

Table XII

Scores on the Crichton Geriatric Behavioural Rating Scale by Group Subjects Before and Following Group Sessions

Subject	Group Sessions Before	After
A	22	17
B	25	21
C	15	20
D	14	13
E	20	14
F	20	16
G	30	27
H	16	20
I	20	17
J	16	12
K	25	20
L	23	14
TOTAL	246	211

N = 12

Scores < 20 mild dementia
20- 30 moderate dementia
> 30 severe dementia

Apart from C and H, whose physical health deteriorated during the study, the remaining group members are rated lower following completion of group sessions. This is indicative of less social withdrawal (or dementia in terms of the rating scale). The scores of irregular, as well as regular attenders decrease. Although G the non-attender has a decreased score, the category of dementia is not altered. Of initial classification of dementia of group subjects as severe(1), moderate (7) and mild (4) there is progression to mild (7) and moderate (5).

Evaluation Scale for Group Performance

The subjects' scores on the Evaluation Rating Scale (Gibson, 1967) as rated by the group leader following each group session are shown in Appendix J, Table M. For the scale used see Appendix I. Scores indicate the level of performance of group subjects, and can be classified as good, fair or poor for each session. In Table XIII is shown both the range and the modal score for each subject on the evaluation scale for the number of sessions attended.

Table XIII

Range and Modal Scores for Performance in Group by Subjects for Number and Sessions Attended

Subject	Range	Mode
A	7-10	7
B	5- 9	6
C	9-13	11,13
D	10-15	14
E	8-12	11
F	6-10	8,9
G*		
H	7-12	9,11
I	5-10	8
J	9-13	13
K	10-14	14
L	8-13	13

* did not attend any group session

N = 11

Good	12-15
Fair	9-11
Poor	0-8

From performance ratings of seven poor and five fair, the first session, there is a gradual progression to the good category of two or more subjects each session from the third session. Ratings for the final group session are three poor, two fair, and seven good. The differences between the lowest and peak scores for all attending members is three, with an increase of four points for B, C, E, F, J and K, and five points for D, H, I and L. For all but A the median score tends to correspond with the modal or lower of the bimodal scores.

Dayroom Interactions of Group Members

An indication of interactions by group subjects in the dayroom is presented to aid individual sketches of their behaviour. Comparison of group members and other ward patients is not undertaken as dayroom populations are not static and the proportion of group members to other ward patients during Type I observations fluctuated. In Table XIV is the number and percentage distribution of interactions involving group subjects in the dayroom during Type 1 periods of observations.

Table XIV

Subject	Interactions during observation periods							
	1		2		3		Total	
	No.	%	No.	%	No.	%	No.	%
A	1	1.10	2	1.40	1	.68	4	1.05
B	12	13.19	8	5.59	5	3.43	25	6.58
C	8	8.79	7	4.90	15	10.27	30	7.90
D	15	16.48	25	17.48	28	19.18	68	17.89
E	7	7.69	15	10.49	9	6.17	31	8.16
F	18	19.78	19	13.29	23	15.75	60	15.79
G	5	5.49	2	1.40	0	0	7	1.84
H	6	6.59	10	6.99	8	5.48	24	6.32
I	3	3.30	6	4.20	2	1.37	11	2.89
J	1	1.10	6	4.20	22	15.07	29	7.63
K	11	12.09	31	21.67	19	13.01	61	16.05
L	4	4.40	12	8.39	14	9.59	30	7.90
TOTALS	91	100.00	143	100.00	146	100.00	380	100.00

N = 12

The scores of nine patients in the second period of observation, that is, immediately after the activation sessions, are higher than in the first observation period. This may be interpreted as a lessening of social withdrawal through involvement in an increased number of interactions. It cannot be substantiated, but is possible that group members spent more time in the dayroom in the second period following development of a group awareness during the activation group sessions.

The scores for the number of interactions involving all patients in the dayroom during Type I observation periods(Appendix J, Table D) may be compared with those of the group subjects (Table XIV). For each observation period the proportions of group subjects in relation to dayroom subjects result, .29, .37 and .41 respectively, and .36 overall. A trend for an increase of participation by group subjects in the dayroom situation is apparent.

For analysis of interactional episodes by group members during the Type I observation periods in the dayroom for range of verbal and activity categories refer to Appendix J, Tables N and O respectively. The patient scores for the range of verbal categories associated with an interaction during Type I observations for all patients in the dayroom (Appendix J, Table G) may be compared with those of the group subjects (Table N). For each verbal category the proportions are .32 for comment, .33 for instruction, .46 for question, .79 for initiated conversation, and .33 overall for group subject performance in relation to all dayroom subjects. There is a marked tendency for group subjects to ask more questions and initiate more conversations than other patients.

The scores for the patient activity associated with an interaction during Type I observations for all patients in the dayroom (Appendix J, Table J) may be compared with those of the group subjects (Table O). For each activity category the proportions are, .27 for functional, .42 for social, .23 for expressive, .58 for servicing and .37 overall for group subject performance in relation to all dayroom subjects. There is a trend for group subjects to have more actions classified as social or servicing. This can be interpreted as a trend to exhibit more assertive behaviour. The proportion for the learning category is .33.

Sketches of Group Members

Patient A

At age 68 years A had been a patient for 18 years. His main observed occupations were smoking, sitting in isolation and watching selected television programmes. He engaged in no participatory event in the dayroom. When in the group he kept his head averted, with a hand across his forehead and surreptiously watched group activity through downcast eyes.

He was coaxed to attend group sessions on seven occasions by a male nurse, or co-leader W. The last three sessions were not attended. During the last attended meeting he walked out following a coughing spell.

He attended seven sessions and passed 18 comments. For 10 of the observation periods in the dayroom the patient was not recorded for any interactional activity. Of 4 interactions observed in the dayroom 3 were connected with his smoking habit.

Patient B

This 68 year old had been a patient for 10 years. He was physically active, deaf unless spoken to clearly and individually, and tended to be an isolate. He was not observed participating in ward activities such as cards or housie, but would write or dabble with paints when given the opportunity. He often retreated from others in the dayroom and group by lying for long periods on the floor. He attended all group sessions but was usually already in the sunroom.

For the first six group sessions B sat on a chair among other patients for no longer than 10 minutes of two sessions. By the eighth session he progressed to sitting on the floor preparatory to sitting on a chair the next session. Occasionally he would leave the group sessions.

Until the sixth session B responded to suggestions but made only occasional noises and coughing spells as verbal communication. During the seventh session he contributed when asked letters of the alphabet in quiz form. When given a crayon to draw an animal he wrote his name - perhaps a form of introduction. During the eighth session he made many sounds and may have been hallucinating. By the next session B responded but mainly non-verbally, when spoken to quietly. Thus, from about the eighth session the patient was more disposed to communicate within the group. With selected nurses in the dayroom he

gave clear and ready response to speech before, and during group sessions.

Originally other group members showed signs of resentment at B's presence. As time progressed, and he gradually took part in activities, others became more tolerant. In Gestalt terms, he originally appeared as the group member in the "hot seat".

Patient C

This 57 year old had been a patient for seven months. During the study he required medical attention for incontinence. He presented as anxious and unable to relax. Although selected as an alert patient for the group,he made few spontaneous remarks but had much factual information on a range of topics when questioned. Any statements made were brief. From the first session co-leader W attempted to draw this patient out but with varying degrees of success. It is possible this patient was concerned and embarrassed by his incontinence. By the twelfth session (following the insertion of an indwelling catheter) he appeared more settled, passed more casual remarks and even made one attempt at humour.

C attended all sessions freely and spontaneously. During the fourth session he was collected for a clinical treatment from which he voluntarily returned to the group. His typical attitude to activities such as housie was "I can take it or leave it". He appeared to observe group and dayroom proceedings rather than participate in activities. Before his glasses required repair he would often carry a book about with him. C usually sat facing the dayroom in the group sessions, and could observe the arrival of any visitor for him. Interactional episodes in the dayroom increased during the periods of observation, and were related to increased care for physical needs.

Patient D

D had experienced more than one admission to a psychiatric hospital. He appeared older than his 63 years and exhibited signs and symptoms of chronic cardio-respiratory failure. Concern with his health emerged during discussions. This concern increased following the death of a ward pal prior to the sixth session, and may have

accounted for his more subdued approach in the latter sessions. He may also have been reacting to the proposed change of Charge nurse as he raised this as a topic for discussion on a number of occasions.

D attended all group sessions and appeared to enjoy the change of routine. At all but three sessions he sat in his favoured corner chair which gave good views of hospital grounds and the dayroom. During dayroom observation periods he made occasional sorties into the dayroom from the stated vantage point. D was usually talkative, and interested in expressing his opinion on everyday occurrences in the ward. He therefore often monopolised the conversation. As he often muttered it was difficult to hear all his comments.

This patient often acted as another pair of eyes in the dayroom, directing staff attention to certain aspects of other patients' behaviour. This led to his occasional ordering about attitude to other patients. On 11 occasions D was observed issuing instructions in the dayroom. He was one of two group members to issue instructions to others in the group and these were issued to B and any dayroom patient who strayed into the group situation.

Of 68 observed interactions in the dayroom the majority were related to social activity, and on a number of occasions he initiated a conversation in that setting. Within the group setting he was the highest verbal contributor of the group subjects.

Patient E

Aged 72 years E had been a patient for 27 years. In the dayroom E participated in and enjoyed activities such as cards and housie. He also assisted with several small tasks. All group sessions were attended readily, and he said he liked attending. No spontaneous verbal utterances occurred in the group. Questions were softly answered. Responses were usually monosyllabic, but less so by the tenth session. He seemed as if anxious to please with his efforts. In both dayroom and group settings he was unobtrusive.

On six occasions he asked a question in the group but only for clarification of a question asked him. Most interactional episodes observed in the dayroom occurred during the second period of observation, for no discerned reason. As group sessions continued his scores on the evaluation rating scale improved from 8 to 12, and he improved in the area of "difficult to understand" to "could

sometimes be understood".

Patient F

This 61 year old had an admission history of 9 years. He presented as a person with a mind of his own and frequently approached other persons in the dayroom for casual comment, tobacco, or light for a cigarette. On occasion he distributed sweets to other persons - the only patient seen to share in this fashion.

F did not always attend group meetings, and would not disclose his reasons for non-attendance. Although able to participate in simple question-and-answer games and activities, F had limited ability for following discussion, and was possibly bored by it. His performance in the group was in the poor to fair category. He related to other persons more freely in the dayroom than group setting.

Patient G

Admitted to hospital 10 years previously G appeared older than his 58 years. He presented as withdrawn, ritualistic and usually negative in response to suggestions. He refused, without comment to attend any group session. In the dayroom he appeared to watch television. During 12 days of dayroom observation he was observed in 7 interactions of which 5 were related to functional activity. G initiated one interaction - a subtle kick at another patient - as he walked by him.

Patient H

Aged 83 years H had been a patient for 22 years. His physical health deteriorated during the group and he was transferred to a general hospital during the last week of observations.

All group sessions were attended. He was always amiable even while occasionally responding to his hallucinations with continual mumbling. Although delusions affected some of his comments, other comments were appropriate for time and place. Therefore "A doctor said I was to leave the sock off" (in connection with medical advice), but, "I won the war ... and got the Royal Estate at Sandringham" in general conversation.

Overall his rating for group membership was in the fair category. He was moderately verbal in the group but many of his muttered comments were disregarded as not appropriate to the main theme of group

discussion. Of 24 interactions observed in the dayroom 10 were for functional, 7 for social and 7 for servicing activities.

Patient I

This 77 year old had been a patient for 10 years. His behaviour in the group sessions roughly corresponded with the state of his health which deteriorated about the time of the fourth session, and persisted for some weeks.

I was usually in the sunporch for group sessions as he normally spent most of the day there. His deafness was a marked deterrent for inclusion in group discussion and activities. Ocassionaly he sat in the circle of group participants, but usually outside it, and either dozed or looked at a newspaper. Few dayroom interactions were observed, and were mainly functional and social in category. Most interactions, that is 6, occurred in the second period of observation when he spent longish periods of time beside the observer.

Patient J

This 77 year old had been in hospital for 28 years. His physical health appeared satisfactory for his age. J was noted among staff for writing long letters, reading, watching television, or attempting to tell long drawn-out anecdotes or pointless jokes. Because of the latter trait, several nurses apologised for his inclusion in the group.

In actuality his ability to initiate conversation, flair for coping with simple guessing games and lack of self-consciousness assisted in maintenance of group function. On the other hand, he was often difficult to understand and tended to monopolise the flow of conversation if not checked by the leader. As the sessions progressed J appeared to speak more clearly, did have some quiet spells, and became better tolerated by other group members. He obviously enjoyed participating in the group.

Among topics of conversation he introduced were the television programme Daktari, the Munich Olympic Games, socialism, the death of the Pope, the selection procedure for a new Pope, and Joseph Smith and the Mormons. The group leader was asked "Have you got any benefit from coming?" and "I wouldn't want you to waste your time, that's all." J, with a tally of 44, initiated the highest number

of group topics or change of topic by a group member. Evaluation of group rating was in the good category for all but the first two sessions. Within the dayroom J participated to lesser extent and half the 29 interactions observed were in the social activity category.

Patient K

He was aged 83 years and had been a patient for 12 years. K was confined to a wheelchair from an arthritic condition. In the ward and group settings he appeared to like company. Being deaf and short-sighted meant television was not appropriate as an entertainment medium. In the group he frequently asked for statements to be repeated, and was unable to see detail in photos and magazine pictures used for discussion purposes.

Within the group K's evaluation score ranged from 10-14, that is, from fair to good. His manner was quiet and reflective, and on occasion he attempted to pass jokes. He derived pleasure from participation in the group because "you never know, someone may say something important." Both listening and talking were enjoyed. He was the second highest contributor of verbalisation within the group, and many were in question form due to his deafness. K's range of verbalisations for different sessions ranged 24-108, and he initiated 18 topics of conversation, or change of theme, within the group.

In the dayroom K often looked as if searching for someone who would be willing to talk or listen to him. Of 61 interactions observed 28 were in the social and 15 in the servicing activity category. (He was a smoker.)

Patient L

This man was 67 years old and had been a patient for 11 years. Within the dayroom he was often observed emptying ashtrays and undertaking other small tasks on a voluntary basis. He did not appear to watch television nor take part in card games, housie, painting groups and so on.

This patient's moods were changeable and the value of his contributions varied accordingly. The nature of his possible comments was unpredictable, and this often gave a sense of the unexpected within the group. Scores on the evaluation rating scale ranged from fair to good. L was the fourth highest contributor of verbalisations within the group.

On the whole L appeared to enjoy or tolerate being one of the group. He did not attend the third session because there were more people and more work being done where he was in the dayroom. At the end of the seventh session he remarked that the group was "better than doing nothing". The last seven sessions were attended quite readily. L participated in more dayroom interactions in the second and third periods of observation.

General Comments

A ward Charge nurse selected the group patients according to the degree of alertness (refer Appendix B). In Table XV are the pre-group selections by the Charge nurse, with group leader comment as found applicable to the category of selection from patient presentation in the group.

Table XV

Comparison of Comment on Group Subject Suitability by Charge Nurse Pregroup and Group Leader Postgroup

Subject	Charge nurse comment	Group leader comment
A	Withdrawn	Solitary and preferred own company. Only attended when firmly directed to do so by a nurse.
B	Withdrawn	Deaf, but could hear and respond if spoken to individually. Noisy outbursts at times.
C	Very alert	Moderately, rather than very alert. Able to give factual information, but not spontaneously.
D	Very alert	Talkative, a monopoliser of conversation, and enjoyed the opportunity to express opinions.
E	Moderately alert	Quiet. Spoke only when directly addressed.
F	Moderately alert	Unable to follow discussion and seemed happier with games or activities.
G	Withdrawn	Refused to attend any meeting.
H	Moderately alert	Quality of contributions varied. Often muttered continually to himself.
I	Withdrawn	Too deaf to participate and often read or slept.
J	Very alert	Interested in discussion and contributing.
K	Very alert	Interested in discussion and contributing.
L	Moderately alert	Unpredictable as to quality of contributions and was verbally over-active on several occasions.

N = 12

Physical and psychosocial disabilities which limit interaction on the part of patients are discernible in the group leader and charge nurse comments. For effective group functioning recognition of such deficiencies and appropriate selection for the proposed objectives of the group is necessary. Those classified as withdrawn did not wish to attend or had problems associated with deafness, the very alert were able to participate meaningfully, and the contributions of the moderately alert fluctuated. When a change of Charge nurse occurred during the group a second rating for purposes of interest comparison was obtained. The second Charge nurse's selection statements for the group members are shown in Table XVI.

Table XVI

Comment on Group Subject Suitability by a Charge Nurse during Group Sessions

Subject	Category selected	Charge nurse comment on suitability
A	Very alert	Too paranoid
B	Withdrawn	Too psychotic
C	Moderately alert	?,i.e. considered seriously for selection
D	Very alert	Suitable for selection
E	Moderately alert	Suitable for selection
F	Moderately alert	?,i.e. considered seriously for selection
G	Withdrawn	Too withdrawn
H	Moderately alert	Suitable for selection
I	Moderately alert	Suitable for selection
J	Very alert	?,i.e. considered seriously for selection
K	Moderately alert	Too paranoid
L	Very alert	Paranoid

N = 12

In Table XVII the category selection by each Charge nurse is contrasted. An interval of six weeks occurred between ratings.

Table XVII

Group Subjects as Rated by Two Charge Nurses on a Selection Scale Before and During Group Sessions

Subject	Rating of subjects Before group sessions	During group sessions
A	Withdrawn	Very alert
B	Withdrawn	Withdrawn
C	Very alert	Moderately alert
D	Very alert	Very alert
E	Moderately alert	Moderately alert
F	Moderately alert	Moderately alert
G	Withdrawn	Withdrawn
H	Moderately alert	Moderately alert
I	Withdrawn	Moderately alert
J	Very alert	Very alert
K	Very alert	Moderately alert
L	Moderately alert	Very alert

N = 12

Interrater agreement .59

Given the same criteria for selecting patients, suitability for inclusion may be viewed variously by different raters. Variables possibly contributing to the differences of opinion between the Charge nurses include: time interval between ratings, length and depth of association with the patients, attitude at time of rating, whether rated in terms of a specific or general psychiatric ward population, whether health of the group members had remained constant, and so on.

Such variables as the above may have resulted in differences of rating on before and after measures of the behaviour rating scale (Table XII). However, differences which occurred due to time between the ratings by the Charge nurses correspond with changes in patient behaviour reported in the daily ward reports. For example, scores indicating a lesser dementia rating for I and L correspond with hypomanic phases of a manic- depressive condition for which each requires periodic adjustments of medication. The ratings on the selection scales are consistent with their change of mental state, for example, I from withdrawn to moderately alert. G, the non-attender is described as

withdrawn by both raters and his level of dementia remains in the moderate category, although his score improves by three. Of the attenders C and H whose scores on the behavioural scale rose in conjunction with failing physical health, the extent of dementia is on the increase, but both have borderline scores for movement from mild to moderate dementia. That C and H's ratings move in the direction of greater dementia when their physical health deteriorated indicates the sensitivity of the behavioural scale used in the study for assessing change in patient behaviour.

Selection of group members C, D, J and K as very alert; E, F, H and L as moderately alert and A, B, G and I as withdrawn by the Charge nurse according to the required criteria are mainly substantiated.

Three distinct groups appear in the total number of interactions observed in the three periods of observation (Table XIV). Amongst the group subjects D, K and F have approximately twice as many as the next clumping of scores by C, E, J, L. B and H, and over five times as many as A, G and I. Results from the Type II observations show approximately the same ranking, but constant only for D and J. A, D, K and I tend to spend long periods out of the dayroom. D and K had initial classification as very alert, and A and I as withdrawn. From observation D and K preferred sites from which observations of activity could be made, for example, K often sat near the front door of the ward. A and I frequently withdrew from areas where any activity was occurring.

These three groupings are also apparent in the results obtained for individual performance rating by the group leader for each group session (see Appendix J, Table M). Modal scores of patients initially classified as very alert are in the good category. Of patients classified as moderately alert 3 subjects have modal scores in the fair, and one (L) in the good category. Those patients initially classified as withdrawn have modal scores in the poor category.

The results presented in this chapter on individual group subject behaviour include: no significant difference between scores obtained

before and following the group on the Crichton Geriatric Behavioural Rating Scale using the Wilcoxon matched-pairs signed-ranks statistical test although there are measurable changes for a majority of the subjects; higher scores on the Evaluation Scale used for group performance for those attending regularly; progression to more subjects classified as good, and less as poor for individual performance during group sessions; more interactions for nine group subjects in the observation period immediately following the group and this sustained by four subjects in period 3 of Type I observations; and indications of changing attitudes by different group members such as increasing acceptance of others, willingness to participate, and greater concentration spans.

The above trends illustrate the presence of social withdrawal (a feature of the first three hypotheses) among patients in a group setting and in the dayroom of the experimental ward. The findings partially support the fourth hypothesis which states that participation in a continuing planned group programme will result in measurable changes in a variety of behaviours identified on selected rating scales for the participants. Measurable, but not statistically significant differences, are identified from use of the behavioural scale, and the group performance scale.

CHAPTER 9

ANALYSIS OF THE GROUP

Prior to analysing the group process an overview of the Fundamental Interpersonal Relations Orientation theory (FIRO) is given, and the outline of the programme which evolved for the activation group. Following analysis of the group process from the FIRO theoretical perspective, the results of analysis of group content using the verbal categories of the NPIS are given.

The FIRO theory proposed by Schutz in 1958 identified three interpersonal needs for inclusion, control and affection. These needs are seen as being sufficient to predict and explain interpersonal phenomena and can be used to instance episodes of interaction observed in a group setting. For example, as regards inclusion any individual in a group situation of two or more persons may be found at any point along a continuum from wanting to be the focal point of attention or completely withdrawn and isolated. The need for control ranges from a combination of wanting to control or to be controlled by others.

Schutz (1966) suggested that group formation and development always follows a particular sequence, comprised of the principles of group integration and resolution. With the formation of a group the inclusion phase is prominent. As problems of inclusion lessen, problems of control become prominent. As problems of control become sufficiently resolved then problems of affection become central. The cyclic stages or intervals of FIRO are not distinct and may merge, but with one stage always dominant. At any stage in group life, one problem area is emphasised more than the others (Schutz, 1966). The cyclic stages occur in reverseorder during the terminal stages of the group.

FIRO, with its emphasis on interpersonal relationships, provides an appropriate framework for analysing group process where the emphasis is on lessening patterns of social withdrawal. Burnside (1969) reported attempting use of FIRO as a theoretical base when working with a group described as a communication-facilitating group to diminish isolation and withdrawal patterns.

A recurring theme during the activation group sessions was that of reciprocity, of giving and sharing either more or less of self. Group members varied in their degree of involvement and quality of contribution. Their very presence, however, influenced the direction and nature of group process. As stated by communication theorists, communication is inevitable and a multilevel phenomenon (Marram, 1973).

Programme Outline for the Group Sessions

1. An initial contract period between leader and group members.
   Discussion: the reasons and need for sessions to be taped, magpies, and animals.

2. Discussion: emphasis on names of group members; coughing and cures following D's statement "I've been sick for a long time"; general chit chat; several topics initiated by patients, and possible group activities for future sessions.

3. Discussion: review of the previous meeting; reinforcement of names of group members, and general chit chat.
   Activity: one or two games of housie.

4. Discussion: three patients contributed to a rambling introductory session, and the main theme centred on likes and dislikes (which produced some patient gripes).

5. Discussion: review of the previous meeting; focus on pictures from magazines and travel brochures; the activity at a nearby ward during fire drill, and on fire drill.

6. Discussion: chatter related to Commonwealth Games as seen on television, and the passing of a long term patient (initiated by D).
   Activities: listening to a record (as thought about the deceased patient), and a jumbled letter word-game related to everyday ingredients found in the kitchen.

7. Discussion: election of Popes (initiated by a patient), and chit chat.
   Activities: a quiz about names of animals from selected letters of the alphabet, and the drawing of an animal.

8. Discussion: the previous day's concert arranged by nursing staff in the Community Centre, and who members would invite to perform in a concert if given free choice.

Activities: a game of skittles and an action period initiated by L, using actions of marching although patients remained seated.

9. Discussion: the functioning of the tape recorder, patient paintings found on the sunroom table, different makes of cars, the co-leader's dog and car, socialism,and K spoke about a rodeo event.

10. Discussion: a review of the previous week's discussion, the Mormons and Joseph Smith, D's trip to town, the ensuing change of Charge nurse, Capetown, and the patients' bus trip of the day before.

Activities: listening to tape of old popular songs, and making paper darts following discussion of planes.

11. Discussion: number of remaining group sessions and repetition of group members' names.

Activities: listening to a record, and a scrambled letter word game of objects likely to be found in a patients' dayroom.

12. Activities: the eating of ice creams, and the choosing and eating of several chocolates.

Discussion: general chit chat tending to centre on places where group members had lived, and some boyhood experiences.

The programme format for each session as devised before the group (see Chapter 6 was adhered to in principle but not in practice. It was not practical for group members to present prepared material. Of the very alert patients two had eyesight problems and another was unable to read. During the second session the only response for suggestions of possible activities was put forth by D, endorsed by K, and quietly supported by other patients. The request was for a bottle of beer.

Overview of the Group Process

The initial group sessions were typical of the inclusion phase. Schutz (1966) stated the main concerns of the formative group process as "boundary problems". That is, problems that have to do with entering into a group, and belonging to a group (Schutz, 1966). During the initial phase leader and co-leader were very aware of a dependency phase in process (Bennis & Shepard, 1956).

Less than ten minutes after preliminary remarks by the leader, J asked about the presence and necessity of a tape-recorder. The question "It couldn't be used in a court of law could it?" reflects his guarded reaction to the taping of sessions. Other group members were less vocal, but steadily studied the tape-recorder. The function of the tape-recorder was demonstrated, and is an example of adapting content to the apparent needs of the group. Discussion related to the presence of the tape-recorder was raised by patients on two other occasions. The leader clarified the reason for her presence, and the nature, proposed content, and length of group sessions in the first two sessions.

Another early boundary problem raised by D centred on clarification of whether or not statements made in the group could be reported to nursing staff with possibility of recrimination for comments passed. His concern appeared overstated.

Examples of the inclusion phase were dominant for the first half of the group sessions, and recurred each time a different nurse assisted the group leader. Aspects of the control phase were apparent briefly, but never dominant, during such sessions. Schutz (1966) stated that situations vary with respect to high or low control differentiation. A leadership structure emerged in the group with the leader influencing and controlling the group members, and yet encouraging patient participation. The main co-leader tended to increase her leadership influence as the group progressed. A situation in which some members are controllers and are not controlled (for example, the leader, main co-leader W, and often D) while other members are controlled and do not control is viewed by Schutz as high control differentiation. There tended to be a high rather than low control differentiation in the group.

Patients introduced topics for discussion. Thus during the sixth session the theme of grieving was introduced by D who was mourning the sudden death of a popular patient. J continued the theme in the seventh session with discussion on the death of the Pope.

Some sessions flowed more easily than others. For example, the seventh session had good patient participation as problems of inclusion lessened. The eighth session was laboured as co-leader W

endeavoured to get patients to discuss a concert attended by most group members the previous day. At the end of this session L suddenly led an imaginary parade muttering "left, right, left, right" ... in true military style. Others joined in and a period of camaraderie (an affection cycle state) ensued for a short period. An inclusion phase followed abruptly as the co-leader directed C to the toilet following incontinence. Group members muttered comments such as J's "It is that kind of a place" and D's "He could have asked to be excused".

The problem of inclusion continued in the next, the eleventh session with the leader asking "What is up? You all look half asleep today". There were signs of patient preparation for withdrawal from the group. There were three non-attenders, that is, A, F, and G. H was not very keen on attending but did so (his deteriorating physical health has been mentioned). D implied he wasn't fussy about attending, but later suggested twice weekly meetings as too frequent with the implication that weekly sessions would have prolonged the programme. J queried who would continue taking the group.

Conversation in the final session was low-key and concentrated upon the activities and whereabouts of the patients when younger. There was no definite termination of the final session, but patients gradually took themselves back to the dayroom as I and J each monopolised the leader's attention. The final stages of the group appeared to occur in reverse order of the cyclic process as stated by Schutz. Thus the theme of inclusion was prominent as the group ended.

Inclusion Phase

Inclusion involves establishing one's self as a specific individual and deciding to what degree he wishes to participate in the group (Schutz, 1966). Examples of inclusion type behaviour were exhibited as follows, G excluded himself completely from the group members by his non-attendance. A attended meetings only when so directed by ward staff and by the last session left the dayroom as the group leader arrived. I was usually in the sunroom when the group met and following his own inclinations (that is, sleeping or reading). B often excluded himself by lying on the floor - a characteristic pose. Other group members initially tended to exclude B with remarks such as "Why is

he out here?" when he emitted his characteristic, and loud, verbal sounds. Throughout the group patients interacted for purposes of lighting cigarettes, but minimally for purposes of conversation.

Members may choose different ways of expressing desire to be an accepted group member. Throughout all sessions J contributed unstructured stories and anecdotes from his readings and personal experience. His articulation was poor. With time, such defects lessened and other group members seemed more tolerant of his anecdotes.

In the early sessions there were extremely limited concentration spans for any topic, but by the seventh session patients were more readily recalling and imparting information. Following the reading of a poem by the leader L stated a jingle which was immediately followed with different versions from K and J. Tactics for recognition by patients during inclusion phases varied from contributions which were actively sought by the leader, to spontaneous input. Patients sustained longer discussion of a topic as sessions progressed.

A situation may be characterised by high or low interchange, and high or low differentiation (Schutz, 1966). Inclusion interchange was vital for the interaction and maintenance of group function. A discussion task situation typifies the low inclusion differentiation situation as each member can equally orginate and receive inclusion. The group ranged between high and low points on interchange factors. Patients appeared to accept more responsibility for maintaining spread of interaction as sessions progressed.

Control Phase

Schutz likened the "atmosphere" of Lewin, Lippitt and White (1939) to the term of "amount of interchange". An authoritarian atmosphere requires control, whereas the laissez-faire atmosphere practically inhibits control. The democratic atmosphere neither requires nor prohibits control. The term authoritarian, democratic and laissez-faire atmosphere can be compared with high, middle and low values of control interchange. The control interchange for the group was in the middle to high regions.

Group members differentiated in their apparent need for control mechanisms. For example, a frequent opening gambit from D was "Well, what are we going to talk about today?" Group members exhibiting more features of social withdrawal usually spoke only when spoken to by staff and seemed more comfortable when an activity was introduced. Group members exerted their independence and own controls over their immediate situation when so desirous. Quiz and guessing games were accompanied by higher leader and co-leader level of control. C spoke spontaneously only during housie and when visitors arrived. J enjoyed and participated in both discussion and other activities. D, usually vocal, quietened if a quiz involved knowledge of spelling.

In an effort to encourage the less vocal group members to participate the leader asked many questions directly of such patients during discussion and particularly during activities. The co-leader for eight of the twelve sessions frequently did likewise, but less consistently.

Affection Phase

Many close personal feelings are exchanged within the close relationships of the higher affection area. In the low affection area interchange expression of such ties is usually considered inappropriate. A sense of "bur"group developed but individuals continued to maintain their independence of one another. There were a few instances of pairing, and most included D. For instance, after finding out C had also served overseas D offered him the use of his spectacles on several occasions.

Instances of dyadic relationships and concern with a significant other are examples of behaviour in the affection stage. Patients seldom spoke directly to one another in the group, but tended to address their remarks to the leader or co-leader. Most patient to patient interaction in the group was initiated for purposes of lighting a cigarette. It appeared that as the group progressed members were more aware of other group members in the dayroom, but data to substantiate this observation was not obtained.

In the group sessions there were expressions of positive feelings which were evidenced as personal hostility toward other group members. A cited instance has been that of group members toward B for his unexpected noises. Before one session K and D were heard discussing J's tendency to monopolise conversation. Within a group each individual strives to attain and maintain the most comfortable degree of affectional interchange and position regarding the initiating and receiving of affection for him.

Analysis of Content

For patient members the total number of verbalisations as itemised in group sessions range 210-362, and for leader and co-leader 254-614 (see Appendix J, Table P). The patient scores peak at the ninth session with 375 contributions, and at the twelfth with 362. For all sessions but the fourth, leader and co-leader totals exceed patient totals. Not all the fourth session was available for analysis, as the tape-recorder malfunctioned.

In Table XVIII are contrasted the total verbal units as analysed for patients and nurse leaders each group session. The proportion of patient to nurse totals for each session is shown.

Table XVIII

Proportion of Patient to Nurse Verbal Units as Analysed from Group Sessions

Group session	Number of verbal units Patient	Nurse	Proportion
1	210	254	.83
2	287	374	.77
3	211	304	.69
4	155*	142*	0
5	253	447	.57
6	227	359	.63
7	286	393	.73
8	291	464	.63
9	375	396	.95
10	289	419	.69
11	281	400	.70
12	362	614	.59
TOTALS	3,227	4,566	.71

* Incomplete data N = 9 - 11 patients, and 2 nurses each session

Chi-square test results show significant differences for the totals of patient and nurse statements as analysed in Table XVII between different sessions as follows: the first and the fifth ($p < .01$), sixth ($p < .05$), eighth ($p < .05$) and twelfth ($p < .01$); the second and the fifth ($p < .01$) ninth ($p < .05$) and twelfth, ($p < .05$); the third and the ninth ($p < .01$); the fifth and the seventh ($p < .05$), and ninth ($p < .001$); the sixth and the ninth ($p < .001$); the seventh and the ninth ($p < .05$), and twelfth ($p < .05$); the eighth and ninth ($p < .001$), and the ninth and the tenth ($p < .01$), eleventh ($p < .01$), and twelfth ($p < .001$). Differences are significant between session nine and all sessions but the first, and between the first session and the fifth, sixth, eighth and twelfth. The proportion of patient to nurse statements as analysed is highest in the sessions where no activity was included (that is, the ninth, first and second) and lowest in the fifth session where there was no activity but a more structured approach to encourage conversation.

The total number of interactions in the twelfth session are double that for the first, with a greater increase in nurse than patient contributions. Between the first and fifth sessions a greater increase in nurse than patient units of analysis is apparent, although there is a trend for both to increase during the sessions. The proportion of .59 for the twelfth session may be indicative of the terminal phase of the group process. The high score for nurse questions this session may be indicative of patient withdrawal. On the other hand, patients were given several choices as to which chocolates they would like from a box. This procedure required repeated nurse questions such as "this one?" or "that one?" for the majority of patients, and patients did not contribute to conversation while they ate. Thus results may indicate the content and/or the style of leadership of group sessions.

In Table XIX are listed the number of verbal units as coded for individual patient group members during group sessions, and the rank and percentage score of each patient for all group sessions. For the number of verbal units as coded for nurse and patient members each group session see Appendix J, Table Q, and for the number of units in each verbal category by patients and nurses each group session see Appendix J, Table P.

Table XIX

Number, Rank and Percentage of Interactions by each Patient in Group Sessions

Patient	No.	%	Rank
A	18	.56	11
B	44	1.36	8
C	147	4.56	6
D	863	26.74	1
E	83	2.57	7
F	32	.99	9
G*	0	0	0
H	240	7.44	5
I	27	.84	10
J	662	20.51	3
K	779	24.14	2
L	332	10.29	4
TOTAL	3,227	100.00	

N = 11

* Refused to attend

D, K and J appear as the highest ranking members followed by L, H and C, and finally E, B, F, I and A. Ranks for participation in the group session, when compared with those for dayroom interaction by group members (Table XIV) result in D and K retaining first and second place. J moves from third to seventh , F from ninth to third, and A and I retain low ranks.. F's frequent requests for tobacco from others has been stated. Apart from the performances of J and F, the rankings for group members each group session and in the dayroom are similar.

Analysis of group session content enables determination of variation of verbal categories used by group members (including the leader and co-leader) during group sessions. There is an overall increase in the number of statements analysed during the group sessions. In addition, between sessions 1 and 12 there is a trend for increase in both patient and nurse comment and question.

For the total number of units coded from verbal utterances by nurse and patient members during group sessions refer to Appendix J Table P. Inter-rater agreement for content analysis is .88 (2 raters).

For both patient and nurse verbal units analysed the ranking of comment, question, initiated conversation and instruction is identical. Throughout the sessions patients initiated one more change of conversation and made four more instruction remarks than the nurse leaders. Over all sessions the proportion of patient to nurse comment is .93, and patient to nurse question is .27. The differences in number of patient and nurse items in the various categories each group session result in significant differences occurring in the pattern of verbal categories between many sessions. As content analysis is indicative of quantity rather than quality of contribution by participants an indication of spread of verbal category use by patients and nurses is adequate for purposes of this thesis. There are fluctuating levels of comment, question, instruction and initiation of conversation by nurses and patients in Table P (Appendix J). This may be interpreted as varying levels of participation and hence of social withdrawal.

Discussion

Analysis of the group process from the problem areas of inclusion, control and affection (Schutz, 1966) for the group as a whole, and individual group members, indicated fluctuation of participation throughout the group life as did data from content analysis. Sessions were conducted for increase of patient interaction which includes promotion of verbal and non-verbal interaction. The emphasis in any session was altered from discussion to a more active pursuit if this seemed more appropriate for patient response at that time. Thus verbal interchange results probably reflect group session content as well as change of pattern response. Neither the first or final session were as structured as the majority of sessions. The first session was exploratory with group members possibly assessing personal meaning of membership in the proposed sessions. In the final two sessions some patients appeared as if preparing for their withdrawal from a non-continuing situation.

As problems of inclusion revolve around whether or not to join in, to commit oneself or not, this issue appeared dominant during most of the group sessions in a situation where patients exhibited social withdrawal. The problem of inclusion occurred in cyclic phases interspersed mainly with the problem area of control, and to a limited extent with the problem area of affection. Although one problem area was predominant at one time, individual members were often concerned with one of these areas as related more specifically to their individual needs. The reverse cyclic order, that is, affection, control, and inclusion occurred in the terminal phase of the group, as stated by Schutz (1966).

Relying on the number of verbal statements analysed for verbal category is not a true indicator of the number of interactions of any group member. (See Appendix J, Table Q). Much non-verbal activity and interaction occurred among group participants. Patient scores fluctuated from session to session, with no trend appearing to reflect increasing participation of most group members, apart from increase in number of comments as the sessions progressed. This may be indicative of quicker responses on the part of patients so that more verbalisations were made in approximately the same time span. It has been suggested that content of group sessions and style of leadership have been adapted according to the response of individual group members. Open-ended statements may produce more conversational answers, but some group patients replied more readily to direct questioning. To prevent monopolisation by the more talkative members use of questions to specific patients appeared an appropriate tool.

Among reasons given by Ebersole (1976) for the difficulty of controlling group studies among the elderly the two following are particularly relevant to this study. First, tape recorders are often ineffective as was found in the fourth session when a human error resulted in a non-functioning tape recorder. In playback of other sessions sounds from the nearby dayroom often muffled patient statements, and only one voice was distinct if more than two persons spoke simultaneously. Many patient statements were muttered, or spoken indistinctly in a direction away from the recording apparatus. Therefore some patient statements were not recorded, and hence not analysed. Secondly,

as a participant observer, there is change in each interaction. The mental set of leader and co-leader may therefore have influenced the direction of discussion through responding to the statement of one patient in preference to another.

To the group leader the quality, if not the level, of interaction for group members appeared to change as the group sessions progressed. This was not measured, although verified by the main co-leader. Length of discussion on a topic became more prolonged, and there was more exchange of personal experiences by some group members. The periods of activity seemed to lessen, as more patients became accustomed to listening or talking in a group setting.

Indications are that patient behaviour shows consistent patterns of interaction in and out of the group. Some behaviour is subject to different interpretation in different settings. For example, J's rambling stories interrupted nurse activities in the dayroom, but within a group setting he can be a useful contributing member. C is a very alert patient in comparison with other experimental ward patients on a one-to-one basis, but is too reserved and anxious for spontaneous participation in a group setting. His factual knowledge required extraction through questioning.

Co-leader W expressed the opinion that as group sessions progressed the patients acted less as strangers to one another, became more of a team, and as a group were becoming more tolerant of B and J. Of the individuals, W remarked that C appeared to make an improvement which was not sustained, E as contributing more towards the final sessions, and that although L joined in readily enough his capabilities were limited.

The FIRO theory is appropriate for analysis of group process, and content analysis for group content. Some inadequacies of taping content have been stated. The descriptive analyses indicate that the interpersonal needs stated by Schutz (1966) are compatible with explanation of behaviour from either the disengagement or implicit theory of aging processes. The results of the study do not appear to reflect the concepts of the disengagement, implicit, or personality theories of aging individually. An environmental influence affecting nurse-patient interactions appears implicit to the study.

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CHAPTER 10

APPARENT INFLUENCES ON NURSE AND PATIENT INTERACTION

During the study factors emerged apparently related to more or less interaction in the dayrooms of the control and experimental wards. These factors are presented as nurse, patient, organisation, non-nursing staff and patterns of interaction. Possible avenues for future research on nurse and patient interaction permeate the discussion.

Nurse Factors

Nurse Numbers

The rate of nurse to patient and patient to nurse-initiated interaction may relate to nurse and patient numbers in any setting. Nakagawa and Hudziak (1963) found that the proportion of time devoted to direct patient care was not related to an increase in number of personnel, but they assessed only if and not why this occurred. More generous staffing levels might lead to increased interaction with patients, but also lead to diminishing interaction as staff have greater opportunity for interacting with each other (Altschul, 1972). Such trends were not assessed in this study. Several instances of nurse to nurse interaction, of longer duration than most nurse to patient interactions did occur when certain combinations of three or more nurses occurred. Such episodes were often interrupted with good natured comments to patients in the immediate vicinity.

Numbers of nurses and patients in the dayrooms of both wards differed throughout each day and on successive days. In both dayrooms, but particularly the experimental ward, hospital aids were the most frequently seen category of nurse. Ready access to registered staff occurred in both wards. In Table XX are shown the categories of nurse observed in the dayroom settings of each, and both wards, during the study period.

TABLE XX

Number of Nurses in Different Categories Observed in the Dayrooms of the Experimental and Control Wards

Category of nurse	Experimental ward	Control ward	Both wards*
Charge nurse and above	3	3	1
Staff nurse (psychiatric)**	7	3	2
Staff nurse (general)***	1	2	0
Enrolled nurse	5	5	1
Hospital aid	20	15	8
	36	28	12

* nurses observed in both wards

** registered as a psychiatric nurse

*** registered as a general nurse

Continuity of Staffing

A recommendation of the Commission of Inquiry into Psychiatric Services at Oakley Hospital was for greater emphasis on the need for continuity of ward staff (1971). Altschul (1972) observed that rapid turnover of staff appeared to be one factor affecting isolation of patients hospitalised for more than two months, and also, that where interactions occur from an intuitive response then contraindications of approach by different nurses to the same or similar type patients will occur. It was apparent that certain nurses permitted particular patients to assist with small tasks such as collecting of cups. Different nurses had certain expectations of task behaviour by particular patients and occasionally this resulted in a patient response which was acceptable by one nurse but not another, for example, giving out biscuits to other patients. A possible mode of adaptation to this situation is a withdrawal, or wait and see approach, by the patient. It may be that patients responded differentially to nurses, but this was not assessed. Altschul (1972) found that nurses appeared unaware they might respond to patients with a diversity of approach and that regardless of level of skill and effectiveness each nurse considered her method of dealing with a given situation was "what everyone would do".

Priority of Nursing Care

In both wards care for physical needs appeared to have precedence over that for social interaction, although activities related to functional care require interaction(s) between nurse and patient. Two studies cited by Gunter (1977) include that by Kelleher and Shaughnessy (Boston College, 1963) who reported on a two-phase exploratory study of 136 nursing homes to determine nursing needs. They found that physical needs of patients generally were well met, but nurses infrequently identified psychosocial needs and, therefore, did not meet these needs. Secondly, Hefferin (1975) reported results showing that while nursing staff could readily rate physical and psychosocial aspects of functioning, written care plans for nursing the aged in hospital tended to focus primarily on the patient's physical needs.

In the experimental ward toileting and general supervision of patients was the responsibility of the dayroom nurse(s). However, other ward nurses assisted with particular aspects of routine care throughout the day. Some of these activities, such as after dinner grooming, were performed mater-of-factly so that the hair of a majority of the patients was combed in 2-5 minutes. Any nurse comments passed to patients at these times was usually perfunctory in nature.

Nurses varied in degrees of attentiveness to physical and grooming needs of patients. It is possible that some nurses in the experimental ward did not institute more recreational opportunities for patients through emphasis on supervision of patient behaviour and physical needs. Often one of the two dayroom nurses would institute recreational activities (according to individual preferences) while the other continued care of the patients in general.

Duties listed in the experimental ward dayroom to supplement physical care noticed during the first period of observation included: reading of the newspaper to selected groups, card playing, scrabble, housie, indoor bowls, miniature horse racing, discussion groups, walking parties, painting groups and so on. Some of these activities were observed in both wards, and others in neither ward. No discussion groups were observed.

Less continuing emphasis on functional care was apparent in the control ward where patients were less physically dependent. Hospital aids spending short periods in the experimental ward following duty in the control ward tended to implement recreational activities as in the latter.

Nurse Attitude

In response to the open letter to experimental ward nurses before the study (refer Appendix A) two nurses emerged as showing interest in conducting an activation group. However, both were transferred to other wards before the group sessions commenced. Suitable background readings for nurses interested in assisting with the group were obtained and given to the Charge nurse. Those included: Yalom 1968, Scott (1975) and extracts from Marram (1973)and Aguilera (1977). No enquiries for further literature, or feedback about literature given, occurred.

In both wards registered nurses were usually more able than unregistered nurses to sustain a conversation with patients, including the mentally retarded or more inarticulate. The nurses' level of training may be a factor in determining interaction, plus status and position occupied in the ward (Altschul, 1972). It has often appeared to the author that long-stay patients will approach the registered nurse level rather than below, when knowledge of procedures or events are required.

An effect of Kyes (1969) personalised approach to patient care programme was the Head nurse's reported comment that a change of attitude ensued among the personnel, and that the nurses learned they could not ask the patients to change before they themselves were willing to change ways and attitudes towards patients. Such comment highlights the inter-relatedness of nurse attitude and patient behaviour.

Patient Factors

Patient Behaviour

In general, patterns of behaviour for individual patients could be discerned such as sitting together, getting lights for cigarettes, having messages done at the canteen and passing the odd comment. In the experimental ward three to five patients spent much time in the adjoining sunroom. In the control ward some patients remained constantly in the dayroom, others walked in and out at frequent intervals, and others gathered before and following the midday meal (that is, when not employed in occupations or pastimes away from the ward). Several control ward patients idled away the day in the occupational therapy room. The seating patterns of patients in both wards was reasonably constant. Watchful patients ensured that certain seats were kept for a particular person and demurred strongly if an outsider seemed likely to settle himself in that territory.

Some patients assumed particular roles in the dayroom. In the experimental ward's dayroom both D and a companion acted as unofficial watchdogs and were responsible for the patient instruction items recorded. These two patients, among others in each ward, would contact a nurse if a patient required care escaping nurse attention. Other patients undertook small tasks such as rolling the daily ward supply of cigarettes, turning on television at the appropriate time, emptying ashtrays, and so on.

Patient Behaviour and Attention

According to Altschul (1972) the behaviour of the patient rather than his diagnosis may be the deciding factor as regards the amount of attention he gains from individual nurses. F often approached the nurses for a cigarette and could not be ignored as his approaches were both persistent and consistent. Another patient, very unsteady on his feet was closely observed by nurses if walking about. One restless patient had many comments about his restlessness passed to him.

Tudor (1952) is cited by Altschul (1972) for indicating that an order of priority for attracting attention exists, and those who function just adequately attract least attention. This would explain how A and G remained aloof in the dayroom. Some nurses appeared to interact with particular patients for purposes of social interaction. Hence some aids tended to interact with patients who either played

cards, indoor bowls or could be organised into painting groups.

For the purposes of this study diagnoses of patients were not considered essential information, as emphasis was on observation of interaction and purposeful activity. Manifestations of some conditions did preclude some patients from group selection, for example, too psychotic or too paranoid. Altschul (1972) reported that patients with organic mental disorders had, and obtained a much higher percentage of interactions and interaction time than would have been warranted by their numbers if all patients had received equal share.

Organisation Factors

The Roster System

Nursing staff were divided into three shifts and worked a roster of four days on duty, and two days off. Changes of nursing personnel therefore occurred every two days, even where nurses were employed consistently in one ward. When the Charge nurse and Staff nurse of the experimental ward suggested Tuesdays and Fridays at 1.30 p.m. as an appropriate time for an activation group this precluded continuity of leadership or co-leadership by a ward nurse. This difficulty had been overcome in the pilot group by leader and co-leader conducting the group on the first and fourth days of their identical shift.

The Oakley Hospital Inquiry Report (1971) contained a special section related to the shift and roster system as applicable to nursing staff in psychiatric hospitals, with reference to voluntary overtime. It stated that a "refuelling time" seemed indicated where working hours exceed eight daily. Nurses observed in the study were undertaking voluntary overtime, and often exceeded eight hours duty daily.

Changes of ward leadership no doubt influenced the behaviour of patients, nurses and therefore nurse and patient interaction. In the control ward staff nurses who consistently worked in the ward maintained continuity of leadership during the leave period of the Charge nurse in the second period of observation. In the experimental ward a change of Charge nurse occurred before the second period of observation. This Charge nurse was also relieved, when on leave in the third period of observation, by nurses who consistently worked in the ward.

The Patient's Day

A similar routine was followed in each ward but with modifications for structural differences and the different physical dependence level of the patients. Several activity times were individual to each ward. In the control ward particular times were regarded as activation periods, over and above activation as an ongoing therapy by individual nurses. In the experimental ward Thursday afternoon was the ward's usual day for a bus drive for approximately 30 patients. This activity happened on the three random days of Type II observation, and not during the Type I observation periods.

Non-nursing Staff Factors

An occupational therapy aid was employed in the control ward in the mornings only. During the periods of Type I observation the aid's involvement with patients changed. In the first period of observation she undertook activities in the dayroom and the occupational therapy room; in the second period more time was spent in the occupational therapy room, and in the third period she was on leave.

It is possible that the changing behavioural pattern of the occupational therapy aid affected the increase in episodes of interaction initiated in the dayroom during the third period of observation (refer Appendix J, Table F). More patients may have patronised the dayroom when there were less activities being undertaken in the occupational therapy room. On the other hand, some patients may have utilised the occupational therapy room for a quiet forty winks. Speculation as to the effect of the aid's withdrawal on the level of patient activity cannot be omitted from discussion, although nurse and patient interaction is the focus of the study.

In both the control and experimental wards a physiotherapy aid daily exercised patients with a catch-and-throw ball session. Certain patients, especially the several mentally subnormal of the experimental ward, enjoyed this interlude. Nurses frequently undertook such exercises with the experimental ward patients, and supplemented the time spent by the aid at this activity. Patients with particular physiotherapy needs received individual attention.

The majority of domestics noticed during observation periods appeared to enjoy speaking with selected patients and the latter generally responded to this interest. In the experimental ward certain regular domestic staff undertook extra duties for selected patients by performing required canteen purchases and so on. Interactions related to such purchases were among the longer conversations such patients had during the day.

Patterns of Interaction

Duration of Interactions

Length of durations in both wards were brief (more than 50% under 10 secs.) unless patients and nurses were engaged in activities such as pool, cards and housie. These longer periods of interaction were interspersed with relatively brief comments related to the activity in progress. Where patients held conversations with other patients, these appeared as superficial and of short duration. Where such conversations were more sustained obvious intervals between comments was evident. The art of sustained conversation was seldom noticed apart from a few more alert patients, such as K, in the experimental ward.

Brevity of patient interactions in the psychiatric field have been noted. Moores and Grant (1976) cited Behymer (1953), and Kandler and co-workers (1952), as revealing "not only that staff-patient interactions tend to be of short duration (generally less than a minute) but there also appeared to be a diminishing returns effect operating in that nursing personnel interacted relatively more with each other and less with patients when the ward staffing complement exceeded five" (p.70).

A tendency for hospital aids to interact occurred in the experimental ward when their numbers rose to three or more. Of the nurse-nurse interactions observed conversations were more chatty and sustained. The above generalisations cannot be substantiated from the data.

Estimates of duration of interactions were made during observation periods. Number of interactions assessed for the 12 days of observation in the control ward were 630 and in the experimental ward 1,057.

For the approximate duration of the interactions refer Table XXI. As shaving was usually the longest nursing attention given to patients in the dayroom, and times for this activity ranged to approximately 4 minutes, those interactions of longer length can be assumed to indicate an ongoing social activity.

TABLE XXI

Percentage of Interactions of Various Durations in the Experimental and Control Wards

Ward	Approximate length in seconds							
	< 10	11-20	20-30	31-60	60-120	120-180	180-240	>240
Experimental	54.21	18.07	7.66	9.55	4.26	2.37	.95	2.93
Control	55.71	15.07	3.8	8.25	4.28	1.43	.63	10.83

N.B. Duration of interactions was assessed, not accurately timed

Number of Patients Included in Interactions

Altschul (1972), in undertaking a major study in an Edinburgh hospital, found that only 58% of the 113 patients included received any interactions at all during the periods of observation. She reported that in each of four wards some patients and nurses had higher interaction rates than others, and some nurses and patients were not seen to interact at all. In this study few nurses entered the dayroom, even briefly, without interacting with at least one patient. Numbers of patients and nurses in the two dayrooms of the study constantly fluctuated. The lowest interaction scores of patients frequently in the experimental ward dayroom were recorded as A with .28%, and G with .49% of total interactions and 23 other patients under 2.47%. In the control ward 20 patients interacted less than 2.53% of the total percentage of dayroom interactions.

Opportunities for Interaction

Nurses in both wards initiated interaction for purposes of hygiene, grooming, meal service, between meal snacks, issue of sweets and cigarettes, clinical attention, maintaining safety of patients (for example, for those unsteady on feet), organising patients for activities such as walking parties (especially in the control ward), and occupational pursuits such as playing cards, ludo, draughts, housie and so on. Patients appeared to initiate interaction most frequently for servicing needs such as requesting a cigarette or light for same.

In the experimental ward the time of least patient interaction occurred between 1.30 p.m. and 2.30 p.m. The patients tended to doze or look in the direction of the television set. In the control ward nurse-patient organised activities frequently occurred in the early afternoon. In both wards nursing interventions for purposes of functional or supervisory routines appeared to provide most opportunity for many patients to interact with a nurse.

CHAPTER 11

DISCUSSION

Further discussion of results is undertaken in this chapter relating to methods and instruments used for analysis of data, findings from use of instruments regarding the hypotheses, and comment on conduct of the group. As social withdrawal is a concept common to the first three hypotheses evidence from the results relates but not equally, to all three.

Analysis of Data

The differences of measurement from the NPIS and the PAS for purposes of this study are assumed to reflect degrees of social withdrawal. The NPIS enabled data collection on the initiation and nature of interactions, and the PAS on degrees of purposeful activity. Testing for reliability and validity of the observation schedules as adapted and used for measuring purposes is recommended for future study. The schedules were found appropriate for observation of no more than 14 patients in an admission ward. In the experimental and control ward dayrooms where maximum patient numbers were 40 and 28 respectively, and nurse numbers approximately one to three the pace of activity was less high. This enabled competent completion of the schedules by the researcher. There were few instances of several interactions occurring simultaneously.

Mention has been made of the order of priority for noting the initiation of interactions as nurse-patient, patient-nurse and thirdly, patient-patient. The total number of nurse-patient interactions is lower than actually occurred as ongoing conversations are included as one episode only, and not the sequence of interactions within a conversation. The author suggests that use of the schedules by a person who had pre-knowledge of patient and staff names, enabled their use with a greater number of persons. Patients and nurses accepted the author's role of observer in that few efforts were made to seek her attention in the dayroom setting.

To standardise the frequency of observations in different categories following use of the observation schedules, percentages were calculated. Blalock (1962) recommended that a percentage never be computed where the number of cases on which the percentage is based is less than 50 but this condition occurred in all but Tables A and B (refer Appendix K). To combine the smaller categories would have misrepresented the results. For example, to combine the smaller verbal categories would have detracted from the profile of verbal categories observed.

The conditions for use of chi square with data from the observation schedules used appear to be met, with one possible exception. The assumption of independent observations being met is dubious for a single period of observation but equally dubious between all periods of observation for one ward so that, overall, assumptions may not be invalidated.

For example, on the first day of recorded observations in the experimental ward, one hospital aid initiated 49 interactions, that is, 24 more than any other nurse during the study. Of the 49 interactions initiated 27 were instructional. The frequency of nurse to patient initiated interaction for the three periods of observation in the experimental ward ranged 220-210-199 although showing as 70.52%, 53.85% and 56.06% respectively. Thus the above mentioned aid's tally of interactions did not greatly affect the range of interactions initiated by nurses during a four-day period of observation, but the behaviour pattern of any one nurse or patient could have influenced the trend of results. This particular aid had expressed interest in organising recreational activities in the dayroom but difficulty "because something always happens".

The data collected during the periods of observation in the control ward does not appear to be influenced by the behaviour of particular nurses or patients, except that certain patients tended to stay in the dayroom constantly and others intermittently. Behaviour of patients in both dayrooms is fairly stable and the following of routines by individuals is discernible.

All patients in the control ward had been transferred from another ward immediately prior to the study. Ward staff reported that patients had adapted quickly to the change of environment, and "not like those who were transferred from here". It therefore appears that the change of environment had little effect on the overall trend of results.

This study focused on the patient to reveal insights into nursing practice of elderly patients. In connection with her graduate studies in the U.S.A. Altschul (1972) observed that ward staff were at times unaware of the patient's disturbance, and the departure of a student who had been working with the patient. On occasion students, reported disturbances in their patients not observed by ward staff. Similar mechanisms may have been operating during this study in that staff members did not report any changes in patient behaviour which could be attributable to group membership. The poor feedback from nursing personnel was not entirely unexpected as nurses typically become engrossed in their usual routines and priorities of care, but act as co-ordinators of patient care where such care is of a multi-disciplinary nature.

The Special Report Series, No.46 (1976) stated that in those hospitals where activity programmes are conducted for maintenance of physical fitness and morale the majority are run by physical therapists, that is, occupational therapists or physiotherapists, or both, and that "coverage and quality of programmes is patchy". During the period of this study nurses appeared to take the responsibility for activating those patients unable to attend an occupational therapy area or department. Much activation of patients by individual nurses was apparent in both wards within the limits of staffing constraints and other nursing duties.

There exists a large potential number of interactions where a room contains 30 or more individuals. That as many patient to patient interactions were recorded where the focus was primarily on nurse to patient, and patient to nurse interaction is indicative of comparatively low interactional rates, between nurses and patients. However, nurses were frequently engaged in ongoing interactions assessed as one episode.

Comment on Group Findings

The group leader, in common with Ebersole (1976), found it difficult to stimulate group members, while maintaining safety and control factors for group members. To ease the leader's load a constant assistant is desirable. Changes of assistant appear to affect the flow of group process even where assistants are known by the group members. With each change of co-leader the session initially focused upon inclusion problems (Schutz, 1966).

A contract with group members was undertaken at the commencement of the group as recommended by Burnside (1976). This occurred automatically as the patients were informed about time, place, length, number and possible programme content at the first session. The selected subjects were told there was no compulsion to attend the sessions. It was found that having insight of the philosophy and history of the hospital aids in understanding patient description and interpretation of daily events (Burnside, 1976). Previous knowledge of some group members enables more time for observation and assessment of remaining group members at the group's commencement.

The use of props during group programmes provides some structure to a group, and lessens anxiety in both leader and group members as reported by Burnside (1976). Props may be selected for varying reasons such as giving pleasure through playing of records or increasing verbal interaction through focusing discussion on a particular picture or object. Use of pictures from magazines was only moderately successful in promoting a talking point for discussion as a number of subjects had poor vision. Other handicaps for promotion discussion are patients with lack of hearing and poor speech. Eleven group members is a maximum number for attempting improvement of participation of group members each session. When there are many patients with sensory defects the work of the leader is enhanced (Burnside, 1976).

Goals for groups with regressed patients need to be kept simple, as in this study, as changes occur slowly where group work with the aged is concerned (Ebersole, 1976). Although many varieties of groups can be conducted with elderly persons the group process and pace will depend not only on the physical and mental abilities of the selected

persons, but also on the leadership style. Through analysis of group content an indication of verbal participation by group subjects and co-leaders each session can be obtained. However, analysis of verbal statements is more indicative of quantity than quality of contribution by group members.

The group leader found it necessary to assume responsibility for performing group task and maintenance functions. One form of approach included the asking of questions to obtain a direct response from the less participant group subjects. This tactic may have been overused but some patients became most involved when leader and co-leader acted as directive agents during conduct of quiz and other activities. Conversational abilities were limited, thought processes slow, but spans of concentration were gradually increasing as group sessions progressed.

Burnside (1976) recognised that any group work with the regressed aged can be considered as a remotivation or reality orientation group, but that these are components only of such group work, and neglect the study of human behaviour required to respond and alter one's behaviour if required. This study did incorporate some features of reality-orientation groups, such as constant repetition of patient's name, but was not conducted entirely within the approach.

As the majority of group subjects had acquaintance with the group leader some years previously a nurse-patient relationship had already been established. It has been said that the socialisation of patients in long-stay wards tends to have the majority conforming to the type of behaviour which appears to be expected of them (Filer and O'Connell, 1964). Schutz (1966) theoretical framework permitted adequate explanation of the group process. The theme of reciprocity of interaction occurred in both dayroom and group sessions. It seems logical that the basis for most, if not all, interactions is based between the poles of either wanting to withdraw from or engage with another, to be or not be in control of a situation, and to be loved (liked, appreciated) or not loved.

Rating Scale Results

No significant difference (Wilcoxon matched-pairs signed-ranks test) occurs for the before and after group scores of the selected group patients using the Crichton Geriatric Behavioural Rating Scale. It has been shown that the physical and mental health of patients affected ratings, and that the scores of group subjects varied for the before and after group measurements. Use of a scale which required the rater to have knowledge about usual patient behaviour limited the number of raters through variables such as non-continuity of staffing. It is unfortunate that the number of raters was less than originally suggested. Criticism of the reliability and validity of the scale may be made as reference to these features was elusive in the literature. Further testing of this scale for reliability and validity is recommended.

A gradual improvement of score for a majority of group members is apparent from using the evaluation rating scale by Gibson (1967). This instrument is also suspect regarding reliability and validity. Modification for use as a scale appears necessary from the study. For instance, when one patient appeared well groomed so did the others, and this no doubt reflected the quality of patient care. Brackets of items difficult to rate on occasion are: easy to understand, could sometimes be understood, and difficult to understand; and ideas were relevant, sometimes off the track, and could not follow the discussion. The first bracket requires an item for the individual who makes no verbal contribution, and the latter may be improved with items such as "ideas are mainly relevant", and "often off the track".

An indication of the range of scales available for assessing individual behaviour in the older age group has been given. The Crichton Geriatric Behavioural Rating Scale was selected because it could be completed by ward nursing staff, is comprehensive and yet not overly time consuming. The evaluation scale used for group performance (Gibson,1967) was selected as it had been used for group work by the author with a similar type population. For this study ratings were made after each session, although recommended following the first, sixth and twelfth meetings.

NPIS and PAS Results

Results from use of the NPIS and PAS reflect social withdrawal as defined for this study. Each ward shows results indicative of events occurring within it and over time. Thus increased patient to patient interaction coincided with times in the control ward when the wall cigarette lighter was not functioning. Results showed differing levels of social withdrawal during the study which were affected by variations in nurse and patient interaction.

In the experimental ward there are significant differences ($p < .001$) for data collected between periods 1 and 2, that is, the periods of observation before and following the introduction of programmed recreation in the form of an activation group. The significant differences occurred from use of the PAS which show a trend for increase in purposeful rather than simple activity, and all aspects of interaction focused upon by the NPIS. These latter included initiation of interaction and the verbal and activity categories associated with the initiation of an interaction, The trend is for increase in participation by the patients. Between periods 1 and 3 significant differences ($p < .001$) are present for all but the activity categories associated with the interactions. For the two periods of observation following the group (that is, periods 2 and 3) there is a significant difference $p < .05$ for initiation of interactions and associated activity and $p < .01$ for verbal categories and the PAS data. This may indicate a trend for the equilibirium of interaction, which existed before the group, to be re-established in the dayroom following cessation of programmed recreation such as the activation group into an ongoing ward routine.

Between periods of observation there are less consistent patterns of significant differences for the data collected from the NPIS in the control than experimental ward. There are significant differences for the initiator of interactions between periods 1 and 3 ($p < .01$); verbal categories between periods 1 and 3, and 2 and 3 ($p < .001$) and periods 1 and 2 ($p < .01$) and patient activity between periods 1 and 3 ($p < .001$) and 2 and 3 ($p < .01$). Analysis of PAS data show significant differences between the periods of observation which correspond to those of the experimental ward. A trend for significant differences

occurring between periods 1 and 3 appear consistent in the absence of any change of routine such as introduction of an activation group. Possible reasons for the differences between the first and third periods of observation include changes as patients established routines after a change of ward, a change of several nursing personnel during the third period of observation, the absence of the occupational therapy aid during the third period of observation and the eventual non-functioning cigarette wall lighter. This latter condition accounts for increases in initiating interaction and in verbal comment by patients to others to get cigarettes lit.

The lesser percentage of functional items in the activity category for the control than experimental ward patients is indicative of a lower physical dependency level of the patients. Of the activity items the percentage distribution of social items exceeds the functional in both wards. In neither ward is the activation of patients confined to the dayroom, but less so in the control ward where there is a daily walking party on fine mornings, frequent games of bowls in a hallway, and weekday activities in the occupational therapy room. Refreshments are served in the experimental but not control ward dayrooms and result in many nurse-patient interactions (for example, giving out cups of tea). This procedure increases the functional activity level in the experimental ward. Thus differing structural design of wards, different conduct of a nursing routine and the physical dependence of patients affected the trend of results in and between the wards.

There are significant differences between the experimental and control ward totals for the three periods of observation using the NPIS for the categories of initiator of an interaction, and associated verbal and patient activity ($p < .001$). There is no significant difference between the wards from use of the PAS for determining the degree of purposeful and simple activity. Although the control ward patients had a lower mean age, those remaining in the dayroom were the least voluntarily active, and therefore those with activity levels most closely resembling those of the experimental ward patients.

Hypotheses

This study shows that the degree of social withdrawal of elderly patients in both wards varies over time. These variations in social withdrawal are linked with variations in nurse and patient interaction. The evidence which supports the first hypothesis also

supports the second. The evidence supports the third hypothesis that increased opportunity for interaction for a section of the patient population of a ward in an activation group results in an overall increase of interaction in that ward among patients in a selected setting. With reference to the third hypothesis it can be concluded that the activation group affected the overall level of social withdrawal in the experimental ward. However, as the group and the observations were conducted in an uncontrolled setting it appears prudent to conclude that the third hypothesis is definitely partially, if not fully supported. Variables identified such as change of ward leadership, changing physical and psychological dependencies of patients, as well as changing staff in the experimental ward, may have contributed to the observed changes.

The fourth hypothesis is partially supported. That is, that participation in a planned group activity will result in measurable changes in a variety of behaviours identified on selected rating scales. Evidence and discussion related to this hypothesis has been presented in Chapter 8.

CHAPTER 12

A SYSTEMS MODEL PERSPECTIVE OF NURSING

Throughout the study a discernible underlying theme is that of reciprocity, of giving more or less of self. For this reason the FIRO theory of Schutz (1966) has been appropriate for analysis of the activation group process. This is but one of many theories from the natural, physical, and behavioural sciences which is relevant to the practice of nursing. A growing number of nurses have also attempted development of theories to help professional nurses and nursing (Orlando, 1972). A comprehensive or umbrella type model within which other models or theories may be incorporated appears to have certain merit.

Use of a theoretical approach such as systems theory which is applicable to any structure and its component parts, be they biological or organisational and at macro, mezzo or micro level (Braden and Herban, 1976) appears particularly useful for nursing. King (1971) proposed a systems model with an interactional component. Her selection of broad concepts appears to set boundaries for application of the model. A systems model which functions more flexibly in relation to an environment is seen as preferable.

From social behaviour the disengagement, symbolic and implicit theories are among those proposed to explain the adaptive mechanisms of some aging persons to the developmental tasks of aging. For example where an individual tends to be reticent and reclusive throughout life, it is probable, but not certain, that his habit of withdrawal will become more habitual with advancing years. Thus disengagement theory will aptly describe his presentation in old age, but not simply as a response to aging. For others the implicit theory of aging may be more appropriate due to inherent need for activity or desire to be creative. These theories appear tailor-made for some personality types and preferred life styles.

Following an exploration of the activity theory of aging Lemon, Bengston, and Peterson (1972) found the model insufficient for capturing the complex interplay that occurs between the individual and his changing social system. A model employing systems theory is proposed as more realistic (Lemon et al., 1972). In such a model the emphasis is not seen as on linear relationships, but as permitting construction of a paradigm "reflective of the cyclical qualities implied in feedback loops" (Lemon et al., 1972, p.60). This enables presentation of the complex

interplay which occurs between a person and the environment, and an individual's set of experiences and expectations.

The use of a systems model for examining the nursing of the elderly in institutions, particularly with reference to social withdrawal and the process of aging, seems more realistic than the implicit or disengagement theories. The concepts from systems theory are relevant for presenting the process of aging and personal adjustments to the process. For a flow chart of system concepts of input, process, output, control and feedback applied to the process of aging refer to Figure 12.1.

The process of aging is affected by inputs such as heredity, nutrition and environmental features, and the quality of these affects the output, seen by the author as ongoing aging. Control features of the social process are seen as bio-psycho-social mechanisms. Elderly persons are essentially counterparts of their more youthful selves. Throughout life humans constantly interact with others in a variety of situational contexts, and rarely lead lives devoid of relationships with others. Interrelationships are conducted in both one-to-one and group settings. For maintenance of a satisfactory life style such interrelationships are usually a necessary mechanism for survival. An individual presumably reacts to the cues he does/does not receive from others within his frame of reference. Such cues (as well as his intuitions, premonitions etc.) will affect his/her actions and reactions, and can be equated with the feedback mechanism of the systems approach.

Interactional Component of the Model

To interact is to "act reciprocally, act on each other" and interaction "reciprocal action: action or influence of persons or things on each other" (Oxford dictionary). Relationships are defined as a state of being mutually or reciprocally interested (Brown and Fowler, 1972) and the process of relationships "implies the interaction of two or more persons or things in which changes continuously occur" (p.113). Nurse-patient interaction is not identical with nurse-patient relationship, but a relationship may emerge from a series of interactions.

For purposes of the model which the author is presenting each individual is viewed as an entity with an internal energy system, and an outer membrane or covering which may be more or less permeable depending on the degree of receptivity of the individual to events occurring within and about him. The membrane or covering is viewed in the system's sense of areas of influence, rather than as boundaries in the sense of walls.

Inputs to the entity are seen as nutritional and sensory (for example, visual, auditory, and tactile). The internal body systems for example, cardiovascular, skeletal, nervous system, and so on perform the usually accepted anatomical and physiological functions. The outputs are the normally accepted activities resulting from physiological functioning such as speech, listening, elimination of body wastes, etcetera.

Thus the central area is that of the normal body mechanism of all humans. The outer permeable shell pervades the body system network so that influences from within and without may or may not be responded to readily (Figure 12.2). An energy field is seen, as pervading the entire body system. Rogers (1971) has stated that an energy field is the fundamental unit of the living system, and protrays the dynamic nature of life.

Depending on the state of the individual the outer membrane may be more or less receptive to social engagement or disengagement as well as to physiological stimuli (refer Figure 12.3). Where the outer membrane is impermeable the individual is unaware of attempts to interact with him by others, either verbally or non-verbally. However an over-stimulated person would possess an extremely permeable membrane as regards imagined or actual, verbal and non-verbal cues from others.

Patient and nurse interrelate at certain points in time for specific reasons, and do not function within terms of equal degrees of self-disclosure. Degrees of self-disclosure are affected by variables such as state of consciousness, disinterest and self-preoccupation. Thus in a dyadic relationship two self-energised persons reciprocate to a greater or less extent in establishing, maintaining or ignoring the possibility of interaction. Thus in the group, patient A chose to be on the periphery, and finally, to the extent of leaving the dayroom when the group leader arrived.

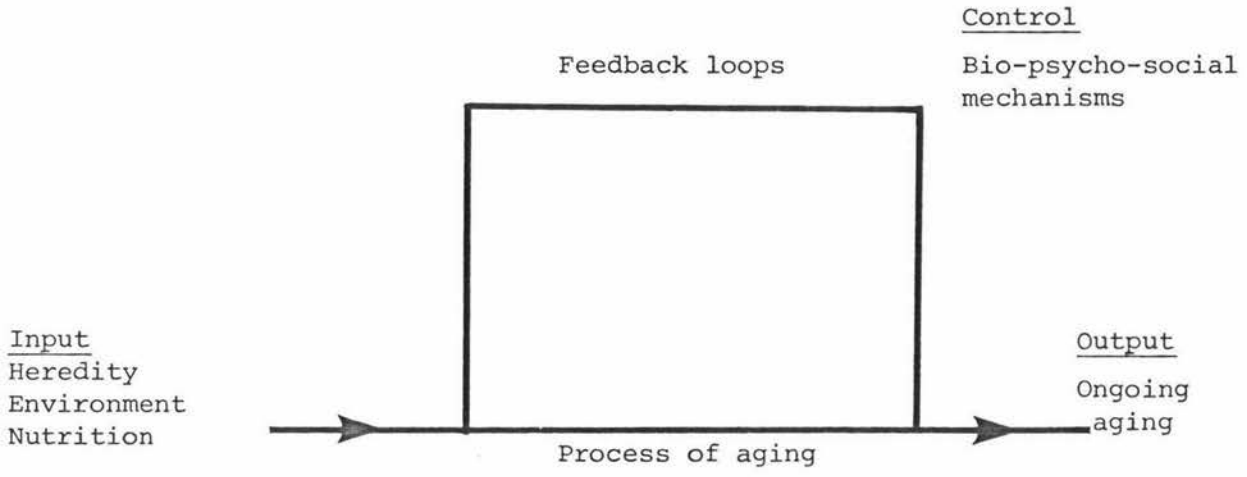

Figure 12.1. The process of aging

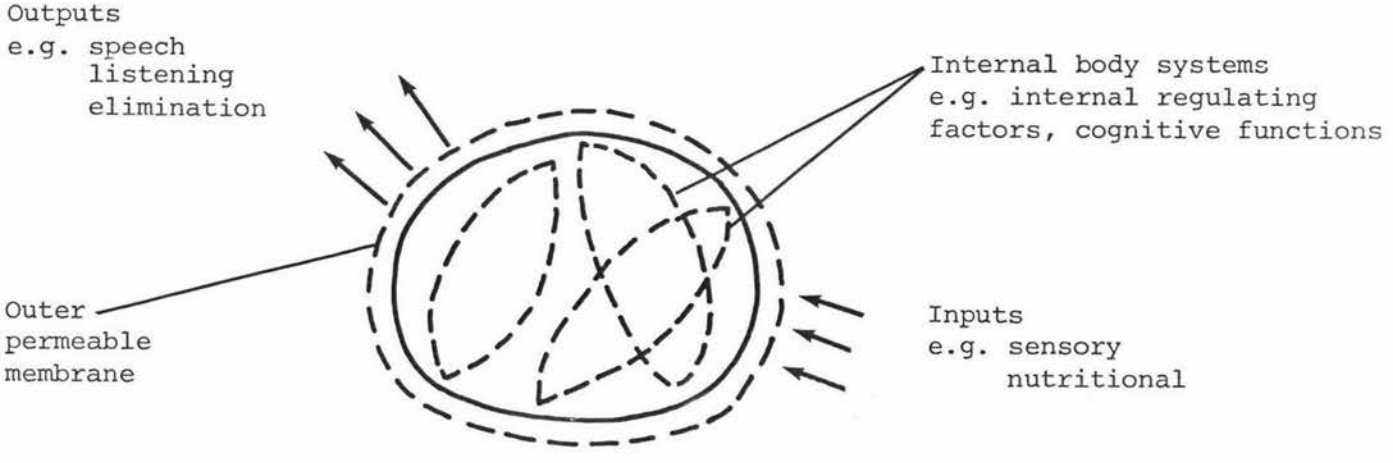

Figure 12.2. Core of the model

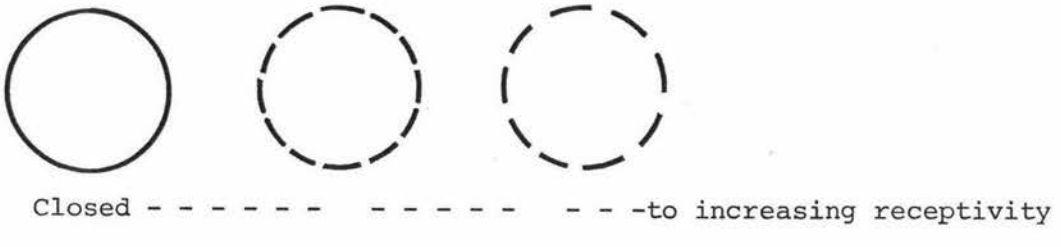

Figure 12.3. State of responsiveness of outer permeable membrane to external stimuli

One of the hypotheses of Altschul's (1972) investigation of nurse and patient dyadic interactions was that in the formation of a relationship there is reciprocity - that nurse and patient both perceive themselves to have a relationship with the other. However, not disputing that interactions lead to relationships (which may be therapeutic) reciprocity appears as a component of any interaction attempts as well as accomplished interactions, that is, the wish to communicate is present in one if not two persons. Communication theory (Ruesch, 1959), incorporating verbal and non-verbal communication components, may therefore be seen as an inevitable component or accompaniment of the interactional process. The concept of feedback is vital to system theory analysis. An interactional component within a systems model framework could be effectively applied in many nursing situations. The exact form of the interactional component is not as yet defined but could be adopted or adapted from the cycle of action, reaction, interaction and transaction, described by King (1971), or action and reaction by Orlando, (1972). This would enable emphasis on the reciprocity of action, a component of interaction which may lead to the development of a relationship or to mutual withdrawal.

It is not adequate to consider the elderly in institutions merely from the viewpoints of disengagement or activity theory. A more composite model is required which includes focus on the nature of interactions, attitudes and environmental settings. The interrelationships of biological and psychosocial factors, as occur in the process of aging, can be assimilated within a systems framework. Inputs toward activation of patients, or decrease of apathy and social withdrawal in institutionalised patients, are the activities of the nurse directed toward involvement of the patient with reality through processes such as communication (which enable interactions to occur). Cycles of dependency, detachment and apathy may or may not be recreated and/or reinforced. Thus the interactional process could be described by systems concepts rather than by terms as used by King (1971) and Orlando (1972) if so desired.

The FIRO theory of Schutz (1966) is appropriate, as in this study, for describing group process in dimensions of inclusion, control, and affection. But for analysis of other processes, such as the process of aging, a systems model is more appropriate than perspectives

such as disengagement or activity theory which describe the process of aging for some persons and not others. Use of a systems model does not exclude discussion of environmental nor personality variables, nor the interrelatedness of biological and psychosocial funtioning as apparent in this study.

It is proposed that an interactional framework be incorporated within a system framework (as did King, 1971) to more fully explain the sequences of interaction which occur as a part of, and during, nursing practice. Such a framework would enable emphasis on the reciprocity of action, a component of interaction which may lead to the development of a relationship or to mutual withdrawal between nurses and elderly patients in long-stay wards.

CHAPTER 13

SUMMARY AND IMPLICATIONS FOR NURSING

Evidence suggests that signs of social disengagement, apathy and restlessness are common characteristics of many elderly in institutions. Long-stay patients of all ages tend to become dependent as part of the patient socialisation process.

Aging is an inevitable, natural and developmental process. Theories of the aging process abound and continue to be developed from different disciplinary perspectives. Gerontology is emerging as a recognised and respectable field of study. Many manifestations associated with aging have been found to reflect medical illness, personality variables, and socio-cultural effects (Butler, 1963).

As aging is a dynamic process the possibility of change (as arrest or reversal) in combating psycho-social conditions, such as social withdrawal, in institutional settings appears probable. A number of studies using differing therapeutic approaches have been cited which had improvement or investigation of the quality of life for the aging patient as a common theme. Undertaking programmes in group form for elderly patients requires adaptations for features of the aging process which will affect participation in groups, such as deafness.

In this study programmed recreation in the form of an activation group is utilised as the medium both for demonstrating the presence of social withdrawal and as the medium for producing change. The term activation group is selected as New Zealand nurses tend to talk about activating rather than socialising or resocialising patients. The presence of varying levels of social withdrawal is illustrated in the dayroom settings of two long-stay psychiatric wards where patients had a mean age of 65.6 years and above. The instruments adapted for the study are assumed to measure degrees of social withdrawal and may do so in other settings than this study, with or without further development or refinement. The number of patients who may be accurately observed

simultaneously will vary depending on the degree of activity in the setting. Further testing for the reliability and validity of the NPIS, PAS,and the rating scales appears indicated.

Of the four hypotheses of the study it is shown that for long-stay elderly patients in two psychiatric wards, the degree of social withdrawal of the patients in a dayroom setting varies over time; variations in social withdrawal of patients in a dayroom setting are linked with nurse-patient interaction,and increased opportunity for interaction for a section of the patient population of a ward in an activation group results in an overall increase of interaction among patients in a selected setting in that ward. As other variables are identifiable as affecting more or less interaction in the dayroom setting (for example, effect of a non-functioning wall cigarette lighter in the control ward) it cannot be assertively concluded that the activation group was solely responsible for the fluctuating levels of social withdrawal in the experimental ward. For this reason the third hypothesis is viewed as partially supported. The hypothesis that participation is a continuing planned group programme will result in measurable changes in a variety of behaviours identified on selected rating scales for the participants is partially supported in that neasurable changes did occur, although not identifiable as significant differences.

As the study was undertaken in a natural setting the following conditions may have affected the trend of results: transfer of the control ward patients from one ward to another shortly before observations were commenced; change of Charge nurse in the experimental ward; no controls over nurse staffing levels or category of nurses in the dayroom; and fluctuating numbers of patients and nurses in the dayroom throughout each and every day of observation.

Leadership of the activation group was assumed by the author because organisational features such as shift changes, possibility of ward changes and the roster system did not permit continuity of leadership by nurses in the experimental ward had any so desired. Thus variables in the implementation and conduct of an activation group for elderly patients aging in an institutional setting are able to be identified through conduct of a group in a long-stay psychiatric ward.

Other variables include the availability of leaders for the group, available facilities and interest by other staff members and appropriate patients to enable attainment of the objectives of any particular group. To identify all the barriers which prevent more such groups being conducted by nurses, other exploratory studies in different settings are required.

An underlying theme of reciprocity, of giving more or less of self, is discernible throughout discussion about group members. Schutz's theory (1966) is therefore appropriate for analysis of group process as used in this study. Indeed this theory appears useful for the description of elderly persons in any setting of two or more. The areas of inclusion, control and affection reflect mechanisms inherent in social reciprocity or withdrawal. The varying levels of contribution made by group members are indicative of differing levels of response as members desired more or less control, inclusion, or affection in the group setting. The FIRO theory is comparatively simple, yet comprehensive for beginners and established practitioners wishing to analyse the process of a group.

Following presentation and consideration of theories such as the disengagement and activity theory the systems theory is advocated as an appropriate framework for nursing practice of the elderly. Inputs towards decrease of social withdrawal are the activities of the nurse toward involvement of the patient with reality through communication, rather than recreating and/or reinforcing cycles of dependency and thus withdrawal, detachment and apathy.

It is proposed that an interactional component be incorporated within a system framework to explain the sequences of interaction which occur as a part of, and during, nursing practice. For example, the interactional component of action, reaction, interaction, and transaction, could be adapted or adopted from the nursing model of King (1971), or that of action and reaction from Orlando (1972). This would enable emphasis on the reciprocity of action, a component of interaction which may lead to the development of a relationship or to mutual withdrawal. Throughout the study the interrelatedness of biological and psychosocial functioning has been suggested, and is

implicit in the proposed model for nursing care of the elderly. Hence the usefulness of the systems model as a conceptual framework.

Avenues for further exploration include: replication of this, or similar type study in long-stay wards of elderly patients in any institutional setting, more controlled studies of elements of the study such as the observation schedules for collecting data on interaction, and the behavioural rating scales; more studies on methodology of group work with the institutionalised aged, and further development and refinement of the proposed model for nursing practice in connection with gerontological nursing or other specialty areas.

Replication of the activation group, or similar, by nurses would appear a worthwhile adjunct to current nursing practice in many New Zealand geriatric settings. Twelve sessions is a minimal period for attainment of measurable change in patient behaviour, but within the group of the study a freeing of restraints regarding maintenance of conversation was occurring. The use of groups enables one or two nurses to initiate more interaction for more patients at one time than interacting with persons on an individual basis. However, there are requirements before commencing a group such as an appropriate setting, interested staff members, continuity of staffing on group session days, access to appropriate materials and money for treats or excursions, time for preparation of materials and the venue,and so on.

Appropriate selection of group members for the type of group, for example, socialisation or rehabilitation is vital for the achievement of objectives. Disabilities from the aging process, such as deafness, need not exclude membership from groups if due recognition of their presence and effect on participation is given. As nurses recognise that elderly patients need to be activated it is surprising that more activities are not undertaken in group settings.

Conduct of groups for elderly and long-stay patients provides nurses with an opportunity to concentrate on more than the physical care and general supervision of patients. Selection of patients to form a group has various pitfalls. Psychogeriatric patients do not necessarily maintain a stable level of functioning either mentally or physically, as happened in this study. These circumstances can alter

actual patient performance from the selector's expectation of probable performance, that is, suitability for group inclusion. Closer involvement with patients in a group setting can alter nurse perception of them as individuals and hence change expectations of their abilities.

Suggested basic steps for implementing a group include: reading material on the process of aging and on types of groups, including their formation and conduct; choosing a leader and co-leader, or co-leaders, who may provide continuity of leadership; forming objectives suitable for group membership attainment; selecting appropriate number and mix of patients; determining a suitable venue, length and frequency of meetings; arranging a programme in accordance with the chosen type of group or therapeutic approach, and deciding on methods of evaluation of group member behaviour and attainment of group objectives.

As a participant observer the habitual actions of some patients assume new dimensions and aid understanding of their motivations. Throughout the sessions most institutionalised patients require open-ended statements or questions to enable them to make verbal response. Of those who made spontaneous contributions in this study these were mainly directed to the leader and co-leader. This possibly reflects the situation where few patients have meaningful conversations with one another apart from those initiated with an ulterior motive such as acquisition of more tobacco or cigarettes.

In this study the programme was not rigidly structured so that any topics introduced by patient members could be discussed. Patients' thought processes were slow and dulled, and therefore responses delayed. Topics involving earlier phases of subjects' lives were productive of discussion in the pilot study, but less so in the main study. As engaging in conversation was a lost art for many group members and concentration spans were limited, the level of discussion needed to be simple, the pace slow, the atmosphere non-threatening, and the allotted time-period less than an hour. The use of props, and the use of simple activities such as playing quoits, making paper darts, throwing beanbags, and so on were useful adjuncts to enable participation by the less vocal. As the sessions progressed concentration spans were slowly increasing.

Throughout the group sessions a non-threatening, low-key atmosphere was striven for to encourage participation by group members. Findings from the pilot and main study show that immediate or dramatic improvements in patient behaviour do not occur from inclusion in a twelve week period of programmed recreation, or an activation group, but that an arrest or reversal in the process of social withdrawal can be initiated.

Only from awareness of their role in producing dependency and social withdrawal can nurses encourage independence in elderly patients. Methods for counteracting dependency and social withdrawal include the use of a variety of therapies and group techniques as described in the literature and in this study. Retention of independence by elderly patients should improve the quality of life for the individual concerned.

"Cast me not off in time of old age;
forsake me not when my strength faileth"

Psalm 71: 9.

LIST OF APPENDICES

Appendix		Page
A	Letter to Nurses of the Experimental Ward	131a
B	Patient Selection Form Instructions	132
C	Behavioural Rating Scale Instructions	133
D	Behavioural Rating Scale	134
E	Selection of Group Members	136
F	Activity Code List	137
G	Observation Schedule Nurse-Patient Interaction	139
H	Observation Schedule for Purposeful Activity	140
I	Evaluation Sheet	141
J	List of Tables	142

Appendix A

Letter to Nurses of the Experimental Ward

TO Nursing Staff

On Tuesdays and Fridays - between 1.45 p.m. and 2.30 p.m. - it is planned to hold a 'socialization' type programme for selected patients in your ward. By socialization programme may be understood a programme which promotes interaction,activity, and/or interest for those participating in it. An objective for the group will be encouraging the participants to talk to one another. However, it is not only a group for purposes of discussion and reminiscing, but also one in which activities such as playing cards, listening to music and so on, can be included.

Because of the intended size of the group it will be possible for only one member of the ward staff to attend any meeting of the group - but any nurse can attend more than one session and may act as leader or co-leader of the group. To act as co-leader will entail assisting the group leader with the group activity(ies) for the day.

If a nurse would like to act as leader for one or more sessions this can probably be arranged. In this instance I would prefer to know in advance the likely programme content for such a session(s). Any suggestions relating to possible activities for the group, or comments about the feasibility, practicality, usefulness, etc.of activity encouraging programmes for geriatric patients, would be appreciated. Such comments may be expressed in written or verbal form.

It is hoped that a number of nurses will participate in the programme. It is unlikely that such a low-key programme will produce much in the way of behavioural change of the group members. However, hopefully, it will produce an appreciated change of routine for some patients twice weekly, for the next six weeks.

Alison Bird

Patient Selection Form Instructions

1. List all ward patients

2. Chart the degree of alertness for all patients as follows:

   Very alert: oriented to time, place and identity
   will respond when spoken to and volunteer information

   Moderately alert: are orientated - will participate in conversation and activity when stimulated

   Withdrawn: - do not participate readily in conversation or activities

3. Complete the comment column related to apparent selection suitability e.g. too restless, frequently on leave, very paranoid.

   Supplement remarks with the following symbols:

   + Suitable for selection

   ? Considered seriously for selection

   o Possible selection at a later date

   * Presence of a physical or mental impairment which severely limits communication with others

4. Complete the initial behavioural rating score column for all ward patients using the behavioural rating scale.
   (It is suggested that there be at least 3 raters. The behavioural rating score is to be an average of the scores obtained by the raters).

5. Complete the final behavioural rating score column using the behavioural rating scale, following completion of the group sessions.
   (The same number of raters, including as many of the original raters as possible, should participate in the final rating. The final score is to be an average of the scores obtained by the raters).

Appendix C

BEHAVIOURAL RATING SCALE INSTRUCTIONS*

1. Select the item in each category which you consider to most accurately describe the patient you are rating.
2. Choose the item which describes the usual,or most frequently observed, pattern of behaviour of the patient.
3. Select items which describe the pattern of behaviour usually presented to ward nursing staff (rather than to relatives, doctors etc.)
4. Indicate the appropriate number for each category chosen.

Supplementary information

Mobility

In item 5 include wheelchair patients as chairfast patients.

Co-operation

Actively co-operative: patient acting of own accord; using action or energy to accomplish the required goal or purpose.

Passively co-operative: patient submissive; offers no resistance or opposition towards accomplishment of required goal or purpose.

Mood

Objective: how the patient's behaviour appears as viewed by the rater.
Subjective: how the patient appears to view himself/herself.

* as used with the Crichton Geriatric Behavioural Rating Scale for purposes of this study.

Appendix D

BEHAVIOURAL RATING SCALE

Score MOBILITY

1 Fully ambulant (including stairs)
2 Usually independent (not stairs)
3 Walks with supervision
4 Walks with artificial aids or under careful supervision
5 Bedfast or mainly so. Chairfast.

ORIENTATION

1 Complete
2 Orientated in ward and identifies persons correctly
3 Mis-identifies persons and surroundings but can find way about
4 Cannot find way to bed or to toilet without assistance
5 Lost

COMMUNICATION

1 Always clear and retains information
2 Can indicate needs. Can understand simple verbal directions. Can deal with simple information
3 Understands simple verbal and non-verbal information but does not indicate needs.
4 Cannot understand simple verbal or non-verbal information but retains some expressive ability
5 No effective contact

CO-OPERATION

1 Actively co-operative
2 Passively co-operative
3 Requires frequent encouragement and/or persuasion
4 Rejects assistance and shows some independent but poorly directed activity
5 Completely resistive or withdrawn

RESTLESSNESS

1 None
2 Intermittent
3 Persistent by day
4 Persistent by day with frequent nocturnal restlessness
5 Constant

DRESSING

1 Dresses correctly unaided
2 Dressing imperfect but adequate
3 Dressing adequate with minimum supervision
4 Dressing inadequate unless continually supervised
5 Unable to dress or retain clothing because of mental impairment

FEEDING

1 Feeds correctly unaided at appropriate times
2 Feeds adequately with minimum supervision
3 Does not feed adequately unless continually supervised
4 Defective feeding because of physical handicap or poor appetite
5 Unable to feed because of mental impairment

Score CONTINENCE

1 Fully continent
2 Nocturnal incontinence unless toileted. Occasional accidents (urine or faeces)
3 Continent by day if regularly toileted
4 Urinary incontinence in spite of regular toileting
5 Regularly/frequently doubly incontinent

SLEEP

1 Normal (hypnotic not required)
2 Requires occasional hypnotic: or occasionally restless
3 Sleeps well with regular hypnotic; or usually restless for a period every night
4 Occasionally disturbed in spite of regular standard hypnotic
5 Disturbed often with heavier sedation

MOOD - OBJECTIVE

1 Normal and stable affective response and appearance
2 Fair affective response; or not always appropriate or stable
3 Marked blunting or impairment of mood or inappropriateness of affect.
4 Retarded, lacks spontaneity but can respond
5 Hallucinations or nihilistic delusions of guilt or somatic dysfunction

MOOD - SUBJECTIVE

1 Well-being
2 Self-reproachful, listless dejected indecisive lacks interest (not completely well though no specific complaints)
3 Marked somabi or hypochondriacal concern. Preoccupied
4 Severe retardation or agitation; marked withdrawal though responds to questioning
5 Suicidal or death wishes. Mute: or agitated to the point of incoherence

from Robinson (1974).

Appendix E

SELECTION OF GROUP MEMBERS

Code No.	Degree of Alertness			Comment related to apparent selection suitability	Behavioural Rating Score	
	Very Alert	Moderately Alert	Withdrawn		Initial	Final

n comment column supplement remarks with the following code:

Suitable for selection
Considered seriously for selection
Possible selection at a later date
Presence of a physical or mental impairment which severely limits communication with others

ACTIVITY CODE LIST

Functional, (1) Activity related to patient's basic physical needs

10. Getting in or out of bed or chair; being put to bed or in a chair.
11. Going to toilet; being toileted.
12. Showering, washing, wiping nose, cleaning face, brushing teeth; being showered, etc.
13. Dressing or undressing, including all parts of either process; being dressed etc.
14. Eating or preparing for meals, e.g. sitting at table, putting on apron; or being prepared for meals, etc.
15. Feeding or drinking between meals; or being given food, drinks, sweets, etc.
16. Applying cosmetics, grooming hair, cutting nails, shaving etc; or being shaved, etc.
17. Changing position e.g. from chair to chair, within bed or chair; or having position changed.
18. Receiving care for medical needs e.g. medication, injections, dressing, first aid.
19. Receiving other basic or technical nursing.

Social (2) Activity related to leisure and social pursuits

20. Casual conversation, chit-chat.
21. Singing, dancing, acting, or being played with.
22. Playing indoor games; draughts, ludo, colouring books, etc.
23. Playing outdoor games; catch a ball, football.
24. Going on visits, walks, shopping, etc.
25. Reading stories or letters to others.
26. Teasing, joking with patients or staff.
27. Having meal with staff member.
28. Enjoying T.V., radio, records, films, etc.
29. Other activities, e.g. collecting pay.

Adapted from Moores and Grant (1976).

Expressive (3) Activity related to overt behaviour indicating assertiveness

30. Fighting, harming self, or wandering off.
31. Moving from one location to another, either within or between units.
32. Walking about with nurse in attendance.
33. Sitting or lying still.
34. Having questions answered.
35. Being given commands or admonitions related to behaviour.
36. Other observable acts of self-expression,giving commands, admonitions, etc.
37. Other supervisory activity.
38. Imitating others.
39. Being consoled, counselled, etc.

Learning (4) Activity related to being taught or supervised task or skill

40. Learning or doing self-help skills: table habits, hygiene.
41. Learning or doing a communication skill: language, money, writing, reading etc.
42. Learning or doing a socialisation skill: shopping, homemaking, social graces etc.
43. Learning or doing an occupational skill: care of tools, manual dexterity, leisure activity, being asked to assist.
44. Being corrected for incorrect performance.
45. Being encouraged or rewarded for performance.
46. Other learning or doing activity.

Servicing (5) Activity related to servicing another's needs, or having activity needs serviced without direct training

50 Being given material for leisure or work.
51. Observing staff re-arranging work or play area and not assisting.
52. Working alongside staff without being shown any task or method of operation.
53. Having task done by staff member without demonstration of method of operation.
54. Having work or task inspected by staff member without receiving any guidance.
55. Other activity related to servicing of activity needs by staff e.g. waiting for more work, etc.

OBSERVATION SCHEDULE NURSE-PATIENT INTERACTION

Ward Date Day Observer Page

Time	Episode Number	Staff or Patient Initiates	Patient Code	Nurse Code	Verbal Code Patient	Verbal Code Nurse	Patient Activity Code	Number of staff and Patients at location Patients	Number of staff and Patients at location Nurses	Duration	Notes/Queries/Comments

Observation Schedule as adapted from the Staff-patient Interaction Sheet of Moores et al., 1976.

Appendix H

OBSERVATION SCHEDULE FOR PURPOSEFUL ACTIVITY

Time	Episode	Number of			Activity		Comments
		Patients	Nurses	Non-nurses	Purpose-ful	Simple	

EVALUATION SHEET

Patient Code Number:

		1	2	3	4	5	6	7	8	9	10	11	12
1. Attended meeting willingly	3												
2. Had to be coaxed	2												
3. Refused to attend	1												
1. Had good grooming	3												
2. Grooming could be improved	2												
3. Poor grooming	1												
1. Easy to understand	3												
2. Could sometimes be understood	2												
3. Difficult to understand	1												
1. Made contributions	3												
2. Had to be drawn out	2												
3. Rarely contributed	1												
1. Ideas were relevant	3												
2. Sometimes off the track	2												
3. Could not follow the discussion	1												
Scores													

12 - 15 Good
9 - 11 Fair
0 - 8 Poor

Date Comments:-

Extracted from Gibson (1967, p.85).

Appendix J

LIST OF TABLES

Table		Page
A	Number and Percentage of Daily Episodes of Purposeful and Simple Activity by Patients in the Experimental Ward - Type I Observations	142b
B	Number and Percentage of Episodes of Purposeful and Simple Activity by Patients in the Experimental Ward - Type II Observations	142b
C	Number and Percentage of Daily Episodes of Purposeful and Simple Activity by Patients in the Control Ward - Type I Observations	143
D	Number and Percentage of Daily Episodes of Interaction Initiated by Nurses to Patients, Patients to Nurses, and Patients to Patients in the Experimental Ward - Type I Observations	144
E	Number and Percentage of Episodes of Interaction Initiated by Nurses to Patients, Patients to Nurses and Patients to Patients in the Experimental Ward - Type II Observations	144
F	Number and Percentage of Daily Episodes of Interaction Initiated by Nurses to Patients, Patients to Nurses, and Patients to Patients in the Control Ward - Type I Observations	145
G	Number and Percentage of Verbal Categories by Nurses and Patients in the Experimental Ward - Type I Observations	146
H	Number and Percentage of Verbal Categories by Nurses and Patients in the Experimental Ward - Type II Observations	147
I	Number and Percentage of Verbal Categories by Nurses and Patients in the Control Ward - Type I Observations	148

Table		Page
J	Number and Percentage of Activity Categories by Patients in the Experimental Ward - Type I Observations	149
K	Number and Percentage of Activity Categories by Patients in the Experimental Ward - Type II Observations	150
L	Number and Percentage of Activity Categories by Patients in the Control Ward - Type I Observations	151
M	Scores on the Evaluation Scale by Group Subjects Each Group Session	152
N	Number of Verbal Categories Used by Group Subjects in the Dayroom during Type I Observations	153
O	Number of Activity Categories by Group Subjects in the Dayroom during Type I Observations	154
P	Number of Units as Coded in Verbal Categories by Patients and Nurses Each Group Session	155
Q	Number of Verbal Units as Coded for Nurse and Patient Members Each Group Session	156

TABLE A

Number and Percentage of Daily Episodes of Purposeful and Simple Activity by Patients in the Experimental Ward - Type I observations

Period of observation	Purposeful activity No.	%	Simple activity No.	%	TOTAL No.	%
Period 1						
Tuesday	394	76.21	123	23.79	517	24.50
Wednesday	350	64.70	191	35.30	541	25.64
Thursday	385	76.09	121	23.91	506	23.98
Friday	383	70.15	163	29.85	546	25.88
TOTAL	1,512	71.66	598	28.34	2,110	100.0
Period 2						
Tuesday	410	80.87	97	19.13	507	24.98
Wednesday	406	84.58	74	15.42	480	23.65
Thursday	433	83.11	88	16.89	521	25.66
Friday	452	86.59	70	13.41	522	25.71
TOTAL	1,701	83.79	329	16.21	2,030	100.0
Period 3						
Tuesday	425	87.63	60	12.37	485	25.53
Wednesday	430	86.35	68	13.65	498	26.21
Thursday	429	85.97	70	14.03	499	26.26
Friday	370	88.52	48	11.48	418	22.06
TOTAL	1,654	87.05	246	12.95	1,900	100.0

N = 32 (i.e. average number of patients throughout the observations)

TABLE B

Number and Percentage of Episodes of Purposeful and Simple Activity by Patients in the Experimental Ward - Type II observations

Random Day	Purposeful activity No.	%	Simple activity No.	%	TOTAL No.	%
Day 1	348	70.02	149	29.98	497	33.33
Day 2	398	79.13	105	20.87	503	33.74
Day 3	421	85.74	70	14.26	491	32.93
TOTAL	1,167	78.27	324	21.73	1,491	100.0

N = 32

TABLE C

Number and Percentage of Daily Episodes of Purposeful and Simple Activity by Patients in the Control Ward - Type I observations

Period of Observation	Purposeful activity		Simple activity		TOTAL	
	No.	%	No.	%	No.	%
Period 1						
Tuesday	209	69.21	93	30.79	302	22.60
Wednesday	211	72.76	79	27.24	290	21.71
Thursday	264	75.00	88	25.00	352	26.35
Friday	303	77.30	89	22.70	392	29.34
TOTAL	987	73.88	349	26.12	1,336	100.0
Period 2						
Tuesday	263	88.55	34	11.45	297	22.52
Wednesday	273	85.58	46	14.42	319	24.18
Thursday	294	85.47	50	14.53	344	26.08
Friday	327	91.09	32	8.91	359	27.22
TOTAL	1,157	87.72	162	12.28	1,319	100.0
Period 3						
Tuesday	275	86.75	42	13.25	317	23.38
Wednesday	251	88.38	33	11.62	284	20.94
Thursday	299	80.38	73	19.62	372	27.43
Friday	306	79.90	77	20.10	383	28.25
TOTAL	1,131	83.41	225	16.59	1,356	100.0

N = 21

TABLE D

Number and Percentage of Daily Episodes of Interaction Initiated by Nurses to Patients, Patients to Nurses, and Patients to Patients in the Experimental Ward - Type I observations

Period of observation	Interaction initiated by Nurse to Patient No.	%	Patient to Nurse No.	%	Patient to Patient No.	%	TOTAL No.	%
Period 1								
Tuesday	89	74.78	15	12.61	15	12.61	119	38.14
Wednesday	44	66.67	12	18.18	10	15.15	66	21.15
Thursday	34	53.12	15	23.44	15	23.44	64	20.51
Friday	53	84.13	4	6.35	6	9.52	63	20.20
TOTAL	220	70.52	46	14.74	46	14.74	312	100.0
Period 2								
Tuesday	56	50.91	20	18.18	34	30.91	110	28.21
Wednesday	51	55.44	15	16.30	26	28.26	92	23.59
Thursday	59	55.66	21	19.81	26	24.53	106	27.18
Friday	44	53.66	10	12.19	28	34.15	82	21.02
TOTAL	210	53.85	66	16.92	114	29.23	390	100.0
Period 3								
Tuesday	53	51.46	14	13.59	36	34.95	103	29.01
Wednesday	47	62.67	6	8.00	22	29.33	75	21.13
Thursday	38	46.34	2	2.44	42	51.22	82	23.10
Friday	61	64.21	13	13.68	21	22.11	95	26.76
TOTAL	199	56.06	35	9.86	121	34.08	355	100.0

TABLE E

Number and Percentage of Episodes of Interaction Initiated by Nurses to Patients, Patients to Nurses and Patients to Patients in the Experimental Ward - Type II observations

Random Day	Interaction initiated by Nurse to Patient No.	%	Patient to Nurse No.	%	Patient to Patient No.	%	TOTAL No.	%
Day 1	38	66.67	10	17.54	9	15.79	57	24.05
Day 2	56	56.57	27	27.27	16	16.16	99	41.77
Day 3	51	62.96	16	19.75	14	17.29	81	34.18
TOTAL	145	61.18	53	22.36	39	16.46	237	100.0

TABLE F

Number and Percentage of Daily Episodes of Interaction Initiated by Nurses to Patients, Patients to Nurses, and Patients to Patients in the Control Ward - Type I observations

Period of observation	Interaction initiated by Nurse to Patient		Patient to Nurse		Patient to Patient		TOTAL	
	No.	%	No.	%	No.	%	No.	%
Period 1								
Tuesday	21	55.26	9	23.69	8	21.05	38	22.62
Wednesday	37	72.55	4	7.84	10	19.61	51	30.36
Thursday	15	45.45	3	9.10	15	45.45	33	19.64
Friday	24	52.17	5	10.87	17	36.96	46	27.38
TOTAL	97	57.74	21	12.50	50	29.76	168	100.0
Period 2								
Tuesday	26	56.52	12	26.09	8	17.39	46	22.01
Wednesday	38	63.33	10	16.67	12	20.00	60	28.71
Thursday	17	34.70	4	8.16	28	57.14	49	23.44
Friday	18	33.33	9	16.67	27	50.00	54	25.84
TOTAL	99	47.37	35	16.75	75	35.88	209	100.0
Period 3								
Tuesday	37	61.66	4	6.67	19	31.67	60	23.72
Wednesday	22	33.33	19	28.79	25	37.88	66	26.08
Thursday	27	45.00	6	10.00	27	45.00	60	23.72
Friday	20	29.85	12	17.91	35	52.24	67	26.48
TOTAL	106	41.90	41	16.20	106	41.90	253	100.0

Number and Percentage of Verbal Categories* by Nurses and Patients in the Experimental Ward - Type I Observations

Period of observation	Verbal category by patient 1		2		3		4		Verbal category by nurse 5		6		7		8		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Period 1																		
Tuesday	55	35.48	4	2.58	1	.65	1	.65	41	26.45	32	20.64	8	5.16	13	8.39	155	37.35
Wednesday	32	37.21	0	0	2	2.33	1	1.16	27	31.40	11	12.79	4	4.65	9	10.46	86	20.72
Thursday	36	41.86	3	3.49	4	4.65	0	0	32	37.20	6	6.98	3	3.49	2	2.33	86	20.72
Friday	29	32.95	1	1.14	3	3.41	0	0	31	35.23	10	11.36	2	2.27	12	13.64	88	21.21
TOTAL	152	36.63	8	1.93	10	2.41	2	.48	131	31.57	59	14.22	17	4.10	36	8.66	415	100.0
Period 2																		
Tuesday	75	46.87	7	4.37	3	1.88	3	1.88	41	25.62	11	6.88	17	10.62	3	1.88	160	27.31
Wednesday	71	51.08	4	2.88	4	2.88	0	0	43	30.93	5	3.60	10	7.19	2	1.44	139	23.72
Thursday	73	45.91	5	3.14	10	6.29	2	1.26	52	32.71	3	1.89	9	5.66	5	3.14	159	27.13
Friday	79	61.72	3	2.34	2	1.56	0	0	35	27.35	3	2.34	6	4.69	0	0	128	21.84
TOTAL	298	50.85	19	3.24	19	3.24	5	.85	171	29.18	22	3.76	42	7.17	10	1.71	586	100.0
Period 3																		
Tuesday	88	50.57	8	4.60	10	5.75	2	1.15	40	22.99	16	9.19	8	4.60	2	1.15	174	29.44
Wednesday	59	47.97	4	3.25	1	.81	4	3.25	34	27.64	10	8.13	7	5.69	4	3.25	123	20.81
Thursday	78	58.65	11	8.27	5	3.76	0	0	24	18.04	11	8.27	3	2.26	1	.75	133	22.51
Friday	83	51.55	4	2.48	5	3.11	1	.62	35	21.74	15	9.32	13	8.07	5	3.11	161	27.24
	308	52.12	27	4.57	21	3.55	7	1.18	133	22.50	52	8.80	31	5.25	12	2.03	591	100.0

* as analysed from interactions in Table D

Key:

Patient		Nurse	
Comment	= 1	Comment	= 5
Instruction	= 2	Instruction	= 6
Question	= 3	Question	= 7
Initiated Conversation	= 4	Initiated Conversation	= 8

TABLE H

Number and Percentage of Verbal Categories* by Nurses and Patients in the Experimental Ward - Type II Observations

Random Day	Verbal category by patient 1		2		3		4		Verbal category by nurse 5		6		7		8		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Day 1	23	31.50	4	5.48	0	0	2	2.74	20	27.40	14	19.18	7	9.59	3	4.11	73	20.98
Day 2	66	45.52	1	.69	3	2.07	4	2.76	46	31.72	7	4.83	14	9.65	4	2.76	145	41.67
Day 3	50	38.46	4	3.08	5	3.85	3	2.31	35	26.92	18	13.85	9	6.92	6	4.61	130	37.35
TOTAL	139	39.94	9	2.59	8	2.30	9	2.59	101	29.02	39	11.21	30	8.62	13	3.73	348	100.0

* as analysed from interactions in Table E

Key:

Patient	Nurse
Comment = 1	Comment = 5
Instruction=2	Instruction= 6
Question = 3	Question = 7
Initiated = 4	Initiated = 8
Conversation	Conversation

TABLE I

Number and Percentage of Verbal Categories* by Nurses and Patients in the Control Ward - Type I observations

Period of observation	Verbal category by patient 1		2		3		4		Verbal category by nurse 5		6		7		8		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Period 1																		
Tuesday	30	50.85	1	1.69	4	6.78	0	0	12	20.34	7	11.87	4	6.78	1	1.69	59	23.14
Wednesday	31	41.89	2	2.70	4	5.40	0	0	12	16.22	8	10.81	12	16.22	5	6.76	74	29.02
Thursday	36	67.93	4	7.55	0	0	0	0	8	15.09	0	0	3	5.66	2	3.77	53	20.78
Friday	34	49.27	3	4.35	3	4.35	3	4.35	10	14.49	1	1.45	11	15.94	4	5.80	69	27.06
TOTAL	131	51.37	10	3.92	11	4.31	3	1.18	42	16.47	16	6.27	30	11.77	12	4.71	255	100.0
Period 2																		
Tuesday	43	51.81	0	0	2	2.41	2	2.41	25	30.12	2	2.41	5	6.02	4	4.82	83	25.15
Wednesday	43	46.24	0	0	5	5.38	2	2.15	29	31.18	4	4.30	9	9.68	1	1.07	93	28.18
Thursday	44	67.69	1	1.54	1	1.54	0	0	13	20.00	4	6.15	1	1.54	1	1.54	65	19.70
Friday	61	68.53	1	1.13	3	3.37	1	1.13	12	13.48	5	5.62	3	3.37	3	3.37	89	26.97
TOTAL	191	57.88	2	.61	11	3.33	5	1.52	79	23.94	15	4.54	18	5.45	9	2.73	330	100.0
Period 3																		
Tuesday	40	44.45	3	3.33	6	6.67	1	1.11	33	36.67	2	2.22	3	3.33	2	2.22	90	23.56
Wednesday	51	51.00	2	2.00	9	9.00	0	0	31	31.00	0	0	7	7.00	0	0	100	26.18
Thursday	42	50.00	2	2.38	8	9.52	0	0	30	35.72	1	1.19	1	1.19	0	0	84	21.99
Friday	70	64.81	4	3.70	5	4.63	1	.93	23	21.29	3	2.78	1	0.93	1	.93	108	28.27
TOTAL	203	53.14	11	2.88	28	7.33	2	.52	117	30.63	6	1.57	12	3.14	3	.79	382	100.0

* as analysed from interactions from Table F.

Key: Patient: Comment = 1, Instruction = 2, Question = 3, Initiated Conversation = 4

Nurse: Comment = 5, Instruction = 6, Question = 7, Initiated Conversation = 8

TABLE J

Number and Percentage of Activity Categories* by Patients in the Experimental Ward - Type I Observations

Period of observation	Activity Functional No.	%	Social No.	%	Expressive No.	%	Learning No.	%	Servicing No.	%	TOTAL No.	%
Period 1												
Tuesday	36	30.25	30	25.21	35	29.41	4	3.36	14	11.77	119	38.14
Wednesday	19	28.79	27	40.91	10	15.15	0	0	10	15.15	66	21.16
Thursday	15	23.43	27	42.19	9	14.06	2	3.13	11	17.19	64	20.51
Friday	24	38.09	19	30.16	11	17.46	1	1.59	8	12.70	63	20.19
TOTAL	94	30.13	103	33.01	65	20.83	7	2.25	43	13.78	312	100.0
Period 2												
Tuesday	35	31.82	40	36.36	12	10.91	5	4.55	18	16.36	110	30.13
Wednesday	26	28.26	40	43.48	7	7.61	3	3.26	16	17.39	92	25.21
Thursday	33	40.75	27	33.33	5	6.17	5	6.17	11	13.58	81	22.19
Friday	18	21.95	46	56.10	5	6.10	1	1.22	12	14.63	82	22.47
TOTAL	112	30.68	153	41.92	29	7.94	14	3.84	57	15.62	365	100.0
Period 3												
Tuesday	31	30.10	42	40.78	10	9.71	1	.97	19	18.44	103	29.01
Wednesday	12	16.00	37	49.33	14	18.67	1	1.33	11	14.67	75	21.13
Thursday	21	25.61	26	31.71	16	19.51	4	4.88	15	18.29	82	23.10
Friday	40	42.10	30	31.58	14	14.74	3	3.16	8	8.42	95	26.76
TOTAL	104	29.30	135	38.03	54	15.21	9	2.53	53	14.93	355	100.0

* as analysed from interactions in Table D

TABLE K

Number and Percentage of Activity Categories* by Patients in the Experimental Ward - Type II Observations

Period of observation	ACTIVITY Functional No.	%	Social No.	%	Expressive No.	%	Learning No.	%	Servicing No.	%	TOTAL No.	%
Day 1	19	32.76	22	37.93	8	13.79	1	1.73	8	13.79	58	24.37
Day 2	35	35.35	43	43.43	15	15.15	2	2.02	4	4.05	99	41.60
Day 3	28	34.57	22	27.16	16	19.75	2	2.47	13	16.05	81	34.03
	82	34.45	87	36.56	39	16.39	5	2.10	25	10.50	238	100.0

* as analysed from interactions in Table E

TABLE L

Number and Percentage of Activity Categories* by Patients in the Control Ward - Type I. Observations

Period of Observation	ACTIVITY Functional No.	%	Social No.	%	Expressive No.	%	Learning No.	%	Servicing No.	%	TOTAL No.	%
Period 1												
Tuesday	5	13.16	24	63.16	2	5.26	0	0	7	18.42	38	22.62
Wednesday	7	13.73	33	64.71	5	9.80	2	3.92	4	7.84	51	30.36
Thursday	4	12.12	22	66.67	5	15.15	0	0	2	6.06	33	19.64
Friday	5	10.87	25	54.35	1	2.17	1	2.17	14	30.44	46	27.38
TOTAL	21	12.50	104	61.90	13	7.74	3	1.79	27	16.07	168	100.00
Period 2												
Tuesday	10	21.74	27	58.70	3	6.52	0	0	6	13.04	46	22.01
Wednesday	14	23.33	31	51.67	0	0	0	0	15	25.00	60	28.71
Thursday	3	6.12	35	71.43	1	2.04	0	0	10	20.41	49	23.44
Friday	7	12.96	28	51.85	5	9.26	3	5.56	11	20.37	54	25.84
TOTAL	34	16.27	121	57.89	9	4.31	3	1.44	42	20.09	209	100.00
Period 3												
Tuesday	10	16.67	28	46.67	2	3.33	0	0	20	33.33	60	23.71
Wednesday	5	7.58	31	46.97	6	9.09	2	3.03	22	33.33	66	26.09
Thursday	14	23.33	22	36.67	9	15.00	0	0	15	25.00	60	23.72
Friday	10	14.93	26	38.81	9	13.43	0	0	22	32.83	67	26.48
TOTAL	39	15.42	107	42.29	26	10.28	2	0.79	79	31.22	253	100.00

* as analysed from interactions in Table F.

TABLE M

Scores on the Evaluation Scale by Group Subjects
Each Group Session

Subject	Session number												
	1	2	3	4	5	6	7	8	9	10	11	12	TOTAL
A	7	1	8	7	9	10	9	1	7	1	1	1	62
B	6	5	6	5	6	6	8	8	7	9	7	8	81
C	9	9	11	11	13	13	13	10	10	11	11	13	134
D	10	10	12	12	12	14	13	14	13	15	14	14	153
E	8	9	8	10	11	11	11	11	11	12	12	12	126
F	6	7	8	8	9	1	10	8	1	9	1	9	77
G	1	1	1	1	1	1	1	1	1	1	1	1	12
H	7	8	11	8	11	12	11	9	9	9	10	12	117
I	7	5	6	8	8	9	7	8	8	8	8	12	92
J	9	10	12	12	11	13	13	13	13	13	13	13	145
K	10	10	11	14	12	12	13	12	13	14	14	14	149
L	10	11	8	1	11	13	13	13	13	13	12	12	130
TOTAL	90	86	102	97	114	115	122	108	106	115	104	119	1,278

N = 12

Scores 12 - 15 Good
9 - 11 Fair
0 - 8 Poor

Minimum score = 1 indicates subject did not attend the group session
Maximum score = 15

TABLE N

Number of Verbal Categories Used by Group Subjects in the Dayroom During Type I Observations

Subject	Verbal category Comment	Instruction	Question	Initiated conversation	Total
A	3	0	0	0	3
B	7	3	0	0	10
C	13	0	0	0	13
D	53	6	1	5	65
E	20	2	0	2	24
F	36	0	5	1	42
G	2	0	0	0	2
H	15	0	2	0	17
I	6	0	1	0	7
J	19	0	4	2	25
K	45	6	9	1	61
L	22	1	1	0	24
TOTAL	241	18	23	11	293

N = 12

TABLE O

Number of Activity Categories Used by Group Subjects in the Dayroom During Type I Observations

Subject	Activity category Functional	Social	Expressive	Learning	Servicing	Total
A	1	0	0	0	3	4
B	10	7	4	0	4	25
C	11	6	2	3	8	30
D	10	45	6	0	7	68
E	6	15	2	1	7	31
F	13	27	1	0	19	60
G	5	2	0	0	0	7
H	10	7	0	0	7	24
I	5	4	1	0	1	11
J	2	15	3	1	8	29
K	5	28	12	1	15	61
L	5	8	3	4	10	30
TOTAL	83	164	34	10	89	380

N = 12

TABLE P

Number of Units as Coded in Verbal Categories by Patients and Nurses Each Group Session

Session number	Patient units 1	2	3	4	Nurse units 5	6	7	8	Total
1*	176	0	26	8	185	0	59	10	464
2**	235	0	33	19	225	1	131	17	661
3*	156	0	39	16	204	0	90	10	515
4**	134	0	15	6	92	0	49	1	297
5*	215	4	25	9	274	0	156	17	700
6**	171	0	42	14	248	0	103	8	586
7*	232	1	43	10	208	0	169	16	679
8**	251	1	29	10	323	2	129	10	755
9**	320	1	43	11	217	0	167	12	771
10**	249	3	31	6	258	1	149	11	708
11***	236	0	42	3	240	0	151	9	681
12**	282	0	63	17	376	2	229	7	976
TOTAL	2,657	10	431	129	2,850	6	1,582	128	7,793

* N = 13 (i.e. 11 patients and 2 nurses)

** N = 12 (i.e. 10 patients and 2 nurses)

*** N = 11 (i.e. 9 patients and 2 nurses)

Key:

Patient

Comment = 1
Instruction = 2
Question = 3
Initiated conversation = 4

Nurse

Comment = 5
Instruction = 6
Question = 7
Initiated conversation = 8

TABLE Q

Number of Verbal Units as Coded for Nurse and Patient Members

Each Group Session

Session number	Patient A	B	C	D	E	F	G	H	I	J	K	L	Patient total	Leader	Main co-leader	Other co-leaders	Nurse total	TOTAL
1	0	1	9	97	1	0	a	14	0	62	24	2	210	216	38	0	254	464
2	a	0	9	69	9	6	a	21	10	49	67	47	287	265	0	109	374	661
3	1	0	16	56	4	1	a	39	0	42	50	2	211	206	98	0	304	515
4 *	4	0	5	59	4	3	a	4	0	36	40	a	155	136	0	6	142	297
5	7	1	37	53	9	4	a	14	2	16	81	29	253	278	169	0	447	700
6	1	0	5	40	2	a	a	13	0	54	70	42	227	264	95	0	359	586
7	5	6	20	36	4	3	a	12	3	86	87	24	286	391	0	2	393	679
8	a	14	5	135	10	1	a	8	0	64	35	19	291	299	165	0	464	755
9	0	2	11	127	12	a	a	54	0	59	63	47	375	323	0	73	396	771
10	a	3	12	87	8	4	a	1	0	69	61	44	289	296	123	0	419	708
11	a	9	6	44	6	a	a	39	2	42	93	40	281	312	88	0	400	681
12	a	8	12	60	14	10	a	21	10	83	108	36	362	401	213	0	614	976
TOTALS	18	44	147	863	83	32	-	240	27	662	779	332	3,227	3,387	989	190	4,566	7,793

N = 14 (12 patients and 2 nurses)

a = absent

0 = present, but did not speak

* = incomplete data

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