

PRIVACY DISSONANCE AND THE HOSPITALIZED PATIENT;

A CLINICAL INVESTIGATION

by

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A CLINICAL INVESTIGATION

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" Individuals have needs for disclosure
and companionship and group affiliation
...the intimacy of family...and still at
other times to be totally alone... "

Pastalan (1970)

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TABLE OF CONTENTS

<u>Chapter</u>		<u>Page</u>
I	INTRODUCTION	
	Statement of the Problem	1
	Review of the Literature	3
	Purpose of the Study	7
	Definition of Terms	9
II	METHODOLOGY	
	Subjects	11
	Data Collection Instruments	12
	Procedure	14
	Analysis of Data	15
III	RESULTS	
	Privacy Preference Scale	17
	Interaction Form	21
	Patient Rating Form	27
IV	DISCUSSION	34
V	SUMMARY, RECOMMENDATIONS, AND CONCLUSIONS	
	Summary	38
	Recommendations	39
	Conclusions	39
	REFERENCES	41
	APPENDICES	
	A. Partial Model for Interpersonal Distancing	45
	B. Consent to Participate Forms	48
	C. Privacy Preference Scale; Scoring Instructions for Privacy Preference Scale	51
	D. Interaction Form	60
	E. Patient Rating Form	67

LIST OF TABLES

	<u>Page</u>
Table 1. Privacy Preference Scores for Nurse Subjects	18
Table 2. Privacy Preference Scores for Male and Female Patient Subjects	19
Table 3. Summary of Behaviors From Interaction Forms for High Privacy Preference Scores	25
Table 4. Summary of Behaviors From Interaction Forms for Moderate Privacy Preference Scores	26
Table 5. Comparison of Match and Dissonant Nurse-Patient Interactions from Patient Rating Form	28

LIST OF FIGURES

<u>Figure</u>		<u>Page</u>
1	Comparison of Match and Dissonant Interactions on Co-operative/Unco-operative Continuum	31
2	Comparison of Match and Dissonant Interactions on Undemanding/Demanding Continuum	32
3	Comparison of Match and Dissonant Interactions on Pleasant/Irritable Continuum	33

Chapter 1

Introduction

Statement of the Problem

Recently, there has been a growing concern about individualized nursing care of hospitalized patients, from both inside and outside of the nursing profession. The studies done by Minkley and Allekian demonstrate nursing attempts to understand patient behavior. The Joint Commission for Accreditation of Hospitals, from an outside perspective, requires individualized nursing care plans before an institution is accredited. The development of care plans by the nursing staff, then, has a high priority among myriad nursing responsibilities. From a third perspective, Ginsberg (1972) has pointed out that consumers are also concerned about the depersonalization that often occurs with hospitalization. This author cites the growth of patient advocacy programs in hospitals across the country as demonstrating a need for closer study of the hospitalization process.

Patient behaviors have been studied by individuals in many disciplines. In the field of psychology, "behavioral mapping" has been recorded by Proshansky (1972) in a mental institution, where, in a certain setting, different patients engaged in similar behaviors at differing time periods. Another example is the schizophrenic behavior studies done by Howard and Evans (1973) where a hatrack was used to simulate a human figure. When schizophrenics were compared

to the "normal" group, they were found to have larger areas of comfort in respect to how close the hatrack was placed to them. All health care workers can benefit from the results of these interdisciplinary studies, but especially nurses whose primary concern is patient behavior.

A particularly useful concept was first described by Erving Goffman (1963), a sociologist, who observed that a person will give clues to what he is thinking by the placement of his body in his environment. He called this type of communication "embodied communication" and included such aspects as the person's body position, his facial expression, and the distance he puts between himself and the person he is relating to. This nonverbal communication has also been called "body language," a concept nurses find useful in determining how a patient might feel.

Robert Sommer, an environmental psychologist, has conducted studies illustrating how people extend themselves out into their environment (1969). An example of this idea is provided by the situation where the student spreads out his books over a table in the library, essentially establishing that he has claimed it as his territory. Sommer calls this "self-extension," stating that it is a useful means of self-expression, in that the individual can use his "personal space" to control his environment. "Personal space" is defined by Sommer as an emotionally charged zone around each person which may be drawn like a soapbubble, and which functions as a spacing device to keep people appropriately away from each

other in the physical environment (1969). Edward Hall (1969) has also studied the use of personal space, which he labels "distancing behaviors." He found that these behaviors are often normative and culture-bound. The wide variations of the expression of these behaviors according to age, sex, culture, and situation has resulted in differences in findings when previous studies were replicated (Howard, 1973). The explanation given for this problem is failure to adhere to strict experimental methodology. Nonetheless, the study of personal space by nursing clinicians is vital, not only as a means to determine how a patient feels about his current situation, but also warrants recognition as a way patients express their individuality.

Review of Literature

The term personal space did not become a subject heading in the psychological abstracts until 1973. Since that time an interdisciplinary interest in personal space is evidenced by the increasing numbers of articles published in nursing, hospital, psychology, and social work journals.

The origin of the concept of personal space comes from the study of territorial behaviors of both animals and man. A similarity of function in the use of distancing behaviors to designate ownership and convey messages was noted by Hall (1969). The complexity of human distancing behavior cannot be explained solely on this basis of genetic determinism, some sociologists claim. Beck, Horowitz, and Stea, for instance, have pointed to the concept of an inner

"self-extension," which accounts for individual differences in personal space behaviors (cited in Ittleson, Rivlin, & Proshansky, 1970). This inward expansion of personal space territory reflects the dreams, wishes, and fantasies of the person and may be influenced by his culture.

The communicative aspect of personal space behaviors was first used by such men as Westin (1967) and Pastalan (1970) to relate distancing behaviors to the concept of privacy. "Individuals have needs for disclosure and companionship and group affiliation . . . the intimacy of family . . . and still at other times to be totally alone . . ." (Pastalan, 1970, p. 97). However, it was Proshansky (1970) who noted that the most important aspect of privacy is the freedom of choice about how to express it. He explained that "to be left in privacy when one wants companionship is as bad as the inability to have privacy when one wants it" (p. 197).

The first studies of privacy centered on defensive measures people used to discourage social engagements (Sommer, 1970). Next evolved the components and functions of privacy as delineated by Marshall (1970) and Proshansky (1970). Privacy was seen in its varying states as necessary for personal autonomy, where the individual pulls in personal space boundaries to avoid manipulation or domination by others; as a condition for emotional release, where the person puts aside his role and finally, as a facilitator of self-evaluation, where integration of experiences and plans of action is allowed to happen.

Nurses have recognized recently the importance of the concepts of personal space and privacy to nursing practice. Carlson (1970) includes an explanation of the functions of privacy in a text called Behavioral Concepts in Nursing Intervention. Minkley (1968) studied the territorial behaviors of patients in the recovery room and found that their feelings of identity were closely tied to the areas they had marked off as "theirs" within the hospital environment. Closely related to this study is the research reported by Allekian (1973) about intrusion of personal space necessitated by the hospitalization process. She found that patients did not respond as anxiously to intrusion of their body space by treatments as they did to violations of their territorial space, like closets or nightstands.

One of the most recent nursing studies of privacy was done by Schuster (1975) who attempted to develop a conceptual model of interpersonal distancing, applicable to the hospitalization experience. In this model the author placed privacy behaviors on a continuum which coordinates with the perceived needs of the patient. Schuster sees these behaviors as demonstrating the withdrawal/retreat maneuvers of the patient at one end, and at the other end the bipolar behaviors to satisfy communication/disclosure needs. (See appendix for a partial copy of this model.) The withdrawal/retreat behaviors are specific examples of Marshall's two generalized means of gaining privacy: the use of defensive measures, such as the erection of barriers to vision and audition to discourage

social engagements, and the control of self-disclosure by "not neighboring" or by placing oneself in anonymous situations (Marshall, 1972). Marshall's conceptualization of privacy attainment in specific behavioral descriptions as proposed by Schuster is helpful for those doing research in this area.

Another finding of the Marshall study was that persons with differing backgrounds have different privacy preferences. Specifically, then, the behaviors of certain individuals would fall more frequently at one end of the Schuster continuum than at the other. Studies show that patients are quickly judged by how demanding they are of staff time (Cropper, 1972). The "difficult patient" asks questions or shows curiosity about his care and become "un-cooperative" when expectations are not met. When Schuster's continuum is applied to a specific situation, it appears that behaviors on the withdrawal/retreat end of the scale are apparently preferred by nursing personnel. An explanation given by Zderard (1968) for such labeling is concerned with the differing cultural backgrounds of patient and nurse, that is, "two people coming from very divergent cultural or sub-cultural backgrounds and/or divergent socioeconomic class groups may have less chance for establishing prevalent relatedness than two people from more similar life situations" (Zderard, 1968, p. 19). She defines relatedness as the mutually shared experience of being together or in agreement so that a therapeutic relationship can develop. When relatedness does not develop,

the patient may be seen as a problem patient.

Other nursing studies have shown that patients who become "problem" or "difficult" patients are usually expressing their anxiety about not being understood (Robinson, 1973 & Cropper, 1972). Either the patients are not communicating their needs clearly enough, or the nurses are not interpreting their communications accurately. Cultural differences can account for some communication difficulties, but consideration must also be given to the possibility that the nurse may be stereotyping behaviors to needs that do not exist for the patient at that time. The nurse may feel that in a specific situation withdrawal/retreat behaviors are "good" and disclosure/communication behaviors are "bad", especially if her own behavior preferences are located at the "good" end of the continuum. The nurse's own preferences are predominant instead of those of the patients.

Purpose of the Study

The number of studies done by nurses in the area of patient privacy is limited. However, both the Minkley and Allekian studies found an increase in patients' anxiety levels when personal space preferences were not respected. How patients express their privacy preferences has not been clearly defined. Minkley noted that some patients hid under covers or faced the wall in order to indicate their need to be alone. The following questions arise on further study of privacy behaviors: how is the nurse to know if these

withdrawal behaviors really do indicate a plea for more time alone; is the patient who overuses his call light or who seems demanding of staff time actually saying that his needs for socializing are not being met, that he is getting too much privacy? These are important issues since the patient cannot feel that he is being treated as an individual unless his privacy/socialization needs are considered. Recognition of privacy preferences of both nurse and patient might be the first step in pinpointing privacy or socialization needs.

A study of the individual's privacy preferences can be done by the use of the Privacy Preference Scale. This scale classifies persons according to the following: those with high privacy preferences, those with moderate or neutral privacy preferences, and those with low privacy preferences. It is hypothesized that observed behavior patterns of persons in the above designated groups will result in consistent behaviors that can be considered representative of those groups. For example, the high privacy preference patient may need preparation or increased reassurance when being examined by several physicians simultaneously. However, the low privacy preference patient may respond best to this type of experience, feeling that the more people involved, the better his care.

These assumptions of high and low privacy preference behaviors described above need verification. One way to collect data about

patient behaviors in various private and nonprivate situations would be to have staff record interactions with patients, noting both verbal and nonverbal communications of the patient. After administration of the Privacy Preference Scale and evaluation of staff-patient interaction forms, those behaviors which appear repetitively in patients in a specified group could be considered representative of that group.

Nursing studies have shown that patients who are labeled as difficult, demanding, or uncooperative are expressing an anxiety about not having needs met (Arracost, Turner, Martin, & Hott, 1974). It seems reasonable to expect, then, that patients with privacy or sociability preferences which differ from those of the nurse may, as with other cultural variables, cause the nurse frustration and consequent labeling as difficult or uncooperative. To test this idea, a patient rating scale was used in the study.

In summary, the purpose of this descriptive study will be to correlate privacy preferences to specific privacy behaviors. A second interest of this study will be to test the hypothesis that patients with privacy preferences which differ from those of the nurse will be labeled by that nurse as difficult, demanding, or irritable.

Definition of Terms

Privacy is considered to be the ability to control the degree to which people and institutions impinge on one's life, and to

adjust the level of privacy obtained to personal, changing needs. Privacy preferences are evaluated and scaled by the Privacy Preference Scale which rates an individual's privacy preferences on a continuum from high to low for the purpose of comparison. High privacy preference scores in this study range from 188 to 280 points; moderate privacy preference scores range from 94 to 187; and low privacy preference scores range from 0 to 93.

Privacy dissonance is the situation in which the patient shows a particular score on the Privacy Preference Scale and the nurse who is evaluating him shows a different score on the same scale. For example, the patient is in the moderate range and the nurse is in the high range.

Interactions refer to the verbal and nonverbal exchange between patients and staff for the purpose of communicating needs, information, and giving or receiving medical treatments. Primary focus in this study is on the following types of interactions: the initial interaction where the staff and patient first introduce themselves; the social interaction where staff and patient meet informally; and the treatment interaction where the nurse interacts with the patient for a particular purpose, such as giving medicines or to teach the patient about his condition.

Chapter II

Methodology

Setting of the Study

The study was done at a small community hospital with 93 beds. The population served by the hospital was primarily rural. Patients in the study were located on both surgical and medical floors, and at times of high census, on the obstetrics unit.

Subjects

The total sample size was 47 persons, 30 of whom made up the patient subject group, and 17 the nurse subject group.

The following criteria were used for selection of the patient group:

1. general surgical patients
2. age range 25-55 years
3. high school education
4. white Americans.

The patient group was selected from the surgery schedule. Those patients who met the selection criteria and who agreed to participate became part of the patient subject group.

The following criteria were used for the selection of the nurse subject group:

1. registered nurse
2. caring for patients in subject group at time of patients' admission to the hospital.

Although 17 nurses were oriented to the study and given the first questionnaire, only 13 completed the final forms. Because four of the nurses were not present at the time of admission of the patient subjects, they were dropped from the sample.

Upon suggestion of the administration, each physician was approached for permission to include his patients in the study. A total of 30 physicians were contacted. Because one physician refused permission, his patients were eliminated as possible patient subjects.

Data Collection Instruments

The Privacy Preference Scale, devised to measure privacy preferences by sampling statements about privacy in a variety of situations, has 56 summative statements requiring one of the five following alternative responses: strongly agree, agree, neutral, disagree, and strongly disagree. A total Privacy Preference Scale score was calculated by assigning numbers from one to five to the responses, with items summed to equate a high score with high preference for privacy.

Marshall gives the validation process of the Privacy Preference Scale in the article "Dimensions of Privacy Preferences" (1974). It was shown that the relationship of Privacy Preference Scale scores to personality measures and self-reported privacy-oriented behavior is significant. The factor analysis of responses to the Privacy Preference Scale produced seven major rotated factors;

from the six that appeared in both sample groups, the following subscales were constructed: Intimacy, Not Neighboring, Seclusion, Solitude, Anonymity, and Reserve. "To test homogeneity of items on the subscales, coefficient alpha . . . was computed and yielded reliability coefficients ranging from .80 for Not Neighboring to .56 for Intimacy" (Marshall, 1974, p. 264).

Marshall states that "the validity for the Privacy Preference Scale is supported by its ability to differentiate between age and sex groups, and by its personality scale and reported behavior correlates" (Marshall, 1974, p. 269). The Extraversion-Introversion scale of the Myers-Briggs Type Indicator was significantly related to Privacy Preference Scale total score "($r=.30$, $p<.01$; high E-I score indicates introversion), and to the Not Neighboring ($r=.22$), Seclusion ($r=.24$), and Reserve ($r=.24$) subscales at the .05 level. The Thinking-Feeling scale was also significantly related to Privacy Preference Scale total score ($r= -.25$ $p<.01$; high score indicates feeling), as well as to Not Neighboring ($r= -.31$, $p<.01$) and Reserve ($r= -.22$ $p<.05$)." (Marshall, 1974, p. 266). In addition to these tests, the total score version of the scale was correlated "with the four Affection and Inclusion scales of FIRO-B in the earlier study with university students, and correlations were generally larger ($r_s = -.54, -.44, -.44, -.49$)" (Marshall, 1974, p. 269).

The second instrument used, the Interaction Form, is a checklist of patient behaviors which the nurse records during three

interactions with the patient. These behaviors are based on Schuster's "Model of Interpersonal Distancing Within the Hospital," (1975) a part of which can be found in Appendix A.

The last instrument, the Patient Rating Form, is a survey of the attitudes of the nurse toward a patient. The nurse is asked to state her perception of the patient on three dimensions: cooperative-uncooperative, undemanding-demanding, and pleasant-irritable. The descriptions can range from one to ten, with the positive adjectives located at the low end of the scale (1-4), and the negative adjectives at the high end of the scale (5-10).

Procedure

After the investigator explained the purpose of the research and outlined the procedure, each nurse subject was given the Privacy Preference Scale as Part One of the study. Part Two of the study included completion of the Privacy Preference Scale by patient subjects. Part Three consisted of nurse subject completion of the Interaction Form and Patient Rating Form. Both patient and nurse subject groups were given an explanation of the numbering system used to insure confidentiality. Patients were numbered 1 to 31 consecutively upon their inclusion into the patient subject group. All forms that they completed were then appropriately labeled by number instead of name. Nurse subjects were similarly given numbers, 37 to 55, which were then used on documents completed by that nurse.

Once the nurse subjects were oriented to the project, patients

who fit the criteria were approached. If he or she agreed to complete the privacy questionnaire, the Consent for Human Research Project form was completed and the investigator presented the Privacy Preference Scale. Verbal instructions reinforced the printed instructions. One change was made in the marking of the answers; that is, the numbers chosen by the patient were written in the margin instead of on a separate sheet, as given in the instructions. Only two patients who were approached did not agree to participate in the project.

Following the completion of the Privacy Preference Scale by the patient, the nurse who was responsible for the patient at the time of his admission was given the Patient Interaction Form and the Patient Rating Form, and asked to return them within a day or two. Two forms were not returned, one Privacy Preference Scale from a nurse who left employment at the hospital and one set of patient behavior and rating forms from a discharged patient.

Analysis of Data

The first step of the analysis was the comparison of the privacy preference group most frequently scored for the nurse subjects to that privacy preference group most often scored for the patient subjects. As it is contended that recognition of these privacy preference groups is important, it would be helpful to know how the privacy preference groups differ in terms of behavior. The second step was the recording of the behaviors

of individuals in each of the privacy preference categories. The behaviors were analyzed by frequency counts. Those most frequently recorded for persons in a specific category were considered most representative of that category.

Frequency counts were used to determine which types of interactions, whether "match" or "dissonant," most often accompanies negative patient evaluations. Finally, behaviors most representative of negative evaluations were pinpointed by analyzing which behaviors were found most frequently on the negative rating forms.

Chapter III

Results

Privacy Preference Scale

The scores of the Privacy Preference Scale for the nurse subject group fall into two categories: those who scored in the range of 94 to 187 points, that is, the moderate privacy preference group; and those in the range of 188 to 280 points, or the high privacy preference group. With a total of 17 nurse subjects participating, six scored in the moderate privacy preference group and eleven in the high privacy preference group.

In the second part of the study, scores for the patient subject group were obtained. These scores also fell into either the moderate or high privacy preference groups. Upon considering the total group of 30 persons, 9 scored in the high privacy preference group and 21 in the moderate privacy preference group. The patients were also considered by sex. Of 15 women patients, 6 scored in the high privacy preference group and 9 in the moderate preference group, a ratio of 2 : 3 high privacy preference to moderate privacy preference. There were also 15 men patient subjects, 3 of whom scored in the high privacy preference group and 12 in the moderate privacy preference group; this is a ratio of 1 : 4 high privacy preference to moderate privacy preference. The distribution of scores for nurses and patients is shown in the following two tables.

Table 1
 Privacy Preference Scores for Nurse Subjects

Nurse Number	Scores	
	High Privacy (188-219)	Moderate Privacy (94-187)
37 - - - - -	- - - - -	185
38 - - - - -	200	
40 - - - - -	- - - - -	175
41 - - - - -	189	
42 - - - - -	212	
43 - - - - -	192	
44 - - - - -	193	
45 - - - - -	200	
46 - - - - -	191	
47 - - - - -	205	
48 - - - - -	- - - - -	168
49 - - - - -	195	
50 - - - - -	199	
51 - - - - -	- - - - -	158
53 - - - - -	191	
54 - - - - -	- - - - -	174
55 - - - - -	- - - - -	140

Note - Nurses were numbered 37 - 55

Nurse #39's score was omitted as form not completed. Nurse #52 form was misplaced, and nurse was given #53 form.

Table 2

Privacy Preference Scores for Male and Female Patient Subjects

Patient Number	Scores	
	High Privacy (138-219)	Moderate Privacy (94-137)
<u>Female</u>		
1	201	
2	199	
3		183
4	203	
7		167
11		176
12		187
15		173
14 ^a	190	
20	201	
24	190	
26		160
27		166
28		178
31		135

Table 2 (Cont.)

Patient Number	High Privacy (188-219)	Moderate Privacy (94-187)
Male		
5		172
6		170
8		143
9		177 ^a
15	199	
16		178
17		160
18		186
19		171
21	218	
22		181
23	191	
25		166
29		172
20		175

Note - Patients were numbered from 1-31. Patient #10's score was omitted as form not completed.

^a Subject was black female patient

Interaction Form

The results of the Interaction Form, used to collect information about observed behaviors exhibited by patients in one privacy preference category as compared to another, were analyzed next. During this part of the study, patients were observed in three situations, so that a total picture of the patient could be obtained. In Tables 3 and 4 that follow this section, each behavior set "a" through "o" contains three numbers; the numbers 1, 2, and 3 designate which of the consecutive behaviors were checked for each situation. (See Appendix D for the list of behaviors.) After the nurses checked which one of the 15 sets of bipolar behaviors they observed, these behaviors were then compared, first according to privacy preference category, and secondly, according to sex. In 10 of the 15 sets of behaviors, one behavior most representative of both high and moderate preference groups was also representative of female and male behaviors. An example of this is behavior set "f" as can be seen in Tables 3 and 4, where "1" was most frequently recorded across all the categories. There were 5 sets of behaviors that were split in the recordings, so that no one behavior could be called representative of a group. The splits were noted both according to privacy preference and according to sex. For example, in behavior set "g" where patients were observed to either approach the nurse to initiate conversation or not approach the nurse, in the male high privacy preference groups, initiating conversation

was most representative. In the female group, one-half initiated conversation and one-half did not. However, in the moderate privacy preference group, as seen in Table 4, more female patients proportionately approached the nurse than did male patients. Data from the observed behaviors of "j" category indicate a sex difference in the high privacy preference group. Females were observed to interact "very much" with roommates, while the males were seen as interacting one-half "little" and one-half "moderately" with roommates. Observation of the moderate privacy preference group in this same behavior category showed one-half of the females interacting "little" while the other one-half interacted "moderately." Males in the moderate privacy preference group were observed to interact "moderately."

Other behavioral differences noted were closing curtains, number of family visits, and making and receiving telephone calls. Members of the high privacy preference group were observed to close the curtains more frequently than were those individuals in the moderate privacy preference group, as can be seen under behavior "b". Females in the high privacy preference group had a "moderate" number of family visits, behavior "n", while male members had "few" visits most frequently recorded. Members in the moderate privacy preference group had a "moderate" amount of family visits. Of the members of the high privacy preference group who were observed to make or receive telephone calls, "few" was recorded most frequently on their forms. The moderate privacy preference members were split

in their telephone behaviors, behavior "o": females received and made a "moderate" amount of calls and males received and made "few".

The ratio, then, of total same to total differing behaviors in both preference groups is 3 : 2; that is, the data showed the ten same behaviors for both privacy preference groups out of a total of 15 behaviors. The female/male differences were five instances of differing behaviors for both sex groups, out of 15 sets of behavior, or a ratio of 1 : 3. There is a variation in the differing behaviors, however. For example, there is congruence about closing or opening curtains, according to sex, but there is a separation in the category "discussed personal problems" into either "moderately" or "mostly impersonal", as can be seen in behavior "m". Females were observed to discuss "moderately" personal problems more frequently than males. This occurred in both high and moderate privacy preference groups. The moderate privacy group, who have lower privacy preferences, show behaviors inconsistent with their preferences when the sex factor is not considered. Consequently, it does not appear valid to describe a group according to privacy preference alone. Female moderate privacy preference group members make "moderate" amounts of phone calls in the hospital; male members make "few" phone calls. Female members of the high privacy preference group have a "moderate" number of family visits; male members of the group have "few".

In conclusion, the most frequently observed behaviors for both moderate and high privacy preference groups were as follows: they tended to either open or leave open the door to their room. They watched the nurse and showed interest in her activities rather than attending to their activity, such as reading a book or newspaper. They listened closely when the nurse spoke to them, and they asked questions. Most patients did not feel that the room was too crowded; they did not touch the nurse. Most used the call light little. Finally, the majority of the patients spent a moderate amount of time alone.

Table 3
 Summary of Behaviors From Interaction Forms for
 High Privacy Preference Scores

		Behaviors														
Patient																
Number		a	b	c	d	e	f	g	h	i	j	k	l	m	n	o
Female																
2		222 ^c	111 ^b	222	222	222	111	212	222	211	211	111	222	222	2	2
4		122	221	020 ^a	202	222	111	100	000	100	000	000	121	032 ^d	1	1
20		222	222	222	222	222	111	111	222	222	000	222	222	111	2	1
1		222	111	000	222	222	111	202	020	222	333	111	122	111	2	1
14		222	111	000	222	222	111	202	022	222	333	111	122	222	2	1
24		000	000	000	000	200	100	100	200	000	300	100	100	000	1	1
Male																
15		000	000	222	222	222	111	111	222	222	232	111	111	333	1	1
25		000	111	222	222	222	111	111	222	111	111	111	222	333	2	2
21		222	222	222	222	222	111	222	222	111	000	111	333	333	1	1

a0 - not applicable from nurse's viewpoint

b1 - indicates first answer marked in behavior set

c2 - indicates second answer marked in behavior set

d3 - indicates third answer marked in behavior set

Table 4
 Summary of Behaviors from Interaction Forms for
 Moderate Privacy Preference Scores

Behaviors																
Patient																
Number	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	
Female																
7	000	000	222	222	222	111	222	222	212	000	222	323	233	1	2	
12	222	222	222	222	222	111	111	000	222	000	333	222	222	2	2	
13	222	000	222	222	222	111	222	222	222	222	222	333	223	1	2	
11	000	000	222	111	021	121	222	222	222	111	111	211	222	2	1	
26	222	121	222	221	222	212	222	222	222	000	111	222	333	3	2	
31	112	112	222	222	222	111	111	111	222	111	111	222	222	2	1	
23	221	000	222	222	222	111	111	222	222	000	111	333	222	2	1	
27	222	222	222	222	222	111	222	222	222	222	111	222	333	2	2	
3	222	222	222	222	222	111	111	222	222	000	111	222	333	2	2	
Male																
5	222	222	222	222	222	111	111	222	121	000	111	111	222	2	1	
6	000	000	222	222	121	111	010	220	222	000	331	222	003	2	0	
9	002	002	122	222	222	011	011	001	011	000	111	110	220	3	1	
18	222	111	222	222	222	111	222	000	222	000	111	222	333	3	1	
8	000	000	222	222	222	111	222	222	222	222	111	211	333	1	2	
25	000	000	000	000	200	000	000	000	000	000	100	100	000	3	1	
29	000	000	222	222	222	000	000	000	222	000	111	111	333	2	1	
30	000	000	000	222	222	000	000	000	222	222	111	111	331	1	1	
16	221	221	222	222	222	111	221	222	222	111	112	222	333	2	2	
22	111	111	222	212	112	111	111	222	221	221	111	122	333	1	1	
17	000	000	222	222	222	001	221	222	222	122	111	322	333	2	2	
19	000	000	222	222	222	111	112	000	222	000	111	222	222	3	3	

Patient Rating Form

The results of the Patient Rating Form were analyzed according to type of nurse-patient interaction first, and then according to nurse attitudes about a patient. The type of nurse-patient interaction was signified by the scores on the Privacy Preference Scale. The patients and nurses who were in the same range of scores were said to have a "match" type of interaction. Those interactions in which the nurse was in one privacy preference category and the patient in another, were called the "dissonant" type.

As can be seen in Table 5 that follows, there were 30 nurse-patient interactions; 15 turned out to be "match" interactions and 15 "dissonant" interactions. In reference to sex, in the "match" group, there were 7 female patients involved and 8 male patients. The "dissonant" group of interactions was made up of 7 male members and 8 female members. All the nurses involved in the interactions were females, and one nurse interacted with more than one patient, in some cases, as can be noted in the table.

The forms were then analyzed according to ratings the nurses made about the patients with which she interacted. She was to mark her ratings on three continua called Cooperative-Uncooperative, Undemanding-Demanding, and Pleasant-Irritable. Scores ranged at the "positive" end if they scored from 1-4; they were seen as "negative" if they ranged from 5-10. (See Appendix E for a sample of the Patient Rating Form.)

Table 5
 Comparison of Match and Dissonant Nurse-Patient Interactions
 from Patient Rating Form

Patient-Nurse Numbers	Positive Responses (Scores 1-5)	Negative Responses (Scores 5-10)
Dissonant Interactions		
22-46	1	2
5-42	3	0
19-33	3	0
17-38	2	1
5-49	3	0
6-44	0	3
9-44	2	1
15-40	3	0
27-46	3	0
23-46	3	0
31-50	1	2
26-50	1	2
20-43	3	0
11-44	0	3
24-55	3	0

Table 5 (Cont.)

Patient-Nurse Numbers	Positive Responses (Scores 1-5)	Negative Responses (Scores 5-10)
Match Interactions		
1-50	3	0
2-49	3	0
25-55	3	0
4-47	3	0
18-54	3	0
3-40	3	0
7-40	3	0
12-40	1	2
13-54	3	0
14-46 ^a	3	0
30-48	3	0
29-48	3	0
21-47	3	0
25-46	3	0
16-37	1	2

^aInteraction with black female patient

In the final step, the number of positive and negative ratings were analyzed according to type of interaction. It was found that within the group of "match" interactions, there were 41 positive scores and 4 negative scores. For the "dissonant" interactions, there were 31 positive and 14 negative. This is an increase of negative ratings found in the "dissonant" group of $3\frac{1}{4}$ times over that of the "match" group.

The scores for each continuum are illustrated according to type of interaction in Figures 1, 2, and 3 that follow.

Comparison of the Match and Dissonant Interactions
on Co-operative/Unco-operative
Continuum

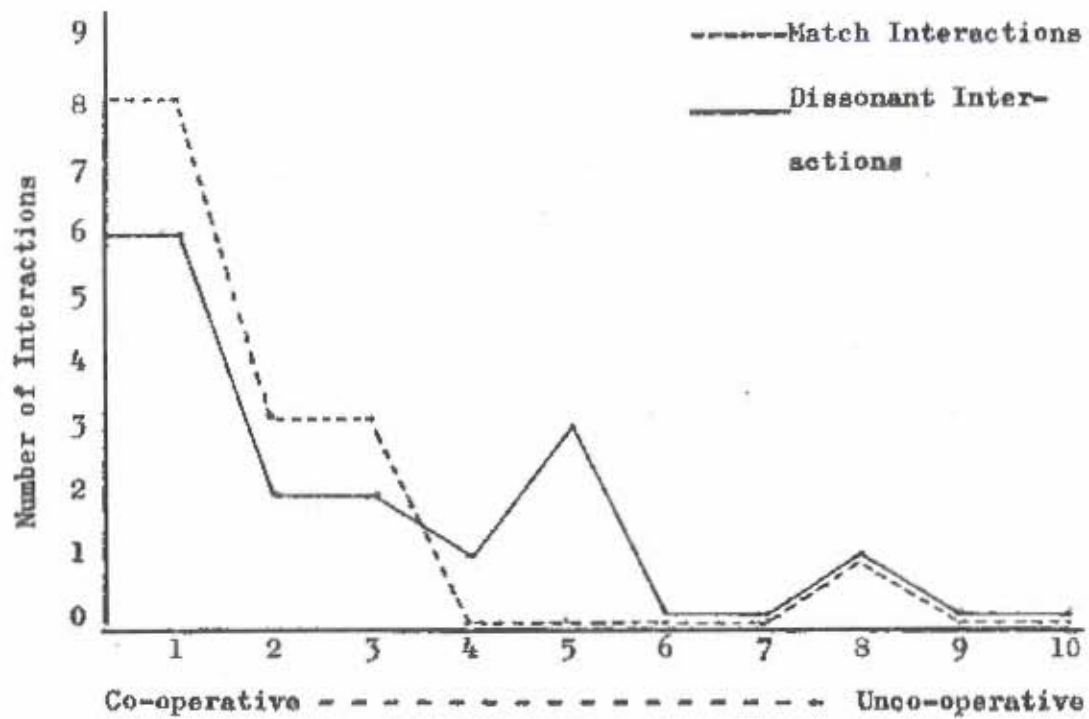


Figure 1 - Degree of Co-operativeness

Comparison of the Match and Dissonant Interactions
on Undemanding/Demanding Continuum.

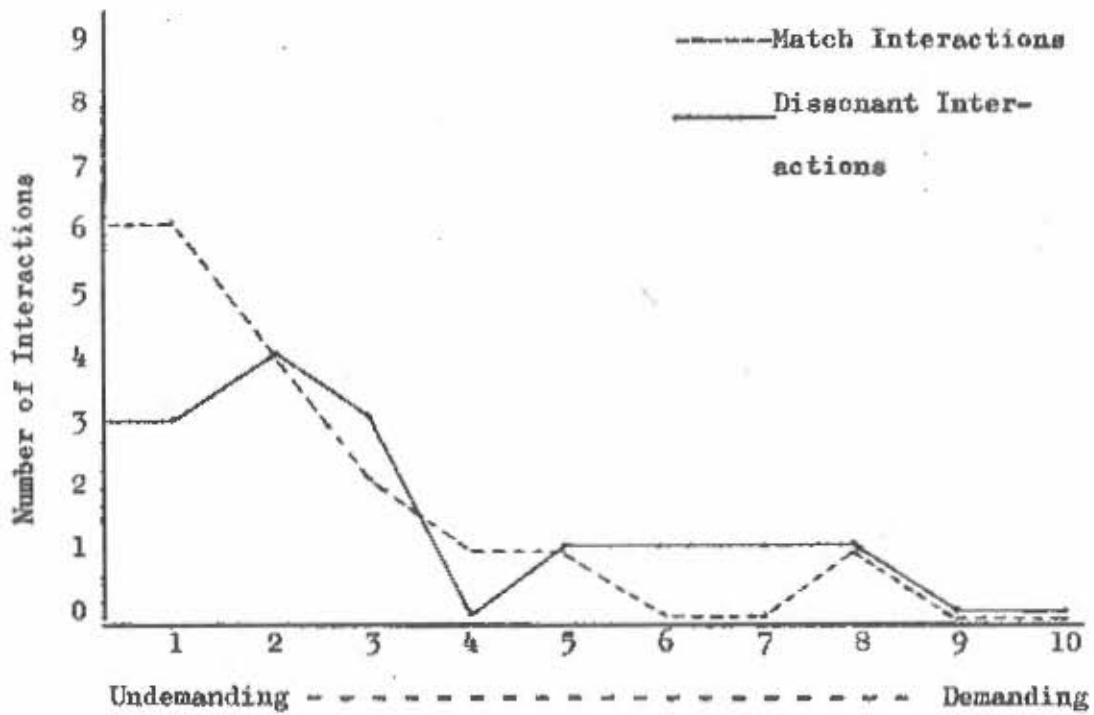


Figure 2 - Degree of Demandingness

Comparison of the Match and Dissonant Interactions
on Pleasant/Irritable Continuum

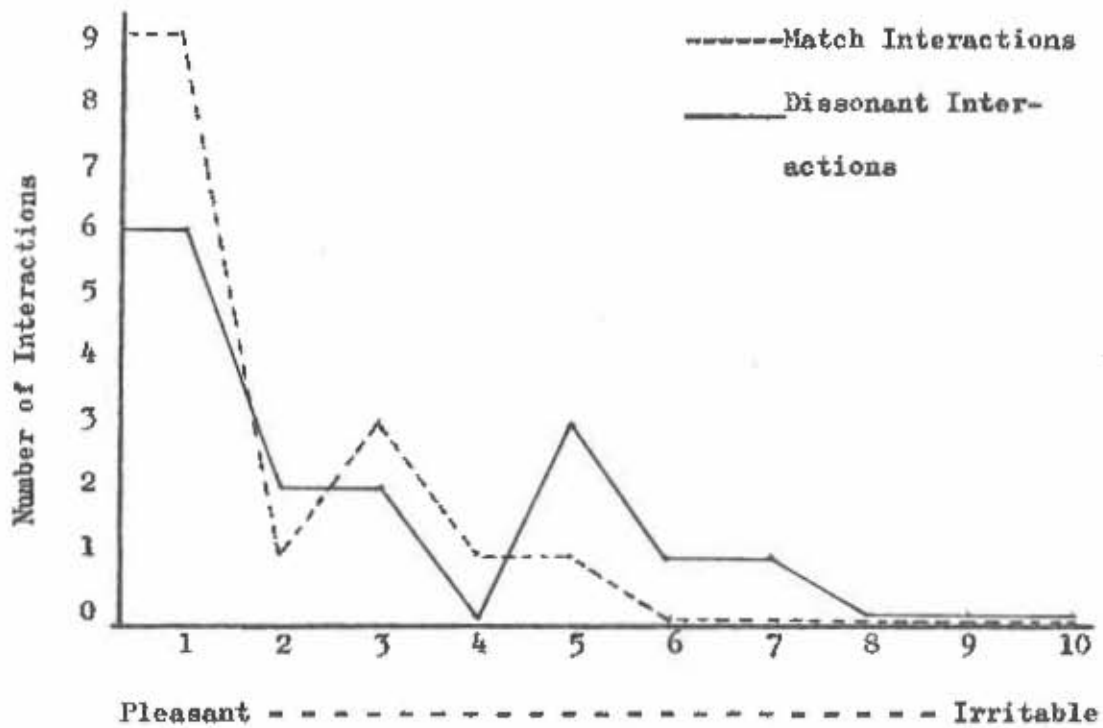


Figure 3 - Degree of Pleasantness

Chapter IV

Discussion

The recognition of one's own privacy preferences and those of others, if they are seen as both a cultural and individual variable, is important. Nurses are concerned with Ginsberg (1972) about personalizing patient care. A broad understanding of how cultural factors affect behavior would seem to be a prerequisite for accomplishing this.

Marshall (1972) and Hall (1969) see privacy behaviors, which are also called distancing behaviors, primarily as culture-bound. In Hall's studies of cross-cultural use of personal space, he found some notable differences. Children's space boundaries were flexible and well tolerated by adults, whether large or small. European men used smaller spaces in their interactions with other men than women did with other women. Subsequently, according to Hall and Marshall, men had lower privacy preferences. In this study, Marshall's Privacy Preference Scale scores for the patient group showed both male and female in the moderate category most of the time. The difference in the ratio of the preference by sex was remarkable. The female ratio of preference for moderate privacy to high privacy was 3 : 2; for male, 4 : 1. The nurses' scores showed a strong tendency also; almost 2 : 1 for high over moderate privacy preference. This finding supports Marshall's claim that the Privacy Preference Scale is able to differentiate between subgroups within a culture (Marshall, 1972), and points to

the possibility that higher socioeconomic groups may have higher privacy preferences, since the majority of the patients had only a high school education.

Hall also studied racial variations of interpersonal distancing. He saw Blacks and Latin Americans as having smaller distances for interaction. In this study, a black female patient was given the Privacy Preference Scale and found to score in the high preference category. The nurse-patient interactions turned out to be "match" and the nurse ratings positive. Although these are contrary to Hall's results, the small size of this sample is appreciated.

It has also been expressed by some authors like Zderard (1968) that individuals who are too different in their cultural backgrounds may not be able to relate in a therapeutic manner. The resulting frustration for the nurse may be ventilated in a negativism toward the patient.

In this study it was hypothesized that, when patient and nurse differed at the level of privacy preferences, more negative attitudes would be expressed about that patient than positive. As has been illustrated by the data, in this study one-half of the interactions of the subject group were "match" interactions and one-half were "dissonant" interactions. The finding that twice as many nurses as patients fell in a certain category would seem to make the possibility of dissonance greater, when it did in fact result in an even split in the types of interactions. When the positive and negative ratings in both "match" and "dissonant" interactions

were compared, it was found that there were almost 3½ times as many negative ratings in the "dissonant" group than in the "match" group. The nurse rated the patient negatively by marking him high on uncooperativeness, demandingness, and irritability.

A few current authors like Robinson (1973) and Cropper (1972) take the position that patient behaviors that are passive and accepting of treatments or medication without hesitation on the patient's part are the types of behaviors nurses prefer and reinforce. As was demonstrated in this study, no recurrent specific behaviors were observed that were common to just negative ratings. The nurses involved in "dissonant" interactions who made negative ratings, did so for patients who used call lights "little," who initiated conversations, that is, who appeared friendly, and who in other ways scored behaviorally like those who received positive ratings. Consequently, no group of behaviors can be said to be irritating or uncooperative in the eyes of the nurses in this study.

There were few behaviors recorded that differentiated the high privacy preference group from the moderate privacy preference group. However, some generalizations about the high privacy preference group can be made. They did not approach the nurse as frequently as the moderate privacy preference group to initiate conversation, had fewer family visits, and made fewer phone calls. Implications for these beginning descriptions of behavior might be that the nurse should watch for signs of sensory deprivation and/or feelings of isolation as the patients act on their "natural" inclinations for gaining and maintaining privacy. On the other hand, those in

the moderate privacy preference group may need some insulation from the many family visits and phone calls they ^{were} observed to have ^A while in the hospital. The need for privacy in order to evaluate changes they are undergoing in body image may be greater at this time than in other situations. A time to "get out of role" must be provided for these people who generally have less time for privacy in their ordinary life style.

It was not substantiated in this study that certain preference groups behave in specific ways. The small size of the sample is recognized as a possible cause for this. Another explanation may be that there is an accomodative ability of people to adjust to whatever privacy they can get, so that experiences over time may influence current privacy preferences.

Chapter V

Summary, Recommendations, and Conclusions

Summary

In Part One of the study, the scores for the Privacy Preference Scale showed variation for the three subject groups. The nurses were predominantly in the high privacy preference group, female patients most frequently in the moderate group, and male patients mostly in the moderate group. These results substantiate other findings in the literature.

In Part Two of the study, the behavioral survey of patients by nurses, it was found that most members of both high privacy preference groups and moderate privacy preference groups acted similarly across the three interactions. These behaviors, then, were judged as representative of both groups in the hospital situation. For those behaviors which differed per group, it was found that the sex factor had to be considered for accurate interpretation. Men and women acted differently even though they had the same privacy preference.

Part Three of the study considered the type of interaction the nurse and patient were involved in, that is, in terms of privacy preference. One-half of the 30 interactions showed congruence of nurse and patient privacy preference, the other half, dissonance. As hypothesized, the "dissonant" interactions produced more negative ratings of patients by the nurses, and specifically in this study, there were almost $3\frac{1}{2}$ times as many negative ratings

made by the "dissonant" group than made by the congruent or "match" group.

Recommendations

This study is descriptive and needs an experimental design for validation. Following are some recommendations.

1. Such measures as getting baseline data about how each nurse routinely rates patients would be helpful in clarifying whether or not some nurses frequently see patients negatively, or if they consistently rate those who are in privacy preference groups other than their own more negatively than others.
2. It would be helpful for nurses' behaviors to be observed and recorded for further information about how persons in differing privacy preference groups behave.
3. The patients could rate the nurses on how they saw them interacting; comparison of the nurses' and patients' ratings would provide data about nurse-patient communication skills.
4. Findings from scores on the Privacy Preference Scale could be shared with participants as a means of increasing self-knowledge.
5. Sorting out the variables of privacy preference development needs to be done. One way to accomplish this might be longitudinal studies of privacy preferences and distancing behaviors of members of various cultural groups. In this way, behavioral differences would be visible initially and consequently should be easier to measure.

Conclusions

The nurse has the special task of assessing the patient's

needs and acting on them. Knowledge of the patient's cultural characteristics, one of which is his privacy preference, will assist the nurse to accurately identify what the patient really needs.

Finally, the nurse may find that the expectations of the role of "patient" may invalidate whatever preference the person may usually express. It seems that the nurse is in a good position to assist the patient to move from the role behaviors to those behaviors that demonstrate the person he really is.

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APPENDICES

APPENDIX A**Partial Model For Interpersonal Distancing**

Goal: Withdrawal/retreat

Perceived needs

1. Being out
of sight

2. Resting

3. Thinking

4. Bathing

5. Dressing

Actions

1. Closing
door

2. Drawing
curtain

3. Leaving
room

4. Erecting
physical
barrier
(e.g., book
in front of
face)

5. Adjusting
facial ex-
pression or
posture

Goal: Disclosure/communication

Actions

1. Asking

2. Telling

3. Listening

4. Watching

5. Monitoring

Perceived needs

1. Sharing
concerns

2. Gaining or
giving in-
formation

3. Allaying
fear (with-
in self or
another)

4. Gaining or
giving assist-
ance

5. Gaining or
giving reas-
surance

- | | | | |
|----------------------------------|-------------------------------------|---|-------------------------------|
| 6. Elimination | 6. Inattention | 6. Adjusting posture or facial expression | 6. Protecting self or another |
| 7. Grieving | 7. Changing subject of conversation | 7. Touching | |
| 8. Shutting out external stimuli | 8. Not answering | | |
| 9. Excluding sources of threat | 9. Not inquiring | | |

Note - Goals, needs, and actions are from Schuster (1975)

APPENDIX B

Consent to Participate Forms

Consent for Human Research Project

I, _____ agree
(First Name) (Middle Initial) (Last Name)

to serve as subject in the investigation named, Privacy Dissonance and the Hospitalized Patient, under the supervision of _____
_____. The investigation aims at finding how patients obtain privacy in the hospital setting.

It is my understanding that I will be required to answer questions to a pencil and paper test. The questions relate to privacy preferences. The time required of me is about ten to fifteen minutes.

All information that I give will be handled confidentially. My anonymity will be maintained on all documents, which will be identified by means of code numbers.

I may not receive any direct benefit from participating in this study, but understand that my contribution will help expand the degree of knowledge in regard to patients' privacy preferences.

_____ has offered to answer any questions I might have about the tasks required of me in this study.

I understand that I am free to withdraw from participation in the investigation at any time without this decision otherwise

affecting my medical treatment.

I have read the above explanation and agree to participate
as a patient in the study described.

Signature _____

Witness _____

Date _____

APPENDIX C**Privacy Preference Scale; Scoring Instructions
For Privacy Preference Scale**

Preference Inventory

This questionnaire is part of a study concerned with beliefs and attitudes about interacting with other people. In some questions you may be asked about living situations that you have not experienced. Please answer on the basis of how you think you would react to the situations or choices described. Use the following five categories to describe how you feel about the statements:

1. strongly disagree
2. disagree
3. neutral or don't know
4. agree
5. strongly agree

Mark your answers on the special answer sheet; please do not write on the test booklet. In marking your answers on the answer sheet, make sure that the number on the sheet is the same as the number of the item in the test booklet. Be sure to answer every question, even if you must guess.

1. I would like to have a private retreat which no one would enter without asking me.
2. I dislike being completely alone, either in a house or in the wilderness.
3. I wouldn't mind living in a large city -- at least everyone

wouldn't know everything about you.

4. It is important to me to be able to be alone when I want to be.
5. I would like to have acquaintances at work, at home, in clubs, and so forth that don't know each other because each group would only know a part of me.
6. There should be an area in the house where the husband and wife can get away from the rest of the family.
7. I dislike talking about personal matters to a friend in a crowded place where other people can overhear us.
8. Acquaintances often ask questions that I consider rude and personal.
9. I sometimes want to get away from everyone for awhile, even my close friends.
10. I would not like to live in a small town because there is too much gossip about your private life.
11. Even members of a family need to get away from each other now and then.
12. I usually prefer to spend a free afternoon with one friend rather than with several.
13. It would annoy me if a friend or family member borrowed something of mine without asking first, even if I would lend it freely if asked.

14. I would like to live in a large city because neighbors and acquaintances there would probably be less concerned about my private life.
15. I usually don't tell people I don't know very well personal things about myself.
16. I occasionally enjoy getting away from the rest of the world with an intimate friend.
17. There are times when I like to get away from people who know me by getting lost in a crowd.
18. It is important for a family to have time together away from friends or relatives.
19. It is important to be able to confide in someone and know that your confidence will be kept secret.
20. I am usually upset if other members of the family come into my bedroom when the door is closed without asking.
21. There are times when I really want other people to leave me alone and not intrude on my thoughts, even though we're in the same room.
22. "A house should be so far away from a neighbor that only by yelling at the top of one's lungs can one be heard."
23. I want my friends to feel that they can drop in at my house any time they like.
24. It is very relaxing to get away from other people with just

your family or close friends.

25. I would rather not have my close friends living next door to me.
26. It wouldn't bother me to be able to overhear the noises of everyday living from neighboring houses (footsteps, water running, etc.).
27. Although I enjoy walking in the woods, I would rather not go alone.
28. I like to have someone to whom I can tell everything about myself, even my deepest and most personal thoughts and feelings.
29. It is important to me to live where I can do what I want to without bothering other people.
30. If my living room window were within 20 feet of someone else's, I would probably keep the curtains closed most of the time.
31. Although I occasionally enjoy talking to my neighbors, I don't like to get very involved with them.
32. I don't like to talk about personal things with friends until I have known them for a long time.
33. It usually annoys me to have people come to my home without letting me know they are coming.
34. I would like to live in a neighborhood where people do things together now and then.

35. I often like to go to a secluded place to talk to an intimate friend.
36. I often get lost in my thoughts and am not really aware of what is going on around me.
37. If I were at home and didn't feel like being disturbed, I probably wouldn't answer the phone.
38. People should respect other's right to be individual and different.
39. I would prefer a neighborhood where neighbors had a tendency to drop in all the time to one in which it was difficult to get to know them.
40. It is important for a child to have a room of his own after he reaches a certain age.
41. I really enjoy being able to loan things to friends.
42. I would dislike having a patio or balcony that neighbors or passersby could see into.
43. Even intimate friends should respect your desire to keep certain things to yourself.
44. "Fences make good neighbors."
45. There are often times when I would enjoy spending an afternoon or evening at home alone.
46. I enjoy having friends living nearby who feel free to come into my home when they please.

47. If I were not living with my family, I would rather share a two-bedroom apartment with three friends than live alone.
48. I would be very upset if a friend read something I had written or my personal correspondence without my permission.
49. The constant noise of modern life is really rather exciting.
50. I would like to live in a secluded house out of sight of any other houses.
51. It is important to me to have a house away from the noise of traffic.
52. The idea of a house with windows that look toward the sky rather than toward other houses appeals to me.
53. I would dislike living in an urban area where I never got to know my neighbors.
54. When I really need to find a solution for a problem, I do it best by talking with others rather than working alone.
55. Close friendships require having time to be alone together.
56. When I have a very important decision to make I prefer to make it alone.

Dr. Nancy J. Marshall
 Portland State University
 Portland, Oregon

Privacy Preference Scale

If you use this scale in research, I would appreciate it very much if I could have access to the raw data in order to verify my principle components analysis on a larger sample. A duplicate data deck would be particularly useful to me if you use computer analysis. If you prefer to give a somewhat shorter questionnaire, it would be very helpful to me if you included all of the subscale items.

Subscale names and item numbers:

Intimacy: 12, 16, 19, 24, 35, 38, 47, 55.

Not Neighboring: 23(-), 25, 31, 33, 34(-), 39(-), 41(-), 46(-),
 53(-)

Seclusion: 1, 22, 26(-), 27(-), 29, 49(-), 50, 51, 52.

Solitude: 1, 2(-), 4, 9, 11, 21, 45

Anonymity: 3, 5, 10, 14, 31, 34(-)

Reserve: 7, 8, 15, 32, 42, 44, 48

Scoring

Assign values to the answers as follows:

Strongly disagree	1
Disagree	2
Neutral or don't know	3
Agree	4
Strongly agree	5

If a (-) appears after the item number, reverse the scoring

so that strongly disagree = 5 and strongly agree =1.

Sum values for all items for PPS Total Score; sum values for items on each subscale for Subscale scores.

APPENDIX D

Interaction Form

Interaction Form

Instructions: Please check which of the behaviors best describes your interaction with the patient in the following three types of interactions: your initial interaction, a social interaction, and a medicine or teaching interaction. Only check one of the given pairs.

1. During your initial interaction with the patient, where introductions were made, the patient:
 - a. pt. closed door
 pt. opened door
 - b. pt. closed curtains
 pt. opened curtains
 - c. erected physical barrier between self and nurse (book or newspaper)
 monitored nurse's actions
 - d. showed inattention
 watched nurse
 - e. changed subject of conversation
 listened to nurse
 - f. asked questions
 ignored questions
 - g. approached nurse to initiate conversation
 did not approach nurse

- h. ___indicated room too crowded
___did not indicate room too crowded
- i. ___touched nurse
___did not touch nurse
- j. ___pt. interacted with roommate
___little
___moderately
___very much
- k. Used call light
___little
___moderately
___very much
- l. Spent time alone
___little
___moderately
___very much
- m. Discussed personal problems
___very personal
___moderately personal
___mostly impersonal
- n. Family visits
___few
___moderate
___very many

o. Telephone calls

 few moderate very many

2. During your social interactions with the patient, where you interact informally with the patient, he:

a. closed door opened doorb. closed curtains opened curtainsc. erected physical barrier between self and nurse (book or newspaper) monitored nurse's actionsd. showed inattention watched nursee. changed subject of conversation listened to nursef. asked questions ignored questionsg. approached nurse to initiate conversation did not approach nurseh. indicated room too crowded did not indicate room too crowded

- i. touched nurse
 did not touch nurse
- j. Interacted with roommate
 little
 moderately
 very much
- k. used call light
 little
 moderately
 very much
- l. spent time alone
 little
 moderately
 very much
- m. discussed personal problems
 very personal
 moderately personal
 mostly impersonal

3. During your interaction with the patient where you are administering medications, treatments, or are teaching, the patient:

- a. closed door
 opened door

- b. closed curtains
 opened curtains
- c. erected physical barrier between self and nurse (book or newspaper)
 monitored nurse's actions
- d. showed inattention
 watched nurse
- e. changed subject of conversation
 listened to nurse
- f. asked questions
 ignored questions
- g. approached nurse to initiate conversation
 did not approach nurse
- h. indicated room too crowded
 did not indicate room too crowded
- i. touched nurse
 did not touch nurse
- j. interacted with roommate
 little
 moderately
 very much
- k. used call light
 little

___moderately

___very much

l. spent time alone

___little

___moderately

___very much

m. discussed personal problems

___very personal

___moderately personal

___mostly impersonal

APPENDIX E

Patient Rating Form

Patient Rating Form

Instructions: Please circle the number on each of the three continuums below which best describes how you feel the patient has interacted with you; take an average of a variety of situations you and the patient have been together. Below your rating, please include two or more examples of the behaviors that resulted in the number you chose.

1. Co-operative -- Unco-operative

1 2 3 4 5 6 7 8 9 10

2. Undemanding -- Demanding

1 2 3 4 5 6 7 8 9 10

3. Pleasant -- Irritable

1 2 3 4 5 6 7 8 9 10

AN ABSTRACT OF THE CLINICAL INVESTIGATION OF

JANET L. MATHEWS

For the MASTER OF NURSING

Date receiving this degree: June 11, 1976

Title: PRIVACY DISSONANCE AND THE HOSPITALIZED PATIENT:
A CLINICAL INVESTIGATIONApproved: *Mauro Berger*

Recognition of privacy preferences for both nurses and patients is important for understanding human behavior variables and for individualizing patient care. Privacy preferences, which are operationalized by what Hall (1969) calls interpersonal distancing behaviors, can be identified by means of the Privacy Preference Scale developed by Marshall (1972). Differences in privacy preferences and other cultural variables are seen by some authors like Zderard (1968) to influence how nurses and patients relate.

Attention had been paid to the process whereby nurses label patients as "difficult," by such persons as Cropper (1972) and Robinson (1973). They found that nurses condemned certain behaviors that were seen as aggressive, like asking questions, and reinforced behaviors that were accepting of the behavior of the nurse, without question or hesitation.

One of the purposes of this study was to find out if there were differences in the privacy preferences of patients and nurses. Secondly, it was hoped that privacy preference groups could be recognized by characteristic behaviors across a number of hospital

situations.

If there were found to be differences in the privacy preferences of patients and nurses, it was hypothesized that those in differing privacy categories, that is, those in a "dissonant" interaction, would show nurses scoring more negative attitudes toward the patient than would occur in the interactions where patients and nurses were in the same privacy category, called the "match" interaction. Finally, it was hoped that the specific behaviors the patient displayed, which resulted in the negative ratings, would be pinpointed in the study.

The study sample was made up of 47 subjects, 30 of whom were patient subjects, and 17 of whom were nurse subjects. It was conducted at a rural community hospital located outside a metropolitan area. The patient subjects were general surgical patients, from 25 to 55 years of age, white Americans, with a high school education. The nurse subjects were registered nurses who were responsible for the patient subjects upon their admission to the hospital. Both groups were given the Privacy Preference Scale which determined which category of privacy preference they belonged to, whether high or moderate. Next, the nurses observed and recorded patient behaviors on the Interaction Form, a checklist of bipolar behaviors that were marked during three situations. Finally, the nurses evaluated the patients on the following continua: Co-operative/Unco-operative, Undemanding/Demanding, and Pleasant/Ir-

ritable.

The data showed that nurses in this study had almost twice as many persons in the high privacy category as did the patient subject group. The predominance of a subject group in one privacy category as happened in this study, would seem to make the possibility of dissonant interactions greater. One-half of the interactions were found to be "dissonant" and the other half "match."

When looking at the behavioral differences of patients in the two privacy preference groups, that is, the high privacy preference group and the moderate privacy preference group that resulted from subject scores on the Privacy Preference Scale, it was found that they differed only in one out of three behaviors. Two examples of different behaviors were the initiation of conversations with the nurse and the number of family visits. In the first instance, high privacy females approached the nurse more frequently than moderate privacy females. High privacy males had fewer family visits than moderate privacy males. There was also division of behaviors in one privacy group by sex. For example, one-half of the men in the high privacy preference group interacted with roommates "little" and one-half "moderately," while the females in this group interacted "very much."

The "dissonant" interactions produced almost 3½ times as many negative ratings than did the "match" interactions. However, there were no consistent behaviors that accompanied the

negative ratings. Patients received negative ratings although they used call lights little, and whether or not they initiated conversations with the nurse.

Zderard points out that relatedness occurs more easily among people when cultural differences are recognized; these differences are demonstrated by behavior. Attending to the behavioral cues that patients give about their privacy preferences would seem to be helpful for nurses to relate individually and therapeutically. The recommendation, then, that seems to follow is for the investigation of the cultural variations in the expression of privacy preferences. This could be done by longitudinal studies of the distancing behaviors of several cultural groups as they appear in childhood.