

**SURGICAL PATIENTS' PERCEPTION OF THE THERAPEUTIC  
ROLE OF VISITORS IN A SELECTED GENERAL HOSPITAL**

by

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g. j. o.

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## CHAPTER I

### INTRODUCTION

In recent years emphasis has been shifting in the modern hospital from almost exclusive concentration upon the diagnosis and treatment of disease to the diagnosis and treatment of persons in their totality. This shift in emphasis is being reflected in fresh consideration of how patient care should be provided to the hospitalized sick or injured. In any such consideration, the psychosocial as well as the technical aspects of patient care assumes importance. (1)

Not only are the biological aspects of patient care utilized to the therapeutic advantage of the patient, but there is increased consideration of how the physical and social environment affects the patient. Once this affect has been determined, the hospital environment can be better utilized for its therapeutic advantage to the patient.

Some knowledge has been gained in regard to the patient's psychosocial reaction to physical illness. Lederer found ill individuals exhibit fears of separation, deformity and death; they also have marked self-concern. (33) Minna Field and Esther Lucile Brown

noted that during hospitalization the patient develops feelings of exclusion from his family, friends and job and may eventually develop a feeling of hopelessness. (20)(8) Dichter noted hospitalized patients often become depressed postoperatively. (16)

Dichter, Ingles, Minna Field and Esther Lucile Brown suggested the patient's visitors be used to meet adverse reactions in the hospitalized patient. The visitor could give the patient additional emotional support, by communicating to the patient he was not going through a private struggle alone. The visitor would also keep the patient in contact with the outside world. (16)(30)(20)(8)

At present, there is a trend in the modern hospital to relax the previously rigid visiting hours. (2) As currently practiced, visiting hours present many unresolved problems that relaxation of hours alone does not solve. (3)

Lederer noted the ill individual loses his social and business interest. (33) Dichter also noted the hospitalized patient often develops a sense of imperfection and does not wish to have visitors around. (16) Christina Fields noted that responding to a host or hostess role may actually slow down amelioration in the very ill patient. (19) Therefore, visiting the ill patient may not

always be therapeutic.

As the psychological and social needs of the pediatric and psychiatric patient were studied, visiting on these units was adjusted to meet the needs of these patients. (29)(11)(41)(12)(28)

However, as of yet, relatively few studies have been done in regard to the visitors' behavior and the resulting effect in the medical and surgical patient in the general hospital. Accordingly there is little evidence with which to form a basis on which visiting can be further developed for the best advantage to the patient.

### THE PROBLEM DEFINED

#### Statement of the Problem:

As there was more awareness of the effect of the immediate environment on the patient in the general hospital there was increased consideration of how visiting on the medical and surgical units should be further developed for its therapeutic advantage to the patient. (8)(10)

The purpose of this study was to define more clearly the role of the visitor in terms of behaviors which were deemed crucial to the therapeutic success of the visit from the vantage point of

the patient in the general hospital.

Method of Research:

The critical incident technique, described in Chapter II, was the method of data collection. This technique involves the collection of critical incidents, that is descriptions of visitors' behavior deemed especially effective or especially ineffective as observed and described by the patient.

Limitations:

This study was limited to information obtained from patients by the use of the critical incident technique.

This study was limited to the adult, hospitalized patient on the surgical units of one hospital, who met the following criteria:

1. Over 21 years of age;
2. Free from visitors at the time of the interview;
3. Not in isolation;
4. Hospitalized for not less than five days nor more than one month; and
5. Mentally and physically able to respond to an interview by the following criteria:
  - a. had physical facilities for speaking and hearing

clearly;

- b. were not under sedation at the time of the interview; and
- c. were not in the critical phase of illness or under extreme physical or mental discomfort at the time of the interview.

This study was limited to the incidents that took place during the patients' hospitalization in which the interviews were done. No incidents occurring during previous hospitalizations were used.

This study was further limited in that 202 critical incidents were used and since the data were collected in the surgical units of only one private hospital no wide-spread generalizations can be drawn from the conclusions.

#### Definition of Terms:

For the purpose of this study, the following definitions of terms were used:

1. Perception was defined as the faculty of gaining knowledge through one of the senses.
2. Therapeutic role was defined as a social action pattern performed to meet the needs of the patient-person.
3. Visitor was defined as any individual who made a visit to

a hospitalized patient for the purpose of friendship, charity, personal business of the patient, but was not a member of the hospital staff responsible for directing or carrying out the medical or surgical treatment of the patient, or responsible for the maintenance of the patient's hospital environment.

### Assumptions

For this study it was assumed that:

1. The visitor's influence on the patient is important;
2. Visitors play therapeutic and non-therapeutic roles;
3. Patients can perceive the role of the visitor as therapeutic and non-therapeutic; and
4. The interview is a reliable means of obtaining critical incidents, despite the fact people tend to make favorable responses during an interview.

### IMPORTANCE OF THE PROBLEM

Studies have been done to determine the psychological effect of hospitalization on the pediatric patient. One of the most important conclusions of this research was the recognition of the trauma caused by the separation of the parent and ill child. (29) The

relationship on the psychiatric wards has also  
from these studies it was found the visitor  
effect, neutral or non-therapeutic effect on the  
subject was determined by the relationship of the pa-  
visitor and by hospital environmental factors.

As a result of the research in regard to pediatric and psychia-  
tric patients, visiting on these units can be developed and guided  
for their therapeutic advantage to the patient. However, no such  
data have been collected for the medical and surgical patient in the  
general hospital.

At present most decisions regarding the patient's visitors  
are made for the patient, with little consideration of the therapeu-  
tic value to the patient. Visiting hours are usually designed for  
the convenience of the staff, visitors and patients. (8) Relatively  
no data have been collected in regard to the medical-surgical patient's  
perception of the therapeutic and non-therapeutic value of visitors.  
With such data, visiting could be better directed for its therapeutic  
value to the patient.

This study has implications for nursing in that it is often the  
nurse who guides and directs the behavior of the visitors in the  
hospital situation.

## PLAN OF STUDY

The design for this study may be described in the following steps:

1. A tool was developed from information gained in related literature. The tool consisted of an interview guide designed to elicit information which would be consistent with the purposes of the study.
2. Permission to conduct the study was obtained from the hospital administrator, the medical staff and the director of nursing service of a selected hospital.
3. The population of the hospital was studied to find a group of patients who had recently gone through an acute phase of illness and whose illness was relatively short term. For this reason only the patients on the surgical units of the hospital were used for this study.
4. A pilot study was done on six patients.
5. From the pilot study it was decided:
  - a. to revise the tool for collecting the critical incidents;
  - b. to limit further the participants to patients who had been hospitalized not less than five days but not more than one month;
  - c. that the interviewer was to wear a nurse's uniform, with

identifying pins and name plate, thus facilitating establishing rapport and making introduction and identification of interviewer more quickly,

- d. to conduct all interviews between the hours of 9 a. m. to 12. noon, during which time there were fewer interruptions due to visitors, to physicians' rounds and to interruptions by nursing personnel carrying out patient care, and
  - e. to eliminate the patients in isolation units.
6. A list of names of patients who met the criteria of the study, was obtained from the Kardex on each surgical ward.
  7. A nurse on each ward checked the list of names of patients to eliminate the patients who were mentally and physically unable to respond to an interview.
  8. Critical incidents were collected.
  9. Incidents were categorized.
  10. Verification of categories was done by two other judges qualified by virtue of the fact they were both graduate, professional nurses.
  11. Analysis of categories was done and findings translated into percentages.
  12. The study was summarized, conclusions drawn and recommendations made.

## OVERVIEW

A review of the literature is presented in Chapter II which includes present development of visiting hours, studies done on the effect of visitors on the patients, and a description of the critical incident technique. Chapter III describes the conduct of the study, findings and interpretations of the results. A summary of the study, plus conclusions and recommendations are presented in Chapter IV.

## CHAPTER II

### RELATED LITERATURE

#### Introduction

The social environment of the hospital has become increasingly important. As a result of extended research and clinical observation, there has been a realization that body, mind and emotions act as a unit. Therefore, to treat only a surgical or medical illness while neglecting the mind and emotions may not result in a cure when a cure is potentially possible. (8) Utilizing the social environment therapeutically, not only grants the patient respect, but also maximizes the benefits of medical and surgical intervention of illness. The use of visiting is one way in which the social environment can be utilized for its therapeutic value to the patient.

In 1947, a British Physician spoke out for reform in hospitals. Doctor Parry stated: (36)

In too many hospitals an essential fact is forgotten - that they were founded not for the benefit of doctors, nurses, or committees of management but to help to restore the patient to health.

Enormous improvement on the social side of hospital treatment is needed. The social treatment of patients means providing for his comfort, happiness, amusement, occupation and general welfare, which at present are too often forgotten or relegated to a subordinate position. This social medicine means so much to a patient. It not only helps and accelerates his recovery but also brings it about in a much less irksome manner.

At this time progressive British Hospitals permitted daily visits while the traditional hospitals permitted visitors only on Sunday and Wednesday. Doctor Parry noted that many adult patients appeared to look forward to the daily visiting hours. He felt that if frequent visits were an advantage to an adult patient, they were much more of an advantage to a child separated from his parents and in strange new surroundings, often with little love or sympathy and longing for the sight of a familiar face. In his observations he noted that children were occupied and happy when parents were there.

#### Pediatric Unit

Unrestricted visiting of parents has been developed on many pediatric units of hospitals because of the therapeutic effect of parents remaining with the ill child. Formerly it was believed the hospital course of the ill child was smoother, more effective and less disturbing if parents were excluded to the limits of tolerance. Hunt and Trussell stated, "Doctors and nurses often felt the child patient was easier to handle when parents weren't around". (29)

Others felt there would be serious risks of infection conveyed by visitors if visiting hours were extended. (36)

Child psychiatrists scrutinized the roles played by hospitalization, hospital staff and parents during the child's hospital stay. A pediatric nurse developed continued research on the meaning of hospitalization for children at varying ages. (26) One of the most important conclusions of such research was the recognition of the trauma caused by the separation of the parent and the ill child. Although the experience of being sick or undergoing pain and discomfort of surgery was in itself traumatic, it was felt that the separation from the parent was the most important factor producing undesirable reactions in the hospitalized child. (29) As this concept was accepted, visits of parents were recognized for their therapeutic effect on the ill child. This in turn influenced the change in the previous rigid visiting hours.

Barker, O'Connell and Brandt described the trend of permitting the parent to stay with the ill child. Increased family visits were encouraged to children who became depressed, lacked appetite and developed general lethargy; parents were permitted to stay with the child before surgery and also to be present in the recovery room when the child awakened from anesthesia. (2) (35)

Stevens, Coffin, Hunt, and Trussell noted the following beneficial effects of the parent staying with the ill child: the patient

and parent were much happier, the children cried less; the child became well faster and seldom became ill from the "home" variety of bacteria the parents brought in; and there was a strikingly low incidence of phobias or other behavioral disturbances after discharge. (41)(11)(29)

Hunt and Trussell stated that a mother's presence is not always constructive. However, they felt such a disturbed parent would cause difficulty whether present or not. When such a parent is found, Hunt and Trussell felt a well oriented staff could gain important data in understanding the pediatric problem and could sometimes use this information in a constructive and therapeutic way for the entire family. (29)

At present there is a trend toward unrestricted visiting on the pediatric units of hospitals. However, unrestricted visiting on these units usually has been limited to the parent or parent substitute.

#### Visiting on the Medical-Surgical Units

##### Development of Visiting Hours

There are not as much psychological and sociological data on the aspects of patient care in the adult medical and surgical

units of the general hospital as in the pediatric unit. Due to the lack of data concerning the effect of visitors on the medical-surgical patients, the literature indicates visiting hours on these units have been modified for different reasons.

Sister Gerald writes that the primary purpose of the hospital is to facilitate treatment. To provide more time for treatment, which would result in quicker recovery and turnover of patients, she described how visiting hours were curtailed to one two-hour period a day except Sunday which permitted two two-hour periods. The results of such a program were just the opposite from what was expected. Instead of permitting the staff more time for patient care, they were constantly overwhelmed by visitors. This was because there were numerous excuses, infractions and exceptions to these new rules. The new visiting schedule made it necessary for the hospital staff to spend much more time enforcing regulations, thus defeating the aim of providing the staff with more time for patient care. As a result, the regulations were lifted and the visitors were permitted to come and go as they wished. (25)

Flores pointed out that the control of visitors involved many departments. Communications between all these departments made enforcement of visiting regulations complex. Furthermore,

she felt decisions in regard to visitors were often made by individuals not involved in direct patient care. This made visiting determined by regulation only, rather than adjusting it to the patient's desires or needs. (24)

Other reasons for relaxing previously rigid visiting hours have been given by Esther Lucile Brown. Short, infrequent visiting hours made too many visitors at one time. As a result, there were not enough parking facilities; the corridors and elevators were overcrowded; large numbers of visitors present at one time made visiting difficult and over tired the patient, then left the patient for long periods of time when he had no visitors; and with so many visitors present at one time, the patient who had no visitors felt left out. For these reasons, it appeared that it would be less disturbing to the patients and staff to distribute visitors over a longer period of time. (8)

Keller and Hard felt the public image of the hospital often rests with the visitor. As a result, the visitors' wishes needed to be considered more seriously in order to strengthen good public relations. Hard and Keller felt that if the visitors were permitted to see the good care of the patient, the visitor would have more confidence in the hospital. As a result the visitor would be relieved

of the tension which exists because of his concern over the patient's welfare. The visitor would also have more confidence in the hospital if he himself should become a patient. (27)(32)

A desire for a new method of control of the visitor has been implied by many people. In recognition of the many problems of rigid visiting schedules, Flores raised the following questions: (24)

What would happen if all restrictions were removed and people could visit patients when they pleased? Suppose they were given a chance to control their own visiting hours. . . . what would happen?

In response to a survey done by Clothier, one Hospital Administrator, in disclosing the reason for unlimited visiting hours during eight hours of the day, made the explicable statement, "These are patients, not inmates, and they must accept the major responsibility of controlling their visitors." (10)

Doctor M. B. Barton, a Physician Superintendent of a Psychiatric Hospital in England made the following comment in regard to control of visitors: (3)

Patients can always be encouraged to tell visitors when they are feeling tired, and surely a ward sister or a staff nurse is capable of giving the relatives of such a patient friendly advice without causing offense.

### Uniqueness of Visiting the Sick and Hospitalized Patient

The literature indicates the hospitalized patient psychologically reacts differently than the normal individual. This is due in part to the changes in the patient himself because of his illness. It is also due to the environment imposed on the patient.

Changes in the patient influenced by illness. Lederer described these changes when he identified three distinct but overlapping stages of illness; transition to illness, acceptance of illness and convalescence. (33)

During the first stage, transition to illness, the individual has many fears, especially fears of separation, deformity and death. He exhibits extreme self-concern, regresses in his behavior and generally presents the picture of a tired and frightened child.

The second stage, acceptance of illness, is characterized by dependency. The patient still has his fears, mentioned in the transition to illness stage, and still has marked self-concern. He has further psychological regression. He responds to those responsible for his care much as a child responds to his mother and father. He abandons his concern for politics, business and social events. Through social and emotional regression, the sick person redistributes his energies to facilitate the physical healing process.

Convalescence, the third stage, is the period of illness in which the individual leaves his protected world in which responsibilities were minimal and satisfaction of self-centered needs the major concern of himself and those attending him. Psychological re-integration gradually takes place. Although the course of this period is often characterized by fits and starts, the individual finally develops a sense of physical well being and again assumes his former psychological and social functions.

Prange and Martin described how these stages may never be entirely resolved as in the occurrence of chronic illness or when death intervenes. Prange and Martin also pointed out there is a normal lag between the physical and socio-psychological stages of illness. Although the individual exhibits physical symptoms, he may deny his illness psychologically in the stage of transition to illness. His physical symptoms make him dependent before he accepts his dependency psychologically. He remains psychologically dependent in convalescence longer than he remains physically dependent. (34)

Effect of hospitalization. Minna Field describes the effects of hospitalization on the patient. The patient finds himself in a strange world on the hospital ward; he lacks understanding of hospital procedures; he is forced into a dependent role as a patient. He

reacts to hospitalization with increased fear, develops a feeling of exclusion from family, friends and job and may eventually develop a feeling of hopelessness. (20)

Esther Lucile Brown emphasizes that hospitalized patients worry about what is happening at home and in the community from which they have been separated. (8)

Doctor Leo Simmons makes a contrast between the "culture of illness" in the home and in the hospital. He pointed out "... at home physical surroundings were familiar and afforded a sense of security. Home is a haven the world over". But the change in the physical environment and social characteristics of the hospital stimulate dread, apprehension and anxiety in the patient upon entering the hospital. (40)

Uniqueness of visiting the patient in the hospital. Several authors have commented on the uniqueness of visiting the patient in the hospital. Christina Field pointed out the presence of a visitor makes the patient play a host or hostess role. She observed that the playing of this role often placed too much strain on the ill individual. (19) Bodine and C. Brown pointed out the dilemma of the patient when he has a visitor. As a patient, he often has little control over who enters his room. Yet he eats, sleeps, and

spend some time with him if the patient's home was a considerable distance from the hospital. The hospital's purpose for encouraging visitors was "... not only to give additional support to the patient but to teach the relative how to care for the patient at home if necessary."<sup>(8)</sup>

Another indirect purpose has been identified by a British nurse. She found the visitors helped the hospital staff to understand the patient's background more fully. She stated this became very obvious once visiting hours became more liberal and the contact between the staff and the visitors were increased.<sup>(6)</sup>

#### The Visitors' Behavior and the Effect of Visiting

Unfortunately, little has been written in regard to the behavior of the visitor and the resulting effect on the patient. Most of the literature deals with visiting hours in general and the visitor in particular. The literature describes how the visitor is envisioned by the members of the hospital team, whether he should be restricted or limited in his visiting, as well as how the hospital can enlist the cooperation of visitors in observance of the rules of hospital etiquette.

However, as the behavioral sciences were developed in nursing, there was an increased awareness of the need for research

into the emotional and social aspects of nursing care. In regard to research concerning the effect of visitors, Sanford raised the following questions: (39)

What about the therapeutic effect of visitors?...  
What about weeping relatives? Is their so thoroughly disapproved emotionality a real source of stress for the patient or is it vitally needed evidence that someone cared?

The emphasis on the psychological needs of patients in general hospitals has been enhanced by previous developments in the pediatric units. For some time the emotional needs of hospitalized children have been studied and emphasis has been placed on meeting these needs. As a result, many pediatric units recognize the ill child's need for his parents.

Hard paralleled the similarity between the ill child and the ill adult. She said ill adults, "...who are only large babies", like ill children, have need for visible expression of loving interest from their family and friends. (27)

Thelma Ingle criticized the lack of meeting the emotional needs of patients in general hospitals. She pointed out four hospital practices which increase emotional tension in patients. One of these was the policy regarding visitors. Ingle also recognized the similarity between the ill child and ill adult. Recalling that the hospi-

talized child needs his parent, Ingle felt, "Adults frightened by the uncertainties of illness, may feel safer with a family member near." She felt that policies which keep the visitor away from the patient, when the patient needs this sense of security, not only prevent the patient's emotional needs from being met but also cumulate in unnecessary tension in the patient and his family. (20)

Brown corroborated this idea when she stated visiting determined by rules rather than on the basis of individualization could be non-therapeutic because of its over abundance and its abuse. However, she felt it is more likely to be non-therapeutic because of the limitations imposed. (8)

Several authors have pointed out how the visitor can have a therapeutic or non-therapeutic effect on the patient. A Menorah Physician expressed his opinion as to the effect of visitors, "A visitor can have a profound effect on a patient, even to the point of life or death difference." (5) In describing the effect of the visitor in the immediate postoperative period, Audrey Bell stated, "Most of us agree that a visit by mother, father, wife or husband often does more for the patient's well-being than all the drugs that medical science can produce." (4)

Minna Field noted the composure of the visitor often affects the patient. She describes how relatives are often very anxious over the patient's condition and seek knowledge about the patient's condition from the physician who often is unavailable or does not give sufficient time or privacy to the visitor for discussing the patient's condition. Because the visitor has inadequate information he becomes tense and upset. As a result: (20)

A relative who is anxious, fearful and tense, who sits at the bedside with one eye constantly on the corridor trying to catch sight of a doctor, communicates his restlessness to the patient and by so doing negates the beneficial effect of the visit.

Christina Field describes how the visitor needs to adjust his approach to the patient's condition and how this approach effects the patient. (19)

Each patient is different and, therefore, a different approach may be necessary. A pleasant manner is most important. It is devastating for a patient's morale to see a look of shock, pity or even disgust or repulsion on the face of a visitor. Yet, there are situations that call forth these responses from us. A calm, pleasant approach in these circumstances can do much to make a hospital visit successful. Pleasantness is not a boisterous, happy-go-lucky approach that steals away the fine sense of kindness. Not many of us feel happy-go-lucky when we are lying flat on our backs, surrounded by tubes, bottles and gadgets of one kind or another!

Long visits can be detrimental to the patient. As for the length of the visit, Bodine offers some good advice. After doing a survey in his hospital, he found most patients preferred visitors to stay only 15 minutes. <sup>(5)</sup> Christina Field, however, was not so definite as to the length of the visit in minutes, but believed the length should be based on the patient's needs. She stated: <sup>(19)</sup>

It should be short enough not to be exhausting, but long enough to satisfy the patient. An adequate visit will convey a feeling of well-being that comes from the realization that someone cares enough to take and make the effort to come.

Bodine also observed that "nothing wears down a patient like having to play host to a whole party of visitors." For this reason the number of visitors permitted at one time in his hospital was limited to two visitors per patient. <sup>(5)</sup>

Esther Lucile Brown found many hospitals still do not permit children to visit in the hospital. She questioned the premise on which this policy is based. She noted that in the past, children were not permitted because it was felt they contacted and distributed disease readily. Also it was taken for granted children would disturb patients and be a nuisance. She continued: <sup>(8)</sup>

The basic consideration today would appear to be whether patients need to see their children and grandchildren, and whether children need to see their parents or other members of their families. To deprive a mother or father, when sick, of even a glimpse of what may be most dear and important in life runs counter to current philosophy of the therapeutic value of meeting patients' psychological needs. To prevent every child by fiat from seeing his parents or other persons to whom he is psychologically tied may be to do him severe damage.

Several English hospitals have carried out the advice of Doctor M. B. Barton in which he suggests unrestricted visiting hours for all patients. (3) Rhona Jones noted some good effects of unrestricted visiting hours at the Bristol Royal Hospital, an acute general hospital. She found the patient is less likely to feel divorced from his family and anxious about home affairs; the seriously-ill patient has less reason to worry when his visitors are present throughout the day when this is typical of all patients, not just for those patients on the dangerously ill list; there is less noise during the peak of visiting hours which was previously due to a large influx of visitors during a concentrated visiting hour. Jones found one of the disadvantages of extended visiting hours is that the incessant noise from visitors can disturb the very ill patient. Since this disturbance is usually caused by visitors other than the patient's own visitors, she felt this demonstrated the need for private rooms for the very ill patients. (6)

Boyce writes about a busy English general hospital which extended the visiting hours to daily visiting hours between 2 p. m. and 3 p. m. There were many direct and indirect negative effects of frequent, prolonged visits. The nurses found it difficult to carry out nursing care, physicians were constantly hampered in carrying out treatments and examinations. The constant presence of visitors clogged the corridors and patients' rooms and constantly interrupted patient care. Boyce said, "From the patients' point of view, many complained and longed for freedom from visitors. Some even asked the ward sister to restrict the number of visitors allowed as they did not wish to hurt their relatives' feelings. (6)

#### RELATED STUDIES

##### Current Trends in Hospital Visiting Policies

Clothier recently surveyed 13 hospitals throughout the country, regarding visiting policies. An article on his study was published June, 1962. (10) His findings revealed a wide variance in hours for visiting; eleven hospitals did not permit children to visit except under special circumstances; four hospitals had no rules as to the number of visitors allowed per patient, eight limited the number to two visitors, one hospital had a limit of one to four visitors per patient; four hospitals left the responsibility of regulating the hospital visitor

to the nursing floor, five hospitals left this responsibility to the information desk and nursing floor and the other hospital left the responsibility of enforcement to some other point in the hospital.

Clothier came to the conclusion there was a trend toward longer visiting hours and a more liberal regulation of them. He recommended that his hospital tighten the enforcement of visiting regulations but did not know exactly how to do it and where to place the responsibility for the enforcement of these regulations.

#### The Psychiatric Patients' Visitor

Due to the fact that many patients could no longer afford private nurses, relatives were permitted to stay with and care for patients at the Sanatorium Prevost, a voluntary psychiatric hospital in Montreal. A study was undertaken to determine the effectiveness of such a plan of care. This descriptive study was later reported in 1954. (12) Under this study a close member of the family, who continued to maintain a good relationship with the patient, was permitted to remain with the patient at all times except for times when the patient underwent special treatment.

No statistical findings were given in this study. However, the researchers came to the conclusion that this type of care has economic, educational and in some instances therapeutic advantages. The only significant disadvantages arose from an improper choice of participating family members.

The Boston Psychopathic Hospital undertook a descriptive study of the patient-visitor relationship. (28) The methodology used in this study was a detailed observation of the behavior of a group of acutely disturbed women patients and their visitors. From on-the-spot observations, 60 visits were analyzed. Hotchkiss' findings indicated that the patient-visitor relationship could be classified as indifferent, frustrated, friendly, solicitous and corrective or critical. Patients' behavior was classified as indifferent, withdrawn, friendly, over-responsive and demanding or accusing.

Hotchkiss came to the conclusion, "some visits serve as a therapeutic aid, some are neutral in effect and some may actually retard the patient's progress. Nearly all of them, however, are meaningful in one way or another, to both the patient and his visitors." However, in general she felt hospital visits fall short of their potential value for both the patient and his visitor.

She recommended encouraging a more social atmosphere for the visits. Visits could take place among other patients and their visitors which would encourage a healthier group sociability. She recommended that the hospital personnel intervene in visiting situations in which tension is building up and by intervention relieve this tension before a critical situation develops. She also recommended that the visitors be briefed as to the patient surroundings, ward routine and patient treatment. Visitors could also be helped by being briefed on the types of patients they may meet and how best to respond to these patients.

#### Studies in the General Hospital

A study done by the Institute for Research in Mass Motivation was reported by Doctor Ernest Dichter in 1954 on the hospital-patient relationship. (14)(15)(16)(17) In this study the patient's responses to hospitalization were analyzed in terms of the patient's whole life experiences.

One aspect of this study involved depth interviews of 160 individuals, who were either former patients or hospitalized patients at the time of the study. The respondents came from all walks of life, all social-economic levels throughout the United States. The respondents were questioned about their general attitude concerning hospitals.

Among Dichter's significant findings he found 65 per cent of the people interviewed admitted their primary feeling concerning hospitalization was fear. Of the patient group hospitalized at the time of the study, 60 per cent of these patients interviewed expressed a child's need for a symbolic reassuring parent, together with the desire that at times they wanted some distance and privacy. Ninety-five per cent of all respondents felt hospitals should have a warm and friendly atmosphere to relieve the patient's fear.

Dichter came to the conclusion that in every instance the adult patient entering a hospital becomes emotionally a child; he feels helpless and insecure. It can be noted here that Lederer pointed out that all ill individuals go through this emotional adjustment to some degree. <sup>(33)</sup> According to Lederer, the ill individual in the transition stage of illness, emotionally becomes like a child, has feelings of insecurity and then in the dependency stage of illness, becomes dependent emotionally and physically. While Dichter associated these feelings with the hospitalized patient per se, Lederer associated these feelings with all ill individuals, hospitalized or not.

Dichter also noted that patients in the hospital often feel a state of imperfection. This may explain the reason why many hospitalized patients have difficulty in playing a host or hostess role. The incident

cited by Dichter was of a woman patient who disliked having visitors in the postoperative period because she wasn't able to wear her dentures.

Generally, Dichter reached the conclusion that hospital services, apart from the primary medical functions, should be designed to tide the patient through his many stages of insecurity and adjustments.

Dichter recommended that patients be given a symbolic parental substitute. He noted how the ill, hospitalized child gains satisfaction from having a parent close at hand. He also felt the adult patient could be helped in the same manner if a symbolic parental substitute communicated to the patient that he was not going through a private struggle alone. Noting that many patients go through postoperative depression, Dichter recommended this be relieved by permitting a close friend, another patient or a spouse to remain with the patient to give him added emotional support.

Two studies attempted to measure the effect of the visitor on the patient. The first of these studies was done by Doctor E. N. Wineburg. He conducted his study, "The Hospital Visitor: A Study of Responses of Cardiac Patients to Visiting Hours," in 1955 at University Hospital, Zürich, Switzerland. <sup>(42)</sup> The purpose of his study was to determine what immediate effects hospital visits have upon

the patients' momentary state of disease. Sixteen male and sixteen female cardiac patients were used in this study.

The methodology of this study consisted of two parts. In the first part, radial and cardiac pulse rate, blood pressure, respiration rate and temperature were recorded on Visiting Day, one half hour before visiting hours and one hour after visiting hours. A control situation was then set up for each patient on a day in which he had no visitors, and the same readings of vital signs were recorded at the same time of the day. The data of the visiting day were then compared to the data on the control day. The findings of this part of the study indicated all the functions measured showed small increases after visiting hours, with only the increase in blood pressure being statistically significant.

The second part of Wineburg's study was conducted by interview in which he asked a series of ten questions. Findings from this part of the study were: 18 out of 31 patients desired a shorter visiting period than the existing arrangement of one and one-half hours; 15 out of the 32 preferred the existing arrangement of three visits per week; 19 of the patients in terms of general well-being felt worse or tired after the visits, however 21 felt the effects of the visit were calming; the average visiting group included three to

four persons but several patients received five, six, seven or even 16 visitors in one afternoon; unspecific family and neighborhood news was the topic discussed most, the topic next in number of frequencies was the patient's own illness; all patients were happy or pleased to have visitors.

Doctor Wineburg came to the conclusion that the hospital visitor exercised a physiological effect upon the cardiac patients, most clearly measured in terms of increased blood pressure. Women patients were more liable, showing greater changes than men. Hypertonics were the most affected by visitors. Doctor Wineburg also concluded that most patients felt that the one and one-half hour visit was too long, and that they generally felt worse or tired afterwards. All patients nevertheless, reported that they were happy to have visitors, and encouraging remarks during the visit seem to have a beneficial effect on the patient.

Doctor Wineburg recommended: (1) individual regulation of the length of the visit suited to the needs of each patient; (2) control of the number of visitors; (3) suggestions to the visitor that make him aware of his therapeutic effect on the patient.

The above study was repeated by three Sisters of Mercy as a part of a course at the University of San Francisco. This study

was reported in the Nursing Outlook.<sup>(13)</sup> Their study was limited to 20 cardiac patients. Three of the patients in their study were eliminated due to apparent mental cloudiness or lack of visitors, leaving 17 patients in the study.

According to the findings of the study done by the Sisters of Mercy, the variation in vital signs was so slight that no statistical difference was found.

Several interesting comparisons can be made between the finding of these two studies in regard to the questionnaire. In response to the question, "How often would you like to have visitors?", most patients, in both studies gave the existing arrangement of visiting hours as being satisfactory. In Doctor Wineburg's study visiting was permitted three times a week while in the Sisters' study visitors were permitted twice daily. This may be due to the fact that the tool was not sensitive enough to determine the patients' true feelings. Perhaps people find it easiest just to accept the status quo since they have no basis for making comparisons.

There is also an interesting comparison between the two studies in response to the question, "In terms of your general well-being, did you feel better or worse after the last visit?" Doctor Wineburg found 19 patients indicated feeling worse right after visiting hours, four felt no difference while 11 felt better

after the visit. It can be noted here that although Doctor Wineburg stated he used 32 patients for the study, 34 patient's responses were given to this question. There was no information given in this study, as published, which would account for this discrepancy in the number of patients used to respond to this particular question.

At least half of his patients indicated feeling worse after the visits. In comparison the Sisters found 94 per cent of the patients reported feeling better in terms of general well-being, six per cent felt no difference, but none reported feeling worse after the visits. As no difference in length of visiting periods could be detected in the studies, the possibility exists that the number of visitors present in the patient area at any one time may be the disturbing factor. All of Doctor Wineburg's patients were ward patients, thus permitting all the visitors present to disturb all the patients in the ward. Also, Doctor Wineburg found the average number of visitors per patient to be three or four with one patient having 16 visitors.

However, in the Sisters' study the number of visitors in the patient area was controlled by environmental factors and policies regarding the number of visitors per patient. In this study 65 per cent

of the patients were in private rooms and one or two visitors was the characteristic number per patient. It may be the combined disturbance of all the visitors in the patient's area, whether or not the visitors were actually visiting the particular patient in question, was the upsetting factor involved.

Generally the Sisters' findings, conclusions and recommendations concurred with Doctor Wineburg's study except in the following points: the Sisters did not conclude that visitors exercised a physiological effect upon the cardiac patient nor did they conclude that patients generally felt worse or tired after visiting periods.

### CRITICAL INCIDENT TECHNIQUE

Since this study utilizes the Critical Incident Technique, a resumé of the technique has been included in this chapter.

#### The Development and Use

The critical incident technique was an outgrowth of studies in the Aviation Psychology Program of the United States Army Air Force during World War II. The Aviation Psychology Program was established in the summer of 1941 to develop procedures for the selection and classification of aircrews. According to Flanagan: (23)

The critical incident technique consists of a set of procedures for collecting direct observations of human behavior in such a way as to facilitate their potential usefulness in solving practical problems and developing broad psychological principles. The critical incident technique outlines procedures for collecting observed incidents having special significance and meeting systematically defined criteria.

After World War II, further development in this technique was seen in studies undertaken by the American Institute for Research at the University of Pittsburgh which also gave the technique its present name. One study done in the spring of 1948 was concerned with the air route traffic controller's job. <sup>(23)</sup> One of the innovations in technique that took place in this study was the collection of incidents by personnel who had no previous psychological training. It was felt those individuals did a satisfactory job of collecting critical incidents. This study also demonstrated the selective recall of dramatic or other special types of incidents. This bias was especially noticeable in incidents reported several months after their occurrence.

Another study using the critical incident technique was done by Finkel in regard to the critical requirements of industrial foremen. <sup>(21)</sup> He attempted to define different categories of incidents as to degree of deviation from the norm. The findings from this study suggest however, that the types of incidents obtained are not very greatly changed by the variations in the categories regardless of the exact wording of the questions asking for incidents. According to Flanagan,

it seems likely that this was at least partially due to the fact that persons interviewed reported only those incidents that represented a fairly substantial deviation from the norm regardless of the precise wording of the questions. (23)

One of the first studies in human personality using this technique was done by Ellbert. (18) He undertook to develop a functional description of emotional immaturity. Incidents were collected from psychiatrist, psychologist, psychiatric social workers, occupational therapists, nurses and corpsmen from a military hospital. According to Flanagan: (23)

This study illustrates the application of the critical incident technique to the study of personality. It is believed that this study provides an excellent example of the possibilities for developing more specific behavioral descriptions.

The criteria for determining critical requirements for increasing the objectivity and validity of the results have been summarized: (22)(23)(9)

1. Actual behavior must be observed.
2. Recent behavior must be observed in order to ensure reliability. Obtain recent events to ensure that incidents are actual. The recency eliminates selective recall bias of incidents reported several months after their occurrence. However, if only very recent events are included, coverage may not be adequate. Therefore, several collections of

incidents over a period of several months would afford adequate coverage and minimize selective recall bias.

3. Observers must have a fundamental orientation in terms of the general aims of the activity. Instructions to the respondents must be specific.
4. The respondents must be competent to judge the activity observed.
5. The reasons for judgment as therapeutic or non-therapeutic behaviors must be clearly defined.

The method of collecting the data is usually done through a partially structured interview; either the respondent gives a verbal description of the incident during the interview or the respondent himself is permitted to write the critical incident.

One of the most critical aspects of this procedure is the question asked of the respondent. Standard instructions must be used to avoid bias and inherent changes in the characteristics and focus of the reported incidents. The instructions should: (1) state that an actual behavior of what a person did is desired, (2) specify the type of behavior which is relevant and the degree of importance which it must reach to be reported and (3) set any other limits on the selection of incidents as deemed necessary to insure valid data. Once the initial instructions are completed and the questions stated,

the interviewer should remain neutral in manner and remarks, clarifying and restating only as indicated by the respondents' response.

After collection of the incidents and evaluation of each incident according to the critical requirements, incidents are then sorted and grouped according to similarity. This step involves a long and laborious process of repeated inductive category development and definition. This is also the point in the procedure in which increased judgment and subjectivity may enter the procedure. Descriptive categories are then assigned to the groupings and any sub-groupings are determined. To ensure reliability, several judges should be used in category determination.

#### Studies in Nursing Using the Critical Incident Technique

The critical incident technique has been used in nursing to define job requirements of hospital personnel. The observer has usually been some individual in a supervisory capacity, participant in the job herself and in one instance the patient was also included as a respondent.

However, it was interesting to find one study in nursing in which the patient himself was used as a respondent to develop an operational definition of the therapeutic patient-patient interaction.

This was a pilot study done by Frances M. Carter and later reported in the Nursing Research in 1959. <sup>(9)</sup> This study was conducted in a California hospital on a neuropsychiatric teaching unit concerned with prevention, diagnosis and treatment, also the promotion of teaching and research in the field of mental disorders. The purpose of this study was to (1) make an operational definition of what psychiatric patients perceived as therapeutic interaction among themselves in their daily life on a psychiatric ward, (2) to get some general experience with the research tools being used, (3) to plan to continue this study in the future, on a larger scale, and (4) to attempt to apply any concepts formulated to the development of a more therapeutic environment for the psychiatric patient.

This study tested the hypothesis: (1) patients on a psychiatric ward perceive patient-patient interaction as therapeutic, (2) the patients can and will communicate their perception of therapeutic patient-patient interaction, and (3) the patients have entered into interpersonal relationships with each other.

The methodology used in this study was the critical incident technique exclusively. Verbal and written incidents were collected from the patients on the ward at the time the study was made.

The patients were asked to tell about a most recent experience in which they had observed therapeutic patient-patient interaction on the ward. In addition, they were asked to describe a non-therapeutic incident. Thirty-two behaviors were collected. From this, 19 categories were formulated. The findings revealed that the request made for incidents resulted in an 81.2 per cent response, including one negative response. Of the patients from whom requests were made, 18.8 per cent did not respond.

Carter came to the conclusion that the data confirmed the hypotheses of the study.

Her recommendations were as follows:

1. That an extended study, for a more precise investigation with the critical incident technique should be made;
2. That an action program, incorporating the categories formulated from this study, should be instituted on a psychiatric ward and procedures for evaluation devised;  
and
3. That since the present study shows that psychiatric patients are interested, able, and willing, for the most part, to participate in studies that have direct bearing upon themselves, the psychiatric patient as a resource should be used more extensively for this purpose.

## SUMMARY

In summary, there is a trend toward longer visiting hours and a more liberal regulation of them. Visiting on the pediatric units has been encouraged because of the hospitalized child's need for his parents. There is also a trend on the medical and surgical wards of the general hospital toward more liberal visiting. This has often been done because it was more convenient for the hospital and the visitor. Also, it was felt this would more closely meet the patient's needs and desires. In some instances the relaxing of visiting regulations was done in hopes that the amount of visiting and the time of visiting would be regulated when necessary by the patient, by the nursing staff and by solicitating the cooperation of the visitors.

The literature indicates visitors have a therapeutic and non-therapeutic effect on the patient. Hospitalization itself stimulates dread, apprehension and anxiety in the patient; he is forced into a dependent role; he develops a feeling of exclusion from family, friends and job and often worries about what is happening at home and in the community from which he has been separated. Illness makes the patient develop a sense of insecurity. He regresses emotionally and socially.

Because of hospitalization and illness, the patient has a special need for visitors. Yet the uniqueness of the visiting situation in the hospital may make visiting a dilemma for the patient. When a visitor enters the patient's room, the patient is placed in a host or hostess role. Because of his illness the patient may not have enough energy to respond to this role. Often the patient needs privacy because he is extremely uncomfortable or needs to carry out some personal need. However, because of the environment of the hospital the patient is not necessarily free to excuse himself to carry out these needs. Furthermore the visitor often comes at his own convenience, uninvited, thus making it difficult for the patient to adjust visits to his own needs and desires.

Therapeutically, visitors help the patient feel he is still a part of the outside world; the visitor gives the patient support and comfort and diverts the patient's attention from himself and his illness. However, the visit can be detrimental if the visitor stays too long, or if there are too many visitors present at one time. The visitor's composure and approach to the patient also is a determinant as to the effectiveness of the visit.

The studies done in regard to the psychiatric patients' visitors, revealed that visitors can have a therapeutic, neutral or non-therapeutic effect on the patient. Dichter noted in his

study on hospital-patient relationships, that hospitalized adults have a child's need for a symbolic reassuring parent, together with the desire that at times they wanted some distance and privacy. He noted that patients often have a feeling of imperfection which makes it difficult for them to play the host or hostess role at times. Noting that many patients go through postoperative depression, he recommended that a close friend, another patient or spouse be permitted to remain with the patient to give him additional emotional support during this period. Two studies have been conducted to determine the effect of visiting hours on the cardiac patient. Results from these studies indicate visitors have a therapeutic effect on the patient but that the length of visiting and the control of the number of visitors should be suited to the needs of each patient.

The critical incident technique has been used previously in nursing to determine job requirements of hospital personnel. Patients have been used as satisfactory respondents in some of these studies. Carter performed a pilot study to identify the patients' perception of the therapeutic patient-patient interaction on a psychiatric ward. The critical incident technique was used in this study. Carter felt the patient did perceive therapeutic and non-therapeutic interactions and did communicate this through the description of critical incidents.

CHAPTER III  
CONDUCT OF THE STUDY

The Problem Defined

As there has been an increased awareness of the effect of the immediate environment on the acutely ill patient in the general hospital, there has been increased consideration of how visiting on the adult medical and surgical units should be further developed for its therapeutic advantage to the patient. This study was an attempt to secure more information of how the patient perceives his visitors. The purpose of this study was to define more clearly the role of the visitor in terms of behavior which was deemed crucial to the therapeutic success of the visit from the vantage point of the patient in the general hospital.

Limitations

Before the onset of the pilot study the limitations of the study were defined and developed.

The study was limited to one hospital. The number of critical incidents to be collected was arbitrarily set as 200. In recognition of the fact that reporting incidents several months or more after occurrence would bias the data due to the selective recall

of dramatic or special incidents by the participants, (23) it was decided to limit the data to incidents which occurred during the patient's hospitalization at the time of the study.

As was pointed out by Lederer, the acutely ill individual does not react psychologically as he does in his normal state of health. (33)

Claude Brown and Esther Lucile Brown also described how the patient's perception of his environment is changed when he becomes hospitalized in a strange environment over which he has little control. (7)(8)

Therefore, a patient's perception of the therapeutic and non-therapeutic value of visitors may be altered by the fact he is now ill and by the fact he has been placed in the hospital. Because of these factors, the selected hospital was studied to locate or identify a group of patients who most nearly represented hospitalized, acutely ill patients. Because surgical patients more than the medical patient represented a group of patients who are either acutely ill or who have recently gone through an acute phase of illness, it was decided to limit this study to the surgical units of the selected hospital.

The pediatric and adolescent patients have personality reactions associated with ages which differ from those of the adult, and thus would tend to complicate the data, and thus it was decided

to limit the study to patients over 21 years of age.

In recognition of the fact that the patient may not feel free to respond to questions about his visitors in the presence of these visitors, it was decided to eliminate the patient who had visitors present at the time the interviews were conducted.

Due to their limited experience with visitors, all patients who had been hospitalized less than three days, were excluded from the study. It was also hoped this limitation would also eliminate the patients who could not respond to an interview because they were still in an acute postoperative phase of their illness. However, the patient's ability to respond to an interview is not determined by the number of days spent in the hospital; it is in essence determined by the patient's general condition. Because of this fact it was decided to limit this study to the patient who could mentally and physically respond to an interview by the following criteria:

1. had physical facilities for speaking and hearing clearly;
2. was not under sedation at the time of the interview; and
3. was not in the critical phase of illness or under extreme physical or mental discomfort at the time of the interview.

### Assumptions

The theoretical assumptions underlying this study were:

1. The visitors influence on the patient is important;
2. Visitors play therapeutic and non-therapeutic roles;
3. Patients can perceive the role of visitors as therapeutic and non-therapeutic; and
4. The interview is a reliable means of obtaining critical incidents, despite the fact people tend to make favorable responses during an interview.

### The Setting

The participating hospital in this study is a 411 bed general hospital located in Portland, Oregon. This is one of nine hospitals located in the city. This hospital is privately owned by a religious organization and is recognized as a non-profit institution. The hospital has facilities for medical, surgical, obstetric and pediatric patients.

The hospital is fully accredited by the Joint Commission on Accreditation of Hospitals. The resident and intern training program of this hospital is approved by the Council on Medical Education and Hospitals of American Medical Association. This hospital also cooperates with a collegiate school of nursing. Other appro-

private agencies have approved the hospital's training programs for medical and x-ray technologists.

The particular focus of this study was the surgical wards of the hospital. The surgical department includes six wards, all of which were included in this study. The average length of stay per patient during the year 1961 was 6.6 days. During the same year 10,986 surgeries were done. In July, 1962, the month the study was conducted, the daily census was nearly 100 per cent capacity at all times.

Visiting hours for the surgical patients in the project hospital were from 1 to 4:30 p. m. and from 7 to 8:30 p. m. daily. These visiting hours were in effect during the entire duration of the study. Special consideration, however, was given to permit visitors during hours other than the regular visiting hours if the patient was acutely or critically ill, just returning from the recovery room or surgery, or if the visitor was from out of town and had traveled some distance to visit. Special consideration was also given to the patient in a private room who wished to have visitors.

It was a hospital policy to permit children to visit during the regular visiting hours. However, the child visitor under the age of 16 was excluded from the pediatric and obstetrical unit of this

hospital.

Previous to March 1, 1962, this hospital's policy in regard to visitors, permitted visiting between the hours of 11 a. m. to 8:30 p. m. daily. However, this policy was revoked in March of the year this study was conducted in favor of more limited visiting hours. This was done in regard to the best interest of patient care. While the visiting hours of 11 a. m. to 8:30 p. m. were in effect, nursing personnel found it very difficult to carry out adequate nursing care with so many visitors present throughout the day.

The control of visitors was done through the cooperation of the information desk and the individual nursing stations. It was the policy of the nursing staff to give the patient an opportunity to make the decision each day as to whether or not he wished to have visitors that particular day. This was done each morning while the charge nurse made her rounds to the patients. She asked each patient if he wished to have visitors or not on that day. This information was then relayed to the information desk. Special medical orders regarding "No Visitors" were also relayed to the information desk by the nursing staff. Visitors asked first at the information desk if they might visit a patient. The information desk personnel then would give the information to the visitor

as to whether or not the patient was permitted to have visitors that day.

The patient handbook of the hospital gave some useful information in regard to visitors. Besides indicating the hours for visiting, it stated: (37)

We rely on the good judgment of your visitors to keep their visits short and reasonably spaced. Most patients enjoy company for a short while during the day, usually no more than ten minutes. . . It is desirable that not more than two visitors be present at the same time.

#### Pilot Project

The critical incident technique, described in Chapter II, was the method of study. After a hospital was selected, a pilot project was conducted. The purpose of the pilot project was to find out whether the questions were readily understood by the patients and met the objectives of the study; whether the patient could respond to the method of study by writing the answers to the questions. Also the pursuance of the pilot project gave the interviewer opportunity to gain some skill in handling the interviews. Subsequent revision of the design of the study, the tool and the procedure was done following the pilot project.

As the pilot project and the actual study itself were conducted in the same hospital, administrative approval and staff cooperation was sought before the conduct of the pilot project. Administrative approval was first obtained from the administrator of the hospital, who in turn informed the surgeons on the staff that such a study was planned. The administrator informed this group that if any individual surgeon did not want his patient included in the study, he should notify the hospital administration of his wishes. However, no surgeon came forth with the request that his patient or patients be withdrawn from the study.

An attempt was made to gain the cooperation of the hospital's employees prior to the pilot project. The researcher published a short article in the hospital employee's paper. (Appendix A). The article described the purpose of the study and indicated the staff assistance needed. Each surgical ward's nursing staff was also contacted personally by a nursing supervisor and informed that the study would be conducted on that unit.

The pilot project took place during the last week of June, 1962. Six patients were interviewed for the pilot project; a total of eight critical incidents were collected. All patients in the pilot project were from the same unit of the hospital.

A preliminary orientation at each interview included an explanation of (1) the sponsorship of the study; (2) the purpose and characteristics of the method of study; (3) the qualifications of the patients which made their contribution of value by virtue of their position to make observations; (4) the anonymity of data obtained from the standpoint of the patient and the visitors involved in the incidents; and (5) the possibility of practical application of the results of the study. (See Appendix F).

The respondents were asked to describe especially good or effective visitor behavior observed in a specific situation. The standard verbal instructions were:

Think of the most recent time in which a visitor or visitors did something which made you feel better. Describe exactly what happened.

Identify the type of relationship or kind of association the visitor or visitors were to you. (Appendix B)

After the good incidents were collected instructions were given to obtain the poor incidents. The standard verbal instructions were:

Think of the most recent time in which a visitor or visitors upset you. Describe exactly what happened. What was actually going on at the time?

Identify the type of relationship or kind of association the visitor or visitors were to you. (Appendix C)

Before the onset of the study, it was planned to collect oral and written incidents. Prepared booklets were made for recording the situation and the behavior of the visitor in the incidents. (Appendix B and C). However, it became apparent during the pilot project the patient would be unable to give descriptions of incidents in writing. The patient was often in a reclining position and/or too ill to carry out the mechanics of writing under the limited facilities for writing in the patient's unit. Therefore, the collection of written incidents was rejected in favor of collecting all incidents orally. The patient's description of the incident was written by the interviewer during the interview.

It was recognized that the disadvantage in using the interview is that the patient might be reluctant to give his true response in that he may conceal his real attitude from the interviewer and instead, express the socially acceptable response. (38) Other barriers to interviewing, mentioned by Kalm and Cannell, which apply to this study are: failure of memory, emotional forces between the interviewer and respondent, and the manner of wording questions as to motivating or probing. (31)

To eliminate tension and distrust of the patient, it was necessary to emphasize the purpose of the study. This purpose was to find out from the patient what he found visitors did that made him,

the patient, feel better or that upset him. This information would be useful to the nursing staff, so they might better guide and direct visitors to be more helpful to the patient.

It was necessary to stress at this point that the visitor and the patient would be kept anonymous. As the transcription of the critical incident took place during the interview, this also tended to relieve tension as the respondent could see for himself that no patient or visitor was identified by name in the writing of the data. If the patient still appeared apprehensive in giving information, it was further emphasized the purpose of the study was not to curtail the visits of the visitors, but to learn effective visitor behavior.

The pilot study gave the interviewer the opportunity to gain some skill in handling the interview. Among the skills needed were: simple, precise and consistent interpretation of the purpose of the study; emphasis on the use and anonymity of data in relation to the respondent and the visitor involved; direction of the respondents' attention to specific situations which they had experienced; and identification of the aspect of the incident which was therapeutic or non-therapeutic. The real need seemed to rest in the interviewing skill per se to effect a more rapid orientation phase, thus provide more productive time in the actual working stage of describing the incidents.

The pilot study was useful in making the following revisions in the design, tool and procedure of the actual study itself:

1. All critical incidents were to be collected orally rather than written for the reasons described earlier.
2. Revised tool was to state, "Was the visitor a member of your immediate family, a relative, friend or someone with whom you worked? (See Appendix D and E).
3. The interviewer was to wear a nurse's uniform with the identifying "R. N." pin, School of Nursing pin, and name tag. Other studies, conducted by nurses, have demonstrated the usefulness of wearing these identifying symbols. It has been found patients will relate confidential information more readily to a nurse in uniform than to an interviewer wearing street clothing. <sup>(1)</sup> The wearing of the name tag was done to decrease the time previously necessary to introduce adequately the interviewer to the patient respondent.
4. The actual study was to be limited to the patients who were hospitalized from five days to one month instead of three days to one month as was done in the pilot study. This change was made because it was found during the pilot study that most postoperative patients were still

too sick and usually under heavy sedation when they were only in their third or fourth day of hospitalization. It was also noted during the pilot study that most patients hospitalized for only three or four days had had very limited experience with visitors and often could not describe any incidents.

5. The patient in isolation was to be eliminated from the study. Special regulations regarding visitors in the isolation area, did not make this patient a homogeneous member of the sample group chosen for the study.
6. The hours of 9 a. m. to 11 a. m. were chosen for conducting the interviews. Patients were usually well rested during this time of the day. Also, the interviews were seldom interrupted by Doctor's rounds, by nurses giving patient care, or by visitors during these morning hours.

None of the data collected in the pilot study were used in the final study.

Procedure for Collection of Critical Incidents for  
the Major Study

This study was conducted in a 411 bed, general hospital. The particular focus of this study was in the surgical units of the hospital. All patients who met the previously described criteria were participants in the study.

A schedule of patients to be interviewed was established each day. The schedule was set up before 9 a. m. so the remainder of the morning was free to conduct the interviews.

In setting up the interview schedule, the Kardex on each unit was checked to obtain the name, room number and bed of each patient who met the stipulations of the study. The bulletin board of each unit was checked to eliminate the patient who was scheduled for surgery that day. A head nurse or staff nurse then reviewed the interviewer's schedule of patients to eliminate the patient who was not a surgical patient, or who had recent sedation, or who was off the unit that morning or who was not physically or mentally able to respond to an interview.

A decision regarding the type of interview method used for the collection of data was made on the basis of the findings of other studies and the pilot project. Each patient was interviewed indivi-

dually. The recording of the data was done by the interviewer. The responses of the patients were written verbatim during the interview.

One of the possible biases that could have entered the study at this point was that one patient's oral response could influence the succeeding responses of other patients in the same ward. This would have been possible if the patients could over-hear the previous patient's responses and by association give similar responses.

However, as the study progressed it became evident that one patient seldom, if ever, influenced the responses of other patients. This was generally due to the fact that one patient seldom had the opportunity to over-hear previous interviews. The ambulatory patient in the ward were interviewed first. This was done in a lounge or sitting room away from other patients, thereby preventing subsequent patients from over-hearing the responses. Also it was found that because of the limitations of the study, many patients in a ward were eliminated. As a result few patients were interviewed who were in close proximity. When several bed patients were interviewed in the same ward, they were usually scattered throughout the ward. As a result, the general disturbance in the wards made it difficult for one patient to over-hear the conversation in other areas of the same room.

It appeared throughout the study that patients seldom had the opportunity to bias subsequent patient responses. This was validated in that patients in the same ward gave unrelated responses except on two occasions. On these two occasions several patients gave the same or similar responses. However, the incidents reported were associated with general ward disturbance. Because it was general ward disturbance, all patients confined to that unit could have found this behavior to be non-therapeutic. On one occasion, all three patients in a ward gave the identical incident of visitors, who the night before, had turned the T. V. set too loud in the adjoining room. This same incident was described by other patients in other rooms on the same surgical unit. All interviews on that surgical unit took place on the same morning. The patients had no opportunity to discuss the study among themselves. On another occasion, two patients in the same room described the same incident of two small and unruly children as being non-therapeutic behavior on the part of the visitor. It may be assumed, therefore, that the many descriptions of the incident involving the loud T. V. and the two incidents reported of disturbing children, could have been common disturbing behavior noted by many patients, rather than one patient influencing the other patients' responses.

Admittance to the patient's presence was gained quite readily.

The interviewer wore a nurse's uniform with identifying insignia and name tag. The patient was addressed by name. The patient was asked how he was today. This also gave the interviewer an opportunity quickly to identify the patient who had just been sedated or was too ill to respond to an interview and had not been eliminated from the study previously. Rapport was easily established. After an introduction of the interviewer, a preliminary orientation at each interview included an explanation of (1) the sponsorship of the study; (2) the purpose and characteristics of the method of study; (3) the qualifications of the patient which made their contributions of value by virtue of their position to make observations; (4) the anonymity of data obtained from the standpoint of the patient and the visitor involved in the incident; and (5) the possibility of practical application of the results of the study. (See Appendix F).

The respondents were asked to describe especially good or effective visitor behavior observed in a specific situation and to describe particularly poor or ineffective behavior in a specific situation. The standard instructions were:

Think of the most recent time in which a visitor or visitors did something which made you feel better. Describe exactly what happened. Was the visitor a member of your immediate family, a relative, friend or someone with whom you worked?... (Appendix D)

Following the collection of good incidents, instructions were then given to obtain poor incidents. The standard instructions were:

Think of the most recent time in which a visitor or visitors upset you. Describe exactly what happened. Was the visitor a member of your immediate family, a relative, friend or someone with whom you worked?

(Appendix E)

The patients' responses, in answer to the identical questions asked of all participants, were recorded by the interviewer in the presence of the participants. No names of the participants or visitors were recorded. This tabulation of data appeared to put many respondents at ease when it was noted no identification of the patient or visitor was used.

It was interesting to note that the patients seemed little interested to know who the interviewer was. Those who seemed interested or seemed reluctant to reply for fear of consequences, were told the interviewer was a graduate student from the University of Oregon School of Nursing doing a study to find out how patients perceive the therapeutic and non-therapeutic effect of visitors. The patients were told that only the completed study would be given to the hospital. The respondent and visitor would remain anonymous in the completed study.

### Treatment and Findings of Critical Incident Data

Critical incidents were obtained over a three-week period. A total of 126 patients were contacted. Four patients could not describe any incidents. A total of 204 incidents were collected from the remaining 122 patients interviewed. After the interview, each incident was transcribed to a three by five inch card. A decision was then made about the usability of each incident by application of certain criteria, that is: was a comprehensive report of relevant factors in a specific situation given and was actual visitor behavior observed and reported? Two incidents were discarded because they did not describe actual behavior on the part of the visitor. A total of 202 incidents were then used in this study.

An inductive category formulation process was developed after the collection of data. Essentially, the categorizing system which was devised provided a means of classifying raw data, or incidents, into areas which served best the purpose of developing a procedure for evaluating visit effectiveness to establish a criterion of success. Randomly selected incidents were sorted and tentatively grouped together on the basis of similar or like behavior. Each tentatively established category was labeled and defined accordingly, with reference to visitor-behavior content. Additional incidents were

classified into these categories, and the need for redefinition and development of new categories was noted. Overlapping categories were grouped together, labeled and defined accordingly. Major categories were divided into sub-areas in which incidents, describing more nearly identical types of critical behavior were grouped. More explicit definition of each of these sub-areas was made.

Because of the element of subjectivity arising from personal judgment inherent in this type of procedure, two other judges, both professional nurses, were used for classifying incidents into the categories. A high correlation of agreement was gained by all three judges on all incidents.

One of the difficulties in categorizing visitor behavior was that patients often perceived the same type of visitor behavior differently. This difference in perception seemed to be based on sub-cultural group mores, factors inherent in the patient's personality and the degree of the patient's illness.

One Italian gentleman said his wife made him feel better each time she visited him. When asked what his wife did when she came that made him feel better, he replied, "She cries". After the interviewer repeated the words, "She cried", and followed this phrase

with a pause in the interview, the patient went on. "You know it makes you feel so good to think someone thinks so much of you that they would cry!", he explained. On another occasion a woman perceived the display of strong negative emotions on the part of a visitor as being non-therapeutic behavior. The incident she described was her grown son who displayed extreme concern for her in his facial expression. This woman made the statement, "I wish they wouldn't be so concerned about me. If they would just come and see I am all right and then go home again!".

Previous studies on pain have revealed differences between the Italian and American mores. <sup>(43)</sup> The American pioneer type will respond to pain in a quiet and distant manner. It is felt this group identifies the physically weak individual as an inferior person. As a result, it is not considered acceptable behavior to complain or exaggerate one's physical weakness in order to gain sympathy. As a result it is acceptable behavior on the part of the Italian male to acquire the tears and sympathy of his mother or wife. The Italian gentleman aforementioned, described the critical incident of his wife crying over him as being therapeutic, whereas the woman patient perceived her grown son's show of strong feelings of concern for her as being a non-therapeutic critical incident.

Another example was the grandmother who said it upset her to have her grandchildren come to visit. In other instances, patients perceived the mere presence of grandchildren as therapeutic. In the instance mentioned as a non-therapeutic critical incident, the grandmother related the story of how as a child she was taken only once to the hospital for a visit. On this occasion she said she went to visit her grandmother. The patient said, "I never saw her again after that. She died shortly after I visited her. Of course you know, years ago they only brought people to the hospital to die. Now they go there to get well."

The patient's perception of the therapeutic and non-therapeutic behavior of the visitor seemed not only affected by what the visitor actually did, but it was also affected by personality factors inherent in the patient, by the cultural mores of the group to which the patient belonged, and by the degree of the patient's illness.

Final category definitions were stated in terms of effective and ineffective critical visitor behaviors. Examples of visitor behavior for each category, sub-category and sub-area were given. A total of 22 categories, sub-categories and sub-areas resulted from the classification system. (See Appendix G & H)

A percentage distribution was done on all behaviors. The percentage distribution of therapeutic behaviors is given in table 1. The percentage distribution of non-therapeutic behaviors is given in table 2.

**TABLE I. -- PERCENTAGE DISTRIBUTION OF THERAPEUTIC BEHAVIORS IDENTIFIED IN 148 CRITICAL INCIDENTS DESCRIBED BY 122 SURGICAL PATIENTS**

Category	Sub Areas %	Sub Total %	Sub Category %
<b>I. Fulfills supportive roles:</b>			
<b>A. Provided psychological support:</b>			
1. Provided a sense of security by mere presence . . . . .	6.9		
2. Provided for ventilation of patient's feelings . . . . .	1.0		
3. Showed acceptance of patient's disease and limitations . . . . .	1.5		
Total of Sub-category A		9.4	
<b>B. Provided spiritual support</b>		3.0	
<b>C. Facilitated physical care:</b>			
1. Helped with patient care . . . . .	4.4		
2. Facilitated needed rest . . . . .	1.0		
3. Brought needed personal items . . . . .	1.5		
Total of Sub-category C . . . . .		6.9	
<b>TOTAL OF CATEGORY I</b>			19.3
<b>II. Kept patient in contact with outside world:</b>			
<b>A. Kept patient in contact with home and family</b>			
1. Kept patient a part of daily, happy family life . . . . .	19.7		
2. Relieved patient of anxiety in regard to home problems . . . . .	12.4		
Total of Sub-category A		32.1	
<b>B. Kept patient in contact with business world</b>		3.0	
<b>C. Kept patient in contact with his former social world . . . . .</b>		8.9	
<b>TOTAL OF CATEGORY II</b>			44.0
<b>III. Provided for diversion</b>			
<b>A. Relieved patient's boredom . . . . .</b>		9.4	
<b>B. Brought diversional activities . . . . .</b>		0.5	
<b>TOTAL OF CATEGORY III</b>			9.9
			<b>SUM TOTAL THERAPEUTIC BEHAVIORS 73.2</b>

TABLE 2. -- PERCENTAGE DISTRIBUTION OF NON-THERAPEUTIC BEHAVIORS IDENTIFIED IN 54 CRITICAL INCIDENTS DESCRIBED BY 54 SURGICAL PATIENTS

Category	Sub Total %	Sub Category %
<b>I. Disturbs or disrupts patient's environment:</b>		
A. Causes general disturbance on ward . . .	4.4	
B. Prevents patient from having necessary privacy . . . . .	3.5	
C. Interrupts patient care * * * * *	1.5	
D. Made environment depressing . . . . .	2.0	
<b>TOTAL OF CATEGORY I . . . . .</b>		<b>11.4</b>
<b>II. Overtires the patient:</b>		
A. Expected patient to fulfill hostess role when patient was unable . . . . .	2.5	
B. Friends stayed too long . . . . .	3.5	
C. Too many visitors in patient area. . . . .	5.4	
<b>TOTAL OF CATEGORY II . . . . .</b>		<b>11.4</b>
<b>III. Destroyed patient's confidence</b>		
A. Destroys patient's confidence in himself and his future . . . . .	3.0	
B. Destroys patient's confidence in his physician and/or hospital staff. . . . .	1.0	
<b>TOTAL OF CATEGORY III . . . . .</b>		<b>4.0</b>
<b>SUM TOTAL OF NON-THERAPEUTIC BEHAVIORS . . .</b>		<b>26.8</b>

From the analysis of the percentage distribution in table 1 and 2, it was found that 73.2 per cent of all critical behaviors were described as therapeutic while 26.8 per cent of the critical behaviors were described as non-therapeutic. Therefore, there were nearly three times as many therapeutic as non-therapeutic incidents described.

Of the incidents described, 44 per cent of all behaviors were identified as therapeutic in that the visitor kept the patient in contact with the outside world. (See table 1, category II). Thirty-two and one tenth per cent of all behaviors described were identified as therapeutic because they kept the patient in contact with home and family life. Only 3 per cent of all behaviors were identified as keeping the patient in contact with his business world. Eight and nine-tenths per cent of all behaviors were identified as keeping the patient in contact with his social world. Therefore, three-fourths of the incidents in this category or approximately one-third of all incidents were identified as being therapeutic in that the visit kept the patient in contact with home and family life.

The fact that the visitor fulfilled a therapeutic role accounted for 19.3 per cent of all behaviors. Nine and four-tenths per cent of all behaviors were identified as giving psychological support;

six and nine-tenths per cent identified as facilitating physical care and three per cent as giving spiritual support. Therefore, the fact that the visitor gave the patient psychological support accounted for over half of the incidents in this category or almost one-fifth of all incidents.

Only 9.9 per cent of all critical behaviors were identified as providing diversion.

From the analysis of table 1 it was evident that over half of the therapeutic behaviors described were identified as keeping the patient in contact with the outside world.

The percentage distribution of non-therapeutic behaviors revealed 11.4 per cent of all behaviors described were found to be in category I, disturbs and disrupts patient's environment. (See table 2). The patient found the general disturbance caused by visitors' attitude, often, made the general environment depressing, to be the factors making the visitors' behavior non-therapeutic.

Category II of non-therapeutic behavior, overtiring the patient, also had 11.4 per cent of all incidents. This category was described as being non-therapeutic in the following ways: visitors expect-

ted the patient to take the lead in the conversation although the patient had little to offer to this type of social interaction or was too uncomfortable to visit; the friends stayed too long; and there were too many visitors present in the patient area at one time.

Category III, destroying patient's confidence in himself, his future and his treatment accounted for only 4 per cent of the total behaviors described. (See table 2).

Therefore almost 23 per cent of all behaviors described were identified as non-therapeutic because the visitors' behavior disturbed the patient's general environment, disrupted patient care or over-tired the patient.

This study was concerned only with what patients said with no attempt to ascertain if the visitors really had a therapeutic effect and what were the actual results from the non-therapeutic behaviors.

122 patients, a total of 202 incidents were collected and categorized. From these incidents a total of 22 categories, sub-categories and sub-areas were formulated. (Appendix G & H).

A percentage distribution was done on all behaviors. From the analysis of the percentage distribution it was found that 73.2 per cent of the critical behaviors were described as therapeutic and 26.8 per cent as non-therapeutic. Therefore, there were nearly three times as many therapeutic as non-therapeutic incidents described.

Of the incidents described, 44 per cent of all behaviors were described as therapeutic in that the visitor's behavior kept the patient in contact with the outside world; nineteen and three-tenths per cent found the visitor to play a therapeutic supportive role; only 9.9 per cent of the incidents were found to be therapeutic in that the visitor's behavior provided diversion for the patient.

Of the incidents described, 11.4 per cent of all critical behaviors were identified as being non-therapeutic because the visitor's behavior disrupted patient care or disturbed the patient's general environment. Eleven and four-tenths per cent of all critical behaviors described, were identified as non-therapeutic in that the visitors overtired the patient. Only 4 per cent of all

critical behaviors were described as being non-therapeutic because they destroyed the patient's confidence in himself, his future and his treatment.

This study was concerned only with what patients said with no attempt to ascertain if visitors really had a therapeutic effect and what were the actual results from the non-therapeutic behaviors.

### Conclusions

An analysis of the data secured indicates the following:

1. The critical incident technique is a useful procedure for identifying therapeutic and non-therapeutic visitor behavior in the general hospital.
2. As most decisions in regard to visiting regulations are usually made by the hospital staff, this study shows the value of seeking critical incidents from patients. Such information would give a wider perspective of the problems involved and give more information on how to better guide and direct visiting to the advantage of the patient.
3. The acutely ill patient has difficulty in playing the host or hostess role. From the data secured in this study it can be concluded that the patient perceives the role of the recipient of social interaction as being more therapeutic

than that of being the leader of social interaction.

4. Although there were nearly three times as many incidents reported of therapeutic value as of non-therapeutic, there is no means of determining from the findings that the effects of the visitors were actually in that proportion; that is a few non-therapeutic incidents could outweigh the benefits of a large number of therapeutic incidents.

#### Recommendations

The recommendations from the experience of this study are as follows:

1. That a more extended study, for a more precise investigation with the critical incident technique be undertaken to identify the effect of the different stages of illness and the effect of the psychological relationship between the patient and visitor in determining the patient's perception of the therapeutic role of visitors. This study could also identify the sub-cultural mores that play a part in determining the patient's perception of the therapeutic and non-therapeutic role of the visitor.
2. Since this study was limited to one selected hospital which

had unique policies and regulations in regard to visitors and unique environmental factors, it is recommended this study be repeated in a different setting preferably in an institution in which the patient's family and friends are not geographically located near the hospital to determine whether the findings of this study can be generalized more widely or if they are inherent only in this setting.

3. A study be conducted to compare the incidents reported by patients in private rooms with those reported by patients in multiple-occupancy facilities.
4. That a study be undertaken to determine from visitors what further information they need to guide them in playing a therapeutic role while with the patient.

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## APPENDIX A

COPY OF ARTICLE PUBLISHED  
IN HOSPITAL EMPLOYEE'S NEWSPAPER

RESEARCH AT \_\_\_\_\_ HOSPITAL

A study will be conducted on the surgical wards to determine the therapeutic and non-therapeutic effect of visitors on patients. It is hoped this study will define more clearly how visitors effect the acutely ill patient. Once this is better defined, nursing will be able to give better guidance to visitors.

\_\_\_\_\_ Hospital was chosen for this study because in the past it has demonstrated interest in the patient's visitors. This study is being done through the University of Oregon Graduate School of Nursing and the Administration of \_\_\_\_\_ Hospital. Mrs. Oekerman, a Graduate Student, will conduct the study through patient interviews. The interviews should take only about five to ten minutes of the patient's time.

From time to time Mrs. Oekerman will contact the nursing staff on the wards as to which patients are able to respond to a short interview. Otherwise it is suggested that the staff refrain

from discussing this study with the patients before they are interviewed so that patients' opinions will not be influenced in any way.

The cooperation of the staff will be one of the determining factors in completing an accurate study which will be of value to hospitals and nursing in improving patient care.

## APPENDIX B

## SAMPLE QUESTION OF PILOT PROJECT BOOKLET FOR COLLECTION OF "GOOD" CRITICAL INCIDENTS

Think of the most recent time in which a visitor or visitors did something which made you feel better. Describe exactly what happened. What was actually going on at the time?

Identify the type of relationship or kind of association the visitor or visitors were to you.

## APPENDIX D

## SAMPLE QUESTIONS OF INTERVIEW GUIDE FOR COLLECTION OF "GOOD" CRITICAL INCIDENTS

Think of the most recent time in which a visitor or visitors did something which made you feel better. Describe exactly what happened. What was actually going on at the time?

Was the visitor a member of your immediate family, a relative, friend or someone with whom you worked?

## APPENDIX E

## SAMPLE QUESTION OF INTERVIEW GUIDE FOR COLLECTION OF "POOR" CRITICAL INCIDENTS

Think of the most recent time in which a visitor or visitors upset you. Describe exactly what happened. What was actually going on at the time?

Was the visitor a member of your immediate family, a relative, friend or someone with whom you worked?

## APPENDIX F

INTERVIEW GUIDE FOR PRELIMINARY ORIENTATION  
OF RESPONDENT TO THE STUDY

1. Sponsorship of the study: Administration of \_\_\_\_\_ Hospital and the University of Oregon Graduate School of Nursing.
2. The Purpose and Characteristics of the Method of Study. We wish to know how we can guide and direct the visitors to be more helpful to the patients. In order to do this we need to find out from the patients what they as patients have found that visitors did that was helpful and made the patient feel better.
3. The Qualifications of the Patient Which Made Their Contributions of Value by Virtue of Their Position. Patients are the only individuals who really know what visitors did that was helpful and what was upsetting. The hospital staff and visitors can only observe the effects of visits.
4. The Anonymity of Data Obtained from the Standpoint of the Patient and the Visitor Involved: No names of patient or visitors will be recorded. Need only the description of the incident with identification of the type of relationship between the patient and the visitor.
5. The Possibility of Practical Application of the Results of the Study: Once we find out what is most helpful to the patient we can pass this information on to the visitors. The hospital staff can then further guide and direct the visitor to be helpful to the patient.

## APPENDIX G

FUNCTIONAL DESCRIPTIVE CATEGORIES  
OF EFFECTIVE CRITICAL BEHAVIORS OF VISITORS

- I. Fulfills supportive roles.
  - A. Provided psychological support.
    1. Provided a sense of security; example: parent, husband, wife or very close friend stayed with patient during acute postoperative period; friends from home came to visit out of town patient, who had not seen a familiar individual since admission.
    2. Provided for ventilation of patient's feeling; example: gave the patient an opportunity to describe her auto accident; listened attentively when patient talked about the recent death of his wife.
    3. Showed acceptance of patient's disease and limitations; example: answered truthfully, when the cancer patient asked if she had cancer; when patient described her limitations, discussed limitations freely with a positive outlook and helped plan for future care with patient.
  - B. Provided spiritual support; example: prayed for patient while visiting; disclosed how religious organization was praying for patient.
  - C. Facilitated physical care.
    1. Helped with patient care; example: helped patient to eat and drink while patient had I. V. in arm; emptied urinal when needed; cleaned glasses for debilitated patient; helped patient put in false teeth; changed position of immobile patient as patient requested.
    2. Facilitated needed rest; example: wife kept other members of the family from interrupting patient's rest; wife went home when patient stated he wanted to rest; suggested patient ask for analgesic when needed for rest.

## APPENDIX G (continued)

3. Brought patient needed personal items; example: brought clean gowns; brought cosmetics.

## II. Kept patient in contact with outside world.

- A. Kept patient in contact with home and family life.
  1. Kept patient a part of daily, happy family life; example: made special effort to see patient; reported long distance phone calls from other members of the family; made statements such as "I love you"; cried over patient; brought patient's children or grandchildren to visit; brought mail; reported happy family occurrences.
  2. Relieved patient's anxiety in regard to home problems; example: told patient with physical limitations how they were preparing the home for his return; described payment of household bills; reported progress on accident claims; tells how responsibilities of small children or invalid family member has been assumed satisfactorily; reports death of elderly member of family who has been seriously ill for a long time; reported the lawn has been mowed.
- B. Kept patient in contact with his business world; example: tells patient his job will still be waiting for him after convalescence; describes progress at the office; describes new developments in the patient's trade; talked about mutual friends at work; business client made special effort to see patient.
- C. Made patient feel he was still a part of his former social world; example: told of local news of friends; made a special effort to come; brought special gifts of flowers or candy.

## III. Provided for diversion.

- A. Relieved patient's boredom; example: cheerful and humorous conversation; arrived when patient had had a quiet day.
- B. Brought diversional activities; example: brought the patient an interesting book.

## APPENDIX H

FUNCTIONAL DESCRIPTIVE CATEGORIES  
OF INEFFECTIVE CRITICAL BEHAVIORS OF VISITORS

- I. Disturbs or disrupts patients' environment.
  - A. Causes general disturbance on ward; example: undisciplined children yelling, crying, running around and climbing on furniture; children bumping against patient's bed; visitors turned T. V. set too loud; unfamiliar visitors in the room of patient who has eyes bandaged and head held immobile.
  - B. Prevented patients from having necessary privacy; example: casual friend stayed throughout visiting hours thus preventing patient from discussing confidential matters with special visitor; casual friend dominated entire conversation; visitors present in ward over long periods of time which prevent patient from using urinal, passing flatus; visitor stayed while patient took nap even though patient expressed desire to be left alone.
  - C. Interrupted patient care; example: arrived during meal time; entered room when patient had heat lamp to buttock.
  - D. Made environment depressing; example: visitors displayed total despair over non-acutely ill patient's future in front of all patients in the ward; visitor wore gray clothing on each visit and spoke in depressing tone of voice; visitor talked about nothing but his own personal problems.
- II. Overtired the patient.
  - A. Expected patient to fulfill host or hostess role when patient unable to carry out social interaction; example: permitted long lags in conversation while patient searches for topic of common interest of large group of visitors; expects patient, who is in severe pain to

## APPENDIX H (continued)

respond in conversation; visited patient while patient had difficulty in breathing, and had a sore and swollen tongue; many people arriving during same visiting hour making it necessary for patient to make numerous introductions.

- B. Friends stayed too long; example: 4 or 5 visitors stayed throughout both visiting periods the day before the patient went to surgery; friends stayed for one to one and a half hours.
- C. Too many visitors in patient area at one time; example: several large groups of visitors in the same room all speaking at once; four to 11 visitors trying to visit the same patient at the same time.

### III. Destroyed patient's confidence.

- A. Destroyed patient's confidence in himself and his future; example: constantly talked about patient's impending medical-surgical procedures; displayed facial expressions that depicted worry; constantly got up and down out of chair; brought small grandchildren to visit the patient who came from culture which only sent the dying individual to the hospital; described other acquaintances with similar disease who died as the result of the disease; using statements such as "you know you're only living on borrowed time"; talked about going fishing, when patient was just becoming aware of his limitations and the fact that he could no longer go fishing with these friends.
- B. Destroyed the patient's confidence in his doctor and nurses; example: contradicted doctor's diagnosis and method of treatment; contradicted patient's hospital diet and nursing care.

Typed by

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