SOME EFFECTS OF NURSE-LED GROUP THERAPY FOR MOTHERS OF DISTURBED CHILDREN

by

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P R O L O G U E

When we step into the family,
by the act of being born,
we do step into a world
which has its own strong laws,
into a world which could do without us,
into a world which we have not made.

G.F. Chesterton

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INTRODUCTION

1. The Broad Problem

In the past generation, psychiatric nursing has faced two revolutionary transitions. First, the nursing care of the emotionally ill has changed from custodial to therapeutic (58). Thus, psychiatric nursing care concerned with the patient's recreational activities, occupational diversions, family problems, dietary requirements and his twenty-four hour needs has changed to include the sharing of these concerns with many diversified specialists, coordinating the work of professional colleagues and directing the efforts of non-professional workers (54). The second and most recent transition is the development of community mental health programs. From this transition, it can be hypothesized that the focus in the near future will be toward short-term, intensive treatment of the patient, with movement toward day hospitals, night hospitals, out patient services and home care (58). The objective is to keep the patient out of the hospital, and to have the community care for him while using the hospital for consultations, family counseling, and family psychotherapy (58). President John F. Kennedy's State of the Union message to Congress on January 14, 1963, and the recommendations in the Joint Commission's report on Action for Mental Health further document these transitions.

The overwhelming problem of meeting the community's present and future mental health needs is one that can be observed by visiting the state's mental hospitals, talking with members of the mental health professions, and reading daily periodicals. Leaders in psychiatric nursing recognize this problem and advocate the expansion of the role of the psychiatric nurse (54)(58)(2). This expansion may be in providing individual therapy with selected patients, in providing group therapy experience and in dealing therapeutically with the patient and his family in the home (54). Other roles which the psychiatric nurse may be expected to assume are as follows (58):

1. Collaborator in the identification of treatment goals.
2. Group therapist.
3. Group co-therapist.
4. Therapist in supportive treatment.
5. Nursing consultant in psychiatric problems of:
   a) medical-surgical patients
   b) maternity patients
   c) pediatric patients
   d) others
6. Leader of nursing care conferences in relation to the general hospital patient with psychiatric problems.
7. Counselor.
8. Facilitator of hospital to community transition.

9. Play therapist.
10. Leader of prenatal classes.
11. Leader of young mother's classes.

If psychiatric nursing is to continue its professional growth and significantly contribute toward meeting the increased needs of our society, it must assume the responsibility of studying, defining and expanding the present roles of its members.

2. A More Limited Problem

The literature validates the need for the expansion of the psychiatric nurse's role.

How can this need be studied? Would a study of the consumer, his opinion of his needs, his level of adjustment, and his evaluation of the service received identify the need and direction of this expansion? Would the added service of a proposed nursing role make any difference in the consumer's opinion of the service received?

This study proposed to answer these questions through the comparison of opinions of two groups of mothers whose children attended a Pediatric Mental Health Clinic during January to June, 1964. The Pediatric Mental Health Clinics met on Mondays and Wednesdays. The mothers and their children were assigned to one of the clinics. The staffing pattern, the treatment philosophy and the setting were similar for both Monday's and Wednesday's clinic. One clinic had the added

service of short-term, nurse-led group therapy; the other did not have this available. This study was primarily concerned with the mother's description of the problems with which they needed help, their opinion of the service they received, and their evaluation of the child's present adjustment.

The data were analyzed to determine if there were any response differences between the group of mothers who attended the short-term nurse-led group therapy versus those who did not attend. Implications were offered concerning the need for services of proposed "future" nursing roles.

3. Justification for the Study

Nursing lacks a clear definition of the professionally well-prepared nurse's role in psychiatric settings (54). Society is faced with the staggering burden of mentally ill patients. Members of mental health professions are lacking in number to fulfill the needs of society, and are being urged to adopt and practice a broad and liberal philosophy of what constitutes treatment and who can administer treatment. The patient and his family are the consumers of psychiatric nursing services. A controlled study which identifies the need and direction of expansion of the psychiatric nurse's role would certainly facilitate the understanding of this problem. Through the analysis of the consumer's stated needs, level of improvement and opinion of service received, important insight can be obtained. This

importance of the study is determined by the effort to increase the knowledge of an existing need, and by its practical value as a follow-up service to the clinic and to the patient. Also, further research of psychiatric nursing roles may be generated and thus add to the value of this study.

4. Hypothesis

It is hypothesized that nurse-led group therapy for mothers of disturbed children will have certain effects on the mothers. It is further hypothesized that a favorable opinion of their child's level of improvement and of the clinic service will be one of these effects.

5. Assumptions

The basic assumptions on which this study was predicated are as follows:

1. The need for the expansion of the psychiatric nurse's role and the direction of this expansion could be identified by studying the consumer's characteristic responses, expressed needs and opinion of service received.
2. The mothers or mother substitutes studied would cooperate with the administration of the data collecting tool.
3. The data collecting tool would be sensitive and reliable for the purpose of this study.

6. Limitations

This study was limited as follows:

1. Only the mothers or mother substitutes whose children attended the Monday or Wednesday Pediatric Mental Health Clinic of one Medical School's Department of Child Psychiatry during January to June of 1964, were studied.
2. Only mothers or mother substitutes who met the above criteria and lived within a one hundred mile radius from the setting for this study were investigated.
3. Only one proposed nursing role, namely that of Group Therapist was provided by the one nurse for mothers or mother substitutes who attended the Wednesday Pediatric Mental Health Clinic.
4. The Therapy Group followed usual clinic rotation and changed group membership every six weeks.
5. Only information obtained by review of the child's clinical records, interviews with the mother or mother substitute, and review of the content of the mother's group was studied.

7. Steps in Procedure

This study was organized and conducted in the following steps:

1. The area of study was chosen, and an extensive survey of literature was undertaken. The

following areas were surveyed: The parent-child relationship; the philosophy of group therapy; group therapy for mothers of disturbed children; the nurse as group therapist.

2. Permission for the investigator to conduct mother therapy groups was obtained from the acting clinic director.
3. Lectures and demonstrations in Child Psychiatry scheduled for the medical students, were attended by the investigator.
4. During January to June, 1964, three mother's groups of five to six sessions each were conducted by the investigator. The groups followed the regular clinic rotation. The content of each group was immediately recorded by the investigator at the end of each session. The recording was hand written.
5. All clinical records of patients attending the clinic under study during January to June, 1964, were reviewed. Pertinent information was tabulated on cards.
6. An interview tool was compiled and reviewed by experts in psychiatry. After the necessary revisions were made, it was submitted to a group of registered nurses for further comment. It was found that no additional revision was necessary.

7. The mothers were visited by the investigator in their homes. The revised interview tool was utilized to elicit information.
8. The obtained data were recorded and tabulated.
9. The responses of the mothers attending the Monday and Wednesday clinic were studied, and comparisons made.
10. The content of the short-term, nurse-led, group therapy sessions was studied.
11. The study was summarized.
12. Conclusions were drawn.
13. Recommendations were made.

8. Overview of the Study

The remainder of the thesis is organized and presented as follows:

Chapter II contains a review of the literature and related studies.

Chapter III contains a detailed presentation of the various elements of the problem and the specific procedures followed.

Chapter IV presents the data, analysis and interpretations.

Chapter V summarizes the study and presents conclusions, subjective comments, and recommendations.

C H A P T E R 1 1

REVIEW OF THE LITERATURE AND RELATED STUDIES

1. Introduction

The role of the psychiatric nurse must be expanded if the mental health needs of the community are to be met. The need for this role expansion may be identified by studying the opinions of the consumer of mental health services. The child is the primary consumer of the services of the Pediatric Mental Health Clinic, yet the mother was chosen as the subject of this study. The objective of the following discussion is to validate this choice.

2. The Parent-Child Relationship

Parent-child interactions are extremely important in shaping subsequent child behavior. Symonds (17) traced the evolution of this concept to Sigmund Freud. From The Interpretation of Dreams, written by Freud in 1913, Symonds quoted thus:

> I have found that those persons who consider themselves preferred or favored by their mothers, manifest in life that confidence in themselves, and that unshakable optimism, which often seems heroic, and not infrequently compel actual success.

Symonds reviewed the writings of other early authorities in psychoanalysis. Their recognition and concern of the important parent-child relationship can be illustrated by the following statements (17). Stragnell, an American practicing psycho-

analyst, in 1925, stated that there was a relationship between anxiety in his patients and the early over solicitude of their parents. Hinkle and Wickes, both whom were followers of Jung, in 1923, wrote of their recognition of the relationship between parental attitudes and subsequent child personality. Aichhorn, a Vienneese psychoanalyst, known for his work with juvenile delinquents, in 1925, wrote about parental neglect and rejection as causes and delinquent trends as effect.

The intimate psychological relationship between the parent's unconscious conflicts and the disturbed behavior of the child is reported in current literature by Slavson, Glidewell and Cutter (16)(4)(36). The parent is the first and most important model for the child. The child identifies with the available emotional strengths or weaknesses of the parent. His primary environment for many years is the small world of interaction which his parents can provide. His early interpretations of the parental environment influence his future behavior, and as he matures, his parents continue to serve as reinforcing agents in his behavior and his socialization (4).

Controlled investigation of the dynamics involved in the parent-child relationship is a product of only the last twenty or thirty years (32). Early studies as reviewed by Symonds (17) lack information concerned with statistical validation, reliability of sample, use of control groups and other procedures geared toward validating the results of the

investigation. Nonetheless, results reported by early investigators indicate their awareness concerning the important influence of the parent's pathological relationship with the child's subsequent maladjustment. Lewis in 1930, studied the relationship between parental attitudes and lying in children. He concluded that 90 percent of the non liars came from stable homes, while 75 percent of the liars came from poorly adjusted homes. Zimmerman in 1930, recognized the specific importance of the mother in the child's mental health. He studied the relationship between maternal adjustment and attitudes and the behavior problems of five and six year old children. He concluded that the aggressive child tended to have an over-protective or rejecting mother, while the timid child had an over-anxious or solicitous mother.

The importance of the parent-child relationship influencing subsequent child behavior is thus supported by early and current literature. The specific importance of the mother in this relationship is recognized by Freud and other early psychoanalytic authorities (17), and by Slavson (16), Durkin (6), and other current psychiatric authorities. To further clarify this position, it is important to examine some particularly relevent studies in greater detail. Cass (32) and others (49)(51)(4), report studies concerned with the mother of the disturbed child. Cass (32), a clinical psychologist, conducted a study for the purpose of determining if the degree of conflict in the mother-child relationship is a function of the awareness the mother has for

the child's attitudes and the degree of parental control exerted by the mother. The independent variables to be measured were four: (1) Parental awareness; (2) the child's identification with the parent; (3) parental projection; and, (4) control exerted by the parent.

The researcher hypothesized that parental awareness provided positive reinforcement for the child's identification with the parent and parental control provided negative reinforcement in this process. Identification was defined as the child's imitation of the parent and projection was defined as the parent's false belief that the child is imitating her. A highly structured check-list questionnaire was administered to the selected sample of mothers and their adolescent children. The intended purpose of each item was disguised as an attempt to control the respondent's bias. This tool was designed to measure variables 1, 2 and 3. The fourth variable was measured by a parent-control questionnaire which was administered to the children.

The sample was selected by sending a questionnaire to mothers whose children attended a suburban high school Of the 165 who answered this questionnaire, mothers of 47 boys and 42 girls were selected as normative. The specified questionnaire was administered to these mothers. A subgroup was selected on the basis of whether the mothers indicated a high awareness and low control score or low awareness and high control. This subgroup was made up of eight mothers

of girls and eight mothers of boys. The parent-child conflict of this subgroup was measured through the use of an incomplete sentence test modeled after Rolter's incomplete sentence blank.

The results of this study are as follows. The data collecting tools were tested and found to be sensitive for the collection of the intended data. Statistical analysis of the data indicated that as the mothers scored high in the variable that measured awareness of their children's attitudes, their children scored high in the variable that measured imitation of the mother. Mothers who scored high in awareness scored low in the variable that measured false beliefs that the child was imitating the parent. It stands to reason that in a relationship in which one member is aware of the other's attitudes and is being imitated by the other, conflict would be minimal.

This study provides interesting results which could contribute toward prevention and treatment of mother-child conflicts. The results emphasise the important influence of the mother in determining the degree of conflict in the mother-child relationship. However, there are questions that this investigation did not answer. The sample for this study was selected from mothers who answered a selection questionnaire. Would a study of the mothers who did not answer the questionnaire yield different results? The data collecting tools utilized primarily written responses. Does verbal or written behavior correlate with the actual behavior

the parent utilizes? The answers to these questions are important in providing increased understanding of the rejecting and disinterested mother.

Another study concerned with the mother of the emotionally disturbed child was published by Levitt (49), in 1956. This study was supported by the Institute for Juvenile Research of Chicago, and was conducted for the purpose of determining the validity of the mother's perception of the degree of emotional disturbance of the child. Seventy-three children and their mothers selected at random from a child guidance clinic, were used for this study. The Children's Manifest Anxiety Scale was administered to the children and the same scale was administered to the mothers after each item was changed from "I" to "my child."

The results of this study are as follows. Each response was coded numerically so that it was possible to score and average the mother's and children's responses. It was found that both the children's and mother's averages were very similar which indicated that as a group the mothers agreed with the children's responses. Each mother's individual total score was then paired with the total score of her child. There was no significant difference found in the value of these paired scores. This indicated that the mother, in general, agreed with the responses of her child. Each item in the mother's scale was also paired with the corresponding item of her child's score. Once again, agreement was found in the mother's response to each individual item of her scale

with that of her child's scale. It was therefore concluded that mothers and their children showed agreement in their responses concerned with the degree of psychopathology of their children.

The findings of this study are important because frequently the mother is the main informant of her child's illness. However, certain experimental shortcomings lessen the importance of this study. The reliability of the Children's Manifest Anxiety Scale was not described. The results of the study are generalized to include all types and degrees of psychopathology even though the scale used only measures anxiety. The reliability of the children as informants of their own emotional illness was not tested. Therefore, the mother's agreement with possibly inaccurate information given by the child would not increase her value as a reliable informant.

Madoff (51), illustrated his awareness of the importance of the mother's child-rearing practices to her child's pathological behavior by a study published in 1959. This study was conducted for the purpose of determing if child-rearing attitudes of mothers of seriously delinquent adolescents were significantly different from the attitudes of mothers of healthy children. Fifty mothers of institutionalized delinquents were selected from several agencies on the basis of the child's age, behavior history, intactness of the home and availability of the mother. Fifty-seven mothers of "healthy" adolescents were selected from three school systems on the basis of their I.Q. distribution, academic achievement

and socio-economic level. The Parental Attitude Research Instrument was administered to both groups of mothers.

The results of this study indicated that the mothers of institutionalized children differed from the mothers of healthy children. This difference was seen in their response to nine scales which measured authoritarian and control behavior. The mothers of the institutionalized children expressed the more positive, controlling and authoritarian attitudes. These results indicate the great need for active teaching of mothers to influence healthier attitudes and child-rearing practices. It also indicated specific treatment goals for mothers whose children demonstrate behavior problems.

Once again, however, the results of this study do not indicate the reliability of the tool used to measure child-rearing attitudes. The correlation of verbally reported attitudes to the actual practices of the mother is not known. Evidence was not given to indicate that the reported attitudes of punitiveness, control and authoritarianism have influenced the child's misbehavior, rather than the child's misbehavior having influenced the reported attitudes.

3. Group Therapy for Mothers of Disturbed Children

Group therapy for parents often facilitates the treatment of the disturbed child (20)(6). Group therapy has been found to be specifically effective with mothers of disturbed children (20)(6)(16). The Brookly Child Guidance Center

conducted group therapy for both children and mothers in 1937, (18). These groups were led by Amster, Gabriel, Kolodney and others under the direction of S. R. Slavson, and the sponsorship of the Jewish Board of Guardians. These groups dealt with the parent-child relationship rather than with deeper problems of the mother. Therapeutic success was reported. This method was continued and its use was increased. The director and leaders of the groups continued their interest in this method and published its effectiveness (16)(18)(20)(40).

Group therapy for mothers has also been reported to facilitate school adjustment for the child. In 1949, Buchmueller and Gildea (31), reported the use of group therapy for mothers of children with behavior problems in schools. The purpose of the study was to attempt to remedy the problems of the child by working with his mother. Two elementary schools were selected for this study. Problem children were referred by the teachers. The mothers of these children were invited to attend individual interviews. Eight mothers were obtained in this manner, representing thirteen children. Follow-up study of the thirteen represented children indicated that nine showed considerable improvement, while four remained unchanged. In the other school studied, twelve mothers, representing twelve children, attended one or more group sessions. A study of these twelve children indicated that nine were improved considerably and three remained unchanged. Criteria used to measure improvement was not described.

The results of this work are very relevant to this thesis. They indicate that a high degree of school adjustment can be attained by the child whose mother attends a very small number of group therapy sessions. Some of the faults of this study should not be overlooked, however. The number of mothers studied was quite small. A more personal subject recruitment might have resulted in a bigger sample. Criteria for suitability for group therapy should have been described and validated. Criteria used to measure improvement should have been described and validated also. Level of improvement of the children whose mothers attended the group therapy sessions should have been compared with those whose mothers did not attend the group therapy sessions.

Long term use of group therapy for mothers of disturbed children has also been reported to be effective. In 1954, Durkin published Group Therapy for Mothers of Disturbed Children. This volume represents Durkin's work with group therapy for mothers since 1939. Therapeutic effectiveness is reported and attributed to the group's assistance with the mother's unconscious conflicts to which the child responds, to discussion of problems which bear a direct relationship to their child's conflicts, to the helping with interpersonal relationships by focusing on the relationships within the group, and to the mother feeling understood by the group. Evidence of the effectiveness of this approach is presented by the following observations: The mother's interference with the treatment of the child was eliminated; the mother's

relationship with her children and other family members was improved; and, character changes were noted in the mothers.

Therapeutic success of group therapy for mothers using different methodology is reported by S. R. Slavson's Child-Centered Guidance of Parents. The difference in methodology consists of using group guidance technics rather than group psychotherapy. Free association, recollection of early memories and wide margins of hostility, tension and social pathology are not permitted in the group sessions.

Therapeutic effectiveness is attributed to the leader's communication of positiveness, constructiveness, and helpfulness to the group members who establish a similar pattern of good will and guide one another. Awareness of empathy with children, self acceptance, emotional objectivity, security and identification with the leader is achieved, knowledge is acquired, and parental instincts and mature functioning is encouraged. Supervision is provided for the practice of parenthood.

The use of this approach in influencing more effective treatment of the disturbed child is not limited to followers of a specific psychological approach. In 1950, the Community Child Guidance Centers in Chicago established group therapy for mothers. These centers are Adlerian in their psychological approach (1). The variety of group therapy methodology employed by Durkin, Slavson, Buchmueller and others further emphasizes that a difference in psychological orientation does not limit therapeutic effectiveness (6)(16)(27).

Use of group therapy is not limited to the parent or parents of the emotionally disturbed child. In 1951, Cummings and Stock described brief group therapy for mothers of mentally retarded children (34). In 1953, Millikin reported group descussions for parents of handicapped children (56). In 1959, Pershkin and Abramson described group therapy with parents of children having intractable asthma (59). All of these investigators expressed enthusiasm concerning this treatment modality.

4. The Philosophy of Group Therapy

Group therapy can be historically traced to the year 1000, when the Trappist and Benedictive Monks met once or more each week for the purpose of calling attention to unrecognized traits (8). Group therapy methods can also be traced to the Church of England, to Anton Mesmer of France, to Simmel of Germany and to Alfred Adler in Vienna (8). In America, Doctor J. H. Pratt is said to have made the first deliberate application of group therapy in 1905, at a Boston dispensary with a group of tubercular patients. He called this approach, "class method of treatment," and his purpose was to teach hygiene to these patients.

The practioner of group therapy is not guided by a specific philosophy concerning the use of group therapy. The literature fails to demonstrate consensus in definition, methodology and objectives. Even the term group therapy is not always used. Group therapy and group psychotherapy are

at times used interchangably (8), and at times used to refer to different processes (35). The variations are attributed to the unsystematic growth of group therapy and to the difference of the conceptual framework of the practioners (8).

Definitional variation includes the following: 1. A socialization task of the action level by group members whose interaction is related to a concrete activity (2); 2. primarily a social and psychological process in which an emotional re-education can occur (8); 3. either a technical or non-technical reference, the non-technical including common sense aides to wise living and the technical including specific methods of altering neurotic process (8); 4. a technic of using groups in which personality reconstruction is not the primary goal (35).

The specific technic used is largely dependent on the educational orientation of the therapist and on the type of group therapy employed.

Frank and Powdermaker (12), describe the following general types of group psychotherapy that are currently in practice: (1) Didactic groups; (2) therapeutic social groups; (3) repressive-inspirational groups; (4) psychodrama; (5) free interactional groups.

Didactic groups consist primarily of lectures given by the leader of the group. Therapeutic social groups afford identification, encouragement, acceptance, understanding, and reassurance to people with physical and emotional illness. Repressive-inspirational groups usually employ a

strong, authoritative leader who uses a variety of formats in a structured way. He elicits group responses and group feelings by group singing, testimonials, recreational or occupational programs. Psychodrama employs the group methods developed by Moreno, in which significant events of an individual life are acted out on a stage. Free interaction groups are at times referred to as analytical group therapy, group analysis and psychoanalytic group therapy.

Group therapy as a method of intervention in psychiatric illness has many objectives. Some of these are to produce fundamental change in the attitude of people (39), to improve reality testing and aid socialization (18), and to meet the basic needs of affection, security, success, achievement, belonging, acceptance and meeting the opposite sex (65).

From these stated goals, it can be inferred that meeting a variety of objectives in a variety of ways by a single therapist for a group of people is a great advantage of group therapy. Other advantages are the opportunity for the patient's observation of his problematic interactions (2), the opportunity for the staff to understand the patient more accurately (8), and the provision of factors which are generally recognized as bringing about modification of attitudes (39).

The use of group therapy is not limited to members of a specific profession. Group therapy is currently being used by the professions of psychiatry, psychology and social work (8). Armstrong and Rouslin, Bueker, Hargreaves, Martinez and other members of the nursing profession have also reported its use (2)(25)(41)(51).

5. The Nurse as Group Therapist

Nurses can effectively assume the role of therapist for certain types of group therapy. In 1950, Hargreaves and Robinson (44), reported that nurse therapists were responsible for nine patient groups at Boston State Hospital. Training and supervision was provided. These groups were beneficial in helping the patient help himself and others and in stimulating the patient to seek help from his psychiatrist.

In 1951, Kaldeck (48), published a study concerned with demonstrating the usefulness of nurse and attendant group psychotherapists. Instruction and supervision was provided for the selected nurses and attendants. The first seven groups were started in 1949. By 1951, these groups were increased to twenty-one, with extremely satisfactory results observed. These results were the patient's increased ability to verbalize freely, to control destructive behavior, to compare his problems with those of other patients and to visit with his family more often. The additional benefits of increased staff morale and satisfaction were also reported.

In 1954, Galioni and others (41), reported a study supported by the California Department of Mental Hygiene. The purpose of this study was to evaluate the treatment problems of the "backward" patient. A sample of four hundred patients was selected. The selection procedure was not described. The average age of this patient sample was forty-one, average hospitalization was ten years. All the participating patients

were male. A control and experimental group was formed by pairing individual patients according to age, diagnosis, education, marital status and activity. The control group was housed in one of the over-crowded wards of the hospital, while the experimental group was moved to treatment cottages. The treatment cottages had new furniture, no window guards and a staffing component of 7 nurses and 73 psychiatric technicians. The control group had no nurses and a lesser number of technicians.

The treatment program consisted of three aspects; group psychotherapy, rehabilitative therapy and other specific measures. The nursing staff emphasized the individual worth of the patient and conducted the psychotherapy program exclusively.

Reported results were described as 18.5 per cent discharge rate in the experimental group as compared with 5 per cent in the control group. Eight patients went home on indefinite leave as compared to two from the control group. Eighty-nine visits were made by the experimental group as compared to thirty-two of the control group. Psychological testing indicated greater psychological functioning of the experimental group.

While it is difficult to establish the specific variable related to the favorable results obtained from this study, it is significant to observe the ability of the nurse to conduct a program of group psychotherapy. The success of this endeavor helped to establish group psychotherapy as part of the treatment program of this hospital.

In 1957, Bueker (29), a nurse in charge of the insulin and group therapy program at St. Elizabeth's Hospital in Washington, D.C., reported her experience as group therapist. She conducted group therapy with 7 to 10 male patients receiving sub-insulin shock. She later asked a doctor to join the group as co-therapist, because she felt unable to provide the "security that a doctor could provide."

From her experience, Bueker concluded that the patients had a lesser amount of adverse reactions to insulin when they discussed their problems during the treatment. Patients assumed responsibility in giving immediate attention to the physical needs of others. Feelings of insecurity and defensiveness expressed initially by the patients, continued even after the doctor joined the group. The nurse concluded that her own insecurity had contributed to her seeking the assistance of the doctor.

In 1958, Martinez (52), described the nurse as group psychotherapist in a Veterans Administrative Hospital. A nurse and a male psychologist were selected as co-therapists because of the therapeutic possibilities of recreating a symbolic Oedipal situation. Eight chronic schizophrenic patients were selected as group members. The patients involved were observed frequently to give up the use of bizarre discussions, show warmer feeling towards other patients and to be discharged sooner. No specific measuring tool or control group was described. The use of the nurse as one of two psychotherapists was assumed to be therapeutically effective.

In 1962, Brown (25), a nursing director, described the preparation and gradual expansion of the nurse's role to include group therapy. Preparation began in 1956, when the nurse leaders for group therapy were selected and trained in various workshops. In 1958, the first nurse-led group was started with patients from an acute intensive treatment ward. Nurses then became responsible for the leadership of twelve patient groups. The problems in the development of this program were many. The greatest was that of, " ... actually selling the value of a nurse doing group therapy to members of the medical staff."

Specific benefit attributed to the expansion of the nurse's role to include group therapy was the increased discharge rate of patients.

In 1962, Clark and Wackerman (33), two nurses doing graduate study, described their experience as group therapists. Five female patients diagnosed with schizophrenia and hospitalized in a psychiatric institution from 9 to 20 years were selected. The nurse therapist alternately filled the roles of group leader and group recorder. These therapists concluded that group therapy is conducive to patient learning and thereby promotes behavioral change. Analysis of six recorded group sessions showed change in the patient behavior pattern of rivalry to mutual respect and consideration. It was further concluded that group therapy led by nurses was effective in influencing such a change.

Realizing the therapeutic potential of the nurse as group therapist, Kalkman and others (2)(10)(62), have advocated specific education to equip the nurse for this role. In 1958, Kalkman's, Introduction to Psychiatric Nursing, included seventeen pages dealing with group therapy in nursing. Specific criteria, indications, nurse participation and kinds of group therapy were described. In 1960, Sommers (62), a research psychologist, encouraged the learning of principles derived from social and psychological research as an attempt to equip the nurse for the use of group technics. In 1963, Armstrong and Rouslin published, Group Psychotherapy in Nursing Practice. The important contribution of this introductory textbook towards the utilization of the therapeutic potential of the nurse group therapist is apparent. Dr. Hildegard E. Peplau, an eminent nurse educator, in the forward of this text, advocated nurse education in group therapy.

> There are various types of special educative experiences for patients through which the lacks in interpersonal and intellectual competence, so glaringly evident in the mentally ill, can be remedied. Group psycho-therapy is one such experience. Nurses ought to be participants in this endeavor in behalf of recovery of the mentally ill; psychiatric nurses ought to use their individual responsibility and opportunities to learn what is required for their participation in group psychotherapy.

Realizing the importance of the mother-child relationship in influencing the emotional stability of the child, the therapeutic effectiveness of group therapy for mothers of disturbed children, and the nurse's proven ability to

conduct certain types of group therapy programs, it is therefore appropriate to study the expansion of the role of the nurse to include leadership of group therapy for mothers of disturbed children.

C H A P T E R 1 1 1

PROCEDURE

1. Subjects

Date for this study were obtained by the use of an interview questionnaire with twenty-seven mothers or mother substitutes whose children attended a Pediatric Mental Health Clinic during January to June, 1964. The mothers, ranging in age from 23 to 63 years, were Caucasion with the exception of one who was Negro. All were of approximate socio-economic level as evidenced by the welfare qualifications that must be met for Medical School Clinic patients.

2. Subject Recruitment

Referral to this clinic usually comes from the main Pediatric Clinic of this Medical School's Out-Patient Clinic. The child with medical or psychiatric problems is initially seen there; other departments are used for consultation. If further evaluation or treatment is needed, the child is referred to another clinic for treatment of the special problem. The child needing further treatment or evaluation of a psychiatric problem is referred to the Pediatric Mental Health Clinic. This clinic meets on Monday and Wednesday. The referred child and his mother are assigned either to the Monday or Wednesday clinic for six weeks. Effort to distribute evenly among the two

clinics the number of children according to type and severity of their presenting problem is made by the clinic's staff, who read the referral information and conduct a preliminary interview with the child and his parent. Description of the mothers and children assigned to the Monday and Wednesday clinics is made on Tables 1, 2, 3, 4 and 5. During January to June, three different groups of subjects rotated for six weeks in each of the clinics. The three groups in each clinic were designated as Group A, Group B, and Group C.

Table 1. Numerical distribution of children and mothers in two Mental Health Clinics during January to June, 1964

Clinic Members	Monday Clinic Group A	B	C	Wednesday Clinic Group A	B	C
Mothers	4	3	5	5	5	6
Children	4	3	6	5	6	7
TOTALS	8	6	11	10	11	13

The clinic meeting on Wednesday was randomly selected to be the experimental group for this study. The Monday clinic was selected as the control group. These clinics were assumed suitable for use as experimental and control groups due to their similarities in having the same acting director, serving similar patients, having medical students-therapists of the same academic standing, use of similar topics and demonstrations for the students and rotating for the same number of weeks. Statistical evidence in support of the

Table 2. Age distribution of mothers attending two Mental Health Clinics during January to June, 1964

Age Range	Monday Clinic Group A	B	C	Wednesday Clinic Group A	B	C	TOTALS Mon.	Wed.
21-25	0	0	2	1	0	0	2	1
26-30	0	0	1	1	1	3	1	5
31-35	3	1	0	1	2	1	4	4
36-40	0	1	0	2	1	0	1	3
41-45	0	0	2	0	0	0	2	0
46-50	0	1	0	0	0	1	1	1
51-55	0	0	0	0	0	0	0	0
56-60	0	0	0	0	0	0	0	0
61-65	1	0	0	0	0	1	1	1

Table 3. Distribution of classification of mothers attending two Mental Health Clinics during January to June, 1964

Mother's Classification	Monday Clinic Group A	B	C	Wednesday Clinic Group A	B	C	TOTALS Mon.	Wed.
Natural Mothers	3	3	3	4	3	3	9	10
Step Mothers	0	0	1	0	0	0	1	0
Foster Mothers	0	1	0	0	1	3	1	4
Grandmothers	1	0	0	0	0	0	1	0
Aunts	0	0	0	1	0	0	0	1

Table 4. Age distribution of children attending two Mental Health Clinics during January to June, 1964

Age Range	Monday Clinic Group A	B	C	Wednesday Clinic Group A	B	C	TOTALS Mon.	Wed.
1-3	0	1	1	0	0	0	2	0
4-6	0	0	3	1	1	4	3	6
7-9	1	0	0	1	1	1	1	3
10-12	3	2	2	3	3	2	7	8

Table 5. Sex distribution of children attending two Mental Health Clinics during January to June, 1964.

Sex	Monday Clinic Group A	B	C	Wednesday Clinic Group A	B	C	TOTALS Mon.	Wed.
Male	3	5	3	4	4	6	11	14
Female	1	0	1	1	1	1	2	3

assumption of group equivalence is offered in Chapter IV. The investigator, a registered nurse preparing for a graduate degree, conducted group therapy for all mothers in the experimental group. These mothers were invited to attend the group therapy sessions by their primary therapist or by a member of the clinic staff.

3. Experimental Setting

The Monday and Wednesday Pediatric Mental Health clinics provided the experimental setting for this study. These clinics function under the direction of a Department of Child

Psychiatry in a Medical School's Out-Patient Clinic. Its dual purpose is to provide intensive short-term evaluation, diagnosis and treatment for children under twelve years of age and to provide child psychiatry theory and experience for medical students of senior standing.

The clinic's staff consisted of a full time social worker who had the position of acting director, one part time psychiatrist for each clinic, a full time psychologist, a psychology intern and a third year psychiatric resident for each clinic.

The treatment and teaching approaches are eclectic. Emphasis is given to specific student and patient goals rather than to following procedures associated with a specific school of thought. The student assumes the responsibilities of the primary therapist for one or two children for six weeks. Supervision, demonstrations and lectures are provided. The student may either see the child alone, the child and the parent together or the parent alone. At the end of the six weeks, a detailed summary is written by the student. The child's history with diagnosis, treatment and disposition are included in this summary. The parent is given recommendations which may include continued therapy for the child in the regular Child Psychiatry Department.

The experimental therapy room used for this study was a large comfortable office which was equiped with two-way mirrors. While the mothers met in this room for the group

therapy sessions, the children played in a nearby waiting room equiped with toys and supervised by a member of the secretarial staff.

4. Nurse-Led Group Therapy

The group sessions started after the children and the mothers were seen by their therapist. The children went to the designated area and the mothers went to the experimental group area. The investigator wore no uniform and gave no information of her qualifications other than, "I work here on Wednesday and I am interested in finding ways of being helpful to mothers like yourselves." The group was initially told that their doctor or a member of the staff might at times come to listen to their discussions by the use of the two-way mirrors.

The criteria used were based on the investigator's belief that mothers whose children are having emotional problems (1) are in need of recognition from others of their own difficulties and frustration, (2) are potentially able to help themselves and other mothers by sharing their experiences, (3) are in need of a place to go where their feelings of guilt and frustration are accepted.

Technics used in group therapy had the objectives of: (1) Encouraging meaningful discussions of problems; (2) development of cohesive group feeling; (3) encouraging new behavior; and, (4) developing a sense of importance through constructive participation. The technics used by the group

therapist were many. Some of these were: (1) Helping the member feel at ease by greeting her warmly, assuming a comfortable posture, using words that the members used, and verbally admitting feelings of tension and discomfort; (2) generating group feeling by discouraging teacher-pupil relationships, referring questions asked back to the group, treating members as experts of problematic situations, and using collective references such as, "we," "this group," "mothers;" (3) provoking discussion by making brief, reflective, statements of what the group seemed to be saying. These statements could be used for clarification, for arriving at group consensus or for verbalizing the group's meta-communication; (4) encouraging member-centered discussions by using brief comments, remaining silent, controlling impulsive statements, helping the quiet members participate, asking the group's help and expecting verbal participation; (5) encouraging acceptance and supportive attitudes by demonstrating these whenever appropriate; (6) reinforcing serious, here and now discussions by nodding, looking more interested, making eye contact and commenting favorably; (7) discouraging verbal dominance of few members by making eye contact with the other members who were silent, by controlling verbal or non verbal communication that would encourage continued verbal dominance; (8) providing verbal continuity by summarizing discussion throughout the session, repeating key words and making short reflective comments.

The group therapy procedure consisted of forming a small circle with the available chairs, waiting for the

members to finish their discussion with their therapist, greeting them and offering them chairs. Members not present were inquired about, members returning from absence were welcomed back. Sessions were started at 2:00 P.M., by saying, "It is now 2:00 P.M., the group is open." Discussion usually followed rapidly and the leader served as coordinator of the discussion. Frequent summaries were made during the group session. Leader participation varied according to the group discussion. At the end of the session, a member was asked for her summary of what the group had discussed. This summary was reinforced by the leader. Group members were invited to return, and this concluded the session.

5. Interview Questionnaire

A questionnaire interview tool was constructed so that the hypothesis which was formulated could be tested from the data. The constructed data collecting tool was submitted to two experts in psychiatric research. After the necessary revisions were made, it was submitted to a group of registered nurses for further comment. It was found that no revision was necessary. Refer to Appendix A. for presentation of the questionnaire used.

Part one of the questionnaire consisted of presentation of twenty symptoms. The mother was to indicate whether these symptoms were her child's presenting problems at the clinic. For all affirmative answers, she was asked the following questions:

1. Is this symptom better, same or worse?
2. What is your opinion of why this symptom is better, same or worse?
3. Your concern or worry about this symptom is less, same or more?
4. What is your opinion of why your child had this difficulty?
5. What was your opinion before going to the clinic of why you had child difficulty?

Part two consisted of questions geared to find out the needs the mother had, whether these needs were met at the clinic, and whether these needs were important. Space was provided for suggestions or comments concerning clinic service.

The questionnaire consisted of one and one-half typewritten pages and the approximate time for administration was fifteen to forty-five minutes, depending on the length and tangentiality of the respondent's comments.

6. Administration of Interview Questionnaire

The interview questionnaire was administered to the experimental group which consisted of fifteen mothers and to the control group which consisted of twelve mothers. The original control group number was fourteen. One was disqualified because her foster child attended the clinic sessions with a social worker rather than her mother. Another mother moved out of the state. In the experiment group,

the original number was seventeen. Two were disqualified because one lived out of the one-hundred mile radius limit set by the study, and another moved out of the state. Therefore, both control and experimental group lost two respondents. The investigator visited the mothers in their homes with the exception of one in the control group who would only agree to see the investigator at a beauty school where she was receiving training. One interview from the control group and one interview from the experimental group were conducted by phone due to flood conditions in the state. One father in the control group and one in the experimental group insisted on participating in the interviews with their wives.

C H A P T E R I V

DATA, ANALYSIS, AND INTERPRETATIONS

1. Monday versus Wednesday Clinics

The Monday and Wednesday Pediatric Mental Health clinics used as the control and experimental groups for this study were assumed to be equivalent. This assumption was based on their many similarities as mentioned in Chapter three. Evidence in support of this assumption was found through the analysis of two existing clinic variables. An analysis of the children's emotional problems was done to determine whether the types of problem treated in the experimental setting were similar to those treated in the control setting. The diagnoses given to each child by a medical student therapist at the end of the evaluation period from January to June of 1964, were surveyed.

The diagnoses for both clinics were of two categories, Adjustment Reaction of Childhood and Organic Brain Disorders. The Adjustment Reaction of Childhood category included sub-categories of neurotic, conduct and habit disturbances, while the second catagory included mental retardation and neurologic disorders. The predominantly used diagnoses for both clinics was Adjustment Reaction of Childhood. Three children of the control group and one of the experimental group were not given diagnoses. Clinic equivalence based on the severity of the presenting problems was not established due to the lack of specific diagnostic refinement. Omitted diagnoses constituted a lack of uniform

representation necessary to establish statistical evidence of diagnostic equivalence. The evidence as presented in Table 6 is descriptive.

Table 6. Survey of diagnoses given to twenty-nine children attending two Mental Health Clinics during January to June, 1964

Classification	Monday Clinic Number	Monday Clinic Percentage	Wednesday Clinic Number	Wednesday Clinic Percentage
Adjustment Reaction of childhood	10	76.1%	12	70.5%
Organic Brain Disorder	0	00.0%	4	23.7%
Diagnoses omitted	3	23.9%	1	5.8%

Lacking specific grades for the Mental Health Clinic experience and supervisor ratings, statistical evidence of equivalence of medical student therapists competence was determined by a survey of the composite grades given those students for the Pediatric Clinics during their senior year. Description of the findings are found in Table 7.

Table 7. Senior year pediatric grades given medical student therapists attending one of two Mental Health Clinics during January to June, 1964

Grade	Monday Clinic Number	Wednesday Clinic Number
A	6	8
B	7	10
C	2	0

The Pediatric grades were coded and a Mann-Whitney U test was done. This test was used with this and other variables throughout this study because it is the most powerful of the non-parametric tests. A non-parametric test was done because parametric tests should not be used with data in an ordinal scale. As described in Table 8, a non-significant U of 119 was found. Thus, the grades given to the medical student therapists attending the experimental clinic were found not to differ significantly with those grades received by the medical student therapists attending the control clinic.

Table 8. Description of Mann-Whitney U analysis of grades given medical student therapists attending one of two Mental Health Clinics during January to June, 1964

Variable	Monday Clinic			Wednesday Clinic			RESULT	
	Median	No. of Rank	Sum of Ranks	Median	No. of Rank	Sum of Ranks	U'	U
Coded Grades*	2	15	271	2	18	290	151	119**

*Grade codes:
A - 1
B - 2
C - 3

** not significant

2. Analysis of Questionnaire Responses

Twelve mothers in the control group and fifteen in the experimental group completed a questionnaire administered by the investigator. The data were analyzed to test the

experimental hypothesis, that a favorable opinion of their child's level of improvement and of the clinic service are some of the effects of nurse led group therapy. The questionnaire responses were tabulated as described in Table 9.

Table 9. Description of response to a questionnaire administered to twenty-seven mothers whose children attended one of two Mental Health Clinics during January to June, 1964

Reported Variable	Monday Clinic Group A	B	C	Wednesday Clinic Group A	B	C
Number of symptoms	20	10	27	38	37	51
Number of symptoms--better	12	6	6	27	16	22
Number of symptoms--same	7	4	15	9	17	29
Number of symptoms--worse	1	0	4	2	5	0
Number of Clinic needs	23	14	31	30	20	28
Number of needs met	14	6	13	24	3	9
Number of needs--nearly met	3	6	12	1	8	14
Number of needs--not met	6	2	6	5	9	5
Number attended group sessions	0	0	0	15	17	8
Number of mothers in the clinic	4	3	5	5	4	6

The median number of symptoms reported by the control group was four, for the experimental group the median was

nine. A Mann-Whitney U test was done to determine if there was a significant difference between groups for the number of symptoms reported. As described in Table 10, a U of 29 was found. This score was significant at the .01 level. Thus, the experimental group was found to differ significantly in reporting more symptoms than the control group. Inferences concerning this finding are made in Chapter V.

The primary experimental hypothesis was tested with a Mann-Whitney U. This analysis was done to determine whether the experimental group significantly differed from the control group in the number of symptoms reported by the mothers as improved. A non-significant U of 85 was found. This description is found in Table 10. Thus, the experimental group was found not to differ significantly in reporting symptoms as improved.

A Mann-Whitney U test was done to determine whether the experimental group differed from the control group in reporting symptoms as remaining the same. A non-significant U of 85 was found as described in Table 10. The experimental group did not differ significantly in reporting symptoms as remaining the same. The same test was done to determine if the expreimental group differed from the control group in reporting symptoms as worse. As reported in Table 10, a non-significant U of 88.5 was found. Therefore, the groups did not differ in their reporting of symptoms as worse.

The Spearman Rank Correlation Coefficient, a measure of association between two ranked variables was used to further

Table 10. Description of Mann-Whitney U analysis of questionnaire responses of twenty-seven mothers whose children attended one of two Mental Health Clinics during January to June, 1964

Variable	Monday Clinic Median	Monday Clinic No. of Ranks	Monday Clinic Sum of Ranks	Wednesday Clinic Median	Wednesday Clinic No. of Ranks	Wednesday Clinic Sum of Ranks	Results U'	Results U	Level of Significance
Reported as "better" Percentage of symptoms	.50	12	163	.50	15	215	95	85	Not significant
Percentage of symptoms "worse"	.00	12	166.5	.00	15	211.5	91.5	88.5	Not significant
Percentage of symptoms "same"	.42	12	173	.46	15	205	95	85	Not significant
Percentage of needs "met"	.56	12	186.5	.25	15	191.5	108.5	71.5	Not significant
Percentage of needs not "met"	.20	12	160	.25	15	218.5	98	82	Not significant
Percentage of needs somewhat "met"	.18	12	171.5	.00	15	206.5	93.5	86.5	Not significant
Number of reported needs	5	12	179	6	15	199	101	79	Not significant
Number of reported symptoms	4	12	107	9	15	271.0	151	29	Sign. @ .01 level

test the experimental hypothesis. This test was used because of its known sensitivity in testing the existing association between two variables. The two variables to be tested for existing association were the percentage of symptoms reported by the mothers as improved and their percentage of nurse led group therapy attendance.

Table 11. Description of Spearman Rank Correlation Coefficient analysis of questionnaire responses of twenty-seven mothers whose children attended one of two Mental Health Clinics during January to June, 1964

Variable Tested	Monday-Wednesday Clinic	Monday-Wednesday A	B	C	Level of Significance
Group Therapy Attendance-Symp. "better"	RS-0.20	.16	.06	0.63*	Not Significant
Group Therapy Attendance-needs "met"	RS-0.317	.18	.37	.14	Not Significant
Group Therapy Attendance-needs "somewhat met"	RS-0.03	--	--	--	Not Significant

* Almost significant at 0.5 level

As described in Table 11, a score of 0.20 was found. While this score shows a tendancy in favor of the experimental hypothesis, it was found not to be significant. A section to section comparison was done. These sections represent three therapy groups which had a six week evalu-

ation and treatment period at the clinic. The control and experimental groups were paired off according to therapy sections A, B and C. A Spearman Rank Correlation was then done for each of the sections. As described in Table 11, scores for all three sections were found not to be significant. It should be noted that the correlation for section C was .631. For significance at the .05 level, a correlation of .643 was needed.

As described in Chapter three, part two of the questionnaire consisted of questions geared to find out the needs the mothers had, whether these needs were met at the clinic, and whether these needs were important. No differentiation was made by the mothers in selecting the different levels of importance of their needs. They indicated that all the selected needs were very important.

The data tabulated from part two of the questionnaire were analyzed to determine if there was a significant difference in the number of needs reported by the experimental group as compared with the control group. Description of these findings are found in Table 9. The median number of reported needs for the experimental group was 6, for the control group the median was 5. A Mann-Whitney U test was done to determine if there was statistical evidence to indicate difference between the control and experimental groups in the number of reported needs. This finding is important in establishing group to group equivalence according to clinic needs as reported by the mothers. It is also note

worthy to report that while the experimental group was statistically different from the control group in reporting a higher number of symptoms which the child had, the groups were not found to differ statistically in reporting a higher number of needs.

The data were further analyzed to determine whether the experimental group differed from the control group in reporting a higher percentage of needs as met. As described in Table 10, a non-significant U of 71.5 was found. Thus, there was no significant difference between both groups in reporting of needs as met. Noting that the median for the control group was .56 and for the experimental group it was .25, section to section difference was suspected. Further analysis was done to test this suspicion. The control and experimental groups were paired off according to therapy section A, B and C. A Mann-Whitney test was done for each of the three paired sections. As described in Table 10, non-significant U's were found for the three sections. Thus, statistically it was revealed that the experimental groups did not differ significantly from the control group in the percentage of needs reported as met as analyzed in group to group and section to section comparison.

A Spearman Rank Correlation Coefficient was done to determine if group therapy attendance was related to needs reported as met. As described in Table 11, a non-significant correlation of .31 was found. A section to section Spearman Rank Correlation Coefficients were done. As described in Table 11, the correlation for sections A were

.18, for sections B, -.37, for sections C, -.14. This finding reveals a non-significant but interesting negative correlation. Thus, nurse-led group therapy attendance seems to be associated with more infrequent reporting of needs as met.

The Mann-Whitney U was also done to determine if the groups differed in reporting needs as somewhat met, and in reporting needs as not met. As described in Table 9, a non-significant U was found. A Spearman Rank Correlation Coefficient was done between group therapy attendance and needs reported as somewhat met. As described in Table 11, a non-significant correlation was found. Thus, the experimental hypothesis was unequivocably rejected by the evidence provided by the Mann-Whitney U and the Spearman Correlation Coefficient Tests using group to group and section to section comparisons.

C H A P T E R V

COMMENTS, SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

1. Comments

The rejection of the experimental hypothesis, the tendancy for negative correlation between nurse-led group therapy attendance and needs reported as met, and the significantly higher number of symptoms reported by the experimental group lead the investigator to suspect the presence of an unusual group phenomena. While it is statistically difficult to test this suspicion, descriptive evidence can be offered.

As described in Chapter three, part two of the questionnaire provided space for suggestions or comments regarding clinic service. Review of this section of the questionnaire revealed that the mothers of the experimental group consistantly made the more negative statements. Of the fifteen mothers representing the experimental group, only three statements were made to the effect that the clinic experience had been helpful. In the control group, which was represented by only twelve mothers, five statements were made indicating satisfaction with clinic service.

The control group made the following statements:

Should follow through

Should have me back (for treatment)

Should have worked with my child more

Mother's groups should have been continued

More time with my child and me

Most of the time they tell you what you already know

Need more time with the children, I was very worried

I'm slow at catching on, and they did not explain why I should get help. If they thought I was crazy why didn't they lock me up?

Clinic was no help at all

No cooperation

No time for you

Too many people up there

Should have given me a more experienced doctor

No good was done

My family received no help

Too much waiting -- it's a mad house

The fee was too high to get nothing out of it

They were very vague, they did not help much

More suggestions should be given

More reassurance for the mothers

Clinic did not help any

They don't use common sense up there, brothers and sisters with sexual problems were put in the same clinic

They did not understand the seriousness of the problem

Very confusing

Different staff say different things

Very discouraging, gave little hope for cure

Was harmful to child by not providing the promised supervision (little girl sexually stimulated by brother, according to foster mother)

There should be larger mothers group

Too crowded

More places to sit

Too rushed

Discourteous secretarial staff

More information for parents is needed

Tell parents the results of tests

Do what they promise

The control group made the following comments:

Clinic did a real good job (said five times)

More time needed

All of my family should have been seen

They did not get to the root of things

The staff did not seem to see both sides

Too many staff changes during interviews

Longer therapy is needed for my child

Group discussion with families in trouble would help

Going to Church more often makes families happier

Clinic side stepped the problem

I learned very little

No suggestions were given

They would not come out and say things directly

Should have continued to see my child

Too much time was spent with me, not enough with my child

They are kinda cold up there

They feel since you get things for nothing, they don't need to help

They don't handle the kids right

Description of further occurances that might contribute to the group therapy phenomena is as follows: The lack of the establishment of nurse-led group therapy as a treatment modality contributed to several group therapy sessions being concelled. No section was able to have six sections as planned. Nevertheless, verbal participation of all three sections was more active than anticipated. Taboo topics were introduced and discussed by the mothers as early as the first session. These topics were concerned with death wishes for the problem child, lack of sexual activity between the participating mother and her husband, and the sexual perversion of a father towards two of the children brought to the clinic by foster mothers. Topics related with specific difficulties of children were infrequently discussed after the first session. Topics more frequently discussed were concerned with the difficulties with husbands, with being a good mother, with the expression of negative and positive feelings, with the meeting of their own needs, with anger towards doctors, and their own problems of growing up.

2. Summary

This investigation was concerned with validating the need for the expansion of the psychiatric nurse's role. The study of some of the effects of one role proposed for expansion was undertaken. The proposed nursing role was that of group therapist of certain types of groups.

The subjects selected as the control and experimental groups were mothers whose children attended two Pediatric Mental Health Clinics. These two clinics, used as control and experimental groups, were determined equivalent by presentation of descriptive and statistical evidence.

Nurse-led group therapy was provided for the experimental group. The experimental hypothesis maintained that some of the effects of this treatment modality for mothers of emotionally disturbed children would be a favorable opinion of their child's level of improvement and of the clinic service received. Data for the purpose of testing this hypothesis were collected through the use of a queat-ionnaire administered to the selected mothers by the investigator. Favorable opinion of their child's level of improvement was measured by the mother's responses indicating improvements of the child's symptoms. Favorable opinion of the clinic service was measured by the mother's responses, indicating that their needs were met or nearly met by the clinic.

The Mann-Whitney U and the Spearman Rank Correlation Coefficient were used to test statistically the experimental hypothesis. Group to group comparison and section to section comparison yielded non-significant scores. Thus, the experimental group who received nurse-led group therapy was not statistically different from the control group in reporting more favorable opinion of their child's level of improvement nor in reporting more favorable opinion of clinic service. The experimental hypothesis was rejected.

3. Conclusions

From the findings of this study, the following conclusions have been drawn:

1. Favorable opinion of improvement and of clinic services were not some of the effects of nurse-led group therapy.
2. The questionnaire used was not constructed in a manner facilitating the collection of data needed to establish other than the predicated effects of nurse-led group therapy.
3. The findings of non-significant but negative correlations between group therapy attendance and reporting of needs as met may indicate that nurse-led group therapy is associated with more negative opinion of clinic service. Realizing that the goals of group therapy are emotional re-education, and considering the limited

clinic and group experience in relation to the seriousness of some emotional problems, it is then logical to see the appropriateness of existing negative opinions.

4. The descriptive findings presented in part one of this Chapter indicate a more negative opinion of clinic service by the experimental group. The conclusion for this finding is the same as conclusion number three.

5. The statistical evidence indicates that the experimental group was different from the control group in the number of symptoms reported. Lacking pre-testing scores for this variable, the significance of this finding is not clear. The groups may not be equivalent in this aspect or the lack of equivalence may be due to the experimental variable.

4. Recommendations

1. This study should be repeated with a larger number of subjects to facilitate more extensive statistical testing. Pre-testing of the subjects should be done to establish more complete subject equivalence. Providing a different nurse-leader for group therapy of each section would insure that the testing of different sections would be measuring a vari-

able related to the section tested and not to the increased skill of the group therapist.

2. Further studies should be done in the area of role expansion for psychiatric nurses, for the dual goal of contributing to the professional growth of nursing and assuming the responsibility of providing better care for the emotionally ill.
3. Further studies concerning the characteristics, needs and opinions of the consumer of psychiatric nursing service should be done. Increased insight of the very problematic lives of the consumers of our service and the functional value of our treatment becomes apparent when the patient is studied in his home.

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A P P E N D I X A

M or W*

Did your child have trouble:	YES	NO	This is now B	S	W**	The Reason For This May Be	Your Worry About This Is L	S	M***	The Reason For Your Child's Difficulty May Be	Prior to Coming To The Clinic You Thought The Reason Was Due To
1. Eating	( )	( )	( )	( )	( )		( )	( )	( )		
2. Sleeping	( )	( )	( )	( )	( )		( )	( )	( )		
3. Digesting food	( )	( )	( )	( )	( )		( )	( )	( )		
4. Hitting, pushing, misbehaving with children	( )	( )	( )	( )	( )		( )	( )	( )		
5. Not wanting to be with children	( )	( )	( )	( )	( )		( )	( )	( )		
6. Hitting, pushing, misbehaving with adults	( )	( )	( )	( )	( )		( )	( )	( )		
7. Not wanting to be with adults	( )	( )	( )	( )	( )		( )	( )	( )		

* M or W will be circled to indicate attendance at the Monday or Wednesday Clinic.
** B will indicate better. S will indicate same. W will indicate worse.
*** L will indicate less. S will indicate same. M will indicate more.

Did your child have trouble:	YES	NO	This is now B**	S	W***	The Reason For This May Be	Your Worry About This Is L	S	M***	The Reason For Your Child's Difficulty May Be	Prior To Coming To The Clinic You Thought The Reason Was Due To
8. Staying alone	( )	( )	( )	( )	( )	_____	( )	( )	( )	_____	_____
						_____				_____	_____
						_____				_____	_____
9. Unusual fears	( )	( )	( )	( )	( )	_____	( )	( )	( )	_____	_____
						_____				_____	_____
						_____				_____	_____
10. Thumb sucking	( )	( )	( )	( )	( )	_____	( )	( )	( )	_____	_____
						_____				_____	_____
						_____				_____	_____
11. Nervousness	( )	( )	( )	( )	( )	_____	( )	( )	( )	_____	_____
						_____				_____	_____
						_____				_____	_____
12. Overactivity	( )	( )	( )	( )	( )	_____	( )	( )	( )	_____	_____
						_____				_____	_____
						_____				_____	_____
13. Lying	( )	( )	( )	( )	( )	_____	( )	( )	( )	_____	_____
						_____				_____	_____
						_____				_____	_____
14. Stealing	( )	( )	( )	( )	( )	_____	( )	( )	( )	_____	_____
						_____				_____	_____
						_____				_____	_____
15. Destructiveness	( )	( )	( )	( )	( )	_____	( )	( )	( )	_____	_____
						_____				_____	_____
						_____				_____	_____

** B will indicate better. S will indicate same. W will indicate worse.
*** L will indicate less. S will indicate same. M will indicate more.

Did your child have trouble:	YES	NO	This is now B	S	W**	The Reason For This May Be	Your Worry About This Is L	S	M***	The Reason For Your Child's Difficulty May Be	Prior To Coming To The Clinic You Thought The Reason Was Due To
16. Sex	( )	( )	( )	( )	( )	_____	( )	( )	( )	_____	_____
17. Day dreaming	( )	( )	( )	( )	( )	_____	( )	( )	( )	_____	_____
18. Temper tantrums	( )	( )	( )	( )	( )	_____	( )	( )	( )	_____	_____
19. Crying	( )	( )	( )	( )	( )	_____	( )	( )	( )	_____	_____
20. Going to school	( )	( )	( )	( )	( )	_____	( )	( )	( )	_____	_____
21. Behaving in school	( )	( )	( )	( )	( )	_____	( )	( )	( )	_____	_____
22. Doing his work in school	( )	( )	( )	( )	( )	_____	( )	( )	( )	_____	_____

_____

** B will indicate better. S will indicate same. W will indicate worse.
*** L will indicate less. S will indicate same. M will indicate more.

Did your child have trouble:	YES	NO	This is now B	S	W**	The Reason For This May Be	Your Worry About This Is L	S	M***	The Reason For Your Child's Difficulty May Be	Prior to Coming To The Clinic You Thought The Reason Was Due To
23. Wetting	( )	( )	( )	( )	( )	_____	( )	( )	( )	_____	_____
						_____				_____	_____
						_____				_____	_____
24. Speech	( )	( )	( )	( )	( )	_____	( )	( )	( )	_____	_____
						_____				_____	_____
						_____				_____	_____

25. Other difficulties? Please list.

** B will indicate better. S will indicate same. W will indicate worse.
*** L will indicate less. S will indicate same. M will indicate more.

M or W*

When you went to the clinic, what needs did you have? Were these met? How important were these needs to you? The following items are geared to answer these questions.

		YES	NO	M	SM	NM**	I	LI	NI***
1.	I needed to find out what was wrong with my child so he could be helped.	( )	( )	( )	( )	( )	( )	( )	( )
2.	I needed to find out where to get more help.	( )	( )	( )	( )	( )	( )	( )	( )
3.	I needed to find medical attention and medications for my child.	( )	( )	( )	( )	( )	( )	( )	( )
4.	I needed help in understanding myself so I could deal with my child better.	( )	( )	( )	( )	( )	( )	( )	( )
5.	I needed suggestions to find new ways of dealing with my child.	( )	( )	( )	( )	( )	( )	( )	( )
6.	I needed someone who could help me, my child and my family.	( )	( )	( )	( )	( )	( )	( )	( )
7.	I needed someone to tell my troubles to and hear from people with similar problems.	( )	( )	( )	( )	( )	( )	( )	( )
8.	I needed help in understanding my child.	( )	( )	( )	( )	( )	( )	( )	( )
9.	I needed help in solving my religious and financial problems.	( )	( )	( )	( )	( )	( )	( )	( )
10.	I needed help with my marriage.	( )	( )	( )	( )	( )	( )	( )	( )

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* M or W will be circled to indicate Monday or Wednesday Clinic attendance.
** M ill indicate need met. SM will indicate need somewhat met. NM will indicate need not met.
*** I will indicate important. LI will indicate less important. NI will indicate not important.

M or W*

11. The following are suggestions which may help the clinic give better service to other mothers and their children:

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* M or W will be circled to indicate Monday or Wednesday Clinic attendance.

Typed by

Sharon Ducy