A SURVEY OF NURSES' FEELINGS ABOUT CARING FOR PATIENTS WITH PSYCHIATRIC SYMPTOMS IN THE GENERAL HOSPITAL SETTING

by

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CHAPTER 1

INTRODUCTION

Introduction to the Problem

In the past decade, hospital care of mental patients in the United States has changed remarkably as we have seen a shift of inpatients from state mental hospitals to community general hospitals. In 1961 the Joint Commission on Mental Illness and Health recommended that community general hospitals not be regarded as rendering complete service unless they accepted mental patients. Greenhill (1979) contends that this recommendation as well as President Kennedy's 1963 message to Congress calling for the establishment of community mental health centers, set the stage for deinstitutionalization and cast the burden of inpatient psychiatric care upon the community general hospital. At the present time, approximately two-thirds of all psychiatric inpatient populations in the United States are being treated in the general hospital on specially designated psychiatric units, and an undetermined number are being treated on regular medical-surgical wards (Jones, 1979).

The results of this change in treatment structure are discussed at length in the psychiatric literature. Leeman (1980) argues that although these changes have been basically for humanitarian reasons, the fact is that general hospitals are being asked to admit both voluntary and involuntary patients, and the latter group frequently presents some real problems in-patient-care-management. It is evident in the aforementioned

literature that even though some hospitals have structurally revised some portion of the facility, most general hospitals have not been architecturally designed with psychiatric units that are separate from the general medical-surgical units, nor are they adequately staffed to safely manage a mixture of patients with physical, emotional and behavioral problems. Often the very presence of patients with poor impulse control makes the atmosphere within the hospital frightening for other patients and for staff; and the burden of this problem falls upon nurses, who spend twenty-four hours, seven days a week, with the patients. Furthermore, nursing staff who care for patients with predominately medical or surgical conditions frequently do not have either the experience or the environmental support essential to the containment of erratic behavior.

Although Ames (1978) and others (Robbins, 1978; Greenhill, 1979; Leeman, 1980) frequently refer to difficulties in obtaining psychiatric nursing staff and the great need to provide "enough support" to the general duty nurses who are required to care for psychiatric patients, there is little evidence of any exploration of the feelings of general duty nurses who may at some time find themselves involved in this type of a situation. One related study was done by Wolff (1978) in which she considered the patients referred by surgical staff nurses in a general hospital to a psychiatric nursing consultant. Although the generalizability of her findings is limited by her use of a small sample of volunteers (N = 27) from one hospital, and by the use of an instrument that did not have established validity and reliability, her examination of patient behaviors and the nurses' reactions to them is of interest here. She reports that patients referred as needing psychiatric consultation tended

to be seen by the nurses in her study as more depressed, tense, overdramatic, demanding, irritable, withdrawn, worried, suicidal, manipulative and dependent than other, non-referred patients. Additionally, the nurses reacted to referred patients with feelings of depression, frustration, anger, discomfort, hopelessness and uncertainty. These nurses also expressed difficulty relating to patients that they considered to be "psychiatric", and avoided contact with them.

Since, on the one hand, community general hospitals are faced with an increasing psychiatric patient population and are reported to be having difficulty obtaining psychiatric nursing staff, and on the other hand, general duty nurses are more frequently being required to care for patients with psychiatric-related symptoms, and are reported to be uncomfortable and avoiding contact with them, it is time to examine this problem from a nursing perspective.

Purpose of the Study and Problem Statement

The purpose of this study was to assess the feelings of general duty nurses in relation to the care of patients with psychiatric symptoms in the general medical-surgical hospital setting. The problem to be considered is: are these nurses uncharacteristically anxious in patient-care situations that involve psychiatric symptomatology, and could this anxiety adversely affect the delivery of quality nursing care?

Significance of the Study

The findings in this study may have implications for both nursing education and practice. If nurses in the general hospital setting are anxious, and reluctant to care for psychiatric patients, then the quality

of the patient-care in that setting is jeopardized. Given this possibility, the nursing profession must begin an exploration of methods for improving the "nurse-psychiatric patient interaction" of all nurses, since deinstitutionalization continues to be the trend in psychiatric patient-care.

REVIEW OF THE LITERATURE AND CONCEPTUAL FRAMEWORK

Although reference is frequently made throughout psychiatric literature, to the anxiety of the general hospital staff who are caring for psychiatric patients (Berezowsky, 1977; Ames, 1978; Wolff, 1978; Kristic, 1979), a review of the social science and nursing literature reveals that research has not been done in this area. Consequently, there is little empirically supported information available to corroborate these observations or to ascertain the cause of these uncomfortable feelings. However, many studies which explore the attitudes of mental health workers toward mental illness have been done, and among these, a few have involved student nurses, general duty nurses, and psychiatric nurses. The specific findings of these studies will be reviewed along with a brief discussion of some of the applicable literature about the nature of anxiety and the theory of cognitive dissonance.

Attitudes of Mental Health Workers Toward Mental Illness

Rabkin (1972) in her review of the literature related to opinions about mental illness, discusses two areas that are of interest to this study: methods of measurement, and the attitudes of mental health personnel.

Measurement instruments such as Nunnally's Questionnaire, the Star

Abstracts, Gilbert and Levinson's Custodial Mental Illness Ideology Scale (CMI), and Cohen and Struening's Opinion about Mental Illness Scale (OMI), are described in detail by Rabkin. However, since most of the recent studies of nurses have used the OMI, this is the only measurement tool that will be discussed here.

The OMI was developed from a pool of Likert-type opinion items that were either written by the authors, or were adapted from Nunnally's Questionnaire, the California F. Scale, and the CMI. Internal and external validity and reliability were established, and five factors were developed to separate respondents' scores so that the 51 item OMI questionnaire provides five separate scores for each respondent, relating to the factors of authoritarianism, benevolence, mental hygiene ideology, social restrictiveness, and interpersonal etiology.

Rabkin's review illustrates the fact that there are distinct attitudinal patterns for different categories of mental health workers. The investigators she cited typically reported that personnel with lower status are more authoritarian and restrictive in their attitudes toward mental patients than those with advanced professional training.

However, a contradiction to the findings cited by Rabkin is suggested in the data collected by Perry (1963), which indicates that changes occur in the attitudes of nurses after a period of time of working with mental patients in psychiatric specialty hospitals, that differ from those that occur in professional and non-professional personnel in other hospital environments. She reports that nurses with predominately psychiatric experience score higher on authoritarian measures than nurses with less psychiatric experience and other personnel from general hospitals.

Kahn (1976), using the Cohen and Struening OMI scale, examined the effect of long-term experience on a psychiatric ward on nurses' opinions about mental illness. A group of nursing students (N = 11), a group of nurses experienced in caring for psychiatric patients (N = 8), and a control group of medical-surgical nurses matched for age and education with the psychiatric nurses (N = 8), were compared. The nurses with psychiatric experience of one year or more were found to hold significantly more authoritarian opinions about mental illness and were found to adhere less to a belief in the interpersonal etiology of mental illness than the other two groups. Compared to the nursing students, the nurses with psychiatric experience were also found to hold significantly more socially restrictive opinions about mental illness and to adhere less to current mental health ideology. Although the numbers in this study were small, the methodology was such that the results have possible application to a larger population of nurses, and therefore, merit further investigation.

Morrison, et al (1976) conducted a study of the attitudes of nursing students and others about mental illness, in which attitudes were measured using an instrument designed to collect information reflective of current psychiatric ideology and practice (i.e., the psychosocial approach). The instrument used was the Client Attitude Questionnaire (CAQ) which was developed by Morrison and is reported by him to have excellent construct and predictive validity. The student nurse sample (N = 35) consisted of female, senior nursing students in their early twenties, who were completing their studies at a university. This group was compared to: mixed-gender groups of graduate level psychology students (N = 15), medical school psy-

chiatric residents (N = 13), graduate level teacher-students in education (N = 16), and a group of female psychiatric registered nurses (N = 23). The results of the study suggested that student nurses maintain somewhat moderate attitudes toward mental illness, by contrast to the more radically psychosocial oriented psychology students, and the more traditionally conservative teacher-students in education. The student nurses' responses were similar to the psychiatric residents, and this similarity was assumed to be associated with an education oriented toward the medical model. However, an unexpected result of the study was that student nurses tended to be more in favor of the following psychosocial positions than the psychiatric nurses: 1) the abolishment of mental hospitals, 2) the myth of mental illness, 3) the removal of locked wards for treating mental patients, and 4) the unreliability of psychiatric diagnoses. The researchers attributed this difference in philosophy to the possibility that the student nurses had received greater exposure to the more current criticisms of the "medical model". However, it is difficult to adequately assess this conclusion because, even though the ages of the other groups in the study were reported to be within the range of 21 to 39 years, the ages and length of time since initial nursing education of the psychiatric nurses were not reported.

The findings of this attitude study by Morrison et al, as well as those by Perry and Kahn, suggest that additional long-term experience (i. e., one year or more) with psychiatric patients may change the rather liberal opinions developed in a nursing student's undergraduate education to a more conservative stance. This consideration, along with the possibility that general duty nurses are overly anxious, and therefore, reluc-

tant to give care to patients with psychiatric symptoms, parallels the theory of cognitive dissonance. However, before discussing the literature relating to this theory, it is important to establish a basic understanding of the concept of anxiety.

The Concept of Anxiety

The literature does not present any general agreement about the definition or characteristics of anxiety; however, use of the term is widespread, and there is agreement that anxiety is an uncomfortable emotional state. Anxiety and fear have been compared and contrasted at length. Horney (1937) viewed the difference as being related to the individual's perception of what is a "threat", and states that in the case of anxiety, the threat is subjective and hidden, as opposed to the case of fear, where the danger is objective and transparent. Although the danger or threat in anxiety may be perceived as coming from an external source, Horney asserts that "the danger is generated or magnified by intrapsychic factors and the helplessness is conditioned by the person's own attitude."

White (1948) and Sullivan (1953) both associated anxiety in the adult with childhood experiences and maintained that the immediate threat to an anxious individual is in relation to his established methods for feeling safe and secure. Anxiety in the adult, according to this theoretical premise, is related to feelings of insecurity and lowered self-esteem. In addition, anxiety is said to almost always involve the disruption of interpersonal situations which would otherwise contribute to the satisfaction of the needs of the person concerned.

Arieti (1967) studied the physiological differences present in the responses of anxiety and fear, and defined anxiety as the emotional re-

action to an expectation or anticipation of danger rather than to its actual presence. He found that more of the cortex and less of the autonomic nervous system was involved in anxiety than with fear, and described anxiety as the emotional equivalent of physical pain which compels men to take action for future survival.

Thus anxiety as it has been described by researchers during the past four decades, is an individually perceived and highly personal experience that is frequently related to an anticipated danger to the person's self-concept. More recently, researchers in cognitive consistency have been studying a related area, identified as cognitive dissonance, which further emphasizes the relationship of anxiety to the self-concept and deals as well with the phenomena of attitude change. Following is a brief overview of the literature relating to dissonance theory.

The Theory of Cognitive Dissonance

Festinger (1957, 1962, 1963) described a condition of psychological tension that he labeled "cognitive dissonance", stating that this tension occurs whenever an individual simultaneously holds two cognitions (ideas, attitudes, beliefs, opinions) that are psychologically inconsistent. The cognitive approach used by Festinger involves the variables of commitment, choice, and justification as central in human decision making. Although dissonance is cognitive in origin, the theory essentially follows drive-reduction motivational principles. The basic hypothesis of the theory has two parts: 1) the existence of dissonance, being psychologically uncomfortable, will motivate the person to try to reduce it; and 2) when dissonance is present, in addition to trying to reduce it, the person will

actively avoid situations and information that would be likely to increase it.

Experimental research by Zimbardo (1969) and Aronson (1976) has further delineated this theory and supports the conclusion that dissonance effects are limited to situations in which a person's behavior conflicts with self-concept-related cognitions, thus causing lowered self-esteem. In this light, Bramel (1978), in her review of dissonance theory, suggests that dissonance can be distinguished from other kinds of anxiety by the fact that there is a feeling of personal unworthiness traceable to social rejection. Any information which implies that one is incompetent or immoral arouses dissonance, according to Bramel; the reason that it occurs when the person feels personally responsible for his behavior, is because rejection by other people is greatest when they believe the person voluntarily acted in an inappropriate way.

Dissonance theory has also enjoyed considerable notoriety in explaining and predicting the phenomena of attitude change. Research in dissonance reduction by many investigators (Brehm, 1962; Cohen, 1964; Zimbardo, 1969; Kumpf, 1973; and Aronson, 1976) demonstrates the psychological connection between the tension (or anxiety) created by the conflicts with the self-concept and the need for effecting a change in either one's attitudes (cognitions) or in one's behaviors to reduce this tension. They describe dissonance-reducing behaviors as "ego-defensive" behavior because by reducing dissonance, the person attempts to maintain positive self-esteem.

Summary

The literature reviewed suggests that anxiety is a major problem for

general hospital nursing staff who deal with patients who have psychiatric symptoms. It also indicates that many nurses demonstrate a change from the more liberal psychosocial attitude toward mental illness, to a more conservative authoritarian and socially restrictive view after working for a year or more in the psychiatric specialty area.

The literature considered in relation to anxiety depicts this concept as an unpleasant emotional state that occurs in response to a subjectively perceived, frequently hidden, threat to the self-esteem of the individual, as opposed to fear, which occurs in response to an external, objectively perceived, danger. This definition of anxiety is consistent with information about the theory of cognitive dissonance which further associates anxiety to feelings of personal unworthiness related to the anticipation of social rejection due to incompetent or immoral behavior. In addition, cognitive consistency studies have demonstrated a connection between this anxiety and the necessity of changing either attitudes or behaviors in order to reduce the discomfort.

Based upon this review of the literature, the following research questions were derived:

Research Questions

1. Do nurses working in the general hospital setting express uncomfortable feelings about caring for patients who have psychiatric symptoms?

2. Do general hospital nurses indicate a reluctance to care for patients with psychiatric symptoms?

3. Do the feelings expressed by general hospital nurses demonstrate any relationship to the length of psychiatric nursing experience?

4. Do the feelings expressed by general hospital nurses demonstrate any relationship to the nurses' educational background?

5. Do the feelings expressed by general hospital nurses demonstrate any relationship to the nurses' professional age?

Definition of Terms

1. Generic school of nursing: type of educational setting in which initial nursing education was received; either an Associate Degree, Diploma, or Baccalaureate nursing program.

2. General duty nurse: a registered nurse with at least an "entry level" generic nursing education background and less than one year of experience in the psychiatric specialty area, who works in a general hospital setting.

3. Psychiatric nurse: a registered nurse working in a general hospital setting, who has at least an "entry level" generic nursing education background and experience of one year or more in the specialized psychiatric setting.

4. Professional age: the number of years since graduation from the generic nursing education program.

5. Anxiety: an uncomfortable emotional state that occurs in response to a subjectively perceived, frequently hidden, threat to the self-esteem of the individual.

Assumptions

For the purpose of this study, it was assumed that the nurses had learned to use certain adjectives (verbal responses) to describe their affective domain, and that they were able and willing to report these in an honest manner.

CHAPTER 2

METHODOLOGY

Design of the Study

The purpose of this study was to assess the feelings of general duty nurses in relation to the care of patients with psychiatric symptoms in the general medical-surgical hospital setting. Since studies relating to the affective domain of nurses were not found to be available, a descriptive study and sample survey method were used.

Sample and Sample Source

The Source. The source of the sample for this investigation was three hundred registered nurses who were working as staff nurses in three general hospitals in a southern Oregon community. These nurses represent the total of both the full-time and the part-time registered nurse staff of these hospitals. Two of the hospitals are privately owned; one has 111 beds and contains a 10 bed acute-care psychiatric unit; the other has 133 beds and houses a 14 bed alcohol treatment unit. The third hospital is a 417 bed, government-owned medical center which designates 159 beds for acute and chronic psychiatric care and alcohol treatment.

The Sample. One hundred and forty registered nurses responded to the survey for a return of 47%. These were distributed proportionately throughout the three hospitals (N = 53, 42, 45), and represent 127 females and 13 males. The average age of the respondents was 39; however, the distribution

was both broad (20-66 years) and tri-modal, with eight responses each at the ages of 31, 33, and 39. Seventy-four percent (N = 104) of the nurses were working full-time (40 hours or more/week) on a medical or surgical unit. Responses from the different duty shifts were equivalent among the three hospitals, with 48% (N = 67) coming from the daytime, 33% (N = 46) from the evening, and 19% (N = 27) from the night shifts.

The educational background of these nurses was distributed among four levels, with 34% (N = 48) reporting an Associate Degree in Nursing, 30% (N = 42) a Diploma in Nursing, 31% (N = 43) a Bachelors Degree (28 in nursing and 15 in a related major), and 5% (N = 7) a Masters Degree (2 in psychiatric nursing, 2 in another nursing major, and 3 in a related major).

Nurses responding to the survey had a mean professional age of 14.5 years; again however, the distribution was broad, with a range of 1-45 years, and 35% (N = 47) of the nurses had been working for less than six years.

One-third of the sample (N = 45) reported work experience with psychiatric patients after their initial nurse's training; however, only 27 of these corresponded to the operational definition of the psychiatric nurse used in this study (i.e., one year or more of psychiatric nursing experience). Of these 27, 15 were employed at the government-owned medical center, 8 at the hospital with the acute-care psychiatric unit, and 4 at the hospital with the alcohol treatment unit.

Data Collection Methods

Data Collection Instrument. The instrument used for this survey was an anonymous questionnaire constructed by this researcher and designed to

elicit information related to the research questions. It was accompanied by a letter which explained the purpose of the study, and the manner in which consent to participate in the study could be given (Appendix A-1). The questionnaires were color coded for identification of the individual hospitals in order to enable evaluation of the response distribution. It was divided into two sections: 1) questions to measure affective responses to a simulated psychiatric patient-care situation, and 2) demographic data (Appendix A-2, 3, 4).

Content. The questionnaire format was planned for ease of response (most questions required only a check-mark, number, or one word reply), and the demographic questions were purposely placed at the end to offset the possibility that fatigue or boredom on the part of the respondent, might affect responses to the questions related to the dependent variables (Polit and Hungler, 1978).

In order to create an atmosphere appropriate to the simulated patient-care situation, a vignette designed to elicit responses toward broad concepts was used in a manner similar to that described by Flaskerud (1979) and others. This vignette (Appendix A-2) used a real-patient situation in which a young woman with history of previous psychotic episodes had been admitted to a general hospital unit because of deteriorating health and abnormal behavior at three months postpartum (Poole, 1980). Since this type of symptomatology was reported in the literature to produce anxiety in general hospital nursing staff (Wolff, 1978), the subjects of this study were instructed to assume themselves to be the nurse assigned to the care of this patient in their own hospital setting, and to respond to the questions as honestly as possible. Affective responses were obtained through

use of seven bipolar-adjective-pairs placed in a 7-point semantic differential format (Polit and Hungler, 1978), with "1" representing the most comfortable and "7" the most uncomfortable of the choices (Appendix A-2, 3). The direction of the adjective pairs was randomly reversed to prevent response bias.

Validity and Reliability. Five of the adjective pairs chosen for this study (relaxed-tense, comfortable-uncomfortable, pleased-annoyed, elated-depressed, and pleasant-unpleasant) were obtained from a tool used by Segal (1972) and Leonard (1973, 1975) for the measurement of cognitive dissonance. Although both of these researchers have reported success in the use of this instrument, no data were available about the establishment of validity or reliability for the tool. This technique, however, is frequently used to measure attitudes (Polit and Hungler, 1978) and Norris (1978) cites several studies in which a tool similar to that of Segal and Leonard has demonstrated reliability and been judged to be a valid measure of psychological stress. In her discussion of the eight common factors of the Nowlis and Green Mood Scale, Norris reports research done in 1962 by Lazarus who used adjective pairs from the mood scale to explore some of the antecedent conditions that produce psychological stress....(and) a number of the physiological and behavioral consequences. It was found that although all mood scale factors showed greater stress in the experimental than the control condition, the greatest difference occurred for the anxiety factor, followed at some distance by unpleasantness. Norris also describes cognitive consistency studies by Greenberg (1961), Lynch (1963) and herself (1964) in which the mood scale was used and demon-

strated the most sensitive indicator of differential levels of cognitive dissonance to be a scale heavily weighted with adjectives representing anxiety and unpleasantness. Since the bipolar-adjective-pairs used by Segal and Leonard depict these two factors of the mood scale, they were considered valid for detecting psychological discomfort in this study.

Two other adjective pairs (enthusiastic-reluctant, adequate-inadequate) were selected by this investigator as being relevant to the questions under study. In addition, two multiple choice and three open-ended questions were included to obtain nurses' beliefs about symptoms of psychopathology, personal concerns about caring for patients with psychiatric symptoms, and perceptions about hospital support systems that are needed, but not available, in their own institutions.

Pretest of the Questionnaire. The questionnaire was pretested for clarity and applicability to the intended population, with a group of nurses (N = 12), all of whom were assigned to a single unit in one of the three study hospitals. These nurses were chosen because the unit on which they were working was not used as part of the final study, because they were easily accessible and willing to assist with the project, and because they were representative of all levels of nursing education that were present in the study population. The questionnaire content was examined for appropriateness, adequacy, and freedom from bias by two expert judges selected from the psychiatric nursing faculty at the Oregon Health Sciences University School of Nursing. As a result of these examinations, minor changes were made in the content and format of the questionnaire.

Data Collection Procedure. In light of Polit and Hungler's suggestion

that personal contact seems to result in higher completion rates on questionnaires than surveys done totally by mail, permission to conduct the study was obtained from the respective Directors of Nursing Service (Appendix B), and meetings were arranged with supervisors and head nurses to explain the study and enlist their assistance in the distribution of the questionnaires. Self-addressed, stamped envelopes were included with the questionnaires for their return, and follow-up memos were distributed 10 days after the initial contact to remind and encourage any nurses who had not yet responded, to do so.

Analysis of Data

Using the computer program, Statistical Package for Social Sciences (Nie, 1975, 1979), frequency distributions, histograms, and measures of central tendency were obtained for the total sample (N = 140) on all variables. The seven adjective pairs in each of the eight questions that used the semantic differential scale were plotted separately. The data were then sorted into two subsamples according to the operational definition of a psychiatric nurse, i.e., one group of nurses with one year or more of psychiatric nursing experience (N = 27), and the other group of nurses with less than one year of psychiatric nursing experience (N = 113). The mean responses of the two groups to the 56 adjective pairs were computed, then the probability of drawing two samples that differ more then the two tested was computed using the 2-tailed T-test to compare the mean scores of the two groups of nurses. Since the 2-tailed probability of the test for homogeniety of variance (F-value) indicated no significant difference in the two groups on 54 of the 56 variables, the pooled T-value was used. The alpha level of 0.01 was chosen as significant in this study.

Semantic differential responses for the eight questions were totaled and averaged on each point of the 7-point scale for each of the seven adjective pairs. These scores were cross-tabulated respectively with the averages of the demographic information about the nurses' highest level of education, length of psychiatric nursing experience, and professional age.

Since the independent variables were ordinal and the dependent variables were interval in nature, the following associational statistics were computed: 1) Chi square, to measure whether or not a systematic relationship existed between the two variables plotted (the alpha level of 0.01 was considered significant), 2) Kendall's tau, to determine whether the rankings of the two variables were similar (results were considered significant at the 0.01 level), and 3) Eta, to consider how dissimlar the means on the dependent variable were within the categories of the independent variable. A raw score of 0.30 was considered significant, and the Eta squared was used as an intuitive interpretation of what proportion of the variance in the dependent variable was accounted for by the independent variable (Nie, 1975).

CHAPTER 3

RESULTS AND DISCUSSION

The purpose of this study was to assess the feelings of general duty nurses in relation to the care of patients with psychiatric symptoms in the general medical-surgical hospital setting. Included in this chapter is a presentation of the results of this assessment and a discussion of them in relation to the five research questions. In addition, other relevant findings associated with the problem under study are presented and discussed.

Limitations of the Study

Although the 7-point semantic differential format used in this study is widely accepted, Polit and Hungler (1978) describe the following limitations that could have an affect on this study.

1. Respondents may become confused or bored with the type of questions used and may manifest their discomfort by placing all of their check-marks in one place on the scale (usually in the center).

2. Response set bias (i.e., the tendency of certain individuals to respond to items in characteristic ways) is possible. Among these response sets, social desireability (trying to appear in a favorable light) and extreme responses to alternatives, are most likely to be present in this study.

Since the sample used in this survey was "self-selected" and anonymous, the study is limited by the fact that nothing is known about the non-respondent.

Research Question One

Do nurses working in the general hospital setting express uncomfortable feelings about caring for patients who have psychiatric symptoms?

For purposes of answering this question, the frequency distributions of all of the subjects' responses (N = 140) to survey questions related to the simulated patient-care situation were examined (Appendix A-2, 3). The mean scores for 51 out of the 56 variables fell within the median of 3.5 to 4.5 on the 7-point semantic differential scale, however, the response "mode" was found to be in the direction of two negatively stated adjectives (discomfort and inadequacy) on 81% of the survey questions.

Since the distributions were skewed to the left on 41 of the 56 variables, the possibility that a small number of extremely positive responses had distorted the mean was considered likely. In view of this possibility, separate examination of the mean responses of the nurses with less than one year of psychiatric nursing experience (N = 113) and those of the nurses with one year or more of psychiatric nursing experience (N = 27) was done. Tables 1 through 8 which follow show a comparison of these mean scores along with the results of the T-test (with 138 degrees of freedom) for each of the questions relating to the simulated patient-care situation. The mean scores reported in these tables relate to the 7-point semantic differential scale which had a median range of 3.5 to 4.5 (scores greater than 4.5 correspond with the negatively stated adjectives; scores less than 3.5 correspond with the positively stated adjectives).

Affective Responses Relating to Acceptance of Total Care Responsibility for Patients with Psychiatric Symptoms.

As can be seen in Table 1, responses to the anxiety factors (relaxed-tense and comfortable-uncomfortable), the reluctance factor, and the adequacy factor vary significantly between the two groups of nurses. This difference in response suggests that the general duty nurses in the sample are anxious about caring for psychiatric patients and would be reluctant to accept responsibility for providing total care to such a patient. Although the adequacy response of the nurses with no psychiatric experience is within the median, it is interesting to note that there is a very significant difference between this group's response and the responses of the nurses with psychiatric experience. Thus it is suggested that the former group of nurses feels considerably less adequate in this situation than the latter group.

The responses of the two groups show no significant difference on the pleasantness factors (elated-depressed, pleased-annoyed).

Table 1

Total care responsibility

Response	Less than 1 yr. exp. Group I (N=113)	More than 1 yr. exp. Group II (N=27)	T-Value	Probability
Relaxed/Tense	4.61	2.96	4.51	0.00*
Pleased/Annoyed	4.64	3.78	2.41	.02
Elated/Depressed	4.34	4.04	1.14	.26
Comfortable/Uncomfortable	4.66	2.96	4.12	0.00*
Pleasant/Unpleasant	4.30	3.44	2.32	.02
Enthusiastic/Reluctant	4.8	3.33	4.00	0.00*
Adequate/Inadequate	4.42	2.6	4.64	0.00*

*Significant difference

Affective Responses Relating to Being Left Alone With a Psychiatric Patient

Table 2 illustrates an interesting difference between the two groups of nurses in this study. According to the probability figures, the differences between the two groups are more significant than the alpha level (0.01) chosen for this study (i.e., it is not probable that two samples could be drawn that differ more than these two groups on six of the seven variables). However, upon closer examination, it can be seen that the responses of the Group I nurses (less than one year of psychiatric experience) all fall within the median range (3.5 to 4.5) while those of the Group II nurses (more than one year of psychiatric experience) were well to the left of the median (i.e., toward the positively stated adjectives). The lack of strong feelings for or against being left alone with a psychiatric patient on the part of the Group I nurses suggests that these nurses probably are not afraid of being harmed by the patient. However, the very positive feelings expressed by the Group II nurses seems incongruent both to the situation and in comparison to the Group I responses. It is possible that this difference is due to self-confidence gained through experience, or to the response-set bias mentioned earlier in this chapter (i.e., respondents trying to appear in a favorable light). However, considering the significant difference between the responses of the two groups, the possibility of the very positive responses being the result of an attitude change as could be predicted according to the theory of cognitive dissonance (Cohen, 1964; Zimbardo, 1969) must also be considered.

Table 2

Alone with a psychiatric patient

Response	Less than 1 yr. exp. Group I (N=113)	More than 1 yr. exp. Group II (N=27)	T-Value	Probability
Relaxed/Tense	4.26	2.37	4.74	0.00*
Pleased/Annoyed	4.38	3.44	2.83	.01*
Elated/Depressed	4.33	3.78	1.97	.05
Comfortable/Uncomfortable	4.21	2.56	4.24	0.00*
Pleasant/Unpleasant	3.97	2.48	3.98	0.00*
Enthusiastic/Reluctant	4.48	2.89	4.35	0.00*
Adequate/Inadequate	4.19	2.33	4.77	0.00*

*Significant difference

Affective Responses to Conducting a Mental Status Examination

The T-values shown in Table 3 demonstrate a significant difference between the mean scores of the two nurse groups on six of the seven variables. The general duty nurses in the sample (Group I) express feelings of anxiety, reluctance, and inadequacy in this situation, while the opposite is expressed by those nurses with psychiatric experience (Group II).

These scores suggest that general duty nurses are concerned about lacking skills needed in the assessment of a patient's mental status. The very positive responses of the nurses with psychiatric experience could be the result of self-confidence gained through experience, the response-set bias, or related to an attitude change as has been discussed previously.

Table 3

Conducting a mental status examination

Response	Less than 1 yr. exp. Group I (N=113)	More than 1 yr. exp. Group II (N=27)	T-Value	Probability
Relaxed/Tense	4.67	2.67	5.30	0.00*
Pleased/Annoyed	4.50	3.04	4.32	0.00*
Elated/Depressed	4.50	3.93	1.97	.05
Comfortable/Uncomfortable	4.71	2.48	5.82	0.00*
Pleasant/Unpleasant	4.32	2.78	4.12	0.00*
Enthusiastic/Reluctant	4.73	2.96	5.03	0.00*
Adequate/Inadequate	4.75	2.48	5.95	0.00*

*Significant difference

Affective Responses to Dealing With a Patient's Emotional Outburst

Table 4 illustrates another interesting difference in the responses of these two groups of nurses. While the probability figures again show a significant difference in the mean scores of the two groups on six of the seven variables, it can be seen that this time the difference is related to some very anxious, unpleasant, reluctant, and inadequate feelings expressed by the general duty nurses (Group I) compared to median responses of the psychiatric-experienced nurses (Group II). Since the intensity of the Group I responses to this question is considerably greater than their responses on any of the other questions considered, it is apparent that this is an area of considerable concern to them.

The median response of the experienced psychiatric nurses suggests

that there is a broader range of response within the group on this question (possibly due to varying degrees of self-confidence gained from different experiences). Although certainly not conclusive, these findings seem to negate the probability of the response-set bias suggested previously.

Table 4

Dealing with a psychiatric patient's emotional outburst

Response	Less than 1 yr. exp. Group I (N=113)	More than 1 yr. exp. Group II (N=27)	T-Value	Probability
Relaxed/Tense	5.57	3.93	5.27	0.00*
Pleased/Annoyed	4.92	3.96	3.02	0.00*
Elated/Depressed	4.82	4.44	1.22	.23
Comfortable/Uncomfortable	5.50	3.85	4.44	0.00*
Pleasant/Unpleasant	4.94	3.78	3.29	0.00*
Enthusiastic/Reluctant	5.04	3.70	3.83	0.00*
Adequate/Inadequate	5.10	2.93	5.85	0.00*

*Significant difference

Affective Responses to the Prospect of Spending More Than One Day Caring For a Psychiatric Patient

There is a significant difference demonstrated between the responses of the two groups of nurses on all but one of the variables illustrated in Table 5 (elated-depressed). However, here again the difference is due to uncomfortable responses of general duty nurses (Group I) while the responses of psychiatric-experienced nurses are within the median. These scores indicate that general duty nurses feel anxious, displeased, reluctant and

inadequate with the idea of spending an extended period of time caring for a psychiatric patient. Psychiatric nurses in the sample apparently do not have strong feelings in favor or against the idea, although they do express a feeling of being adequate to deal with the situation.

Table 5

Spending more than one day caring for a psychiatric patient

Response	Less than 1 yr. exp. Group I (N=113)	More than 1 yr. exp. Group II (N=27)	T-Value	Probability
Relaxed/Tense	4.96	3.96	2.65	.01*
Pleased/Annoyed	4.98	3.78	3.39	0.00*
Elated/Depressed	4.92	4.22	2.09	.04
Comfortable/Uncomfortable	4.89	3.44	3.67	0.00*
Pleasant/Unpleasant	4.78	3.59	3.31	0.00*
Enthusiastic/Reluctant	4.90	3.70	3.24	0.00*
Adequate/Inadequate	4.98	3.37	3.96	0.00*

*Significant difference

Affective Responses to Self-assessment of Ability to Give Quality Nursing Care to Patients With Psychiatric Symptoms

There is a significant difference between the responses of the two groups of nurses on all of the variables illustrated in Table 6. However, responses of the psychiatric nurses in the sample once again are outside of the median (toward the positively stated adjective) on all except one pleasantness variable, while responses of the general duty nurses are outside of the median (toward the negatively stated adjective) on the vari-

ables related to anxiety, reluctance and inadequacy. These findings suggest that general duty nurses are anxious and reluctant in the psychiatric patient-care situation probably due to a lack of confidence in their own ability to give quality nursing care to this type of patient.

Table 6

Ability to give quality nursing care

Response	Less than 1 yr. exp. Group I (N=113)	More than 1 yr. exp. Group II (N=27)	T-Value	Probability
Relaxed/Tense	4.60	3.00	4.26	0.00*
Pleased/Annoyed	4.45	3.00	4.24	0.00*
Elated/Depressed	4.50	3.70	2.55	.01*
Comfortable/Uncomfortable	4.68	2.70	5.24	0.00*
Pleasant/Unpleasant	4.46	2.85	4.48	0.00*
Enthusiastic/Reluctant	4.67	2.89	4.78	0.00*
Adequate/Inadequate	4.74	2.67	5.22	0.00*

*Significant difference

Affective Responses to Consideration of the Relationship of Nursing Education Background to Preparedness for Dealing With a Psychiatric Patient Situation

Although there is a significant difference in the responses of the two groups on all variables demonstrated in Table 7, the scores of the general duty nurses are on or very near the upper limit of the median (4.5). Whereas, these nurses do not express strong negative feelings about their educational preparation in psychiatric nursing, there is apparently some uneasiness about it.

Responses of the psychiatric-experienced nurses (Group II) were again

to the left of the median (toward the positively stated adjective). Since only two of the seven masters prepared nurses were in this group, the difference in response of these two groups cannot be accounted for by advanced level of education. It seems most likely that either the response-set bias mentioned earlier, or the differing perceptions of the two groups based upon their career histories is reflected in these findings.

Table 7

Relationship of nursing education background to preparedness for dealing with a psychiatric patient situation

Response	Less than 1 yr. exp. Group I (N=113)	More than 1 yr. exp. Group II (N=27)	T-Value	Probability
Relaxed/Tense	4.63	3.15	3.75	0.00*
Pleased/Annoyed	4.50	2.85	4.20	0.00*
Elated/Depressed	4.59	3.70	2.60	.01*
Comfortable/Uncomfortable	4.42	2.96	3.73	0.00*
Pleasant/Unpleasant	4.47	3.11	3.52	0.00*
Adequate/Inadequate	4.48	2.82	4.30	0.00*

*Significant difference

Responses of Nurses Concerning the Relationship of Previous Psychiatric Nursing Experiences to Their Present Feelings of Preparedness to Deal With the Psychiatric Patient

Table 8 illustrates a continued difference between the responses of the two groups of nurses which is significant on all variables; in addition, all responses fall outside of the median for both groups. General duty nurses in the sample again express anxiety, displeasure, and inadequacy, suggesting that their previous experiences with psychiatric patients have not

been very comfortable for them, while the psychiatric-experienced nurses express opposite feelings.

Table 8

Relationship of previous psychiatric nursing experience to present feeling of preparedness to deal with a psychiatric patient

Response	Less than 1 yr. exp. Group I (N=113)	More than 1 yr. exp. Group II (N=27)	T-Value	Probability
Relaxed/Tense	4.75	2.22	6.17	0.00*
Pleased/Annoyed	4.64	2.67	4.94	0.00*
Elated/Depressed	4.66	3.44	3.40	0.00*
Comfortable/Uncomfortable	4.79	2.26	6.23	0.00*
Pleasant/Unpleasant	4.60	2.70	4.56	0.00*
Adequate/Inadequate	4.69	2.30	6.08	0.00*

*Significant difference

Summary

General duty nurses in the sample expressed uncomfortable feelings indicative of anxiety, unpleasantness, reluctance, and inadequacy when thinking about caring for a psychiatric patient in the general hospital setting. In contrast, psychiatric-experienced nurses in the sample expressed no feelings related to anxiety and overall seemed to feel pleasant, enthusiastic and adequate about all aspects of psychiatric patient care. Statistical testing of the "mean" responses established that there was a significant difference between the two groups of nurses on all variables except elated-depressed, for all of the survey questions. These findings indicate that most general hospital nurses are anxious about, and

reluctant to give care to, a psychiatric patient. They suggest further that these feelings are due to concern about personal lack of necessary skills rather than fear of being harmed by the patient.

Research Question Two

Do general hospital nurses indicate reluctance to care for patients with psychiatric symptoms?

In order to answer this question, the response of the subjects to the two multiple choice questions dealing with possible behaviors in relation to frequent contact with psychiatric patients and options for patient-care, were considered (Appendix A-3).

Reactions of Nurses to Frequent Assignment to Care for Patients With Psychiatric Symptoms (Table 9)

Sixty-two percent of the 140 general hospital nurses in the sample (N = 87) expressed some degree of reluctance to care for psychiatric patients. However, subsample analysis of nurses with, and nurses without, psychiatric experience reveals that the reluctance is greatest among those nurses without experience. Many of these nurses expressed a need for more training in the psychiatric specialty before they would be willing to care for such patients.

Table 9

Frequent assignment to care for patients with psychiatric symptoms

Response	Less than 1 yr. exp. Group I (N=113)	More than 1 yr. exp. Group II (N=27)
Willing	30% (N=34)	71% (N=19)
Avoid/Complain	37% (N=42)	25% (N=7)
Refuse	7% (N=8)	0% (N=0)
Terminate job	1% (N=1)	0% (N=0)
Yes, but desire more training	25% (N=28)	4% (N=1)

Options for Dealing With a Psychiatric Patient-care Situation (Table 10)

Although few of the nurses with less than one year of psychiatric experience express willingness to care for this type of patient independently, it is interesting to note that a majority (67%) of them desire specialist consultation, preferrably from a psychiatric nurse.

Table 10

Care Options

Response	Less than 1 yr. exp. Group I (N=113)	More than 1 yr. exp. Group II (N=27)
Independently care for patient	12% (N=13)	52% (N=14)
Desire psychiatrist consult	16% (N=18)	11% (N=3)
Desire psychiatric nursing consult	51% (N=58)	37% (N=10)
Avoid contact	21% (N=24)	0% (N=0)

Summary

A majority of general hospital nurses do indicate reluctance to care for patients with psychiatric symptoms (Table 9), however, their choice of specialist consultation rather than direct avoidance of the situation (Table 10) suggests that their reluctance may be due to concern about lacking the specialized therapeutic skills needed to handle the situation effectively.

Treatment of Data for Cross-Tabulation

The data considered in answering the remaining research questions were handled as follows: the responses on each point of the 7-point semantic differential scale were totaled, averaged and then collapsed into three categories, i.e., low (below 3.5), medium (3.5 to 4.5) and high (above 4.5). Responses to adjective pairs related to the anxiety factor on the Nowlis and Green Mood Scale (relaxed-tense and comfortable-uncomfortable) were averaged together as one variable, and responses to the adjective pairs related to the pleasantness factor (annoyed-pleased, depressed-elated, pleasant-unpleasant) were averaged together as another variable. The advantage of computing one score rather than investigating each factor separately, is primarily that it simplifies the investigation of the questions; however, this procedure assumes that each of the adjective pairs map validly onto the mood factors described. Since this appeared to be the case in view of the previously reported T-test results, and since the procedure has been reported useful in other research (Norris, 1978), it was felt to be suitable for this study; however, it is recognized that an intercorrelation matrix of these adjectives would be desirable if more conclusive results of the cross-tabulations were desired.

The previously mentioned variables as well as reluctance-enthusiasm and adequate-inadequate were compared to the independent variables of educational background, length of psychiatric nursing experience, and professional age, in order to answer research questions three, four, and five that follow:

Research Question Three

Do the feelings expressed by general hospital nurses demonstrate any relationship to the length of psychiatric nursing experience?

As can be seen in Tables 11 and 12 which follow, there is a significant relationship between longer experience in psychiatric nursing and the nurses' choice of the positively stated adjective on all affective variables.

The direct relationship between the positively stated adjectives of all dependent variables and increased length of psychiatric nursing experience is statistically significant at the 0.00 level (see Table 12). However, the data presented in Table 11 demonstrates that the majority of nurses in both categories with less than one year of experience express reluctance, while anxiety and inadequacy are the greatest in the group with no additional experience. These data suggest that something occurs with psychiatric experience that dramatically changes the affective responses of nurses. However, since this study does not demonstrate cause and effect, additional research is needed to determine what causes this change. While it is possible that the more obvious reason of increased length of experience, plus increased knowledge equals increased self-confidence and self-esteem, the findings of this study, when considered with those of the attitude research previously cited, could also be due to the attitude change phenomena reported in cognitive consistency studies (i.e., a psychological conflict

between what the nurse has been taught to believe is necessary to provide quality care to the psychiatric patient, and the behaviors found to be necessary to contain erratic behavior). The latter possibility warrants close consideration since it suggests that the problem may not be so much with the length of the nurse's education, but rather with the philosophy behind that education.

Table 11

Relationship of length of psychiatric experience to the affective responses of general hospital nurses

Affective Response	Length of Psychiatric Experience: 1 yr. or more (N=27)	Less than 1 yr. (N=18)	None other than initial (N=95)	Totals (N=140)
Not Anxious	12% (17)	4% (6)	8% (11)	24% (34)
Median	5% (7)	2% (3)	16% (23)	23% (33)
Anxious	2% (3)	6% (9)	44% (61)	52% (73)
Pleasant	10% (14)	2% (3)	8% (11)	20% (28)
Median	9% (12)	7% (10)	36% (51)	52% (73)
Unpleasant	1% (1)	4% (5)	23% (33)	28% (39)
Enthusiastic	2% (3)	1% (1)	0% (0)	3% (4)
Median	9% (12)	1% (2)	5% (7)	15% (21)
Reluctant	9% (12)	11% (15)	63% (88)	82% (115)
Adequate	14% (19)	5% (7)	12% (7)	31% (43)
Median	4% (5)	1% (2)	16% (22)	21% (29)
Inadequate	2% (3)	6% (9)	40% (56)	48% (68)

Table 12

Statistical relationship between positive affective responses and longer psychiatric nursing experience

Dependent Variable	Chi Square (4df) Raw Score	Signif.	Kendall's Tau(b) Raw Score	Signif.	Eta Raw Score	Squared
Not Anxious	35.39	0.00	0.42	0.00	0.49	0.24
Pleasant	19.44	0.00	0.30	0.00	0.36	0.13
Enthusiastic	35.03	0.00	0.43	0.00	0.49	0.24
Adequate	30.35	0.00	0.37	0.00	0.45	0.20

Research Question Four

Do the feelings expressed by general hospital nurses demonstrate any relationship to the nurses' educational background?

As can be seen in the data presented in Tables 13 and 14 which follow, there is a significant relationship between increased education and the nurses' choice of the positively stated adjective on all of the affective variables except pleasantness.

The statistical association of these variables is shown in Table 14 to be negative indicating an inverse relationship between education and response on the dependent variables (e.g., the less education/the more anxious, etc.). The enthusiastic-reluctant variable demonstrates the greatest statistical significance, suggesting that nurses with a higher level of education are less reluctant to give care to patients with psychiatric symptoms than other nurses. However, while this is demonstrated to be true in the data reported in Table 13, it is important to note that a majority of nurses in all four of the educational levels (N = 115) were reluctant to give care to the patient with psychiatric symptoms. While anxiety and inadequacy, as

well as reluctance, were demonstrated to be related to the nurses' education level and, it might seem, to the length of the initial psychiatric nursing experience, it is apparent that some factor other than the length of initial psychiatric experience is involved here. Diploma programs have traditionally provided the longest student exposure to psychiatric in-patient care. Therefore, if length of exposure were the key to understanding the findings of this study, it follows that one could expect those diploma nurses in the sample to have responded with the least anxiety, inadequacy, and reluctance. However, this was not the case.

Table 13

Relationship of highest level of education to the affective responses of general hospital nurses

Affective Response	Highest Level of Education: Associate Degree (N=48)	Diploma (N=42)	Bachelors (N=43)	Masters (N=7)	Totals (N=140)
Not Anxious	6% (9)	6% (8)	11% (15)	1% (2)	24% (34)
Median	7% (10)	6% (8)	9% (12)	2% (3)	24% (33)
Anxious	21% (29)	19% (26)	11% (16)	1% (2)	52% (73)
Pleasant	5% (7)	4% (6)	11% (15)	1% (2)	21% (30)
Median	19% (27)	17% (24)	11% (15)	3% (4)	50% (70)
Unpleasant	10% (14)	9% (12)	9% (13)	1% (1)	29% (40)
Enthusiastic	0% (0)	0% (0)	2% (3)	1% (1)	3% (4)
Median	3% (4)	3% (4)	9% (12)	1% (1)	15% (21)
Reluctant	31% (44)	27% (38)	20% (28)	4% (5)	82% (115)
Adequate	8% (11)	7% (10)	14% (19)	2% (3)	31% (43)
Median	6% (9)	6% (8)	7% (10)	1% (2)	21% (29)
Inadequate	20% (28)	17% (24)	10% (14)	1% (2)	48% (68)

Table 14

Statistical relationship between positive affective responses and higher level of education

Dependent Variable	Chi Square(6df) Raw Score	Signif.	Kendall's Tau(c) Raw Score	Signif.	Eta Raw Score	Squared
Not Anxious	9.07	NS	-0.18	0.00	0.23	NS
Pleasant	11.40	NS	-0.13	NS	0.18	NS
Enthusiastic	17.87	0.00	-0.18	0.00	0.34	0.11
Adequate	9.39	NS	-0.20	0.00	0.26	NS

Research Question Five

Do the feelings expressed by general hospital nurses demonstrate any relationship to the nurses' professional age?

It was thought that perhaps the previously reported relationships between affective responses and length of psychiatric nursing experience might in reality be merely a reflection of the nurses' general professional maturity as could be described by the years of experience in nursing after graduation from the initial nursing program. This was considered to be especially possible in view of the fact that 35% of the sample reported less than six years since graduation. However, cross-tabulation of the data demonstrated that no significant relationships existed between professional age and any of the dependent variables.

Other Findings

Due to the exploratory nature of the study, several of the questions used in the survey instrument provided information other than that needed to answer the research questions. Since some of the information gained may

have pertinence to the conclusions and recommendations for future study, it will be reviewed briefly.

Responses to the Open-ended Question: "What Are Your Concerns in Caring for Patients Who Have a Psychiatric Diagnosis or Whose Behavior Seems to be Symptomatic of a Psychiatric Problem?"

The statements of the respondents to this question were categorized by this investigator according to their relationship to either concern over personal lack of therapeutic skills or concern that the patient would cause injury to himself or to another person (dangerousness), and the two subgroups of nurses were compared as is shown in Table 15. More than half of all nurses in the sample expressed concerns not related to the dangerousness of the patient. However, it is interesting to note that the major concern of experienced nurses was the possibility of dangerous patient-behavior, while in contrast, the major concern of inexperienced nurses was the adequacy of their own therapeutic skills.

Table 15

Nurses' concerns about caring for psychiatric patients

Concerns	Overall Sample Totals	Nurses "With" Experience	Nurses "Without" Experience
Doubtful of Adequacy of own therapeutic skills	67 (48%)	5 (17%)	62 (55%)
Danger of patient to self or others	45 (32%)	16 (59%)	29 (26%)
Other Concerns	28 (20%)	6 (24%)	22 (19%)
Total of N	140 (100%)	27 (100%)	43 (100%)

Responses to the Open-ended Question: "What Patient Behaviors Do You Consider to Indicate Psychiatric Problems?"

Respondent's statements were categorized by this investigator according to the presence or absence of a description relative to psychosis (non-reality orientation such as delusions or hallucinations) and/or dangerourness (mention of violent, aggressive, or suicidal behavior) illustrated in the subsample comparisons displayed in Table 16. Although the responses were well distributed through the four categories, a greater number of the total sample (N = 47) described problematic behavior in terms of the patient being non-psychotic and non-dangerous. Examination of the subsamples, however, demonstrates that a majority of the nurses "without" experience described problematic behaviors in non-psychotic terms, whereas, the majority of those "with" experience described them in psychotic terms. In both cases, a greater number of nurses described non-dangerous behavior.

Table 16

Behaviors seen as psychiatric problems by nurses in the general hospital

Behaviors	Sub-Samples: Nurses "with" Experience (N=27)	Nurses "without" Experience (N=113)	Overall Sample (N=140)
Psychotic, Dangerous	7 (28%)	23 (20%)	30 (21%)
Psychotic, Not Dangerous	9 (33%)	25 (22%)	34 (24%)
Not Psychotic, But dangerous	4 (15%)	23 (20%)	27 (19%)
Not Psychotic, Not Dangerous	6 (21%)	41 (37%)	47 (34%)
Other	1 (3%)	1 (1%)	2 (2%)

Responses to the Question About Facility Adequacy and Perceived Needs for Improvement

As shown in Table 17, more than half of the nurses felt that their hospital was adequate to deal safely with the needs of psychiatric patients and had no suggestions for improvement. Among the needs identified by the nurses who expressed that they felt their hospital was inadequate, better security for the safety of both the patient and others, and the need for additional staff training ranked highest.

CHAPTER IV

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary and Conclusions

The assumption that psychiatric patients are better treated in their own communities, and the search for alternatives to institutionalization, has resulted in the emergence of the general hospital as a focal point for the delivery of acute mental health care. This change in the in-patient treatment of psychiatric conditions has been accompanied by much concern on the part of psychiatric professionals, many of whom claim that the general hospital environment is not adequate to treat patients of this kind (Greenhill, 1978; Ames, 1978). One of the foremost problems identified seems to be the difficulty that these hospitals have in obtaining nursing staff to work with psychiatric patients who are frequently admitted involuntarily and demonstrate out-of-control (violent or suicidal) behavior.

Since on the one hand community general hospitals are faced with the probability of an increased psychiatric patient population, and on the other hand they are reported to be having difficulty obtaining nursing staff to care for these kinds of patients, it seems timely to investigate the problem from the nursing perspective. However, the few studies dealing with nurses and psychiatric patients reported in the social science, medical and nursing literature, have been done in terms of those nurses' attitudes toward mental illness. Although the studies by Perry (1963) and Kahn (1976) revealed that nurses with one or more years of psychiatric nursing experience have significantly less liberal attitudes toward mental

Table 17

Nurses' comments about adequacy of facility and needs for improvement

1. Facility adequate environmentally?

Yes = 57% (N=80)

No = 43% (N=60)

Facility Needs: (N=60)

a. More privacy for patients (N=4).

b. Segregation of psychiatric patients from others/more structured environment (N=16).

*c. Security for safety of the patient and/or others (N=31).

d. Better recreation for patients (N=1).

e. Other (N=8).

2. Facility adequately staffed with qualified personnel?

Yes = 57% (N=80)

No = 43% (N=60)

Staff Needs: (N=60)

*a. More psychiatric training (N=34).

b. Increased numbers of trained staff (N=16).

c. Specialist for consultation (N=4).

d. Other (N=6).

*Area of greatest response

illness than nurses with less psychiatric nursing experience, they fail to establish any connection between this and the problems which face general hospitals.

The purpose of this study was to examine an area that may well provide this connection--i.e., the feelings that nurses have about caring for patients with psychiatric symptoms in the general hospital setting. The results of this study suggest that:

1. General hospital nurses do feel anxious and are reluctant to care for psychiatric patients. Furthermore, it appears from the data that this anxiety is more likely due to feelings of inadequacy relative to a perceived lack of personal psychotherapeutic ability, rather than fear of the patient being dangerous to himself or others. These findings are consonate with cognitive consistency studies since lack of a behavioral skill, felt by the nurse to be necessary for quality patient care, would certainly be dissonant with the philosophy of nursing and thus the nurse's self-concept.

2. Nurses with one year or more of psychiatric experience consistently relate more positive, i.e., less anxious and more pleasant feelings about caring for psychiatric patients than nurses with less psychiatric nursing experience; however, they describe more concern about psychotic behavior and safety factors than do the other nurses. This finding agrees with cognitive consistency studies related to the phenomena of attitude change (i.e., a conflict between the behavior found to be necessary to control erratic behavior and beliefs about the causes and treatment of mental illness), and with the attitude findings of Kahn (1976), since authoritarian and social-restrictive attitudes are consonate with concerns

about the patient being dangerous.

3. Nurses with a higher level of education, i.e., Bachelors or Masters Degree, tend to have more positive feelings about caring for patients with psychiatric symptoms than nurses with less education. Although these results could be due to an increased length of time in the initial training and thus, a longer psychiatric nursing experience, this seems unlikely since nurses from Diploma programs have traditionally had a longer exposure to psychiatric in-patient care during their educational programs. Therefore, possibilities other than the length of psychiatric experience should be considered in future research. One area that seems to warrant further investigation in view of the previous review of the literature relating to the concept of anxiety, is the relationship of education level to the nurses' self-esteem.

Upon initial examination, the findings of this study seem to indicate a need for longer exposure to psychiatric patients and more indepth training in psychotherapeutic techniques for nurses. However, closer inspection of the data, along with the literature reviewed relating to anxiety, attitudes toward mental illness, and cognitive dissonance theory, produces another concern: Is the present education of nurses the problem, or is the theoretical base of the present education lacking a necessary component? Since current trends in psychiatric care demonstrate a continued focus upon provision of services within the patient's community, the results of this study point toward a need to provide nurses with the skills needed to feel adequate in the care of these patients. However, it seems prudent to also examine the conceptual base of present mental health ideology to consider whether or not it is adequate to meet the real-life situations in which psychopathology presents itself with psychosis and erratic

behavior. Perhaps it is not realistic to expect a single philosophy such as the psychosocial approach to cover all aspects of the mental health/mental illness continuum.

Recommendations

Based on the findings of this study, and in light of the continuing trend toward deinstitutionalization, the following recommendations are made:

1. That generic nursing education programs include more specific training in mental status assessment, the use of at least one psychotherapeutic approach for improvement of mental health, and methods for containing erratic behavior.

2. That general hospitals obtain the services of a Psychiatric Nursing Clinical Specialist for the purposes of: a) consulting with nursing and medical staff about planning for the nursing care needs of any patients with psychiatric-related problems, and b) provision of psychiatric/mental health nursing inservice education.

3. That further studies be undertaken to examine differences between levels of nursing education and the self-esteem of the nurse, especially as it might account for the observed relationship between increased comfort with psychiatric patient-care and non-psychiatric advanced education.

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Appendix A-1

OFFICE OF THE DEAN
SCHOOL OF NURSING

Area Code 503 225-7790

Portland, Oregon 97201

UNIVERSITY OF OREGON

HEALTH SCIENCES CENTER

CONSENT TO PARTICIPATE IN STUDY

You have been selected to participate in a survey study to consider "Nurses' Feelings about Caring for Psychiatric Patients in the General Hospital," conducted by Gwendolyn K. Gould, R.N., B.S.N., under the supervision of Susan J. Will, R.N., M.S.N., Thesis Advisor. This study is part of a masters thesis research project and your help would be greatly appreciated.

If you choose to participate, you are asked to complete the attached questionnaire consisting of thirteen questions related to a hypothetical patient situation, and some background information about yourself. As a participant, it is estimated that this will take about 20 minutes of your time. It is important that you answer each question as completely and honestly as possible, however, you are not required to participate and may withdraw from the study at any time, or decline to complete certain parts of the questionnaire used in the study.

Your participation or non-participation will in no way be used to influence your employment, and the anonymity of each participant is assured.

The completion and return of the questionnaire will be taken as evidence of your willingness to participate and your consent to have the information used for the purposes of this study.

Please take the time to complete the questionnaire and return it in the attached envelope; each response is important! In order that your responses may be used, please complete and return the questionnaire by May 18, 1981.

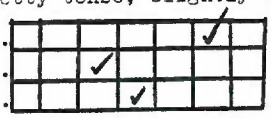
Should you have any questions, feel free to call: Gwen Gould
672-3400

QUESTIONNAIRE

Section I

Directions: Please read the patient situation that follows and assume that the patient has been admitted to the hospital ward on which you are working. Rate the subsequent questions as **honestly as you can, according to your personal feelings.** In rating the questions, be sure to mark on each of the seven lines (a-g) for every question. Be aware that the closer you check to a descriptive word, the stronger you indicate your feelings are in that direction in relation to the particular situation described. **(Please do not discuss your responses with other nurses until after the questionnaires have been completed and returned)**

Example: Right now I feel pretty tense, slightly annoyed, and neither elated nor depressed:



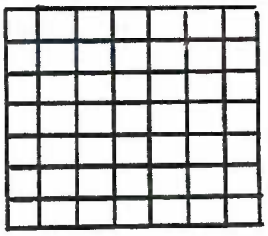
The Patient:

Mrs. C., married for 18 months, is a 28 year old mother of a 3 month old boy. She has experienced two psychotic episodes in the past three years; the last was approximately one year ago. Both episodes were managed with major tranquilizers and hospitalizations of approximately one month. However, Mrs. C. has not been on medication for approximately ten months.

During her pregnancy, Mrs. C. and her husband retreated from her very critical parents by moving here from another state and Mrs. C's. husband has been unable to find work. They have very little money, are living in temporary quarters, and feel isolated from family and friends.

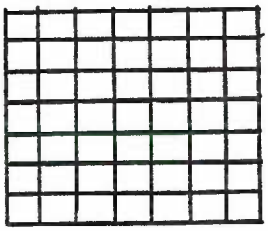
The pregnancy, labor, delivery and post partum period were otherwise medically and psychiatrically uncomplicated. Mrs. C's son has grown and developed normally during the last three months; however, she has recently been feeling that her husband is critical of the care that she gives the baby. During the week before this admission, Mrs. C. became confused, very frightened, agitated, suspicious, and withdrawn. She has been demonstrating loose associations, has critical auditory hallucinations, persecutory delusions of harm to herself and to her baby, and has experienced the regressive delusion that she is a young child again. She is inconsistent in feeding and caring for her infant, often having difficulty seperating her feelings and needs from those of the baby. She also has been neglecting her own diet and hygiene. She is admitted, now, for treatment of dehydration and malnutrition as well as for diagnostic work-up related to cardiac irregularity, fainting, and fever of unknown origin. The hospital is full and your ward has the only available bed.

1. At a staff meeting, your supervisor is asking for a volunteer from each shift to accept responsibility for the total care of this patient in order to maintain continuity of care and reduce the patient's anxiety. This patient's room is located near those of your other patients, and everyone at the meeting seems to be looking to you to volunteer. Your feelings about accepting the responsibility for this patient's care are:



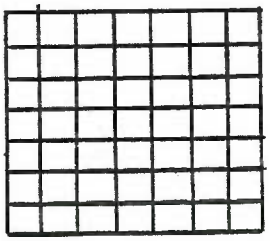
Computer Column
1.
a. b. c. d. e. f. g.

2. You have decided to accept this increased patient load for the next five days. As you prepare to enter the patient's room to make your initial assessment, you realize that no other staff members are nearby,--you are alone. You feel:



2.
a. b. c. d. e. f. g.

3. In addition to the assessment of this patient's physical needs, you need to assess her mental state. This necessitates giving a mental status exam. How do you feel about doing this?



3.
a. b. c. d. e. f. g.

Computer Column

4. "As you are talking with Mrs. C., she tells you of her fear that she and her baby are going to be killed. She becomes very "frantic" (screaming and trying to leave the room), demanding to know where her baby is. As you consider your abiliby to deal with this problem, you feel:

a.	relaxed.....	tense
b.	annoyed.....	pleased
c.	elated.....	depressed
d.	uncomfortable	comfortable
e.	pleasant.....	unpleasant
f.	reluctant....	enthusiastic
g.	inadequate...	adequate

4. a.__ b.__ c.__ d.__ e.__ f.__ g.__

5. Driving home after completing your shift, you realize that you have at least four more days to care for this woman. You feel:

a.	relaxed.....	tense
b.	annoyed.....	pleased
c.	elated.....	depressed
d.	uncomfortable	comfortable
e.	pleasant.....	unpleasant
f.	reluctant....	enthusiastic
g.	inadequate...	adequate

5. a.__ b.__ c.__ d.__ e.__ f.__ g.__

6. In general, how do you feel about your capability to give quality nursing care (considering the physical, psychosocial, and spiritual needs) to a patient such as Mrs. C?

a.	relaxed.....	tense
b.	annoyed.....	pleased
c.	elated.....	depressed
d.	uncomfortable	comfortable
e.	pleasant.....	unpleasant
f.	reluctant....	enthusiastic
g.	inadequate...	adequate

6. a.__ b.__ c.__ d.__ e.__ f.__ g.__

7. Looking back on your nursing education, what are your feelings about it in relation to your preparedness to care for a psychiatric patient such as Mrs. C. ?

a.	relaxed.....	tense
b.	annoyed.....	pleased
c.	elated.....	depressed
d.	uncomfortable	comfortable
e.	pleasant.....	unpleasant
g.	inadequate...	adequate

7. a.__ b.__ c.__ d.__ e.__ f. 8 g.__

8. Considering your personal experiences working in the field of nursing, what are your feelings about that experience in relation to your preparedness in caring for a psychiatric patient such as Mrs. C.?

a.	relaxed.....	tense
b.	annoyed.....	pleased
c.	elated.....	depressed
d.	uncomfortable	comfortable
e.	pleasant.....	unpleasant
g.	inadequate...	adequate

8. a.__ b.__ c.__ d.__ e.__ f. 8 g.__

9. If you were in the position of being asked frequently to include this type of patient in your case load, your most likely reaction would be: (circle one)

a. happy to oblige.
b. complain to my supervisor and try to avoid continuance of the situation
c. refuse to do it.
d. quit my job.
f. other (please explain)_____.

9.__

10. Given the following options for dealing with a psychiatric patient in your work situation, what would your preference of action be? (circle one)

a. transfer the patient to another unit.
b. get the doctor to discharge the patient as soon as possible.
c. plan patient care as usual.
d. ask for a psychiatrist to consult.
e. ask for a psychiatric nursing consultation.
f. other (please describe)_____

10.__

11. What kinds of patient behaviors do you consider to indicate psychiatric problems (from your experience as a nurse in a general hospital)? _____

_____

11.__

12. What are your greatest concerns in caring for patients who have a psychiatric diagnosis or whose behavior seems to be symptomatic of a psychiatric problem?_____

_____

12.__

Computer Column

Section I (cont.)

13. Do you think that the hospital where you work:

a. is environmentally adequate for dealing safely with psychiatric patients?

___ yes; ___ no.

b. If no, please indicate what you think is needed for improvement:_____

_____

c. is adequately staffed with personnel qualified to manage the care of psychiatric patients, safely? ___ yes; ___ no.

d. If no, please indicate what you think is needed for improvement:_____

_____

14. Additional comments:_____

_____

Section II - Background information

15. Your year of birth: 19_ _.

16. Your gender: a. __ male
b. __ female

17. What type of basic nursing education did you complete?

a. ___Associate Degree in Nursing
b. ___Diploma in Nursing
c. ___Bachelor of Science Degree in Nursing
d. ___other (describe)_____

18. Was your basic nursing education obtained in Oregon?

a. ___yes
b. ___ no

19. In what year was your basic nursing education completed? 19 _ _.

20. Please indicate additional education level and/or specialty certification, date of completion, and major field of study:

a. ___ Associate Degree, 19 _ _.
b. ___ Diploma in Nursing 19 _ _.
c. ___ B.S.N. 19 _ _.
d. ___ Masters Degree in Nursing, 19 _ _. Specialty area:_____
e. ___ Other, 19 _ _. Please describe:_____

21. Present employment status:

a. ___ Employed in nursing full-time (40 hrs. or more per week).
b. ___ Employed in Nursing part-time (less than 40 hrs. per week).
c. ___ Other (please describe):_____

22. How many years (total) have you worked in nursing? _____years.

23. In what specialty areas have you worked? (please indicate number of years of experience in each area).

a. ___ Critical Care/Emergency Room, _____years
b. ___ Operating Room/Recovery Room, _____ years
c. ___ Surgical, _____years
d. ___ Medical, _____years
e. ___ Obstetrics, _____years
f. ___ Psychiatric/Alcohol Treatment, _____years
g. ___ Other:_____, _____years.

24. In what specialty area of nursing are you presently working?

a. ___ Critical Care/Emergency Room
b. ___ Operating Room/Recovery Room
c. ___ Surgical
d. ___ Medical
e. ___ Obstetrics
f. ___ Psychiatric/Alcohol Treatment
g. ___ Other:_____

25. What duty shift do you usually work?

a. ___ days (7-3:30; 7:30-4)
b. ___ afternoons (3-11; 4-12)
c. ___ night (11-7; 12-8)
d. ___ other (please describe)_____

13. a. _____
b. _____
c. _____
d. _____
14. 8
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23a. _____
24
23b. _____
25 _____

SCHOOL OF NURSING

A-5

Area Code 503 225-7793

Portland, Oregon 97201

UNIVERSITY OF OREGON

HEALTH SCIENCES CENTER

May 20, 1981

To: ALL REGISTERED NURSES

From: Gwen Gould, RN, Graduate Student, UOHSC

Subject: Research Questionnaire - "Nurses Feelings About Caring for Psychiatric Paitents in the General Hospital"

Just A REMINDER to those of you who may have planned to complete and return the questionnaire, but have not yet done so. THERE IS STILL TIME to include your response in the study if you hurry!

A response rate of at least 50% is desireable for good data analysis in a study of this kind. I have already received 38%, but YOUR RESPONSE IS NEEDED! Please take a few minutes, now, to complete the form and drop it in the mail by May 28, 1981. THANKYOU!!

MANY THANKS TO THOSE OF YOU WHO HAVE ALREADY RETURNED THE QUESTONNAIRE. Your cooperation and assistance with this project is very much appreciated!

APPENDIX B

March 6, 1981

_____
Director of Nursing Service

_____
Oregon,

Dear _____

I am preparing to do a survey study of Roseburg nurses which will explore their feelings about caring for psychiatric patients in the general hospital, as part of my masters thesis research project. The study will be conducted under the supervision of my thesis advisor, Ms. Susan J. Will, R.N., M.S.N., after I receive approval from the Nursing Research Committee at the University of Oregon Health Sciences Center. I anticipate being ready to begin my data collection in late March or early April.

As I mentioned when we talked last month by telephone, the study entails distributing a short questionnaire to the registered nurses on your staff which they will be asked to fill out and return to me in a self-addressed, stamped envelope that I will provide. The questionnaire is three pages in length and consist of 25 questions in two sections, which should take no more than 15 to 20 minutes to fill out. Section I, relates a hypothetical patient situation to which "feeling" responses are requested, and Section II, asks for some information about the individual nurse's educational background and experience.

The anonymity of each nurse is assured since the questionnaires will have no means of identification to individuals. I will, however, be analysing the data in hospital subgroups as well as in an overall description, so the questionnaires themselves will be color-coded to allow identification of the employing institution. I will be happy to share the results of the study with you, if you wish. Your institution will not be identified by name in the study report.

Although we have already discussed this by telephone, it is necessary that I have, on file, your written permission to conduct the study with your employees. I would appreciate hearing from you at your earliest convenience. If you have questions, please feel free to call me at 672-3400. I will, of course, contact you for an appointment to discuss the study in more detail as soon as I receive official permission from the university, to begin.

Sincerely,

Gwendolyn K. Gould, R.N.
Graduate Student, Psych/Mental Health Nursing
University of Oregon Health Sciences Center

Permission received, letters on file

AN ABSTRACT OF THE THESIS OF

GWENDOLYN K. GOULD

For the MASTER OF NURSING

Date of Receiving this Degree: June 1982

Title: A SURVEY OF NURSES' FEELINGS ABOUT CARING FOR PATIENTS WITH PSYCHIATRIC SYMPTOMS IN THE GENERAL HOSPITAL SETTING

Approved: _____
Susan J. Will, R.N., M.S., Thesis Advisor

Deinstitutionalization has brought about many changes in the care of the mentally ill in the United States. With the increased emphasis on provision of this care at the local level, community general hospitals are, of necessity, being required to provide needed in-patient care. Some of the more recently constructed general hospitals have specially designed psychiatric units, but for the most part, general hospitals have only designated certain rooms on one of the other hospital units for "psychiatric holding" and often psychiatric patients are admitted to general medical-surgical rooms.

The presence of patients with poor impulse control within the general hospital often creates an atmosphere which is frightening for other patients and for hospital staff. Reference is made in the literature to the difficulties in obtaining psychiatric nursing staff, the great need to provide enough support to the general duty nursing staff who are required to care for these patients, and to the nurses' increased anxiety in these situations.

Although a few studies of nurses' attitudes toward mental illness have been done, no studies have considered how nurses feel about caring for patients with psychiatric symptoms in the general hospital setting. Consequently, there is no empirical evidence to support or to refute the suggestion that nurses are anxious in this situation and reluctant to care for these patients.

The purpose of this study was to assess the feelings of general duty nurses in relation to the care of psychiatric patients. The sample consisted of 140 self-selected registered nurses from a population of 300 nurses working in three general hospitals in a southern Oregon community who were invited to participate. A descriptive study, using a sample survey method (self-administered, mailed, questionnaires) was conducted to obtain the affective responses of these nurses to a simulated patient care situation.

The data were computer analysed using the Statistical Package for Social Sciences and examined descriptively in terms of frequency distribution, and central tendency. Associational statistics were used to determine if any relationship existed between the affective responses of the nurses and certain demographic data. Through use of the T-test of the response means, it was found that there was a significant difference between the responses of a few nurses in the sample who had more than one year of psychiatric nursing experience (N=27) and the other nurses (N=113). Results of the study suggest that:

1. General hospital nurses do feel anxious and are reluctant to care for patients with psychiatric symptoms. It appears from the data that this anxiety is more likely due to feelings of inadequacy relative to a perceived lack of personal psychotherapeutic ability, rather than

fear of the patient being dangerous to himself or others.

2. Nurses with one year or more of psychiatric experience consistently relate more positive (less anxious and more pleasant) feelings about caring for psychiatric patients than nurses with less experience, however, they describe more concern about psychotic behavior and safety factors than do the other nurses.

3. Nurses with a higher level of education (Bachelors or Masters Degree) tend to have more positive feelings about caring for patients with psychiatric symptoms than nurses with less training, which is not related to specialty training.