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UNIVERSITY OF SOUTHAMPTON

AN INVESTIGATION OF STUDENT NURSES'  
ATTITUDES TOWARD OLD PEOPLE IN  
HOSPITAL



THESIS SUBMITTED FOR THE  
DEGREE OF DOCTOR OF  
PHILOSOPHY, 1982.

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UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF SOCIAL SCIENCES

PSYCHOLOGY

Doctor of Philosophy

AN INVESTIGATION OF STUDENT NURSES' ATTITUDES

TOWARD OLD PEOPLE IN HOSPITAL

by Pauline Fielding

The aim of this study is to examine the attitudes of student nurses toward old people in hospital. First of all in Chapter 1 the position of the elderly in society is considered, with particular reference to demographic trends in population; to the dependency of the elderly on health services and to the development of geriatric medicine and geriatric nursing.

The literature relating to attitudes of health professionals toward the elderly is reviewed and special attention is paid to the methodological aspects of nursing studies (Chapter 2).

The concept of 'attitude' is then called into question and Chapter 3 considers traditional means of measuring cognitions. In Chapter 4, another major class of measurement, namely the observation and analysis of overt behaviour is considered with particular reference to conversational analysis.

It is concluded that traditional attitude research has reached an impasse, and in Chapter 5 some alternatives are considered. Two complementary methods are proposed. Firstly, an 'accounting' methodology to facilitate the nurse's justification of her conversations with patients, and secondly, a repertory grid methodology to examine changes in nurses' perceptions of old people during the course of training.

Chapter 6 reports a Pilot Study of 'accounting' in a geriatric unit and Chapters 7 and 8 report the Main Study of 'accounting' in a medical and geriatric unit. In Chapter 9, the repertory grid study is reported.

Additional information regarding student nurses' responses to geriatric nursing and choices of careers was also sought by means of questionnaires. This study is reported and discussed in Chapter 10.

Finally, Chapter 11 reviews the results of all the studies and makes recommendations for future attitude research and for nursing education and practice.

## CHAPTER ONE

### AN OVERVIEW OF AGEING IN SOCIETY

#### 1.1 INTRODUCTION

This chapter introduces the demography of ageing in our society and weighs the implications of this for the health service in general and for nursing in particular. The commitment of nursing to the care of the elderly is viewed as it currently exists within the constraints of a medical model of care, and the consequent dissatisfaction manifested in recruitment problems is considered. The negative stereotyping of the elderly within our society, and the reflection of such stereotyping in the health care professions, is discussed with particular emphasis on the role of attitudes in determining the quality of care received by elderly people.

#### 1.2 DEMOGRAPHY OF AGEING

"Britain faces social disaster because of the rate at which the proportion of elderly people in the population is rising".

Sir Ferguson Anderson, The Times, 26 Nov. 1976

Whilst it is true that by the turn of the century more than 1% of the total population in England will be over 85 years of age, statements such as the above have created a certain degree of misunderstanding regarding demographic changes concerning patterns of the elderly in our society.\*

Bosanquet (1978) suggests that the anticipated rise in the proportion of elderly people in the United Kingdom from 12% in 1941 to 21% in 1971 as indicated in the Beveridge Report, failed to materialise on two grounds.

---

\*The terms "elderly" and "old people" are somewhat problematic. It is not always clear from the literature exactly what is meant by such terms. Researchers commonly rely on information from official sources and it is important to note what official definitions are employed. The Office of Population and Census Statistics (OPCS) defines the elderly population as women 60 years and over, and men of 65 years and over. Unless otherwise stated, this definition will be adopted forthwith.

First, the low birth rates of the 1930s did not continue, and secondly, there was no great improvement in mortality rates. In 1971, the over 65s in the United Kingdom comprised 13.1% of the population. The latest available figures, based on a mid 1979 estimate of the total population, suggest that by the year 2001, the number of over 65s as a proportion of the total population will remain at 14% having peaked at 15.1% in 1991.

However, the pressure on services for the elderly is unlikely to be eased for some time, as the Office of Population and Census Statistics' figures show that the percentage of over 75s, who are heavy users of the caring services (Owen, 1976), will rise slowly for the time being, peaking around 1991 at 6.5%. From Table 1.1 it can be seen that in the remainder of this century, it is the very old (85+) who will be requiring an increase in services. In particular, there is nothing in the statistics to suggest that the elderly will be demanding less in the way of health and social services for some time to come.

Table 1.1 Recent and Projected Growth in Elderly Population in the United Kingdom

YEAR	POPULATION (MILLIONS)				PERCENTAGE TOTAL POPULATION			
	60-64	65-74	75-84	85+	60-64	65-74	75-84	85+
1961	2.8	4.0	1.9	0.3	5.3	7.5	3.6	0.6
1971	3.2	4.7	2.1	0.5	5.7	8.4	3.8	0.9
1976	3.1	5.1	2.3	0.5	5.5	9.1	4.1	0.9
1980	2.8	5.2	2.6	0.6	5.0	9.3	4.6	1.1
PROJECTIONS								
1986	3.0	4.9	2.8	0.7	5.3	8.7	5.0	1.2
1991	2.8	4.9	2.9	0.8	4.9	8.6	5.1	1.4
1996	2.6	4.8	2.8	0.8	4.5	8.3	4.8	1.4
2001	2.7	4.5	2.8	0.9	4.6	7.7	4.8	1.5

Source OPCS Social Trends (HMSO 1982)

### 1.3 DEPENDENCY OF THE ELDERLY

When considering the cost to society, it is of course crucial to know how dependent the elderly will be on others for care. Bosanquet (1978) has suggested that in our concern for the numbers of old people in our midst, we may have overlooked an important increase in the proportion of old people living alone. Whilst some old people live in family units, others may have someone on whom they can call for some measure of support in illness or social distress. Without that support, a person becomes much more dependent on the provision of personal and social services from the state. Table 1.2 shows that over the last 30 years, there has been a significant increase in the number of elderly single person households and in 1978, 47% of elderly people lived alone. Thus the elderly, at a time of life when they are often less able to cope with it, are facing an increasing challenge, that of living alone.

Table 1.2 Elderly Population in Private Households  
Living Alone (Great Britain)

MEN	<u>1951</u>	<u>1966</u>	<u>1971</u>	<u>1977/78</u> percentages
65-74	6.5	9.0	10.9	13.0
75+	10.5	14.7	17.7	28.5
All elderly men	7.7	10.8	13.0	16.0
WOMEN				
60-74	15.6	23.1	27.0	38.0*
75+	23.1	31.4	37.5	53.0*
All elderly women	16.8	25.4	30.0	28.7*

---

\*60-74 years

Source: OPCS Social Trends (HMSO 1980)

Health also has a bearing on the elderly person's potential for dependency. With a greater emphasis on the prevention of illness in early life, old age has become even more associated with ill health and decline in physical and mental powers. The numbers of old people suffering from chronic illness and disability which restricts their daily activities is positively correlated with increasing age (see Table 1.3).

Table 1.3 Persons reporting Chronic Health Problems, by sex and age

AGE	MALES	FEMALES (Rates per thousand)
16-44	109	112
45-64	267	252
65 or over	397	455

Source: General Household Survey, combined data for 1979 and 1980 (HMSO 1982).

There is also an increased incidence of mental illness in old age, the prevalence of which was demonstrated by Kay, Beamish and Roth (1964), (see Table 1.4).

Table 1.4 Estimated Total Prevalence Rates for the  
Main Psychiatric Disorders per 1,000:  
Population aged 65 or over (Newcastle 1960)

Disease	Total Prevalence
Senile and Arteriosclerotic Dementia	45.6
Other severe brain syndromes	10.5
Manic-Depressive disorder	13.6
Chronic Schizophrenia	10.8
Late Onset Paraphrenia	10.8
Psychoses, all forms	80.5
Mild brain syndromes	57.1
Moderate/Severe Neuroses and Allied Disorders	89.3
Character Disorder including Paranoid States	36.1

Source: Kay, Beamish and Roth (1964)

#### 1.4 IMPLICATIONS FOR THE HEALTH SERVICE

The cost of treatment and services for the elderly population is considerable. Owen (1976) estimated that 35% of the total Health and Personal Social Services Budget expenditure in England is used on those aged 65 and over, and 20% of the Budget on the over 75s. Home nurses spend 50% of their time caring for the elderly and in 1975 almost three million old people were seen by a home nurse (HMSO 1980).

Departments of Geriatric Medicine have been increasing in number and size ever since Marjorie Warren identified the field as a speciality in the 1930s. In 1974 51,000 geriatric beds were occupied daily. However, the ailing over 65s are not merely to be found in geriatric beds but are major users of all other beds with the obvious exceptions of paediatrics and maternity. In 1973 they occupied 49% of general medical beds, 38% of orthopaedic beds and 47% of psychiatric beds (Owen, 1976). This means that the National Health Service and Social Service resources are directed towards the elderly more than towards any other age group. In 1978, the average per capita cost of care and treatment of the over 75s was seven times greater than that of a person of working age (D.H.S.S., 1978).

An attempt to rationalise priorities in health and personal social services was made in a consultative document (D.H.S.S., 1976). This stated that a primary objective must be to enable the elderly to remain in the community for as long as possible. To this end emphasis should be placed on the development of domiciliary services and the provision of adequate facilities in general hospitals with easy access to diagnostic, therapeutic and rehabilitation sources. The aim was that eventually 50% of geriatric beds would be located in general hospitals.

This close liaison between geriatric and general medical care has also been fostered within the growing speciality of geriatric medicine.



## 1.5 DEVELOPMENT OF GERIATRIC MEDICINE

From the outset, geriatric medicine has derived its model of care from its counterpart - general medicine. Hall (1973) writes:-

"If these patients are to be dealt with in the most effective manner then they should be cared for from the outset by physicians trained in the special problems of 'senile pathology'. Ideally, therefore, geriatric medical teams must work alongside general medical teams and share common ward areas".

p.5

Possibly in an attempt to make geriatrics a respectable branch of medicine, emphasis has been placed on early diagnosis, assessment and treatment of reversible conditions in the fashion of acute medical treatment. This emphasis is reflected in the report of the Royal College of Physicians Working Party on Medical Care of the Elderly (1977). It recommends that:-

"All acute medical and geriatric facilities in the district general hospital or its local equivalent should evolve into one integrated operational unit....There should be a progressive integration of all acute hospital medical work so that an arbitrary age barrier would no longer be necessary. Where excellent geriatric services have been built up they should be maintained though it is expected that with time they will become progressively integrated with general medicine".

p.9

However, in addition to those patients who will benefit from short term acute medical care, there is a considerable number who will require periods of longer rehabilitation and continuing care. The medical profession has retained administrative control of this type of care but the thrust of speciality development has been into the acute, curative areas.

Throughout its development however, the specialty has experienced problems of recruitment. Indeed the motivations of those who choose to work in long stay units, have been regarded with suspicion as Wright and Simpson (1967) indicate:-

"If, at an interview, a doctor said he wished to enter geriatrics because he had always wanted to work with old people, it would be reasonable to assume that he was making a false statement in an effort to please, or that there was something odd about him".

p.507

The report of the Royal College of Physicians Working Party on Medical Care of the Elderly (1977) recognises the difficulties of recruitment and states that at the end of September 1975, about 10% of all geriatric consultant posts in England were vacant and an unknown number filled by locums for indefinite periods. The Report states that:-

"Many junior posts remain unfilled or filled by people who would have preferred to work elsewhere. Trainees see little attraction in geriatrics; there is even apprehension that to occupy such a post will be considered a disadvantage when applying for the more sought-after acute medical posts".

p.5

Thus it seems that there has been a very real difficulty in attracting staff to work in the field.

One possible cause of such dissatisfaction has been pinpointed by Arie (1971) who writes:-

"The unattractiveness for staff of long-term care for incurable patients derives in large measure from the fact that hospitals function on the medical model. A chronic unit in a hospital willy-nilly sets itself standards similar to an acute unit. It measures success by the traditional aspirations of acute medicine - curing and discharging patients".

p.168

If this is the case, then it is not suprising that staff find such work unrewarding, as they are seeking inappropriate rewards for their labour. To pretend that long stay geriatric patients are as interesting clinically as patients seen in acute practice is to evade the issue that such patients may not present primarily medical problems at all.

However, the prevailing ethos of care is medical and it is in this light that geriatric nursing has to be viewed. Similar problems of recruitment apply to nursing staff in geriatric areas, particularly the chronic, long stay wards, and a consideration of the development of geriatric nursing is appropriate.

#### 1.6 DEVELOPMENT OF GERIATRIC NURSING

Historically, geriatric nursing derived from the Poor Law of the 19th century. White (1978) outlines the development of two types of nurses - the Voluntary Hospital Nurses and the Poor Law Nurses. The Voluntary Hospital Nurses cared for the acute sick and the middle classes and shared the prestige which was heaped onto their medical colleagues. They were, right from the beginning, associated with a curative ideology arising from 'scientific medicine'. By contrast, the Poor Law Nurses cared for the poor, those with long term illnesses and the elderly sick. They became the first geriatric nurses and the low status of the doctors with whom they worked, rested on them also. Poor Law Nurses worked in the workhouses which Abel-Smith (1960) describes in the following terms:-

"Most of the patients were chronic and bedridden; many were classed as 'incurable'. There was less opportunity for the exercise of skill or at least there was less visible reward when skill was exercised. Workhouses were places of custodial care and lacked all the variety and interest of the voluntary hospitals".

Gradually there were reforms of the workhouses and new municipal infirmaries began to appear. In 1948 the birth of the National Health Service saw the amalgamation of the Voluntary Hospital Nurses and the Poor Law Nurses. However, it has been suggested (Baker, 1978) that 30 years later, the Poor Law still casts its shadow over much of our thought and action about the elderly sick and their nurses.

As doctors have overall control of care given to ill old people, nursing is seen as primarily supportive. Baker (1978) in her study of geriatric nursing writes of the extent to which the doctor expects the nurse to carry out his orders:-

"The doctors believed that their policy was in the best interest of the patient and that they alone were competent to judge these interests, and that the nurse should be supportive, if not servile in relation to themselves. They expected from the nurse unquestioning support for their policies, and the assigning of priority to any nursing work which involved 'assisting the doctor'".

p.282

Geriatric nursing then, is carried out within the framework of a medical model of care. This remains so despite the conclusions of the World Health Organization's Summary Report of a Working Group on the Evaluation of Inpatient Nursing Practice (1978) that:-

"In care services for the elderly, especially in the community, the nurse has a contribution to make as an independent professional practitioner".

p.410

But just as doctors find the work unrewarding, so too do members of the nursing profession. Success is measured by the traditional aspirations of acute medicine - curing and discharging patients - and the

work cannot help but fail to meet these criteria of success. Rands (1972) enumerated three reasons why many nurses would not apply for the post of Nursing Officer in a geriatric unit:-

1. Such an appointment would be considered a retrograde step.
2. Fear that their colleagues would consider geriatric responsibility to be a retrograde step.
3. Fear that experience in such a unit might be a bar or handicap to future promotion prospects.

Recruitment of trained nurses in geriatric units seems to be a problem but the extent to which this is so is difficult to determine. A breakdown of national statistics as of 30th September, 1979 of National Health Service nursing staff (excluding learners) working in designated geriatric hospitals in England reveals a preponderance of untrained Nursing Auxiliaries (D.H.S.S. 1981) (see Table 1.5).

Table 1.5 Analysis of NHS Nursing Staff working in Geriatric Hospitals in England

<u>GRADE TITLE</u>	<u>TOTAL NO. WHOLE TIME EQUIVALENTS</u>
Registered Nurses	2381.7
Enrolled Nurses	2085.0
Nursing Auxiliaries	5307.5

Source: SBH2 (D.H.S.S. 1981)

These statistics are useful as an indication as to which nurses are giving care to the elderly, but cannot of themselves indicate how many nurses are needed to care for the elderly. Pinel and Seriki (1976) report that an establishment nurse:patient ratio of 1:1.4 was found to be inadequate when sickness, absence, and professional development for courses for staff were taken into account. They also emphasis the effect of shorter working weeks and longer holidays on nursing establishments.

Evidence of a shortage of nurses was highlighted by Doreen Norton (1967) who, in a national study of long stay hospitals, discovered that only 56% had their full quota of State Registered Nurses at the time of the enquiry. She writes:-

"Being manned almost entirely by part-time, married women (...) there is usually an inadequate coverage of night, evening and weekend shifts and of Bank Holidays. There is no staffing leeway to cover absenteeism (sickness and repeated home demands of the married woman) nor to cover staff holidays which are invariably required at every school holiday period. In consequence, the remaining staff are grossly overstrained, often resulting in more sickness - absenteeism or in their leaving to find more congenial employment".

p.47

Geriatric nursing has not been highly valued by the nursing profession as clinical experience in its own right. It has been seen as a useful part-time area for the married woman with family commitments. The care of the elderly has been accorded low status by the nursing profession, but in order to appreciate nurses' attitudes toward the care of the elderly, it will be useful to examine the wider context - first, the negative stereotyping of old people in society and secondly, the reflection of society's views within the health care professions.

#### 1.7 NEGATIVE STEREOTYPING OF THE OLD IN SOCIETY

The prevalent societal view of ageing is expressed dramatically by Sonntag (1978), a well respected commentator on society:-

"There is a normal sense in which nobody, men and women alike, relishes growing older. After 35 any mention of one's age carries with it the reminder that one is probably closer to the end of one's life than to the beginning...Advanced age is undeniably a trial, however stoically it may be endured. It is a shipwreck, no matter

with what courage elderly people insist on continuing the voyage".

p. 72

Modern western society eulogises youthfulness. Being "young at heart" is a virtue no-one questions. Advertising campaigns capitalise on the fact that purchasing power and age are negatively correlated in our society and we are constantly arraigned to drink, eat, wear and use those items which will emphasise our youthful characteristics. The lack of advertising aimed specifically at the elderly reflects their lack of purchasing power and the inability of the advertisers to make their products appear attractive to young and old alike.

Emphasis is therefore placed on youth and youthfulness and nowhere is this reflected more clearly than in the field of unemployment. David Hobman, when Chairman of Age Concern in 1976, commented:-

"...there is general agreement that all new plans and programmes must be concentrated on meeting the needs of young school leavers at the thresholds of their careers; whereas those who are older are expected to make their contribution by sacrificing themselves on the altar of premature retirement".

p.196

And this despite the notion that older workers may actually be more productive and hence more use to an ailing economy (Hobman, 1976).

It appears that negative stereotypes of the old, in western society at least, are nothing new and most commentators seem to associate their origins with the advent of industrialisation. Evidence to support this view comes from studies of primitive societies where old people are few in number and consequently hold knowledge which is valuable to the wider social grouping (McTavish, 1971). In an industrialised society,

the elderly are less useful socially - society generally relying on younger workers who are considered to be better fitted for a part in the cycle of production.

Literature has depicted the old person in a variety of roles and Seltzer and Atchley (1971) have suggested that negative stereotypes may not be as prevalent as is commonly supposed. Nevertheless, popular television programmes often feature old people in stereotyped roles but how this compares with the stereotyping of other social groups is difficult to determine.

Robert Butler (1975), director of the American National Institute on Ageing, attempted a composite statement of society's stereotyping of the older person:-

"An older person thinks and moves slowly. He does not think as he used to or as creatively. He is bound to himself and to his past and can no longer change or grow. He can learn neither well nor swiftly and, even if he could, he would not wish to. Tied to his personal traditions and growing conservatism, he dislikes innovations and is not disposed to new ideas. Not only can he not move forward, he often moves backward. He enters a second childhood, caught up in increasing egocentricity and demanding more from his environment than he is willing to give to it. Sometimes he becomes an intensification of himself, a caricature of a lifelong personality. He becomes irritable and cantankerous, yet shallow and enfeebled. He lives in his past; he is behind the times. He is aimless and wandering of mind, reminiscing and garrulous. Indeed his is a study in decline, the picture of mental and physical failure. He has lost and cannot replace friends, spouse, job, status, power, influence, income. He is often stricken by diseases which, in turn, restrict his movement, his enjoyment of food, the pleasures of well-being. He has lost his desire and capacity for sex. His body shrinks, and so does the flow of blood to his brain. His mind does not utilise oxygen and sugar at the same rate as formerly. Feeble, uninteresting, he awaits his death, a burden to society, to his family and to himself".



It seems that one of the major factors an old person has to face is the attitude of others toward him. Tuckman and Lorge in the 1950s were the pioneers of research in this area and they along with Nathan Kogan developed research instruments which have subsequently been used extensively in the field (see Appendix A).

#### 1.8 ATTITUDES TOWARD OLD PEOPLE WITHIN THE HEALTH CARE PROFESSIONS

Particular attention has been paid to the attitudes toward old people held by health professionals. As we have already seen, the elderly are major users of the health services and so it is reasonable to suppose that the attitudes held by professional workers will to a certain extent, determine the quality of care old people receive. Robb (1967) shocked the British public with her account of the cruel and thoughtless care meted out to the hospitalised elderly. Such callous treatment was not limited to Britain however, as Stannard (1973) pointed out in his description of patient abuse in a nursing home in the United States of America. Widespread shock and dismay at the exposing of such unsavoury conditions led to a new emphasis on the importance of right attitudes in the care of the elderly and to some systematic enquiry into the status of existing attitudes toward the elderly amongst doctors, nurses and other health workers. Attitudes were seen to be defective and in some way responsible for the unsatisfactory treatment meted out to patients. In the remainder of this chapter we will consider the research on the attitudes of health professionals other than nurses, leaving discussion of the nursing literature until Chapter 2. There are a few studies, however, which include nurses amongst other personnel and these are discussed here.

The research can be grouped into 3 main areas. Firstly, those studies which consider the differences in attitudes between professional and non-professional

staff; secondly, those studies which focus on attitudes associated with particular professional ideologies, and thirdly, those studies which consider the attitudes of students in the professions.

#### 1.8.1 Professsional vs. non-professional staff

As we have already seen, much of the day to day care of elderly patients in hospital is provided by unqualified personnel and some researchers have considered the implications of this for the quality of care.

Kosberg, Cohen and Mendlovitz (1972) studied the attitudes and opinions of supervisory staff in a home for the aged, on the presumption that the supervisors' attitudes would influence the unqualified staff. They administered an 84 item questionnaire to 26 supervisors whose responses were judged by three social work experts. For all the 84 items there was 78.5% agreement between the supervisors and judges indicating a high coincidence of positive attitudes. However, certain methodological points need to be considered.

Firstly, whilst the supervisors were grouped according to their areas of responsibility (social workers, registered nurses, business office personnel and non-professionals i.e. maintenance, housekeeping and dietary staff), the judges were biased toward the first of these groups. Whilst this would be a cause for greater concern had the percentage of agreement between judges and supervisors been lower, the fact that Kosberg et.al. do not report the numbers of staff within the occupational groups, means that the results must be regarded with caution. Secondly, the method of scoring employed by Kosberg et. al. favoured extreme responders whereas a simpler agree-disagree response would have eliminated any doubt that a respondent "slightly agreeing" was as much in agreement with the judges as a respondent "strongly agreeing" with a statement. Thirdly, there was no attempt to ensure that the statements were equally understandable for all supervisors.

Scores were related to education and Kosberg et. al. suggest that the difference in scores between registered nurses and social workers might be due to a difference in ability to conceptualize questions.

A later study by Kosberg and Gorman (1975) repeats some of these methodological faults. A 29 item questionnaire was administered to 157 people associated with a home for the aged (social workers, secretaries, occupational and physical therapists, housekeepers, qualified and unqualified nursing staff, members of the board of directors, volunteers, relatives and residents). For the staff, there is no indication of how large a sample was taken; for the non-staff members, almost the entire board of directors is represented whereas only 10% of residents were sampled. Kosberg and Gorman recognise that the sample of residents was limited by physical and mental ability, nevertheless they are likely to differ in important ways from the rest of the residents.

The questionnaire elicited respondents' perceptions of the rehabilitation potential of the aged within an institutional setting and again, the preferred responses were determined by 3 social work experts, with the same scoring method as in the earlier study. The results showed social workers to have the most therapeutic orientation and housekeepers the lowest with professional nurses falling second to social workers and residents themselves just above the housekeepers. However, the small numbers in the staff groups (a maximum of 9 for therapists and non-professional nurses and a minimum of 5 for social workers), combined with a lack of information about the total population, again must lead to caution in the interpretation of these data.

Holtzmann, Beck, Hodgetts, Coggan and Ryan (1977) considered attitudes toward the elderly and their rehabilitation potential of medical students, family

practice residents and professional and non-professional staff members of a nursing home. The attitude scale used was derived from the Tuckman Lorge Attitude Questionnaire (TLAQ) and consisted of 9 items. As the TLAQ comprises 137 items in total, the selection of 9 is somewhat problematic. As well as the attitude scale, the Perceptions of Rehabilitation Potential scale (PRP) developed by Kosberg and Gorman (1975) was also used. Again, although the numbers within the occupational groups are reported, no details are given as to the size of the total population. A further point concerns the imbalance of positively and negatively loaded items in the instrument. The negatively loaded outweigh the positively loaded by 13 to 7 and this may have affected subjects' responses. Holtzmann et. al. consider the theoretical mean to be the neutral point of the scales but admit that without a mean value for a cross section of the population, this interpretation is problematic.

The results of the study suggested that the professional staff held significantly more positive attitudes than did non-professional staff but because of the foregoing criticisms, these results must also be viewed with caution.

#### 1.8.2 Professional ideologies

Holtzmann et. al. (1977) suggested that a shared professional ideology among health care personnel might be an important factor in determining attitudes toward the elderly. A number of studies have examined the differences in ideology between health professionals in this regard. Coe (1967) reports a study which compares physicians, dentists, physical therapists, nurses and social workers. A group discussion was held with each occupational group and the same questions asked of each group. The discussion was tape recorded, transcribed and statements made were classified into several categories. The results suggested that attitudes were closely bound to professional ideology - physicians viewing older patients in terms

of the disease process etc., whereas social workers emphasised socio-emotional and socio-cultural components of ageing. All the respondents agreed, however, that the older person "tended to be rigid in behaviour and inadaptably to change, either in environment or in habits". Acceptance of these results must, however, be tempered by a consideration of some methodological shortcomings. We are not told how many members comprised each "small group"; to what extent their work was concerned with the elderly; from what kind of institution they were sampled or indeed how they were selected. No information is given regarding the nature of the questions asked or on the method of classification.

Futrell and Jones (1977) examined and compared the attitudes of 3 samples - physicians, nurses and social workers. They conducted a postal survey in an urban community with a response rate of 61% and a major part of the questionnaire was Kogan's Old People scale (KOP). Unfortunately, the results are not presented in any detail and Futrell and Jones simply report a "slightly positive attitude" for all groups when responses were measured on a 6 point scale.

A study by Keith (1977) focussed on nursing home administrators. Forty five administrators, representing a 98% sample in a ten-county area of a midwestern state, were given an 8 item questionnaire to which they responded on a 5 point scale. From the results obtained it seems that those administrators with the highest percentage of female residents in their home, held the most negative stereotypes. But again, caution must be exercised in the interpretation of these data. It is not clear from where 7 of the 8 items were derived, although a reliability level of .73 is reported. Keith also states that the theoretical range of scores was 7-40, not 8-40 as would be anticipated. No details are given as to how a preferred response was judged and by whom. It seems from an examination of the items that the concept being rated was not consistent throughout, which may have affected scoring. The terms used were "most old

people", "older people" and "old people".

### 1.8.3 Student professionals

A study by Wolk and Wolk (1971) elicited stereotypes held by students of social work, psychology and nursing, as well as older professional workers. Wolk and Wolk criticized questionnaire items which, whether worded positively or negatively, are based on negatively valued qualities. Their approach to the study was to construct a 3 item questionnaire which enabled a greater degree of freedom in responding. A 73% response rate was obtained from 300 questionnaires.

The stereotypes elicited were classified by two gerontological psychologists with an inter-judge reliability level of .86. This rating by judges of one speciality of the responses of another speciality raises similar problems to those discussed earlier. Moreover the number of negative stereotypes outweighs the positive by more than 4 times and a closer look at the particular questions asked shows that Wolk and Wolk may not have avoided the point they had themselves criticised in other studies. They asked "What stereotypes of aged people are you aware of but do not accept?" The question, by mentioning only "stereotypes" and not "positive and/or negative stereotypes" may have influenced the respondents to think mainly of negative stereotypes and this may have been reinforced by the addition of "but do not accept?"

For the question "What are old people like?" the only statistically significant difference was found in positive attitudes towards the elderly when younger professionals (including students) below 30 years of age, who chose to work with the elderly, were compared with their peers who chose not to work with the elderly. Those choosing to work with old people held the most positive attitudes.

A study by Burdman (1973) took a nationwide perspective in a stratified proportional sample of 250 subjects

of the rehabilitation counselling (sic) graduate students and gerontology graduate trainees enrolled in training programmes throughout the continental United States of America. Of the 250 approached, 86% responded. No indication is given however, of the size of the total population. Insufficient details are given regarding the attitude instrument used for thorough evaluation although Burdman reports that it comprised "a semantic differential attitudinal measure of the concepts of "old person, average person, and sick person". According to Burdman, the results indicated (no details are given) that all subjects regarded the concept of "sick person" significantly more negatively than either of the other concepts and that the concept of "old person" was in turn regarded more negatively than the concept of "average person". However, the use of the term "average person" necessarily polarises the other concepts albeit in an unspecified direction and in this context "average" would seem to be defined as "not sick" and "not old". The terms are not useful comparisons as there is no control for age differences in concepts and subjects may in reality have been rating either "young sick person" or "old sick person", "average young person" or "average old person".

Another study reported by Shulder (1973) also gives insufficient detail for proper evaluation. A questionnaire was mailed to 304 law student, social work students and gerontology students at the University of Southern California. A 59% response rate was obtained. No details are given of the instrument used except that it was based on the Nine Needs Areas as specified by the 1971 White House Conference on Ageing, and contained 3 sections: Background Information, Perceptions of the Aged, and Attitudes toward Social Welfare Policy and Services for the Aged. According to Shulder, social work students ranked first in liberality in all 13 statistically significant instances.

A more helpful study was carried out by Gale and Livesey (1974) which investigated attitudes toward

geriatrics of clinical medical students (CMS) and junior hospital medical staff (JHMS) in the King's College Hospital Group in London. The questionnaire of 50 items was distributed to all CMS and JHMS in the Medical School and Hospital Group. Response rates of 57.8% for CMS and 59.6% for JHMS were obtained. A factor analysis of scores indicated that the attitudes of CMS were determined by a consideration of the patient and his treatment, whereas for the JHMS, the more relevant aspects were educational and personal career prospects. This suggests a picture of patient orientated students who might later become more career orientated but Gale and Livesley report that both CMS and JHMS had more favourable than unfavourable attitudes.

Geiger (1978) examined the views of graduate students in 3 fields - social work, law and medicine. She obtained a postal response rate of 83.1% from 83 subjects. Whilst this study does not purport to test attitudes per se, it tests knowledge about old people and assesses preferences for working with the elderly. An objective test of knowledge about old people revealed that the medical students, although the most accurate in their answers, exaggerated the extent to which old people were limited in their activities by chronic physical conditions. None of the 69 graduate students registered a first choice preference for working with the elderly and 88% of 26 medical students considered the elderly only as a last resort.

A more recent study by Solomon and Vickers (1979) used the TLAQ to measure the attitudes of medical students, housestaff members and members of a mobile psycho-geriatric screening team. Relatively low response rates were obtained (36.2% of medical students; 13.8% of house staff; 53.4% of geriatric staff) and it is not known in what way the usable sample differed from the refusers. Solomon and Vickers report several statistically significant differences between groups but do not report mean scores and so from this report it is not possible to determine the extent of



acceptance of negative stereotypes. However, it is reported that medical students working in a geriatric setting viewed the elderly in a more "realistic" way than those working in a medical setting.

From these studies then, bearing in mind the various methodological issues which many of them raise, no clear picture emerges. There is some evidence of positive attitudes toward the elderly on the part of student professionals, combined with a general unwillingness to pursue a career in geriatrics, and amongst older professionals, both a general professional attitude which emphasizes rehabilitation and a particular professional ideology which stresses a particular orientation.

Because of the variety of methods used, and the various settings in which the studies were carried out, no two studies are directly comparable. All except one are American, hence cultural differences prohibit direct translation, and none of the studies attempts to relate attitude to behaviour except in the form of preferences or intentions.

#### 1.9 IMPLICATIONS OF ATTITUDES FOR THE PROVISION OF CARE

Bennett and Eckman (1973) suggest that attitudes toward ageing may be critical for adjustment and survival. Negative attitudes toward aging on the part of old people themselves may mean that the elderly are less willing to avail themselves of the services and help that are available. Negative attitudes on the part of other age groups may lead to a rejection of the old in our society.

Bennett and Eckman comment on this process:-

"Negative attitudes of old people may affect others in their environs, who in turn may feel free to respond negatively to old people or to ignore them completely. Negative views toward ageing among the aged may reinforce negative views toward ageing in the young, resulting in a feedback loop that further

reinforces negative views in both young and old. The short-range effects of this feedback process may be to widen the gulf between young and old; the long range effects may be to cause the young to dissociate themselves from their own ageing".

p.575

Thus it can be seen that the attitudes of both the old and young may be an important factor in the ageing process itself. The question of negative feedback is particularly important in the provision of health care. None of the studies reviewed in this chapter assess the provision of care but Brown (1967) has suggested that nurses themselves may cause much of the childish behaviour seen in elderly patients. After a series of studies involving nurses she suggests that a self-fulfilling prophecy operates whereby a nurse behaves toward a patient on the basis of her stereotyped beliefs which associate age with illness and dependency, and the patient in turn lives up to the nurse's expectations. The nurse has her prejudices confirmed and the circle is completed. A related concept is that of "infantilization" of the elderly which Gresham (1976) suggests, is a misapplication of child psychology to the elderly resulting in the childish socialisation of elderly patients in institutions.

It seems to be generally accepted that the attitudes of health workers in general and nurses in particular are important determinants of quality in care. It could be argued that this is especially important in geriatric nursing where, although administrative control is retained by the physician, the nurse has a much greater opportunity to function as a practitioner in her own right. Indeed Baker (1977) suggests that this is a distinct possibility for the future. Gunter and Miller (1977) also emphasise the importance of nurses' attitudes toward the elderly

because of the "possible effect of these attitudes on nurses' ability to intervent (sic) therapeutically with elderly patients and on patient behaviour". Likewise, the Joint Board of Clinical Nursing Studies, in outlining the objectives for a post-basic course in geriatric nursing, state that a nurse should "show a caring and interested attitude in the welfare of elderly people" (1976). Therefore, nurses' attitudes are of concern because it is thought that they influence the nursing care and ultimate well-being of patients. In the next chapter, the literature on nurses' attitudes toward old people and geriatric nursing will be examined in detail.

## CHAPTER TWO

### A REVIEW OF THE NURSING ATTITUDE LITERATURE

#### 2.1 INTRODUCTION

This chapter reviews the literature on nurses' attitudes towards old people and geriatric nursing and draws conclusions as to what is known or implied about such attitudes. In Great Britain there have been relatively few studies to date, consequently most of the reported studies are American. Generalisation of the findings to British nursing is, therefore, problematic. Methods of nurse training are different in the two countries. A glossary of terms used to describe nurses is presented in Appendix B. All of the studies reviewed here attempt to relate attitudes to one or more variables and these will be discussed in turn.

#### 2.2 AGE OF THE NURSE

##### 2.2.1 American Studies

Age has been identified as a factor that has some influence on a person's attitude towards old people. Campbell (1971) used the Axelrod and Eisdorfer (1961) variation of the TLAQ to examine the acceptance of stereotypes amongst Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Nursing Assistants (NAs) in two teaching hospitals in North Carolina. She states that age did not seem to be an important influence in terms of the acceptance of stereotyped statements but her study has been cited by Gillis (1973) that "the older subjects demonstrated more positiveness in their attitudes towards the aged than did the younger subjects." What Campbell actually says, without presenting the numerical data in support, is that the older nurses had more favourable attitudes towards the elderly but that only the RNs (who were the youngest age group) showed a consistent pattern in the relationship

of successive age groups and the decrease in acceptance of negative stereotypes. In fact all three groups of nurses had more than a 50% acceptance of stereotyped statements. On the basis of Campbell's study one cannot conclude that age is a significant factor influencing a nurse's attitude towards old people.

Gillis (1973) hypothesised that "Nursing personnel 45 years of age and over will manifest more positive attitudes toward the aged than the nursing personnel who are under 45 years of age". Using a 48 item instrument originally developed by Lowy (1968) and revised by Gillis (1972), she examined 86 RNs, LPNs and NAs from 5 nursing homes and a general hospital. She found no significant difference between the attitudes of nurses over and under 45 years of age. Gillis used a 4 point Likert scale with a high score indicating a positive attitude. Gillis reports no significant difference between older and younger subjects and no discernable trend. When grouped according to qualifications, all groups mean scores were above the mid point of 96, demonstrating generally positive attitudes.

Taylor and Harned (1978) have also considered the age variable. They used Kogan's Old People scale to measure the attitudes of 76 RNs in Oklahoma, a 73.9% response rate from a total population of 96, the majority of whom were employed in either nursing homes or hospitals. They report that all the scores were within the positive to neutral range although younger nurses scored more positively than older nurses. However, age is here confounded with years of experience both of nursing and of old people. Taylor and Harned do not report whether the difference in mean scores between older and younger nurses is statistically significant. Again, on the basis of this study, it is not possible to conclude that age is a factor which influences a nurse's attitude towards old people.

### 2.2.2 British Studies

Wells (1980) in one of the few British studies also used Kogan's OP scale to measure the attitudes of 17 trained nurses in a geriatric unit. This was a small sample representing only 37% of the total population and it is not known in what way the respondents differed from the non-respondents. However, she found no significant association between age and attitude score, although the nurses held generally positive attitudes.

Hooper (1979) also considered age as a variable when she used Kogan's OP scale to measure the attitudes of 63 student and pupil nurses allocated to geriatric units within two district general hospitals and similarly found no significant relationship between the attitudes and ages of those over and under 25 years of age. From the data presented (which does not include mean scores), it is not possible to determine whether nurses had positive or negative attitudes towards old people.

Age is a difficult variable to employ and even more difficult to control in an applied setting. Our common sense notions of how attitudes change over time may tempt us to use age as an independent variable but any casual inference on the basis of differences measured is extremely problematic. Wohlwill (1970) has this to say:-

"Age, it is asserted is at best a shorthand for the set of variables acting over time, most typically identified with experimental events or conditions, which are in a direct functional relationship with observed developmental changes in behaviour; at worst it is merely a cloak for our ignorance in this regard".

p.49

None of the studies reviewed has shown any statistically significant relationship between measured attitude and the age of the nurse, but even the non-significant

differences which have been shown are uninterpretable because the experimental designs used have not isolated the age variable from other relevant variables such as level of education or years spent in geriatric nursing.

### 2.3 RACE, SEX, RELIGION

Only one study seems to have considered these variables as they relate to attitude in a nursing context (Burge 1978). This American study attempts to examine the stereotypical attitudes held by RNs, LPNs and NSs in seven nursing homes for the elderly in Northern Florida. Using the Axelrod and Eisdorfer variation of the TLAQ, Burge found that race was significantly related to the acceptance of negative stereotypes, whereas sex and religion were not. Burge reports that "Black nurses studied had significantly higher stereotyped attitudes toward the aged patients than did the Caucasian nurses". However, this study lacks credibility as it presents no numerical data to support its "findings", the level of statistical significance is not reported and race might easily have been confounded by socio-economic status which was not controlled. It is not possible, therefore, from its published version, to give any credence to this study.

### 2.4 LEVEL OF EDUCATION

Level of education is another factor which has been indentified in American studies as having some influence on a nurse's attitude towards old people. Campbell (1971) compared the attitudes of 165 RNs, LPNs and NAs in 5 medical and surgical nursing units in 2 teaching hospitals. She found that the RNs who had the most extensive educational background were the least willing to accept stereotyped statements on the TLAQ. However, level of education was here confounded with time spent with old people, the RNs spending less time caring for old people than the LPNs or NAs. Campbell suggests that these two variables are the most important in her study and concludes that the stereotype

acceptance decreased as the level of education increased but offers no solution to the confounding of the level of education with time spent in caring for the elderly. The two may, for all practical purposes, be synonymous i.e. the work of a RN may be more administrative and involve less contact with any sort of patient than the work of a LPN or NA. It is still impossible however, to make any causal inference unless one can measure the attitudes of RNs who have a similar amount of contact with the elderly as do LPNs or NAs.

Gillis (1973) compared the attitudes of RNs, LPNs and NAs and hypothesised that "Nursing personnel who have achieved a Bachelor of Science degree in nursing will be more positive in attitudes toward the aged than the nursing personnel who have attained an associate degree or a diploma or who have earned credits in courses which prepared them for employment as licensed practical nurses or nurses' aides". The findings were not as she predicted. Those nurses with an associate degree or diploma had the most positive attitudes. Apart from that there did seem to be a pattern in that the higher the level of education achieved, the more positive attitudes became. Whether this is again confounded with the time spent in contact with aged patients is not known. Gillis suggests that one possible reason for the baccalaureate nurses not having the most positive attitudes is that their curriculum did not include any specialist geriatric nursing theory or experience and consequently the baccalaureate nurses did not see themselves in the role of a geriatric nurse. The effect of specific educational programmes on attitudes has been considered by several studies which will now be reviewed.

## 2.5. SPECIAL EDUCATIONAL PROGRAMMES

### 2.5.1 American Studies

Gunter (1971) considered the possibility that a course on normal growth and development throughout



the lifespan might foster a more positive attitude toward old people on the part of nursing students. One hundred and sixty two senior nursing students completed the TLAQ on the first and last day of a lecture course (we are not told how long the course lasted). The mean number of YES responses (i.e. an acceptance of stereotypes), to the TLAQ was significantly reduced after the lecture course although these student nurses as a group rejected more than 50% of the stereotyped statements. The possible effect of repeated measurement was uncontrolled in this study which is regrettable as presumably it would have been a relatively simple to allocate half the subjects to a control group who completed the TLAQ post-course only.

Kayser and Minnigerode (1975) examined the effect of a two semester course in human development and ageing, on the acceptance of stereotyped statements about the elderly by 311 baccalaureate nursing students at the University of San Francisco. However, this study is unable to do what it sets out to do as no baseline or pre-course measures were taken. The testing materials were administered during the final week of the course only. The five groups of nurses, who were of different levels of seniority, did not differ significantly in their mean scores on the TLAQ but Kayser and Minnigerode do not report the percentage of stereotyped statements rejected so we are unable to judge the degree of their stereotyping of the elderly. Furthermore, with a post-course score only, it is impossible to speculate on how attitudes have changed as a result of the course.

Dye (1979) examined the attitudes of 27 graduate nursing students who were assigned to two experimental treatment groups, one a discussion group and the other a role playing group, each meeting for 16 sessions of 90 minutes each, and a control group. Kogan's OP scale was administered before and after the treatment experiences and again after a 6 week period. When the groups' mean scores were examined, it appeared that respondents were "weakly negative" and "not particularly positive" either.

There were no statistically significant differences either between groups or among groups and no significant treatment effects. Dye suggests that this may be because the attitudes themselves were powerfully resistant to change. Whether neutral attitudes can be strongly held is an interesting philosophical point, but Dye's comment that scores from pre-test to delayed post-test "reflected much more disinterested apathy than nurturant empathy" can probably be taken at face value. It must be noted that only three of the respondents had any prior work experience with elderly patients and the exercise may, therefore, have lacked relevance.

Tobiason et. al. (1979) investigated the effects of a home visiting programme on the attitudes of 54 junior baccalaureate nursing students. The students were required to list three things that came to mind when they thought about ageing, both before and after the programme. Noting the percentage increase of positive terms and the decrease of negative terms, Tobiason et. al. conclude that the programme "exemplified how positive attitudes of nursing personnel can be promoted". However, the measure used, whilst allowing nurses to respond in any chosen way, was particularly subject to bias, as through the intervening period, weekly discussion groups were held, and nurses would have realised the implications of their first three items listed. This study lacks a measure which would examine nurses' behavioural intentions toward the elderly, for instance a willingness to specialise in geriatrics when qualified.

#### 2.5.2 British Studies

The only British study to examine the effects of an educational programme is by Hooper (1979), the "programme" in this case being the geriatric placement for student nurses. A group of pupil nurses without the geriatric experience comprised the control group. Hooper measured attitudes using Kogan's OP scale before and after the geriatric experience. She found no statistically

significant difference either between groups or within groups pre- and post- experience. As noted earlier, it is impossible to determine how positive or how negative nurses' attitudes were from this study. However, this and other studies considered not only the attitude score itself but the possible implications for a willingness to work with old people. These will now be discussed.

## 2.6 WILLINGNESS TO WORK WITH OLD PEOPLE

### 2.6.1 American Studies

Delora and Moses (1969) demonstrated how unfavourably geriatrics as a speciality rated against other specialities amongst 205 nursing students in San Diego. Students expressed their degree of preference for geriatric, medical, obstetric-paediatric, psychiatric, public health and surgical nursing. Geriatric nursing was rated significantly below other specialities. Delora and Moses took some account of nurses' feelings underlying their preference by asking them to select two adjectives from seventeen which described their feelings about each speciality. Geriatrics was lowest in positive attributes and highest in negative attributes such as depressing, dull and slow. However, this limited choice task restricted the nurses' expressions to certain characteristics of the work only and did not allow them to express other aspects of the speciality which might have a bearing on their preferences e.g. working conditions, staff relationships.

Campbell (1971) was perhaps the first to consider the relationship between nurses' acceptance of stereotypes about old people and the age group with which nurses preferred to work. In addition to completing the TLAQ, the RNs, LPNs and NAs were asked to respond to three forced choice situations giving their preference to working with adults, old people or children. She found the RNs who accepted the least number of stereotypes less willing than the LPNs or NAs to work with the elderly. However, it must be remembered that even though the RNs

were the most positive group, they still accepted more than 50% of the stereotyped statements.

Gunter (1971) also considered the effects of a course on normal development in later life on nurses' preferences for specialisation. Unfortunately, the percentages quoted in the text do not comply with the percentages shown in the table (see Table 2.1). However, if the figures in the text are accurate, the decline in interest in working with geriatric patients is even more dramatic than Gunter had supposed and likewise the intention to avoid geriatrics as an area of work.

Table 2.1   Preferences for Work with Geriatric Patients  
(from            as Expressed by Nursing Students Before  
Gunter,           and After Course  
1971)

Level of Interest		BEFORE COURSE		AFTER COURSE	
		No.	Percent.	No.	Percent.
Major interest	6	0	-	1	0.62
Strong interest	5	18	11.11	6	3.72
Mild positive	4	36	22.22	37	22.98
Neutral	3	54	33.33	52	32.29
Mild negative	2	23	14.19	25	15.52
Prefer to avoid	1	18	11.11	17	10.55
Would avoid entirely	0	11	6.79	23	14.28
No answer	-	2	1.23	0	-
TOTAL		162	99.98	161	99.96

"Only 18 percent of the students had a major or strong interest in the nursing care of the aged when the course began. By the time it ended, this had declined to 17 percent. Eleven percent of the students at the beginning of the course said they would prefer to avoid or would avoid entirely this area while, at the end, 15 percent said they would do so".

Gunter (1971) p.469

This error is very unfortunate as Gunter's work has been cited many times in the nursing literature without reference having been made to this possible underestimation of the effect.

Kayser and Minnigerode (1975) asked nursing students of 5 grades to indicate their relative preference between seven fields of specialisation. These included "nursing home" where geriatric nursing would be practised. Nurses were also asked to indicate their preference for working with children, adults or old people as patients. Nursing homes were least preferred by all groups of nurses as were old people as patients. Kayser and Minnigerode suggest that their findings show that the more stereotyped the nurses' attitudes toward the aged, the more likely nursing students were to choose working in a nursing home and to express an interest in working with elderly patients. They claim this on the basis of Spearman rank correlations between TLAQ scores and the number of times the nursing home and elderly patients were chosen. However, as we have already seen, they do not present the necessary data by which the TLAQ can be evaluated and so the implications of this correlation are impossible to assess. It is not clear whether Kayser and Minnigerode have analysed all 137 items of the TLAQ or only 88 as Eisdorfer (1966) recommends. The mean scores reported could indicate a greater or lesser acceptance of negative stereotypes depending on how many items were analysed. The psychological significance of the data is thus difficult to evaluate.

#### 2.6.2 British Studies

Hooper (1979) asked student and pupil nurses, before their geriatric experience, to identify their preference on qualification between working with children, adults, or the elderly. She reports very little variation between groups and within the pupil group, but 11% more students preferred work with the elderly after their geriatric clinical experience. It must be remembered that these learners were in the

first year of their training and consequently a limited range of nursing experience may have precluded their choices. As with most studies using this kind of measure, the reasons for nurses' choices were not elicited.

## 2.7 BEHAVIOURAL INTENTION AND BEHAVIOUR

The aim of an American study by Robb (1979) was to measure behavioural intentions toward the elderly on the part of 153 nursing students and to assess the effect of a course in gerontology. Robb developed a "Characteristics of the Elderly" instrument to measure beliefs about the elderly. The study design was quasi-experimental, combining longitudinal and cross sectional approaches - something which previous studies had not done, but which is highly desirable. The attitudes of the students, when measured before and after the course, showed a significantly positive increase in the behavioural intentions score, which was at the positive end of the scale continuum before the course began. Beliefs did not change significantly. Furthermore, a preliminary analysis of results from the first groups by Robb, indicated low and insignificant correlations between scores on the two instruments. Kogan's OP scale, which correlated significantly positively with the behavioural intention instrument was added post-course. Robb also perceived a lack in previous studies of the use of any external criteria by which to assess social desirability set. Neither the TLAQ nor Kogan's OP scale controls for this and so Robb used the Marlow-Crowne Social Desirability scale to locate individuals who try to achieve the approval of others by responding in a socially desirable manner. Correlations between scores on this scale and the Behavioural Intentions scale were low and with one exception, insignificant. Robb concludes that "subjects presumably responded in terms of their true intentions rather than those normatively regarded as desirable". But of course, no attempt was made to ascertain whether the intentions were translated into actual behaviour.

Another American study by Hatton (1977) attempted to pair measured attitudes toward old people and behaviour. The attitudes of 7 RNs were measured by Kogan's OP scale and their interactions with patients were observed and categorised as either negative or positive. The findings showed a positive correlation between positive scores on Kogan's OP scale and positive interactions, but the negative scale on Kogan's instrument appeared not to predict the level of negative interactions. However, statistical significance was not achieved and there were difficulties in the interaction rating instrument which may have biased the results - for example Hatton reports the difficulty of judging the presence of a negative item "Does not interact to engage the patient" - how many times should the nurse interact to engage the patient? Despite the small sample size and the problems encountered however, Hatton's study is the only one which attempts to relate attitude to behaviour in a direct way.

## 2.8 PATIENTS' CHARACTERISTICS

### 2.8.1 American Studies

Nurses' attitudes have also been related to the characteristics of the patients for whom they care. Brown (1971) associated nurses' semantic differential evaluations of patients with characteristics of those patients. She hypothesised that nurses would not value older patients whose behaviours included:-

1. Soils clothing and bedding with food.
2. Is incontinent of bowel or bladder.
3. Soils floors, walls, trays, furniture with excreta or sputum.
4. Resists medications (holds in mouth, spits out)
5. Requires that medicines be given in special way in order to swallow.

The attitudes of 142 RNs, LPNs and NAs in 7 nursing units were measured by a sociogram for each patient on which

the nurse rated her degree of likeing for that patient, and a 14 item semantic differential scale. The correlation between nurses' attitudes and the behaviours listed above were statistically significant in each case, supporting the hypothesis. Brown notes that the highest correlations were between the attitude scores and incontinent and enviromental soiling behaviours. The greatest proportion of respondents (93) were nurses' aides to whom these particular cleaning tasks would be allocated.

### 2.8.2 British Studies

Fielding (1979) related the attitudes of 22 SRNs, SENs, ANs and student nurses toward old people to the degree of institutionalisation of patients. She used a 9 item semantic differential derived from Thomas and Yamamoto (1975) on which nurses rated the concept of a patient in a Day Hospital, an Assessment Ward, a Rehabilitation Ward and a Continuing Care Ward. She found a significant variation in nurses' rating of the 4 patient types. The Continuing Care Ward patient was rated significantly more negatively than the Day Hospital patient. Nurses' attitudes were also measured using Kogan's OP scale which showed them to hold generally positive attitudes although only 6 nurses had significant correlations between negative and positive scores, indicating that most did not respond consistently to the matched pairs. This was a small study and the nurses were of different grades - it is questionable whether or not it is reasonable to combine SRNs, SENs, ANs and student nurses into one group of nurses in this way.

From these two studies it would seem that greater dependency of patients evokes more negative evaluations from nurses. In Fielding's study, Kogan's OP scale did not correlate significantly with the semantic differential ratings but this is perhaps one indication of the lack of specificity in Kogan's OP scale. There is no real reason to suppose that the two measures, which in Fielding's study are focussing on different attitude objects, should correlate.



A majority of the studies reviewed have utilised either the Tuckman Lorge Attitude Questionnaire or Kogan's OP People Scale. A closer consideration of the use of each in the nursing literature is appropriate in view of the many conflicting findings.

## 2.9 TUCKMAN LORGE ATTITUDE QUESTIONNAIRE IN THE NURSING LITERATURE

Of the 3 studies reviewed which have utilised the TLAQ (Campbell 1971, Gunter 1971, Kayser and Minnigerode 1975), it is not possible to conclude that any two of them used it in an identical manner. Campbell (1971) took heed of Eisdorfer's (1966) recommendation that although the TLAQ should be administered in its entirety, only the 88 items which proved significant at the .01 level in discriminating between age groups, should be analysed. Gunter (1971) does not mention how many items were analysed, but from my calculations on the data she presents, it seems she analysed all 137 statements. Kayser and Minnigerode (1975) likewise do not indicate the number of items analysed and report mean scores only which means it is not possible to calculate the number of items analysed from the data presented. A report by Chamberland et. al. (1978) gives no details or data at all.

The respondent's task when faced with a scale of this kind is to accept or reject the stereotype, but the meaning of this response is ambiguous. Is the respondent who accepts a stereotype doing so because she genuinely holds a stereotyped view of old people which can be shown to be false, or, does she have information which leads her to conclude that the statement is true? Consider the following statement taken from another scale developed by Ontario Welfare Council and reported in Devine (1980):-

"Retired people are happiest in the company of people who are their own age".

Presumably a respondent might reject this statement on the grounds that it assumes all retired people are the

same in their enjoyment of people their own age. On the other hand she might accept the statement because it confirms the data she has assimilated from reading the literature (the author is not here stating her belief in the statement).

Even a rejection of the statement does not allow us to conclude that she does not hold a stereotyped view of retired people - she may reject this statement because she has an alternative stereotype - that retired people are happiest in the company of people younger than themselves.

There is also the question of what is an acceptable level of acceptance of stereotyping on such scales. Presumably, in order to show even a minimally positive attitude, the respondent would have to reject all the stereotyped statements. The response effects which are known to occur in YES-NO answers when subjects tend to respond in a regular sequence instead of considering each response carefully, was one of the criticisms levelled at the TLAQ by Golde and Kogan (1959).

## 2.10. KOGAN'S OLD PEOPLE SCALE IN THE NURSING LITERATURE

Those studies utilising Kogan's OP scale (Dye 1979, Fielding 1979, Hatton 1977, Hooper 1979, Robb 1979, Wells 1980), avoid the ambiguity of interpretation of responses that occurs with the TLAQ. All the studies reviewed employed a Likert response scale which allows the respondent to indicate a degree of agreement and disagreement with a statement. The use of paired statements also allows a check to be made in case of random responding. But neither the TLAQ nor Kogan's OP scale can control for social desirability set. Only one study (Robb 1979) introduced a measure to control for this.

Kogan's OP scale has been shown not to correlate highly with other attitude measures (Robb 1979) amongst

nurses. Hicks, Rogers and Shemberg (1976) compared 5 measures traditionally used to assess attitudes toward old people. The measures were as follows:-

1. The 96 item version of the TLAQ as modified by Axelrod and Eisdorfer (1961).
2. Kogan's OP scale.
3. The semantic differential scale presented by Eisdorfer and Altrocchi (1961).
4. An adjective check list.
5. A behaviour preference list of Wilensky and Barmack (1966).

Their results showed that the intercorrelations among the measures accounted for no more than 24% of the variance between any two measures. They suggest that researchers have tended to use a variety of single measures to assess attitudes toward the elderly, implying a unidimensionality of the attitude construct. Their findings indicate that the various measures are not equivalent, that attitudes toward the elderly are multi-dimensional and that the inconsistencies in the literature are not surprising.

## 2.11 CONCLUSIONS

The literature reviewed on nurses' attitudes toward old people and geriatric nursing presents a varied and confused picture. Insufficient detail in the reporting of many of these studies prohibits accurate interpretation. A common thread, however, seems to be the general unpopularity of geriatric nursing as an area of choice. The attitude scores themselves are difficult to interpret. Because of the generalised nature of many of the required responses (e.g. agreeing or disagreeing with a statement about "old people in general" or "most old people"), the extent to which this relates to an individual nurse with a specific patient in a particular context is problematic. The following chapter will take a more detailed look at the concept of attitude in an attempt to determine its usefulness in an applied setting.

## CHAPTER THREE

### THE USEFULNESS OF ATTITUDE AS AN EXPLANATORY CONCEPT

#### 3.1 INTRODUCTION

The usefulness of "attitude" as a scientific concept is problematic for many reasons. These can be broadly summarised in two areas. Firstly, the term "attitude" has both lay and specialist connotations, and secondly, even within the specialist psychological realm, there appears to be little consensus as to what is understood by the term. Correspondence and interchange between everyday and scientific language is a mixed blessing. "Attitude" is a term readily understood in common parlance but when used by the scientist may not be intended to carry all the connotations of the word which has common sense currency. Between scientists, the differences in meaning reflect major and diverse orientations of research method and tradition.

#### 3.2 HISTORICAL DEVELOPMENT OF THE TERM

Defleur and Westie (1963) have outlined the historical development of the term from its usage as a non-scientific word denoting the position of an artist's subject in relation to a background in the seventeenth century, through its use by nineteenth century philosophers and the early twentieth century behavioural psychologists, to its hey day with the development of social psychology and the popularity of psychometry. "Attitude" is a term on which millions of words have been spoken and written. Sherif and Cantril (1945) described it as a "central" problem in social psychology. It is a concept psychologists have shared with sociologists and it remains a major focus of social psychological investigation.

### 3.3 DEFINITION OF THE CONCEPT

However, despite intensive examination under the scientific microscope, it remains elusive to description and is visible only under the most operational of definitions. This inaccessibility has not, however, deterred researchers in their use of the concept as a variable. Attitudes have been equated with "what the attitude scale measures" and there has been relatively little concern with the adequacy of the concept itself compared with the burgeoning of empirical studies measuring "attitude" over numerous conditions and situations. Deutscher (1973) pointed out the folly of assuming that subjects were providing a single unified concept simply because we had a name for it. He writes:-

"The creation of euphemisms, epithets, or otherwise relabelling a phenomenon has little scientific import, although it may have social value as in the case of the self-fulfilling prophecy...(and)... To subsume all orientations toward an object under a single conceptual umbrella is a nominalistic nullification of the problem. It is magic and not science".

p.285

There have been many attempts to define the concept of attitude for the purpose of measurement. Most researchers include at least a rudimentary definition of what the term is meant to define in their particular study.

#### 3.3.1 Categories of Definition

Two broad categories of definition have emerged. Firstly, a probability conception has been proposed (Krech and Crutchfield, 1948) by which attitude is equated with the probability of the occurrence of behaviour of a given type or in a given direction toward an object. Measurement within this definition is simplified and concentrates on observed behaviour. Secondly, a latent process conception has been proposed (Allport, 1935) which, whilst including the notion of probability, also

posulates the operation of a hypothetical variable through which the behaviour is mediated. Measurement in this instance focusses on cognition. Both these definitions are embodied within a stimulus-response framework which suggests consistency of response to a particular stimulus, but in the latter definition there is the additional idea of an inner mechanism which determines the response.

Both definitions have their attendant problems. A probabilistic conception of attitude, if used as an explanation, results in a tautology. For example, if a nurse is observed consistently to reject a patient and we want to explain this, it is not sufficient to say that it is because she has a negative attitude. A probabilistic conception of attitude cannot explain the nurse's behaviour in any way. But equally, a latent process is by definition unobservable. Defleur and Westie (1963) point out that this argument can be countered by citing the physical scientists' concepts of atoms and electrons which are "not observable either but are inferred or hypothetical variables". Leaving aside the rather doubtful case of electrons which are now visible via the electron microscope, the argument still stands that such phenomena as atoms behave exactly as if the postulated processes were correct. Such convincing empirical evidence as supports the physical scientist's case, has not been forthcoming from studies of attitudes as we shall see when the relationship between avowed attitudes and behaviour is discussed.

There remains then a confusion of conceptual definitions of the term "attitude". The fact that few psychologists have wanted to abandon it entirely may be due more to its common sense currency than to its scientific sophistication.

### 3.4 USE OF THE CONCEPT

Katz and Stotland (1959) write:-

"Few have loved this orphan child, born  
in controversy and fostered in hostility,

yet fewer have been able to abandon it.  
It has served rather contradictory  
functions for opposed theoretical approaches".

p.427

They suggest that the social behaviourists led by Allport utilised the concept to soften a mechanistic model of man, enabling them to become as subjective as their despised mentalist opponents. On the other hand they maintain that the field theorists needed it to provide an anchor in an otherwise fluid system, to account for cognitive organisational stability and constancy.

They conclude:-

"One may interpret this historical paradox in two ways. First, one may hold that a concept which can be seized upon by opposed theoretical systems for opposed purposes is meaningless and should be abandoned. Or, one may contend that dealing with social realities brought the narrowness of the systems into bold relief and that, in practice, the concept of attitude offered their extreme positions a common meeting ground".

p.428

In applied fields such as nursing, attitude has, in practice, been used as a shorthand for the explanation of behaviour, the wider theoretical implications being overlooked in the interests of pragmatism. The aim of Brown (1971) was "to describe the attitudes of nursing personnel toward the aged and their care" because of "empirical and research evidence that many nurses were not interested in geriatric nursing". One of the research questions asked by Burge (1978) was "Is it possible that the attitudes of nurses toward the aged and the aged ill are so negatively stereotyped that they do not want to be associated with this area of practice?". Such approaches have capitalised on a convenient methodology aimed at the prediction of behaviour, in a mistaken attempt to explain behaviour. It has been argued that explanation of behaviour in

this case is tautological; it will be seen shortly that prediction of behaviour is by no means necessarily consequential.

### 3.5 MEASUREMENT OF THE CONCEPT

However, it is not only the conceptual definition of "attitude" and its usage, which have given rise to problems. Its measurement highlights certain issues. Attitude research, whilst not being limited to a laboratory, shares the problems of the psychological laboratory experiment to a large extent. Rosenthal (1963) showed how the experimenter's expectations could influence the outcome of experiments. With human subjects, influence could be exerted by social relationships, the sex of the experimenter and subject, the subject's anxiety, the motivation to please or for success on both experimenter's and subject's behalf (Jourard, 1968).

Shultz (1969) has drawn to our attention the fact that most psychological laboratory studies use subjects from a very restricted population, namely psychology undergraduates. This has far reaching consequences. Any model of behaviour which is generated from a subset of a restricted population cannot be deemed to have wide generalisability unless the findings are replicated in the "real world", and Silverman (1968) showed how such "findings" can evaporate given a "life" context.

The coercive nature of the experimental situation has been demonstrated by Orne (1962) who, when asking people to perform a somewhat unusual task, such as 5 press ups, found them very willing to co-operate when told it was for an experiment. These and other constraints (Silverman, 1977) are present to varying degrees in attitude studies and give cause for concern regarding the validity of data thus obtained.

### 3.6 ATTITUDE RESEARCH INSTRUMENTS

It is against this background then that we now examine the various attitude research instruments. Wherever



possible examples will be chosen from the nursing or related literature in order to maintain close links with the applied field of interest.

### 3.6.1 Self Reports

The use of measures of this kind is perhaps the most prevalent in the literature. The subject is invited to reveal his beliefs, feelings toward, behavioural intentions toward, an object or class of objects. These may be expressed (although rarely) in his own words; more commonly by accepting or rejecting a standardised set of items - an attitude scale. It is assumed that his attitude is indicated by, or even identified with, the self report.

In the 1920s and 1930s research into the attitudes of particular social groupings to specific issues or objects, such as the attitudes of college students toward the Negro (Sims and Patrick, 1936), was the mainstay of empirical social psychology. Pioneers of this kind of research into attitudes toward old people were Tuckman and Lorge who, in the 1950s, conducted a series of studies aimed at the development of a scale to measure attitudes toward old people (1953, 1954, 1956). This scale consists of 137 erroneous statements about old people. Subjects have to indicate their agreement or disagreement with each item. This scale, or modified versions of it, has been used extensively in order to measure the amount of negative stereotyping of the aged by college students (Hicks, Rogers and Shemberg, 1976), medical students, family practice residents, professional and non-professional nursing home staff members (Holtzmann et. al. 1977), medical students, housestaff members and members of a mobile psychogeriatric screening team (Solomon and Vickers, 1979), and student nurses (Gunter, 1971).

Another well used scale is that developed by Kogan (1961) which consists of 17 paired negative and positive

statements about old people. The subject has to indicate agreement or disagreement with each statement by checking a Likert-type scale. Kogan's scale has been used to measure the attitudes of high school students (Ivester and King, 1977), medical students and practitioners (Thorson, Whatley and Hancock, 1974), physicians, nurses and social workers (Futrell and Jones, 1977), nurse learners, untrained and trained nurses (Fielding, 1979), student nurses (Hooper, 1979; Robb, 1979), and trained nurses (Hatton, 1977; Wells, 1980).

Other scales have been developed and utilised in individual studies (Gale and Livesey, 1974; Keith, 1977; Kosberg and Gorman, 1975; Kosberg, Cohen and Mendlovitz, 1972; Levenson, Thornby and Tollett, 1980) but none has been used as widely as the Tuckman-Lorge and Kogan scales.

Also in this category of self reports is the semantic differential. This was originally devised by Osgood (1962) to detect different dimensions of meaning of various words. For example Osgood determined empirically that "nice" had feminine connotations whereas "good" was considered to be more masculine in its definition. The technique which was developed by Osgood, Suci and Tannenbaum (1957) requires the subject to rate a particular concept, for example "an old person" on a series of bipolar adjective scales e.g. nice - nasty, pleasant - unpleasant, active - passive. The assumption is that a person's attitude toward an object is equivalent to the object's evaluative meaning for the person. In a number of factor analytic studies, three basic factors have been found consistently to underly ratings. These are EVALUATION, ACTIVITY and POTENCY, accounting for a large share of connotative meanings, the EVALUATION factor carrying most weight.

Versions of the semantic differential have been used to measure the attitudes of nurses toward geriatric patients (Fielding, 1979), attitudes of college students (Hicks, Rogers and Schemberg, 1976), attitudes of adolescents and young adults (Ross and Freitag, 1976), attitudes of

school children (Thomas and Yamamoto, 1975) and attitudes of rehabilitation counselling students and gerontology trainees (Burdman, 1973).

Another essentially self-report method, but one which was developed in a specific theoretical context, is the repertory grid. This technique, based on Kelly's Personal Construct Theory (1955) is, in the words of Fransella and Bannister (1977) "... an attempt to stand in other's shoes, to see their world as they see it, understand their situation, their concerns." There are many variations to the technique (and for a fuller discussion see Chapter 5) but in essence the respondent is required to discriminate between elements, usually people, known to the respondent. If the researcher supplies adjectives on which the respondent rates the elements, then the technique is little different from the semantic differential, but descriptive statements which discriminate between elements can be elicited from the respondent.

There are no known published studies using this technique to study attitudes toward old people but relevant work is that by Davis (1975; 1977) who used the technique to study student nurses' perceptions of significant others.

Content analysis approaches have also been used in this field (Kahana and Coe, 1969). Subjects are usually involved in group discussions or are asked to write short descriptive passages about old people. Transcripts are then analysed along several dimensions by independent judges.

In some studies questionnaires are used to elicit specific information which is of particular interest to the researcher and from which attitudes are inferred. There is not always sufficient detail given as to the questions asked or the mode of reply (whether spoken, written or in the subject's own words), but studies falling into this category are Fandetti and Gelfand (1976), Zampella (1969), Geiger (1978), Kosberg and

Gorman (1975), Shulder (1973), Wolk and Wolk (1971), Delora and Moses (1969), Hall (1974) and Hillsmith (1978).

### 3.6.1.1 Criticisms

There are a number of criticisms that can be levelled at self report measures. If attitudes are expressed within the scale or questionnaire, then the purpose of the instrument is obvious. Items in the scale or questionnaire are about a certain object or class of objects. Kogan's OP scale items are about "Most old people". Because the purpose of the instrument is clear, the respondent may realise the implications of his responses and make a conscious effort to respond in a particular direction which may not accord with his true feelings. Cook and Selltiz (1964) write:-

"It seems reasonable to suppose that most respondents, presented with tests in an academic setting or under the auspices of some other "respectable" organization, will assume that the responses which will place them in the most favorable light are those which represent them as well adjusted, unprejudiced, rational, open-minded, and democratic".

p.39

Perceived social desirability has traditionally been considered a problem to be overcome by the inclusion in the scale or questionnaire of irrelevant items which hopefully disguise the attitudinal object. For the researcher, the "problem" has disappeared, but the respondent may now be puzzled about the real purpose of the test and may structure his responses accordingly. More recent thinking would consider perceived social desirability to be an important factor in the explanation of behaviour (Harré and Secord, 1972) and not one which it is possible or even desirable to exclude by methodological manoeuvres.

An alternative strategy, suggested by Cook and Selltiz (1964), would be the inclusion of items to which an unfavourable reply is likely to be considered socially

acceptable, e.g. Would you like an octogenarian as Prime Minister? The subject is then able to respond negatively and rationalize his response on grounds other than age prejudice. However, in order to assume a negative attitude with this sort of response, the researcher has to discount the respondent's reasons or explanations for his response - indeed such explanations are rarely sought. Wording of questions which assumes certain behaviour avoids this necessity, e.g. When did you last avoid getting into conversation with an old person? Assurances of anonymity, that there are no right or wrong answers, that people differ in their responses, may encourage a subject to be frank in his response, but are no guarantee that he will be as frank as the researcher would wish to assume.

The value to be placed on any attitude score is more or less problematic depending on the sophistication and elaboration of the scale. If a nurse has a high negative score on Kogan's OP scale, one cannot then assume that she will have a negative attitude toward all classes of old people with whom she comes into contact. The situational variables will undoubtedly exert an influence on the expression of attitude. Over twenty five years ago, Smith, Bruner and White (1956) documented the difficulties of interpreting any single attitude score. After extensive tests and interviews with their subjects, they showed that attitudes were far more complex than simply positive and negative and were bound up with the way in which the subject perceived his world and the social pressures upon him.

Eysenck (1954) has also indicated the difficulties experienced by some subjects when faced with an attitude scale, even though he was inclined to dismiss many of them as "irrelevant". Subjects claimed that the scale forced them to record complex attitudes as "simple dichotomies" and many of them said that they could "write a book" on some of the statements.

The present author has had some experience of administering Kogan's OP scale to nurses (Fielding, 1979; Wells, 1980).

The following are extracts from nurses' comments on completion of the scale:-

"When you speak of old people, do you mean just pensioners, or the very old and disabled? Old people vary and it is sometimes hard to generalise....some of my questions may not be exactly what I feel but I hope they will help you...I found it very difficult to fill in as I have been working with some very old and confused patients on my ward, yet I have a very sensible grandmother of about the same age...Too many questions are the same with different wording...are you trying to trick us?"

It seems that subjects may find attitudinal items either ambiguous or biased, despite the psychologist's belief that the item has a fixed ascertainable value akin to a physical stimulus such as a weight or light, against which the subject's response can be measured. But unlike a physical stimulus, such as an electric light bulb, the attitudinal item has no external referent, and must depend for its value on the judgment of the subject. Since psychologists have not generally been willing to take into account the complaints of their subjects they have had to rely on responses to consensual items to identify negative and positive attitudes. The extent to which there is consensus between subjects in such studies cannot be determined by post hoc analysis, but must influence the results of these studies by varying degrees. The complaints made by subjects are, of course, difficult to include in any study as by their very nature they question the validity of the scale being used. However, an approach which capitalised on the subject's need to differentiate between particular instances or classes of objects could do much to avoid this pitfall.

Ambiguity or bias notwithstanding, shifts in responses may occur over time because of changing values and ideals in a community. To illustrate this point, let us consider two pairs of items from Kogan's OP scale:-

1. Most old people would prefer to continue working just as long as they can rather than be dependent on anybody. (POSITIVE)

Most old people would prefer to quit work as soon as pensions or their children can support them. (NEGATIVE)

2. It would probably be better if most old people lived in residential units that also housed younger people. (POSITIVE)

It would probably be better if most old people lived in residential units with people of their own age. (NEGATIVE)

Agreement with the first statement in each pair indicates a POSITIVE attitude, whilst agreement with the second statement in each pair is taken as indicative of a NEGATIVE attitude.

It is now twenty years since this scale was first reported. The question must be asked as to how the meanings or interpretations of the items have changed and in what direction? It is not hard to imagine that a changing work ethic must have implications for the first pair of items and likewise therapeutic fashion for the second. When the economy is failing and many employers introduce schemes of early retirement, the older worker who readily relinquishes his post to accept a State pension may be regarded favourably because of the beneficial financial implications for his firm. And the person who advocates segregated housing for older people may do so on the basis of a belief that their needs are best met in this way.

The reader will recall that in Chapter 2 (p.39) it was shown how the acceptance or rejection of a response could be ambiguous and that a given response may not allow the conclusion that the respondent holds a stereotyped view of old people, unless the basis for the response is also known.

The complexity of the attitudinal response is also reflected in the phenomenon of attitude-behaviour discrepancy. We will return to this matter for a more detailed consideration after the other types of attitude measured have been discussed.

### 3.6.2 Performance on Set Tasks

Observation of "real life" behaviour is time consuming and costly but is, nevertheless, a major type of measurement often used to infer attitude. This major class of measurement will be discussed in Chapter 4, but there are some related measures which have been used by researchers who wished to reproduce some aspect of social life in the microcosm of the laboratory.

Rosen and Jerdee (1976) devised such a measure.

Participants were asked to assume the role of a manager and were required to make a decision on the basis of a letter or memo in the "in-basket" about the future employment of one of their workers. The aim was to simulate the problem a real life manager might have when faced with a decision regarding an older worker.

Criticisms of this type of measure can be subsumed under those of role-playing in general, itself a major class of measurement.

### 3.6.3 Role Playing

Role-playing as Ginsberg (1979) documents, has a long history in social psychological research. Its advocates see it as an answer to the problem of deception in experiments, which, they claim, leads to suspicion and increases the likelihood of artefacts.

Certainly role-playing involves the subject in the experiment as an equal participant - he has the opportunity to discuss his role and feelings, to make changes and monitor his perceptions as a result of those changes. There is the potential for a free flow of information, ideas and feelings pertinent to the situation. The actor also has the opportunity to rationalise his actions - consequently there are more opportunities for him to respond in undesirable ways and it is less likely that he will distort his responses in order to appear in a more favourable light.

Role-playing is a deliberate simulation of some aspect



of social life. It may be conducted with or without a written script and with varying degrees of directedness. Role performances are interpreted and evaluated in accordance with the research objectives. It has been used in studies of opinion change (Janis and King, 1954) and attitude change (Smith, 1975) in addition to a range of other social psychological problems.

#### 3.6.3.1 Criticisms

Role-playing has not been without its critics. Freedman (1969) suggested that "... the use of role playing strikes at the very root of psychology as a science". To pretend, and admit that one is pretending, is seen as cheating. Role-playing may be seen to be a passive exercise lacking spontaneity. However, such striking examples as the Stanford prison study (Haney, Banks and Zimbardo, 1973) and the Grindstone Island attack and defence exercise (Olsen and Christiansen, 1966) suggest the contrary, that role-playing can be highly absorbing even to the extent that the boundary between the role-play and real-life may not be entirely clear to the participants. Nevertheless, a major criticism of role-playing has been that the actor is aware that his behaviour does not have any real consequences and that a person's statement of what he would do in a given circumstance cannot be equated with his behaviour in such a situation. The use of deception however, in addition to its serious ethical implications, does not guarantee naive subjects (Schulz, 1969) and the use of other experimental manipulations can mask or distort subtle nuances of social situations (Mixon, 1979). Ginsburg (1979) also maintains that data from studies involving deception should not be regarded as normative. He writes:-

"Data generated by deception experiments cannot be used as criterial data, against which the data from other research strategies must be compared. Deception designs contain an inherent ambiguity which precludes the assignment of criterial status to them".

But Ginsburg also points out that role-playing may entail great personal involvement but it need not necessarily do so. Reality and spontaneity, whilst often occurring, are not guaranteed by role-playing.

When considering the question of the validity of role-playing, Ginsburg (1979) advocates the use of control conditions and the avoidance of reactive procedures. Whilst reactive measures are obviously incompatible with the aims of role-playing, the use of control conditions may not have the desired effect of revealing the nature of the deliberately manipulated variables. Mixon (1979) points out that it is often difficult to determine what larger population the control or experimental group represents because of the constraints of the experimental situation. He also maintains that both the situational context and behaviour under study must be well understood and unambiguously described in order that control groups may fulfill their analogic function.

The dependability of measures taken from role-playing is also an important consideration, especially if judgements are made by audiences along prescribed scales. In such cases, the dependability of coders and coding schemes must be questioned. The dependability of measures also has implications for the generalisability of role-playing studies and Ginsburg (1979) recommends control procedures and multifactorial designs in order to extend generalisability as much as possible. Role-playing is not always carried out within an extensive paradigm however, and may be used to identify those features of a situation which are characteristic of a given type of situation. In other words, it may be used intensively to describe a situation in depth.

#### 3.6.4 Reactions to partially structured material

Sometimes researchers try to assess attitudes indirectly by the use of partially structured material. The

subject may be presented with a test of "imagination", "verbal fluency" or "social sensitivity" and be asked to describe a scene, complete a story or predict the behaviour of another person. Thomas and Yamamoto (1975) asked children to write short stories about people whose photographs were shown to them, the assumption being that the children's attitudes would influence their perception and hence be evidenced in their descriptions. Neff (1979) has written of the value of vignettes in attitude research and Kraus (1976) used a similar method to determine the effect of preinformation on nurses' descriptions of patients. The method has the advantage of allowing fine manipulations to be made by the researcher in the stimuli presented.

#### 3.6.4.1 Criticisms

This method depends for its validity on the equation of attitude with response to stimuli, but there is, of course, no guarantee that a written response to a photograph or picture reflects the respondent's attitude to the person in the photograph or picture. Similar limitations are placed on this method as on role-playing and any confidence placed in it would need to be bolstered by evidence of suitable control procedures and multifactorial designs as recommended by Ginsburg (1979).

An important consideration, in view of the writings of Schulz (1969) regarding the so-called naivety of subjects would be the subject's own interpretation of the task in hand.

#### 3.6.5 Performance on objective tasks

Measures of this kind involve the subject in performing specific tasks which are presented without reference to their attitudinal implications, the idea being that a person's performance will be influenced by his attitude and that any systematic bias will reflect the

influence of the attitude. The author is unaware of any studies utilising this method in the field of ageing or nursing. Cook and Selltiz (1964) suggest that this method may be "relatively impervious" to distortion by social desirability effects. They write:-

"It seems reasonable to suppose that most subjects accept these tasks at face value; presumably only someone with rather sophisticated knowledge of research techniques in the social sciences would be aware of their attitudinal implications."

p.51

Such faith in the naivety of subjects is certainly not justified in the light of more recent criticisms of the experimental method (Schulz, 1969; Silverman, 1977). Therefore the sensitivity of such measures must be questioned.

The nature of the direction of attitudinal influence is also problematic. A nurse who says she dislikes dealing with the problem of incontinence in her patients may do so on the basis of her feeling that old people are dirty, or, she may do so on the basis of her belief that incontinence deprives old people of their independence and dignity. Such problems of interpretation greatly reduce the explanatory power of this method and point to the need for supplementary data if the results are to be interpreted with confidence.

### 3.6.6 Observations of physiological responses

These are perhaps the least used kinds of attitude measures. They involve the measurement of certain physiological responses, which are not under conscious control, to an object or its representation, e.g. pupil contraction and dilation in response to unpleasant and pleasant stimuli respectively (Hess and Polt, 1960). It is assumed that the magnitude of the physiological response is directly related to the intensity of the attitude, in either a positive or negative direction - the greater the response, the stronger the attitude.

The author is unaware of any studies utilising this method in the fields of ageing or nursing.

#### 3.6.6.1 Criticisms

One obvious drawback to this approach is the between subject variability in physiological responses - does a galvanic skin response of a certain magnitude indicate a certain attitude strength in all subjects? The magnitude of response and the interpretation of that magnitude is, however, a problem common to all groups of measurement, whether it is the interpretation of numerical scores or the level of GSR.

Physiological responses, whilst the real purpose of them may be disguised, are likely to be susceptible to interference from other extraneous variables. Hevey (1981) has shown how the sex of the experimenter can influence a subject's responses although this is rarely taken into account by researchers. If the real purpose of the experiment is disguised, then once again ethical problems loom large with no guarantee of a naive subject.

### 3.7 ATTITUDE-BEHAVIOUR DISCREPANCY

There is, however, a further aspect of traditional attitude research which has confounded researchers and which concerns the validity of attitude measures in predicting behaviour. The discrepancy between measured attitudes and subsequent behaviour has been the field's major pitfall and the greatest single indicator that traditional approaches are inadequate.

#### 3.7.1 Statement of the problem

It is axiomatic in all attitude studies that what is being measured has some bearing on the individual's behaviour. The *raison d'etre* of attitudes is behaviour. Vernon (1938) suggested that words were "actions in miniature" and that it was through the

use of questions and answers that information could be obtained in a relatively short space of time about a vast number of actions which it would be impracticable to observe.

Studies which have employed techniques such as attitude scales and questionnaires have assumed a one to one correspondence between measured attitudes and consequent behaviour. A nurse's negative score on an attitude scale is taken as an indication of her negative behaviour. Yet the literature is full of examples which do not support such an assumption. The classic study, an investigation of the relationship between racial prejudice and racial discrimination, is by LaPiere (1934). As a researcher LaPiere travelled across the United States of America, 10,000 miles in all, with a Chinese couple, recording their treatment in hotels, motels, tourist hostels and restaurants. After six months, a questionnaire was sent to the proprietors of each establishment asking them "Would you accept members of the Chinese race as guests in your establishment?". Of 251 establishments actually visited, only one motel had refused to accommodate them. Of all the establishments returning the questionnaire, only one indicated a willingness to accommodate Chinese guests.

Since 1934, despite certain methodological criticisms of LaPiere's study (Deutscher, 1973), no-one has seriously questioned his findings and subsequent studies have confirmed that measured attitudes are often out of synchrony with associated behaviour. Wicker (1969) reviewed 46 studies in which verbal attitudes and behavioural responses were obtained from subjects on separate occasions. Wicker concluded that verbal attitudes very often bear only a slight relationship to overt behaviour. Seldom did verbal attitudes account for more than 10% of the variance in the overt behaviour measures. This discrepancy contradicts a widely held common sense expectation that what people do, should accord with what they say. Dollard (1949) suggests that a high degree of consistency between words and

acts has great social utility, making organised social life possible. He writes:-

It enables men to participate in organized social life with good confidence that others will do what they say they will do, will be where they say they will be. Valid prediction of behaviour is not a mere luxury of morality, but a vital social necessity. Every man is under compulsion to keep his promises, to make his acts correspond with his verbal expressions. He constantly watches others to see that they do likewise".

p.624

### 3.7.2 Theoretical approaches

The conceptual definition of an attitude has a bearing on this relationship. DeFleur and Westie (1963) argue that the "latent process" conception implies consistency between attitude and behaviour since the same underlying process mediates the two. However, when they do not correspond, one is left with the problem of deciding which of the two competing responses indicates the "true" attitude. In terms of the LaPiere study, did the hotel and restaurant owners have negative or positive attitudes toward the Chinese?

The "probability" conception favoured by DeFleur and Westie (1963) avoids this dilemma. Each kind of behaviour, both the attitudinal response and the overt behaviour, are equally legitimate and it is a matter for empirical investigation the probability of each occurring under various circumstances.

A conceptual clarification of the behavioural status of an attitudinal response is needed here. Gross and Niman (1975) point out that an attitudinal response, whether spoken or written, is behaviour of a kind. Keisler, Collins and Miller (1969) suggest that "attitudes and behaviour" could more appropriately be termed "Some Kinds of Behaviour and Other Kinds of Behaviour". Similarly Green (1954) writes of an attitude being comprised of a "behaviour universe". If different

kinds of responses, or responses from different universes are implicated in the attitude-behaviour discrepancies, then what researchers have failed to do is to specify the criteria for determining when one response is of a different kind than another (Cook and Selltitz, 1964), unless a consideration of those other factors thought to contribute to the discrepancy could be interpreted as an attempt in this direction. We will return to this point later.

In a consideration of the validational implications of attitude behaviour discrepancy, Wicker (1969) draws attention to a longstanding criticism of attitude methodology i.e. the tendency of some researchers to deny that anything exists beyond the verbal expression of attitude, thereby eliminating the problem of validity. The scales or questions test whatever they test and there is no need to worry about subsequent behaviour. Other investigators such as DeFleur and Westie (1963) argue, based on the probability conception that inconsistency is to be expected and thereby rule out the use of external criteria for testing validity. In a similar vein, Green (1954) suggests that measures should be taken on the particular kind of "attitude universe" in which one is interested, rather than use verbal measures assuming that they will correlate highly with actions.

### 3.7.3 Social considerations

Nevertheless, important though conceptual and validational considerations are, the social implications of attitude-behaviour discrepancy must not be overlooked. We have already emphasised the importance of consistency for social life in general (Dollard, 1949). Our common sense experience leads us to assume untrustworthiness and insincerity for someone whose actions belie his words. The philosophy of practising what one preaches is a generally accepted moral code. But there are numerous exceptions to be made because of specific and often changing circumstances. A consideration of some factors thought to be implicated in attitude-



behaviour discrepancy will be useful here.

#### 3.7.4 Factors in the attitude-behaviour relationship

A case can be made, defending traditional attitude studies, for the view that an attitude is only one part of a complex equation used to predict behaviour. We need to forget, for a moment, that most attitude studies only use one measure of attitude as a kind of shorthand for the prediction or explanation of behaviour. According to the case in question, other factors, associated with the individual, the situation and the instrumentation, have a bearing on a person's behaviour and may account for some of the discrepancy commonly found to exist between verbal attitudes and overt behaviour.

##### 3.7.4.1 Personal factors

Personal factors become evident when one considers the individual and observes that two people with the same attitude behave differently, or that two people evidencing the same behaviour hold different attitudes.

##### *Other Attitudes and Other Behaviours*

Many writers have recognised that there may be many attitudes relevant to any given behaviour (Cook and Selltitz, 1964; Insko and Schopler, 1967; Newcomb, Turner and Converse, 1965; Rokeach, 1967) and that there may be several behaviours relevant to any given attitude (Gross and Niman, 1975). Thus a nurse who has a favourable attitude toward geriatric nursing and yet chooses to work in another field, may have an even more favourable attitude toward the chosen speciality.

##### *Competing Motives*

The strength of motives underlying behaviour may be greater than the strength of motive underlying a relevant attitude (Deutsch, 1949). The expression of either "behaviour" would then depend on the balance of motives.

### *Verbal, Intellectual and Social Abilities*

The abilities of individuals obviously vary and subjects of low intelligence may fail to exhibit appropriate behaviour because they did not understand the instructions or questions. The skills needed for the behaviour may also not be within their repertoire. A nurse may have a positive attitude toward a disturbed psychiatric patient, yet not have the necessary skills with which to communicate effectively.

### *Activity Levels*

Dollard (1949) has suggested that an individual's activity level may be implicated in the attitude-behaviour relationship, the notion being that a more active person is more likely to act in ways consistent with his attitudes, whereas the apathetic individual "...is more or less indifferent to the environment and does not act strongly to gain his ends". This view assumes that a high level of activity is positively correlated with "interest" in the environment and this may not necessarily be the case.

Regarding the contribution of personal factors to the attitude-behaviour relationship, Gross and Niman (1975) write:-

"...researchers who have assumed that the individual difference variable - attitude - is an important determinant in predicting behaviour have been unable, to any significant extent, to corroborate their belief with empirical data. At best, the individual difference variable of attitude accounts for 10 - 12 per cent of the variance in predicting behaviour. Researchers who perceive the situation as an important determinant of behaviour have received more support for their beliefs".

p.362

### 3.7.4.2 Situational factors

Situational factors can, of course, be as many and varied as the situations which arise or are devised.

#### *Anonymity and Secrecy*

The extent to which subjects' attitudes and behaviours are disclosed publicly may affect the consistency of attitudes and behaviour. Hyman (1949) suggested that inconsistency was not surprising if verbal responses were obtained anonymously but overt responses measured openly in situations where the subject may be under pressure from others. The influence of others' opinions often weighs heavily with a person - DeFleur and Westie (1958) report that subjects frequently mentioned the possible objections of friends and families in their decision signing photographic releases.

#### *Normative Prescriptions of Proper Behaviour*

Wicker (1969) suggests that role requirements may influence an individual's response and contribute to inconsistencies. Thus a nurse may exhibit an "official" response to an interview or questionnaire, but in the work situation may experience competing role requirements such as the need to complete a routine or accomplish a set of tasks which might divert her from behaviour in tune with her verbally expressed attitude. She may express dislike of a certain patient by her routine behaviour, but feel nevertheless that a nurse must be polite to all her patients as an expressed policy.

#### *Possibilities for Alternative Behaviours*

Wicker (1969) points out that most attitude scales and measures of behaviour greatly restrict the range of possible responses for the subject, particularly in the laboratory studies. It may also be the case that the range of overt behavioural responses is more limited than the range of verbal responses and that an inevitable inequality is built into the study. Gross and Niman

(1975) make the same point suggesting that when "alternative behaviours in the overt behavioural situation are similar to those available to the subject at the time of attitude measurement, greater consistency will result".

### *Specificity of Attitude Objects*

Fishbein (1966) points out that investigators have tended to measure attitudes toward a group of people and to predict behaviour toward one of that group on the basis of the measured attitude. He writes:-

"Thus we have frequently measured a subject's attitude toward Negroes, and then we have attempted to predict whether the subject would ride with, work with, or co-operate with Negroes. But it is unlikely that the subject's beliefs about the particular Negroes he comes into contact with are similar to his beliefs about Negroes in general".

p.206

Similarly, attitude scales such as Kogan's (1961) measure responses to "most old people" but in a "real life situation" a response is required to a very specific old person. Thus stimulus dissimilarity in the two conditions may have contributed to attitude-behaviour discrepancy.

### *Unforeseen Extraneous Events*

It is of course, quite possible, that unforeseen events might disrupt the relationship between attitude and behaviour. Illness, accident and change of plans cannot be predicted reliably, although it might be possible to ask subjects to anticipate their likely response in the event of a certain occurrence (Wicker, 1971).

### *Expected/Actual Consequences of Behaviour*

Wicker (1969) suggests that this may be the most fundamental of situational factors since most others can be subsumed within it. The subject's perception of the attitude testing "event" is crucial here -

if a nurse is asked for her attitude toward certain groups of patients, her interpretation of why the question is being asked may influence her response. Does the investigator represent her employers? Has the investigator been called in for a specific reason? Does the investigator make recommendations as to her future deployment?

In considering situational factors, Gross and Niman (1975) conclude that such variables have yielded the highest correlation between attitudes and behaviour. They write:-

"Knowledge of situational variables results in better predictions of an individual's behaviour than knowledge of individual differences. Intrapersonal (or individual-difference) variables become more important as predictors when their interactions with situational factors are considered".

p.365

They offer a general postulate regarding situational influences on attitude-behaviour relationships:-

"The more similar the situations in which verbal and overt behavioural responses are obtained, the stronger will be the attitude-behaviour relationship. Situational factors may be thought of as potentially significant dimensions along which environments can vary from the highly similar to the highly dissimilar".

p.366

There has been considerable controversy in recent years regarding the relative contribution to behaviour of personal traits and situations. Some researchers have argued that psychological investigation has focussed on the individual to the neglect of situations (Sells, 1963; Magnusson, 1971). A number of studies have been carried out which have shown that situational factors consistently account for more percentage variance in behaviour than do personal factors (Argyle and Little, 1972; Bowers, 1973; Endler, 1973). With regard, however, to attitudes, the ascendancy of interest in the situation

was what Bowers (1973) was referring to when he wrote:-

"Thus cognitions are scientific slaves, useful until the pyramids of science are complete, and then surreptitiously entombed in the monuments they helped to construct...This ("compromise") perhaps explains how cognitions can be both important and impotent at the same time. It also conveys one sense in which cognitive and phenomenological explanations are incomplete; They are incomplete until their situational determinants are uncovered; then they are obsolete".

p.316

However, as the controversy developed, it became apparent that the issue was not one of whether to concentrate on personal or situational factors in the prediction or explanation of behaviour, but rather to consider the interaction of the two. After a careful consideration of the merits and demerits of situationism, Bowers (1973) writes:-

"An interactionist of biocognitive view denies the primacy of either traits or situations in the determination of behaviour; instead, it fully recognizes that whatever main effects do emerge will depend entirely upon the particular sample of settings and individuals under consideration".

p.327

or biocognitive

Consequent to the interactionist approach has been a development of interest in the perception of situations. Magnusson (1971) argues that the individual's perception and interpretation of different situations is crucial for his behaviour in such situations. But the fact that individuals themselves create, choose or alter situations has caused problems for this approach (Argyle, 1976). A recent development has been to attempt to discover the behaviours or the generative-rules which apply in different situations (Argyle, 1979). This line of research which at present is being developed, promises to be a fruitful one with a variety of methods being brought to bear on the issues in question.

It is also, perhaps, an example of how attitude research has largely been superseded by research which emphasises explanation rather than prediction. We will return to this and related issues in Chapter 5.

#### 3.7.4.3 Instrumentation factors

There are, however, factors relating to the instruments used which have a bearing on the attitude-behaviour relationship.

##### *Reliability*

As stated earlier, ambiguous test items will reduce reliability, since interpretation of them may vary on subsequent occasions.

##### *Item Difficulty*

Gross and Niman (1975) suggest that two measures may not correlate highly despite high reliability having been established, because they are making discriminations at different levels of the attitude or behaviour continuum. Wicker (1969) has pointed out that it is usually the attitudes and behaviour of those at the extremes of a continuum who are compared, therefore the range of responses within the groups is limited and the groups are exclusive of those with middle attitudes or similar attitudes but who do not belong to such a group.

##### *Category Width*

Behavioural responses may have broad categorisations which accommodate several separate categories on an attitude scale. Thus a small difference in attitude measurable on a scale may be undetected in a broad categorisation of behavioural responses.

A more fundamental issue relating to attitude-behaviour discrepancy has been raised by Fishbein (1966) who, commenting on the tendency of psychologists to blame measuring instruments or conceptual definitions when

an expected relationship is not found, suggests that what is needed is questioning of the basic assumption that specific attitudes and specific behaviour must somehow be related. He writes:-

"Indeed, rather than questioning our basic assumption that there is a strong relationship between attitude and behaviour, we have tended to blame our failures on our measuring instruments, on our definition of attitude, or on both. Thus, from its relatively simple beginning as a unidimensional concept that referred to the affect for or against some psychological object, the concept of attitude has grown into a complex, multi-dimensional concept consisting of affective, cognitive, and conative components".

p.199

Fishbein recommends the reinstatement of attitude as a unidimensional concept which is inferred from a separate study of beliefs and behavioural intentions. Such a view does not then imply that any given attitude e.g. positive attitude toward old people, will necessarily be consistent with a particular behaviour or a particular belief. An individual may have a favourable attitude toward old people and yet believe that they have some negative characteristics.

He criticizes LaPiere's classic study on two counts. Firstly, it did not consider the appropriate attitude object; it seems unlikely that the respondents viewed the particular Chinese couple in the same manner as they did "orientals" (they were well dressed, English speaking with a car and expensive luggage). Secondly, it was a study of behavioural intention and not a study of attitude; instead of sampling a range of behavioural intentions in order to arrive at a valid estimate of attitude, LaPiere only considered one or two very specific behavioural intentions.

Fishbein concludes:-

"...rather than making our definition of attitude more complex, we must define beliefs, attitudes, and behavioural intentions separately. We must



continue to investigate their interrelations with one another and with behaviour per se; and perhaps even more important, we must begin to specify the conditions under which different types of behaviour are or are not related to attitude".

p.222

This conclusion again emphasized the prediction rather than the explanation of behaviour. This distinction will be seen to be an important one in due course.

### 3.9 CONCLUSION

We have seen in this chapter some of the difficulties associated with measures designed to tap cognitions. There is, however, another major group of methods referred to on p.54 which can be used to infer attitudes - methods which focus on particular aspects of overt behaviour. It is to these that we now turn.

## CHAPTER FOUR

### A REVIEW OF OBSERVATIONAL METHODS AND CONVERSATIONAL ANALYSIS

#### 4.1 INTRODUCTION

This chapter examines a major class of measurement which has been extensively used to infer attitudes, namely, the observation and analysis of overt behaviour. Behaviour can be divided into two varieties - actions and talk. The fact that people can "do" things with words is not at issue here; what is clear from the literature is that researchers have tried to analyse both the activity of human beings and their conversations and that in this chapter these means of analysis will be examined in order to assess their explanatory potential.

#### 4.2 STUDYING NURSING ACTIVITY

##### 4.2.1 Introduction

Abdellah and Levine (1954) listed 4 techniques which might be used to study nursing activity. These were:-

1. continuous observation by following an individual.
2. continuous observation by staying in one area and recording everything that happens within it.
3. diary keeping by the individuals under study.
4. intermittent, instantaneous observation.

##### 4.2.2 Continuous Observation

Both methods of continuous observation as described by Abdellah and Levine have serious disadvantages. With the first method, there is the problem of choosing the appropriate individual. The whole of that person's activity must be observed, consequently the researcher must subject himself to long periods of observation during which his degree of attentiveness may vary. The effect of close scrutiny over a long period of time

may also prove disruptive to the individual under study. His behaviour may become atypical under stress - he will be aware of the fact that he is being observed and may either attempt to behave in a desirable manner, or, may become anxious and make mistakes not normally made.

If the researcher stays in one area of the ward and focusses upon the activity there rather than on the individual, he may find that remarkably little seems to happen in the area he has chosen. Individual nurses may find avoiding the area preferable to being observed and absent themselves accordingly. Goddard (1953) was the first reported study in this area using this method. Twenty six wards were divided into observational areas and all nursing activity was recorded for 8 consecutive 24 hour periods. Goddard classified nursing activity into 5 categories as follows:-

1. basic nursing
2. technical nursing
3. administration and organisation
4. domestic
5. miscellaneous

This classification was modified slightly in a later study but the method of observation remained the same.

#### 4.2.3 Diary Keeping

This is probably the easiest method to administer but the accuracy of the results is questionable. Respondents are asked to keep a diary of their activities but the researcher has no check on what is omitted, exaggerated or forgotten unless some independent observation is undertaken. This method also has the disadvantage of requiring the respondents to complete what may be seen as an arduous and irksome task in addition to their daily routine. It is however, a useful method of gaining insight into a person's perception of his work, depending of course on the individual's facility with the written

word. Henderson (1977) used this method in her study of the work of health visitors in Hampshire.

#### 4.2.4 Intermittent, Instantaneous Observation

In work study terms this is known as "activity sampling". Whitmore (1970) describes it as "the application of sampling method based on statistical probability to activities of operatives, machines, or processes", the rationale being that any random sample from a larger group tends to have the same pattern of distribution as the larger group. In other words, by studying a random sample of nursing activity we will gain an accurate impression of the total nursing activity. This method has been reported many times in the nursing literature.

Norton, McLaren and Exton-Smith (1975) report a 24 hour observation of nursing routines in 3 wards. This was not intended to be an exhaustive activity sampling study but provided "an opportunity (for the research team) to become familiar with the setting in which they would be working, and to record general observations of the content of the routines". Only patient related activity was of interest here and Norton and her colleagues report that almost 70% was of a basic care nature.

Adams and McIlwraith (1963) also used an activity sampling method to study nurses' work on 6 geriatric wards in one hospital. Their classification system comprised 9 categories as follows:-

1. basic nursing
2. technical nursing
3. dietary
4. domestic
5. clerical
6. teaching
7. human relations
8. absence from ward unit
9. unproductive time

As had previous studies, Adams and McIlwraith reported basic nursing activities to be the most frequent.

Another study of nurses' work followed in 1967 by the Scottish Home and Health Department. They studied 46 wards, 5 of which were geriatric. Callaghan (1968) also studied nursing activity in 3 geriatric wards and both studies report similar results to the earlier studies with basic nursing care occupying the greater proportion of time observed.

A more recent study carried out in the early 1970s is reported by Wells (1980). Four geriatric wards provided the setting in which nurses' activity was sampled and systematically observed. The activity was classified using a modification of the South East Regional Hospital Board Nursing Activity List which consisted of 180 individual activities listed under 9 broad headings as follows:-

1. observation
2. direct care - basic
3. direct care - technical
4. direct care - secondary
5. indirect care
6. housekeeping
7. ward clerical duties
8. tuition
9. personal
10. miscellaneous

Perhaps the most startling finding to emerge from this study was that taking "personal time" was the single most frequently observed nurse activity.

#### 4.2.5 Summary

All the studies reported in this section modified the industry-based activity sampling method. When used in industry to study the efficiency of man-machine systems, there is often the existence of a continuous repetitive

action. Abdellah and Levine (1954) argue that random sampling is not necessary for the examination of nursing activities as these are in essence responses to unpredictable requests from patients. Unfortunately for this argument, subsequent research such as that by Baker (1978) has shown that much of nursing work is taken up with the performance of set routines and so cannot be considered random. A further modification concerns the industrial method of taking an instantaneous "picture" of what is happening every two or three minutes. This was considered to be inappropriate in a hospital ward. Wells (1980) notes that "getting a bedpan" is more meaningful than "walking across a ward".

There remains however, the question as to how useful such studies are in laying bare the attitudes of those whose activities are observed. Deutscher (1973) comments on such studies and makes this point succinctly in the context of attitude-behaviour discrepancy:-

"If we could not count on what people told us, then we had to be much more attentive to what they were doing. Perhaps what they did overtly was the only true evidence for social science (...) It is possible, for example, to determine precisely the relative amount of time spent by nurses in different activities. But it seemed to me not very helpful to know how much time nurses spent at the bedside or at the nursing station, if I didn't know why they were there and why they saw themselves doing whatever it was they were doing. There are very different purposes and consequences in changing sheets brusquely because it is time to change them and in changing sheets casually as a device to talk with the patient. Such "time and motion studies" did not seem to me helpful in understanding the relationship between what people say and what they do".

p.7

### 4.3 STUDYING CONVERSATIONS

#### 4.3.1 Introduction

It is generally agreed that, in the social sciences at least, a functional approach to language is likely to be of most relevance. This is not intended to relegate problems of structure to insignificance. What is

intended is a recognition that purely structural analyses will at best be only partially informative, telling us how language arises, but not what it is for in any social situation. Robinson (1972) writes:-

"The functional-causal dichotomy is one of those dilemmas on whose horns it is in fact unnecessary to impale oneself stemming as it does from what are currently labelled 'convergent' ways of thinking about a problem which has no unique solution".

p.39

Robinson goes on to explain that whilst functional explanation in the biological sciences is only one sort of explanation (which alone may be entirely tautological), asking functional questions such as why embryonic chicks have gills, may lead the researcher along fruitful avenues of thought. This argument becomes even more powerful in the social sciences when one is dealing with man-made systems such as language. The *raison-d'etre* of a particular system is precisely because a particular function is or was served by it. The interesting question for the researcher then becomes the discovery of function to which the structure is subservient.

However, the development of a list of functions served by the verbal interaction of two or more people is likely to be arbitrary unless the terms of reference of the interaction are specified. In the following studies, various terms of reference are specified according to the roles of the participants and their purpose in conversation. The studies are grouped as follows:-

1. analysis of small group conversations
2. doctor-patient consultations
3. therapeutic/non-therapeutic distinctions
4. classification based on activity
5. analysis of levels of responding
6. sentence structure
7. particular client situations

#### 4.3.2 Analysis of Small Group Conversations

Probably the best known and single most used system of analysis is the Interaction Process Analysis (IPA) devised by Bales (1950). Bales considered that all small group interaction could be specified as a problem solving activity describable in terms of 12 categories as follows:-

1. shows solidarity
2. shows tension release
3. agrees
4. gives suggestion
5. gives opinion
6. gives orientation
7. asks for orientation
8. asks for opinion
9. asks for suggestion
10. disagrees
11. shows tension
12. shows antagonism

Categories 1-3 describe social-emotional utterances of a positive affect, categories 4-9 are concerned with affectively neutral task areas, whilst 10-12 refer to utterances which are social-emotional but of negative affect. The IPA has been used in a wide variety of studies involving various group formations and settings (Conant 1965). There are, therefore, many findings regarding interaction patterns of small groups available for comparison with nurse-patient groups.

However, Waxler and Mishler (1966) have contended that comparability between studies is not entirely straightforward. They point out that studies using IPA often approach the scoring in different ways, such as by direct observation of interaction, tape-recording, or typescripts. They write:-

"Several investigators have felt it necessary to revise the category system to reach acceptable reliability levels, to take into account problems inherent in category definitions,



and to make coding easier for inexperienced observers. While each of these revisions has a degree of usefulness with regard to one or another specific problem, basic questions remain regarding the comparability and reliability of the data when the system is used in different ways".

p.29

Psathas (1961) compared scoring from direct observation with scoring from typescripts with notes and tape recording, and found that 23% of the acts were lost with scoring from direct observation. He also showed differential use of the Negative Affect categories, the direct observer using these less often.

Coding from tape-recording and/or typescript necessarily means that nonverbal cues are omitted which might have an effect on the distribution with the expressive categories. However, an advantage is that one is able to correct unitizing errors and prevent the loss of a large amount of data. Waxler and Mishler (1966) compared coding from tape and typescript with coding from typescript only and found, contrary to Psathas, a higher proportion of usage of the Negative Affect categories when tape and typescript was used. This was mainly in category 10(Disagrees), but despite such differences (21.3% of the interaction was classified differently), an overall comparison of the rank order of category use produced a high correlation (Spearman  $\rho = 0.957$ ;  $p < .001$ ). Obviously the method of scoring, no matter what category system is used, will affect reliability. Few studies report coding reliability levels; however if a category system is used, it is essential for interpretation to show how reliable one coder is over time, and in comparison with other coders. With Bales' IPA the matter is complicated by the fact that reported reliabilities using correlations between the sum of scores in one category by two coders can be affected by "unitizing" errors (i.e. the way in which an utterance is divided for categorisation purposes) as well as errors in placing items in various categories.

The possibility of comparability with other studies was a major factor in persuading Conant (1965) to use the IPA in her study of the development and nature of the role relationships of public health nurses and patients in home visits. Conant concluded that:-

"...although use of Bales IPA did provide a great deal of useful information about the interaction patterns of the public health nurses and patients (...) there are difficulties with the scoring of IPA and limitations in its usefulness for nursing research".

p.308

The first of Conant's criticisms concerns the supposedly exhaustive and mutually exclusive nature of the categories. Conant pointed out that an act may not be entirely task oriented or emotional in nature, but may contain elements of both and have more than one purpose and effect. Scorers must place each act into one category only and so the need to make a choice may lead to problems of reliability in scoring. Secondly, Conant emphasises the problem of scorers' unitisation of acts. Bales' unit of analysis is defined as follows:-

"...the small discriminable segment of verbal or nonverbal behaviour to which the observer, using the present set of categories after appropriate training, can assign a classification under conditions of continuous serial scoring. This unit may be called an act, or more properly, a single interaction, since all acts in the present scheme are regarded as interactions. The unit as defined here has also been called the single item of thought or the single item of behaviour".

p.37

The problem for the scorer, as Conant sees it, is that people do not talk in sentences or clauses and the definition of "items of thought" can be problematic. There also seems to be a paradox in Bales' reasoning here: the scorer is required to take the part of the

'other' to whom the speaker is addressing his remarks. Any definition of "items of thought" will then be "of the addressee" and not the speaker. This could lead to false-positive problems of communication being diagnosed or to genuine problems being overlooked. This could be verified by "checking" the categorisation with the participants afterwards but such a measure is not usually employed.

The third problem mentioned by Conant refers to changes in the pattern of an individual's scoring over time. The same interaction may be scored quite differently by the same person at various times. This can only be checked by subsequent rescoring, by the same scorer, of an interaction. A fourth criticism from Conant concerns the question of exclusion of content. Whilst Bales explicitly excludes content from the categorisation system in an interaction sequence, the initiation of specific topics may be crucial for the problem solving task of the group. Certain topics may be avoided between nurses and patients, and it then becomes important to know who raises them and in what context. A related criticism also mentioned by Conant is the loss of contextual information in Bales' system. Her illustration runs as follows:-

"...if a person responds to a question asking for information, the interaction may be categorised into a number of units of category 6 (giving orientation). However, one does not know whether the respondent is giving information which elaborates upon the response to the question, or is introducing a new topic after a brief response to the question".

p.308

Such information may be crucial in determining the manner of response of nurse to patient.

Borgatta (1962) revised the IPA in an attempt to "sharpen up some of the differences between a minimum response (or run of the situation response) and an

active response that transcends the minimum requirements set by the situation". Borgatta recognised that whilst Bales' system was exhaustive i.e. every utterance could be placed in a category, it was possible to divide some categories in order to take into account different classes of behaviour. For example "gives opinion" in the IPA may include both opinions relating to oneself and opinions which are acts of verbal aggression against an absent person. The question of the significance of cumulative responses also concerned Borgatta. For example, a person rated as high in "shows solidarity" may not be the person who is responsive at the strategic moment, but simply the person who scores most in this category. Each action according to Bales is weighed individually. Borgatta argues that it is inappropriate to assume that all actions are equally relevant in regard to consequences and therefore a distinction between an "active" and a passive response would help to identify the importance of the action. Borgatta states that his intention is not to alter the depth of interpretation of acts but merely to subdivide and reorganize the categories to take account of important distinctions. His 18 category system reads as follows:-

1. common social acknowledgment
2. shows solidarity through raising the status of others
3. shows tension release, laughs
4. acknowledges, understands, recognises
5. shows agreement, concurrence, compliance
6. gives a procedural suggestion
7. suggests solution
8. gives opinion, evaluation, analysis, expresses feeling or wish
9. self-analysis and self-questioning behaviour
10. reference to the external situation as redirected aggression
11. gives orientation, information, passes communication

12. draws attention, repeats, clarifies
13. asks for opinion, evaluation, analysis, expression of feeling
14. disagrees, maintains a contrary position
15. shows tension, asks for help by virtue of personal inadequacy
16. shows tension increase
17. shows antagonism, hostility, is demanding
18. ego defensiveness

#### 4.3.3 Doctor-Patient Consultations

Byrne and Long (1977) rejected Bales IPA because of its lack of sensitivity for the general practitioner consultation. Their particular criticism was that there was insufficient room within the IPA to distinguish between "open-ended" and "closed" questions, a distinction of importance to their research. An open-ended question facilitates the flow of information whilst a closed question may effectively "block" a response. The importance of distinguishing between such questions in nurse-patient conversations has been demonstrated by Macleod Clark (1981) of whose work we shall hear later. Byrne and Long developed a categorisation system ideally suited to the general practitioner consultation in which there are specifiable goals i.e. making a diagnosis and where the interaction has a distinct beginning and end. Their differentiation of patient-centred, doctor-centred and negative behaviour is important in determining styles of interaction and the categorisation system has been developed into an impressive teaching tool.

One basic distinction between the general practitioner consultation and nurse-patient interactions concerns the goals of the interaction. Byrne and Long state quite explicitly their assumption that "The doctor/patient consultation is a goal-seeking activity". Some nurse-patient conversations will undoubtedly have this characteristic but the nurse's goal in any particular conversation may not be immediately apparent and may be subsumed, for any one conversation, under a superordinate goal of "assisting the patient's recovery".

#### 4.3.4 Therapeutic/Non-therapeutic Distinctions

Some early attempts to categorise the functional aspects of nurse-patient verbal interaction made a very clear distinction between "therapeutic" and "non-therapeutic" behaviour (Hays and Larson 1963; Topf 1969; Hatton 1977) (see Appendix C). Such an approach is attractive in that it enables one to evaluate the effectiveness of nurses' verbal communication, but it either assumes implicitly that the participants subscribe to the particular model of nursing embodied in the categorisation scheme i.e. an interpersonal or semi-counselling approach, or, it makes no such assumption but proceeds to classify "as if" it were so, thereby measuring the interaction against a particular norm which may not be within the purview of the participants themselves. In practice these outcomes are indistinguishable in the research, most studies using judges who subscribe to a particular interpersonal approach and who, working independently, achieve a respectable degree of correspondence in their categorisations.

The problems with all such approaches, including that by Byrne and Long (1977), is that of deciding on the presence or absence of a particular characteristic. Byrne and Long discuss the difficulty that they experienced in categorising "miscellaneous professional noises" - could they be interpreted as encouraging the patients to continue talking or were they merely noises? One might also suggest that they were an expression of lack of interest - a sign that the doctor was not really listening, or, perhaps they were even a strategy for "buying time". Similarly, Hatton (1977) reports difficulty in knowing when a nurse was not responding on an occasion when it would have been appropriate to do so.

#### 4.3.5 Classification Based on Activity

Other early attempts to classify nurse-patient verbal interaction focussed on the conversation as it related

to nursing activity. Behymer (1953) classified the content of interactions as either "administrative" or "social". Administrative interactions were seen as neutral in affect whilst social interactions were regarded as friendly and positive. This crude distinction allowed no room for interactions which were negative in affect, but nevertheless Behymer's study formed the basis of many subsequent studies. Morimoto (1955) developed the two part classification system of Behymer and allowed "Procedural", "Personal" and "Mixed" categories. Altschul (1972) also employed 3 categories of content in her analysis of nurses' reporting of conversations with psychiatric patients. These were "Physical Care", "Social Conversation" and "Psychological".

Wells (1980) used Morimoto's classification in her study of nurse-patient conversation in geriatric wards. She concluded that this analysis, whilst helpful, did not aid in the understanding of the verbal exchanges. What seemed to be missing, according to Wells, were the perceptions of the participants. She writes:-

"It would seem that there is a major need to both document the exchange and discuss its content with the participants".

p.20

The point is well illustrated by the following conversation taken from Wells' study.

The nurse is helping an elderly, disoriented lady out of bed and on to a commode...

N: *Edith, you don't look very happy at all, do you?  
You hold my hand.  
Oh Edith, why are you crying?  
It's too early in the morning. I can't cope with  
you if you're crying now.*

P: *I can't. I don't know.*

N: Oh Edith, what am I going to do with you?  
 I'd better get you a paper tissue before it all  
 runs down your face.  
 It's a good way of cleaning your face in the  
 mornings isn't it?

P: I don't know.

N: It's the tears. I can see it all going down through  
 the cracks.  
 Give me a big smile, please. That's better. You've  
 got a tear on the end of your nose.

P: Have you got one (tissue)?

N: Yes, I've got tissues, or I used to have.

P: Thank you.

N: All right, just take one. That's it, now a big  
 blow. That's made you feel better. Please say  
 yes, otherwise I'll start crying. Go on say yes.

P: Yes. Thank you.

N: Good.

p.118

In order to understand this conversation, further  
 information is needed regarding the nurse's perception  
 of the patient's need. Wells writes:-

"Is this a conscious attempt to suggest  
 positive behaviour to a mentally impaired  
 patient and to reflect one's own feelings  
 in support? Or is it simply another directive  
 to the patient and an expression of depression  
 on the part of the nurse?"

p.118

#### 4.3.6 Analysis of Levels of Responding

Kerrigan (1957) used an observational method to discover  
 what nurses and patients talked about during the morning  
 nursing care assignment and classified nurses' responses  
 according to Bugental's (1953) scale of levels of  
 responding (see Appendix C). Levels of interaction  
 also feature in the categorisation schemes developed  
 by Methven and Schlotfeldt (1962) and Spring and Turk  
 (1962) (see Appendix C). The aim of Methven and  
 Schlotfeldt was to construct an instrument which "would



be generally useful in revealing types of verbal responses nurses tend to make in emotion-laden situations". Nurses' replies were categorised in terms of 5 mutually exclusive responses ranging from "denotes most skill in reducing patient stress and promoting patient welfare" to "denotes lack of skill and may even be traumatic". Spring and Turk, as well as rating level of response, include approach to patient, topic and focus of conversation, consistency and sentence structure.

One major disadvantage of the "levels of responding" approach is that the level has to be judged without the knowledge of the intention of the nurse and again this is problematic. The approach of Spring and Turk is fairly comprehensive, but assumes that a 'moderately directive' approach is more therapeutic than any other, and that discussion of historical, current or future events is less therapeutic than discussion of psychological feelings, attitudes and values. That this may be so is obviously true, but not that it must always be so, and here the rater must again make a pronouncement without knowing the intention of the nurse, or the appropriateness of the conversation to the situation. Their rating of sentence structure merits closer examination but was excluded from their final instrument because of its lack of association with the other categories of therapeutic behaviour. They suggest that it had some independent value in determining therapeutic efficacy but do not present any data relating to this.

#### 4.3.7 Sentence Structure

Whilst it can be seen that sentence structure need not necessarily relate to functional categories, it is possible that within categories, sentence structure may relate to therapeutic efficacy e.g. are there positive and negative ways of making statements, asking questions and giving directions? Sinclair and Coulthard (1975), in a consideration of teacher-pupil interaction, point out functional dissimilarities between forms of

statement, question and command, which may vary according to the setting, situation and persons present e.g. The door is still open.

The door!

Is that door still open?

Can you shut that door?

Shut that door.

Johnson (1964) developed a tool for categorising verbal utterances which is based on particular sentence forms and suggests that because of this it can be used in settings other than the one in which it was originally developed (see Appendix C). A more recent study by Macleod Clark (1981) identifies "encouraging" and "discouraging" sentence forms and techniques e.g. asking open questions as opposed to closed or leading questions (see Appendix C). This approach, whilst useful in identifying techniques nurses may use in conversations, does not explain why such strategies may be employed. An illustration of this point can be seen in the following conversation from Macleod Clark's study:-

*N: How are you feeling this morning? (open question)*

*P: Hungry.*

*N: Ah well, I'm afraid there's nothing we can do about that, just at the moment. (block)*

*P: But...*

*N: You can have any fluids you like - but just stick on the fluid diet at the moment.*

p.15

The "blocking" strategy is seen quite clearly in this extract, but as with the earlier example from Wells (1980), the nurse's level of awareness and purpose in the conversation are not clear. Macleod Clark's study does not present a categorisation system as such, she explicitly does not attempt to categorise every utterance, rather her aim is to identify nurses' responses to patients' cues.

#### 4.3.8 Particular Client Situations

Many researchers have developed categorisation systems for particular situations. Paton and Stirling (1974) employed a 5 category system for analysing nurse-patient conversations in a mental subnormality hospital. Their categories are as follows:-

1. nurse comment
2. nurse instruction
3. nurse question
4. nurse-initiated conversation
5. patient-initiated conversation

It is suggested however, that such global classifications mask any processes which may occur within conversations.

Moore and Grant (1976) working in the field of mental handicap, developed a 6 item Staff-Patient Interaction Schedule as follows:-

1. commands
2. instructs/teaches
3. converses
4. encourages
5. enquiries/transacts
6. discourages

This system was developed specifically for nurse-patient encounters where the nurse might be attempting to guide or control the patient's behaviour, and all conversations which do not include such attempts are categorised together as simply "converses".

Ashworth (1980) developed a system for categorising the conversation of nurses and patients in intensive care units. Her categories for nurses' utterances are as follows:-

- A. social superficial
- B. social concerned
- C. short-term informative
- D. questions

- E. longer-term informative
- F. command or request
- G. other
- H. reassuring noises

These categories are not, however, mutually exclusive - a point which Ashworth recognised - and so her priority system was aimed at identifying the maximum number of "socially concerned" or "longer-term informative" items.

Dowling (1977) adapted a categorisation system from the Huthwaite Research Group - the Developing Interactive Skills system - for use with family therapists and clients (see Appendix C). This system is designed to identify relevant behaviours in the client-therapist interaction but some of the categories could only be employed with confidence on checking with the participants e.g. "shutting out" - is the intention to shut out present, and does the action have the effect of shutting out? "Challenging" - is the intention to challenge present, and does the action have the desired effect? Supposing it is ignored or not even recognised?

#### 4.3.9 Summary

Thus far, various systems of categorisation of verbal interaction have been reviewed. Some focus on content, whilst others concentrate on form and/or function. The limitations of those which consider content only are recognised. Of those systems which deal with the form or function of conversations, the study of form alone is seen as fruitless - none of the studies deals with this in isolation e.g. Macleod Clark (1981) links form to encouraging or discouraging behaviours. Of the remaining studies which deal with the function/process of verbal communication, Borgatta (1962) seems the most elaborated and comprehensive and is preferred to inventories of desired/undesired behaviour which require the specification of what therapeutic behaviour

is or ought to be, and the consequent necessity to judge interactions "as if" the intentions of the speaker were explicit.

Diers and Leonard (1966) have criticised the application to nurse-patient interaction, of category systems not devised for that specific purpose, pointing out that such a procedure cannot necessarily be expected to produce interpretable results for nursing. They write:-

"The choice of any measuring device is dictated by the quality to be measured. The nurse-patient interaction, though it may resemble interactions in other settings, is a distinct kind of communication between people, guided by a theory unique for the purpose to be accomplished. Though interaction analysis systems developed in sociology or psychology may detect some of the important variations in the nurse-patient interaction, it seems likely that a category system designed specifically for use with this kind of conversation would produce findings more relevant to nursing theory and practice".

p.227

Whilst this point is to be appreciated, and one would not recommend the blind application of one category system to all social interactions regardless of their type, it is not apparent from the categorisation systems that have been developed with nurse-patient conversations that any unified theory has emerged. Rather the explanations offered are narrowly specific and the categorisation systems are often used in one study only. Furthermore, none of the methods of analysis reviewed have any explanatory power, i.e. they may be useful in telling us what function is served by a particular utterance, but offer no clues as to why that particular function has been singled out.

#### 4.4 CONCLUSIONS

Chapters 3 and 4 have examined two sides of a problem. On the one hand it can be argued that knowing a nurse's verbal or written response to an attitude questionnaire is entirely irrelevant unless something is also known about her behaviour. But on the other hand, in swinging the pendulum away from the questionnaire and back to behaviour, it could be argued that the same kind of mistakes have been made in studying simple behavioural items that were made in studying simple attitudinal items. In chapter 5 we shall see how the path has been cleared for a new approach.

### NEW METHODOLOGICAL DEVELOPMENTS

#### 5.1 INTRODUCTION

The literature reviewed thus far illustrates well the emphasis which has been placed on quantification in the examination of what people either say or do. The concept of "attitude", even if it was never intended to, has been used to predict behaviour (as we have seen, somewhat unsuccessfully), but it has not been able to answer the more interesting and vital question - why? Neither simple attitudinal measurements, nor simple behavioural measurements can offer an explanation.

Traditional attitude research, whilst perhaps not declining significantly in the number of studies carried out, has reached a theoretical impasse. Its usefulness is now seen to be limited. But it has not reached this state in isolation from other trends in the social sciences. Its context is to be found in a growing movement which has resulted in many criticisms of the state of social psychology in recent years (Harré and Secord 1972; Armistead 1974; Shotter 1975). This movement within psychology also has close parallels with similar movements in sociology and allied disciplines. To understand the nature of the movement we need to consider the philosophical tradition within which psychological inquiry has been carried out - namely positivism.

In this chapter we will reflect on the implications for psychological inquiry of a positivist position, consider some of the alternatives now being used in the social sciences, and finally consider in the light of the foregoing discussion, how to proceed with the applied research in question, namely nurses and old people.

## 5.2 THE POSITIVIST TRADITION

The term 'positivism' was first coined by the French philosopher Auguste Comte who, on seeing the social chaos which succeeded the French Revolution, suggested that order might be restored by the application of methods similar to those used in the natural sciences. Although Comte had nothing specifically to say about psychology as such, his thought had a profound influence on all the human sciences. In the latter half of the nineteenth century, Darwin's "Origin of Species" located psychological theory in the realm of the biological sciences and the opening of Wundt's psychological laboratory confirmed its method in the experimental tradition.

Positivism reached its peak between 1930 and 1960 under the influence of the logical positivist philosophers of the Vienna Circle. Theirs was a firm commitment to science as providing the only vehicle of human progress, and according to the tradition, what distinguished scientific knowledge from the rest was the logical method by which it was obtained. Mennel (1974) describes the process as follows:-

"Science began with the systematic observation and accumulation of factual evidence. From many particular observations, a hypothetical generalization - a general explanation for what was observed - was derived by a process of induction. The hypothesis would then be tested by further observation including, preferably, controlled experiments".

p.147

It is worth noting at this point, that, as Heather (1976) indicates, what the Vienna Circle set out to do was to dictate how science should be done, not describe how it is done.



### 5.3 IMPLICATIONS OF A POSITIVIST STANCE

The concomitants of the positivist tradition are a mechanistic model of man which explains behaviour in terms either of immediate external stimuli as in the S-R model, or latent stimuli as in the S-O-R model; and a Humean conception of cause which results in a naive determinism (Harré and Secord 1972). Bartlett (1932) noted that the pioneers of experimental psychology were trained in either physics or physiology and consequently they attempted to control their subjects' responses by known variations of stimuli - this led them to explain the former in terms of the latter. It is however, questionable whether one is justified in making a cause and effect assumption purely on the basis of behavioural observation. The most that can be said is that the observed behaviour is compatible with the explanation offered. Joynson (1970) comments that Bartlett was himself unable to offer a solution in his own experimental work. Koch (1969) commenting on the proliferation of what he calls "pseudo-knowledge" has this to say:-

"In their haste to reduce human behaviour to the same microscopic proportion by which other sciences analyze the substances of their domains, psychologists could not afford the luxury of an indefinite period of just watching people do what they do. The result is that we have given selective inattention to the most important, but pithy facet of human psychological experimentation, the ecological validity of our laboratory observations".

p.67

Psychologists have been unwilling to recognise that the scientific model which they emulate, involves at the theoretical level at least, creative, subjective processes which investigators of human behaviour cannot afford to ignore. Complete and total objectivity can be seen to be an illusion. Polanyi (1958) suggests that "...as human beings, we must

inevitably see the universe from a centre lying within ourselves. Any attempt rigorously to eliminate our human perspective from our picture of the world must lead to absurdity". It is entirely erroneous to believe that by accumulating laws describing correlational regularities of observable behaviour, the content of a human science will be exhausted. There will remain an untapped dimension of human experience which gives meaning to the observed regularities.

Neither can a personal bias be excluded from a series of readings recorded by the most sophisticated of equipment. Polanyi and Prosch (1975) point out that even the most exact of sciences rely on a personal confidence in the possession of skill and judgement in establishing a valid correspondence with, or deviation from, experience. They conclude:-

"...no science can predict observed facts except by relying with confidence upon an art: the art of establishing by the trained delicacy of eye, ear, and touch a correspondence between the explicit predictions of science and the actual experience of our senses to which these predictions shall apply".

p.31

Polanyi and Prosch argue that a mechanistic reductionist approach to science cannot logically succeed and the pursuit of such an approach stultifies and severely limits the usefulness of "facts" obtained. The inescapably qualitative context in which quantitative measurements are taken is illustrated well by Campbell (1978) who writes:-

"The qualitative underpinnings of quantitative data can be discovered by tracing back to its sources any punch on an IBM card or any numerical value on a computer print-out. Behind the test scores in a Head Start Program lie the verbal and demonstrational instructions to the test administrator, the verbal and demonstrational explanations

given by the test administrator to the children, the children's qualitative comprehension of the questions, etc.... Recording of responses and the coding of free response answers achieve qualification only as the end product of a qualitative judgemental process. Most of this underpinning of common-sense knowing is so ubiquitous and so dependable that we fail to notice it".

p.192

Whilst the present author would not wish to "outlaw" the use of any quantitative measurement techniques, the fallacy of their total "objectivity" is recognised. In the words of Shotter (1978) what is wrong with our classical methodology is that "while claiming to replace our everyday ways of doing things with a 'scientific' method it still relies heavily upon them".

#### 5.4 ALTERNATIVES TO POSITIVISM

Recent critics of social psychology have argued that subjective meanings cannot be divorced from behaviour if not only prediction but also explanation of such behaviour is required (Harré and Secord 1972). It is impossible to explain a gesture such as a raised hand without considering the meaning of the "doer". An 'objective' conclusion might be that the hand is raised by extension of the arm in an upward direction. Harré and Secord write:-

"...what we see in social reality, is not, for example, an arm moving upwards, but a man trying to attract attention, a man greeting a friend and so on. When we see an action of a certain sort we thus connect what we see with a conceptual context utterly different from that involved in seeing movements, and this context determines the form of explanation that is appropriate".

p.38

In order to take account of the foregoing criticisms, it is necessary to reinstate man, not as an organism

like any other, existing without personal regard for its environment, but as a being whose personal existence can only come about as a result of interaction with other persons.

Man can now be seen not as an isolated subject set over against an objective world, or as a mechanism operating according to certain laws, but as an entity "immersed in the world as an agent, who has the power to act on the world and to change it to accord more with his own needs and interests" (Shotter 1975). This kind of image of man does not regard him in isolation but as a social being, one who derives his identity and gives meaning to his actions from his interaction with others.

#### 5.4.1 The Hermeneutical Approach

One of the "trends" mentioned at the beginning of this chapter, has been expounded by Gauld and Shotter (1977). This "hermeneutical" approach has behind it a long tradition of continental philosophy ranging from Dilthey and Husserl in the last century, to Heidegger, Gadamer and Ricoeur in the present day. Hermeneutics is the study of understanding and although the word is most often applied to the interpretation of literary texts, the problem of interpretation itself is basic to human existence. An example from Palmer (1969) reads as follows:-

"...from the time you wake in the morning until you sink into sleep, you are interpreting. On waking you glance at the bedside clock and interpret its meaning; you recall what day it is and in grasping the meaning of the day you are already primordially recalling to yourself the way you are placed in the world and your plans for the future; you rise and must interpret the words and gestures of those you meet on the daily round...existing itself may be said to be a constant process of interpretation".

Thus hermeneutical psychology will seek to understand why a person does what he does by trying to grasp the intention, desires, beliefs etc. from which that person acts. It will differ from the physical sciences in that it will not be supported by statistical generalisations and will bear a stronger resemblance to introspectionist methods. Conceptual analysis will play a larger role, in particular the analysis of framework concepts viz. the person's intentions, hopes, fears, desires which give meaning to the actions performed. Gauld and Shotter (1977) conclude that all mechanistic explanation must ultimately be reducible to a hermeneutical explanation. They write:-

"...the only hope for mechanistic explanation is for its proponents to give us mechanistic 'translations' of the key concepts of hermeneutical psychology; for them to show, in other words, that it is in principle possible for us to design mechanistic systems whose states and operations could properly be described in such terms as 'intending', 'acting', 'believing', 'following rules', etc."

p.76

#### 5.4.2 The Ethogenic Approach

The main thrust of the approach of Gauld and Shotter has been in the study of infant development. Complementary to their approach have been the writings of Harré and Secord (1972) who proposed an "ethogenic" approach which has at its centre an anthropomorphic model of man, which has arisen and been developed in ordinary language.

According to this model, what differentiates men from all other organisms is that they can reflect upon what they are doing, that they are capable of "monitoring their own self-monitoring". The most characteristic form of human behaviour then can be seen as the conscious following of rules and deliberation in carrying out plans.

The identification of meaning is seen to be at the heart of the explanation of behaviour. This approach Harré and Secord (1972) refer to as "ethogeny". The ethogenic approach utilises an anthropomorphic model of man through which social scientists are recommended to "treat people for scientific purposes as if they were human beings". Human beings have the power of speech and the capacity for self-awareness. They can therefore, not only monitor their own performance, but can also monitor the monitoring of their performance. This they accomplish by following rules, plans and conventions according to their notions of what constitutes an appropriate performance and in the mode of a social self which is deemed appropriate to the occasion. This approach is sympathetic to Goffman's earlier work (1959) on the dramaturgical perspective of human action and the ritualised nature of much of human interaction.

#### 5.4.3 The Analysis of Situations

Another approach which stems from a reaction against a behaviouristic social psychology and from research in an applied field, has been proposed by Argyle (1978, 1979) relating to the study of situations. Argyle and his colleagues noticed that mental patients who had difficulty in behaving appropriately in certain situations would often benefit from a clarification of the "rules" of particular situations as well as by learning the social skills involved. Argyle is in basic agreement with the ethogenic approach, particularly in its emphasis on the roles and rules which sanction and regularise behaviour in social situations, but Argyle has also been interested in other aspects of the situation such as goal structure, sequences of behaviour and levels of skills. A recognition of the importance of situational analysis has also come from Bromley (1977) who, whilst considering the process of personal perception writes:-

"Human action takes place within a set of overlapping and interlocking situations

and a proper account of the stimulus person's behaviour requires some understanding of the "total situation" in which behaviour is embedded".

p.257

Thus it is emphasised that a proper understanding of human behaviour will be gained only when attention is paid to the social context in which the behaviour occurs.\*

#### 5.5 IMPORTANCE OF THE POWER OF SPEECH

Central to this broad new approach to social psychology is the taking seriously of ordinary language, the speech of everyday life. Because human beings have the power of speech, ordinary language is deemed to be the most appropriate instrument for the examination of behaviour and the most important resource for the explanation of behaviour. Harré (1980) maintains that it is "rich in distinctions of the highest precision and abounds in implicit theories of great sophistication". Torode (1976) for example, shows the way in which persons of authority mediate their social status in the words they speak. A nurse may breeze up to a dejected patient and ask "And how are we today?", thereby inferring a great deal about comparative status of nurse and patient. She may use her status most effectively in manipulating a patient's behaviour as when she says "Take this tablet - we do want to get better don't we?"

Speech is also the means of making actions intelligible and warrantable to others. This is achieved by the process of accounting which Harré (1980) defines as "...speech which precedes, accompanies, and follows action which is produced to ensure the twin goals of intelligibility and warrantability, that is, meaningfulness and propriety". Accounts may include implicit

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\*NB A detailed account of this approach is given in Argyle, Furrhham and Graham (1981) which postdates this review.

or explicit statements of rules, explanations of meanings and intentions offered by the actor in support of his action. Harré (1980) writes:-

"Accounts are generated by ordinary people in the ordinary course of social action (and this is encouraged by ethogenically orientated social psychologists) primarily to make actions intelligible and warrantable by interpreting them as proper parts of the structure of interaction sequences".

p.299

Thus ordinary language can be used to uncover the generative mechanisms which underpin a particular action sequence. A person's account of his behaviour is to be taken seriously as an articulation of his implicit knowledge of his social world. He may use speech in order to present himself in a particular way or in order to manage a particular situation. He may also use speech to justify and explain his actions to others. Outhwaite (1975) emphasises the importance of everyday language in any scientific endeavour particularly in the social sciences where it becomes the 'scientific' language par excellence. He writes:-

"Few people would deny, though some would consider it uninteresting, that the starting point of social inquiry is some sort of inter-subjective understanding. This is not merely to affirm that ordinary language is the ultimate meta-language of any science... it is rather that we begin in the Lebenswelt, talking 'everyday language' and using 'everyday accounting procedures'. This initial situation...has a different significance for the social than for the natural sciences; the former take their concepts from everyday life from the language which is common to them and their objects of investigation, and their explanatory principles remain extremely close to those of everyday life. Where social scientists have strayed too far from 'common sense' constructs, the result has been not greater sophistication, but trivialisation."

p. 111



Thus the new approach to social psychology aims to capitalize on a person's ability to use language in this way and views it as an important research tool.

## 5.6 SUMMARY

We can now begin to understand why attitude research, like much of social psychology, has reached an impasse. The methodology employed has assumed that what people say or what people do can be studied in isolation from a social context and without being firmly grounded in the concepts of meaning employed by the participants. It has denied man the possibility of "human" action as defined by Harré and Secord (1972) and has focussed on artificial responses. It is argued that the interpretation of action must take place within a specific context. This context must be defined as such by the actor accounting for his actions. For example grasping the hand of another may have several different meanings depending on whether one is engaged in a karate encounter, a cocktail party, or a wedding ceremony. The definition of the situation, and the intentions, desires and meanings employed by the participants are crucial.

## 5.7 ATTITUDE IN ETHOGENICS

Harré and Secord (1972) argue that, with the exception of Fishbein, there has in recent years been an apparent lack of awareness of the conceptual complexity of attitude. They suggest that the early theoretical treatments by Sherif and Cantril (1945), Krech and Crutchfield (1962) and Katz and Stotland (1959) have been ignored by most researchers who have allowed the attitude scale or questionnaire to 'represent' the concept. The methods adopted, which were discussed in the previous chapters, overlook the distinction which is to be made between the expression of attitude in evaluation and in action. Harré and Secord (1972) distinguish between "avowed attitudes" and "attitudes" - the difference between attitudes which are avowed in a quiet discussion and those which are acted out in

a social situation. There is also a difference between attitudes which are shown in "hot" situations, where the expression of attitude inevitably commits the person to some future action, and attitudes shown in "cool" situations where commitment may be, at most, theoretical.

Perhaps an example of the first distinction would be the attitude of the nurse who, in conversation with her colleagues over coffee, expresses her irritation at Mrs. Brown who asked for a bedpan just as she was about to leave the ward for her coffee break, thereby making her late for meeting her colleagues; and the attitude of the nurse who, when asked for a bed pan in similar circumstances told Mrs. Brown not to be a nuisance and to wait until she (the nurse) returned from her coffee break. The second distinction might be illustrated by two nurses, one working in a geriatric unit, the other in a gynaecology ward - both express a liberal attitude toward abortion. The consequences are incomparable in that for the former, her attitude is merely theoretical, whereas for the latter, her attitude will demand appropriate expression.

The studies reviewed in chapters 1 and 2 were concerned primarily with avowed attitudes, there being no demand for immediate action in accordance with the attitude expressed. As to evaluation, it has not been clear from the scales or questionnaires employed, what qualities were being perceived and evaluated. In most cases, the attitude object "most old people" was attributed certain properties by the researcher via the scale, but there was no facility for the respondent to indicate those particular qualities of an old person perceived by him and which resulted in his evaluation. The attitude scale or questionnaire has biassed respondents' evaluations of old people in terms of stereotyped behaviour and on the occasions when the stereotype has been rejected, has not gathered the more interesting data relating to respondents' alternative perceptions.

Evaluation may, as Harré and Secord point out, depend on the different perspectives which the respondent may bring to the task. Their example is of a housewife describing and evaluating an apple as "extra fancy" thereby placing it high on an ordered scale, but in terms of commendation, preferring not to buy it because its cost outweighs its enjoyment. Another example might be that of a nurse evaluating geriatric nursing as a "worthwhile" and "satisfying" career, but choosing not to follow it because the work was too hard in a physical sense. Fishbein (1967) also recognised that high ranking and preference were not always positively correlated. The problem has been, and still remains in the use of attitude scales, that of disentangling the ranking/preference structure which is not apparent in a person's response to an attitude item. Not apparent, that is, unless the respondent objects to the way in which the question is structured and protests "Well it all depends...". The traditional approach cannot encompass such troublesome respondents but must assume that a person has one and only attitude to a particular object which is present in genuine form in his questionnaire response and which remains invariant across situations.

It is argued by Harré and Secord that "...the empirical exploration of attitudes must begin with a situation in which each of the participants acts out or avows an attitude in a genuine context of commitment". They suggest that the investigator should play an active part in identifying or engineering a situation which would result in the expression of an attitude and then proceed to create a "justificatory context" in which the person's attitude is challenged; the response to the challenge is an 'account' which provides the data for analysis.

## 5.8 SPECIFICATION OF AREA OF RESEARCH

In order to proceed any further, a clarification and specification of the particular area of interest is necessary. Nurses and old people are the foci of the

study but the particular nurses and the specific aspect of their dealings with particular old people must now be settled upon.

#### 5.8.1 Nurses

Many of the studies reviewed in Chapter 2 (Gunter 1971; Kayser and Minnigerode 1975) indicated the preferences of nurses toward different age groups of patients but did not show how this was related to nursing care i.e. how does a nurse who prefers to work with young people, behave toward an old person? Does the fact of preference for working with younger patients mean that a nurse's dealings with older patients are qualitatively less than satisfactory? Student and pupil nurses in England and Wales at present undergo compulsory training in geriatric nursing and are not (during their training) able to exercise their preferences. Because recruitment of trained nursing staff to geriatrics has been identified as a problem the development of student nurses' attitudes toward old people during training is seen to be crucial.

There are therefore, two aspects of the nurses on which to focus - firstly there is her behaviour with a particular patient, and secondly, there is the change or development in her attitude, however defined, toward old people over the period of her training. It was decided therefore, to concentrate the study on student nurses in training for the general part of the General Nursing Council's register.

#### 5.8.2 Old People

Old people are to be encountered by the student nurse in several places. They are to be found in general wards as well as in geriatric wards (Owen 1976). They may be referred to as 'general' or 'geriatric' patients respectively, or, as 'geriatric' patients in general wards. For these reasons, it was decided to focus the investigation on student nurses in two areas, a medical

unit and a geriatric unit.

### 5.8.3 Aspect of Nurse-Patient Interaction

In trying to apply the schema of Harré and Secord (1972) for the empirical investigation of attitudes, it is necessary to identify an occasion on which attitude is expressed. When working in an applied field such as nursing, outside interference is both unwelcome and reactive. The behaviour on which to focus for the expression of attitude must therefore be naturally occurring and of sufficient frequency to permit repeated investigation. One particular behaviour which is perhaps basic to all others in nursing is that of verbal communication. Patients are assessed, care is given and evaluated and the vehicle for much of this activity is 'talk'. Talking to patients is rated highly as a means of social rehabilitation (Altschul 1972) and has been identified as a problem area (Wells 1980). It is what many nurses say they would do if they had more time, but when it has been examined more closely, it has revealed areas of great deficit (Altschul 1972; Ashworth 1980; Macleod Clark 1981). It was therefore decided to focus on student nurses' conversations with patients.

### 5.9 INTENSIVE vs EXTENSIVE APPROACH

Whilst it can be seen that the examination of accounts produced in a justificatory context would facilitate an in-depth investigation of a particular interaction between a small number of nurses and their patients, it does not seem to lend itself quite so readily to the detection of changes in a nurse's perception of old people over time, which may be the result of either a maturational or educational process. Many of the studies reviewed in Chapter 2 were concerned with the effects of an educational programme and the sociological literature (Davis 1968) has drawn our attention to the role of professional socialisation in the changing perceptions of students in medicine and nursing. For this aspect of the study it is necessary to include

more student nurses at various points of the training programme. However, this is not intended as a move away from an intensive design as from the studies reviewed in Chapter 2, large scale extensive designs have told us little about what happens between the nurse and the patient. Rather it is seen as establishing the perceptual framework within which the nurse-patient interaction takes place.

It was decided to use repertory grids for this part of the study as from the methods reviewed in Chapter 3, they offer the greatest opportunity for the individual to use his own language in articulating the concepts he personally uses for evaluation purposes.

We now turn to a more detailed examination of the two chosen methods.

#### 5.10 ACCOUNTS

The collection and examination of accounts as part of an empirical investigation has perhaps a longer tradition in sociological research than it has in psychology where it is a relatively new methodology. Scott and Lyman (1968) define an account as "a linguistic device employed whenever an action is subjected to valuative inquiry". They suggest that accounts are essentially excuses or justifications which are used to explain behaviour. This is in keeping with the later exposition by Harré and Secord (1972) who suggest that accounts can be used to uncover the meaning of behaviour which would otherwise remain hidden to the observer.

##### 5.10.1 Justificatory Context

Harré and Secord (1972) maintain that the investigator must take an active role in order to create a justificatory context for the participant's account. The main problem here lies in the need to interrupt a naturally occurring activity - a conversation between nurse and patient - which is presumably in the long term interest of the

patient. A reactive interruption to the nurse's activity would be at best undesirable, and at worst potentially damaging to the credibility of the researcher and the study. A method was needed which would permit the reconstruction of the original conversation and the creation of a justificatory context. Written recordings would clearly not be sufficiently detailed or accurate for such a reconstruction. Video-recording was rejected because of its limitations in mobility and for its potentially reactive effect. Audio-recording was deemed to be more appropriate and had been used successfully by other researchers for similar purposes (Faulkner 1980, Macleod Clark 1981). The use of a radio-microphone would facilitate the recording of the nurse's conversations with patients without the obtrusive presence of the researcher. The recorded conversation could then be replayed to the nurse when she was not engaged in patient care and the researcher could proceed with the challenge. The nurse's justificatory account in response to the challenge would be audio-recorded and transcribed for analysis.

Harré and Secord (1972) outline what an exploratory procedure might look like as follows:-

"...a participant is manoeuvred into avowing an attitude to abortion...A justificatory context is produced by a challenge from the investigator. Suppose a justification is forthcoming. It might consist of three propositions, that abortion is murder, that it encourages sexual promiscuity, and that it's disgusting anyway. Applying the partition between simple expression of emotion and evaluative attitudes to these alleged qualities of abortion the first two seem to be logically complex evaluations and the third, being a simple expression of attitude related feeling, can be separated, and is not capable of further analysis or exploration at this level... Challenge on the remaining logically complex evaluations will now yield the second stage. This might consist of the propositions that murder is illegal, and that sexual promiscuity is wrong. Only the second of these propositions is, for this person, the avowal of an evaluative attitude while the first is incapable of further justification....The next step would be to try to uncover what features of sexual promiscuity

were the basis of the evaluation,  
and to what rank and preference scales they  
were being related".

p.311

It is recognised that in a naturally occurring conversation there would not always be an overt expression of attitude. However, conversations do not take place in a vacuum and it could be expected that in subsequent accounting for the conversation, nurses would reveal that explanatory framework which underpinned their conversation with a patient.

#### 5.10.2 Account Methodology

In a paper which examines the scientific credibility of accounts Brown and Sime (1977) argue that control is necessary over 3 areas of the procedure. Firstly, the credibility of the informant - in the present study the nurse is accorded the credit to comment on her own experience. This is in line with Harré and Secord (1972) who suggest that "reports that people give of their actions and those of others should be taken seriously". However, accounts are not accepted in an unquestioning manner. The social reality of that to which they refer is never doubted but the researcher may on occasion challenge the account if an alternative explanation seems equally plausible. Secondly, the content of the account - Brown and Sime suggest the traditional concepts of validity and reliability are inappropriate for use with accounts. Nevertheless, the "authenticity" of an account can be achieved by negotiation. Ideally, several accounts of the same episode can be compared, but in the present study only one account will be collected relating to each conversation because of ethical considerations and time constraints. However, the researcher can herself, with the participant, provide an objective/subjective dimension by listening to the conversation as it occurs and noting its antecedents, which will have a bearing on the authenticity of the account. Ideally, the



negotiation of authenticity would involve the nurse, the researcher and the patient concerned, but in this case it was felt to be both impractical and unethical to subject ill persons to such a procedure.

Thirdly, the eliciting of accounts - Brown and Sime suggest that "the psychological investigator's role should facilitate rather than direct such that a person may give his account in his own way within the context of negotiation". In the present study, each account elicitation will differ according to the nature of the conversation. Nevertheless it can focus on areas common to all conversations e.g. the patient concerned, the activity being performed, the intentions of the nurse and her feelings. The style of questioning however, should be open and non-directive so as not to bias the account given.

Finally, Brown and Sime (1977) stress the need for the researcher to make explicit the manner in which accounts are treated if the final account of the accounts is to meet the criteria of attestability and authenticity. In the present research accounts will be transcribed verbatim alongside the conversations to which they refer. Although this is a lengthy process, it was felt that full transcriptions would be necessary for subsequent analysis.

### 5.10.3 Account Analysis

Account analysis may be qualitative or quantitative depending on the purpose of the research. Lofland (1978) presents a series of studies which focus on the strategies by means of which people manage the situations of their everyday lives. The analyses are undertaken by means of a "grounded" approach which develops and constructs a theoretical model from the data obtained by participant observation and open ended interviews. Brown and Sime (1977) on the other hand, adopt a more inductive approach, whilst Brown and Canter (1980) utilise facet analysis - derived from the work of Louis Guttman. The approach to analysis of accounts in the



present study is essentially qualitative. Accounts will be examined for ways in which nurses characterise patients and for those concepts which mark off particular situations as being distinct from others. Also to be isolated are those rules employed by nurses in particular instances. Marsh, Rosser and Harré (1978) note that individual actors do not generally rely solely on their own judgment as to their performance, but will appeal to the standards of others. The expressive aspects of the nurse-patient encounter will also be sought in the analysis of accounts. These will be seen most clearly in the adverbs used to describe action and when applied to the nurse's own behaviour may give an indication of what is considered "appropriate" behaviour in the particular situation. Whatever concepts are subsequently employed in qualitative analysis, it must be stressed that they should stand in a 'faithful' relationship to the original accounts. As Kaplan (1964) commented, the significance of a concept lies in that "the classification it institutes is one into which things fall, as it were, of themselves".

#### 5.11 REPERTORY GRIDS

Given the dissatisfactions expressed in Chapter 3 with traditional psychological methods, the personal construct theory of George Kelly seemed to provide a compatible theoretical framework within which to investigate the development and/or change in nurses' avowed attitudes, and a methodology which would allow the respondents considerable freedom of expression using their own language.

##### 5.11.1 Theoretical Framework

Kelly (1955) drew an analogy between man and the scientist. He saw the concerns of scientific inquiry, prediction and control, as being common to all persons in everyday life. According to Kelly, man does not respond passively to forces beyond his control, but

struggles to master the universe through a process of prediction, observation and hypothesis testing. Kelly articulated and elaborated his theory via a fundamental postulate -

"a person's processes are psychologically channelized by the ways in which he anticipates events".

- and 11 elaborative corollaries (see Appendix D). Whilst the fundamental postulate is the essence of personal construct theory, Kelly was at pains to point out that it is an assumption rather than a statement of truth. Man is seen as striving to make sense of the world and his success is reflected in the extent to which he can anticipate events.

Personal construct theory is comprehensive and has in recent years generated considerable interest. For example it has been used to examine student nurses' perceptions of significant others (Davis 1975, 1977); changes in social workers' construing as a result of training (Lifshitz 1974); the evaluation of map formats (Stringer 1974) and the construing by sufferers of anorexia nervosa (Button 1980) among many others. Although it has been applied to a wide range of fields of interest, it has not been without its critics. Collett (1979) suggests that given the climate in which Kelly wrote, it was understandable that he should choose to emphasize the anticipatory nature of constructions. But, maintains Collett, men's constructions involve a great deal more than private projections; they are concerned with past and present and in making sense of what happens they have to deal with events as they happen. Moreover, prediction, or anticipation, depends upon understanding. Collett writes:-

"Not only did Kelly neglect to articulate the relations between men's conceptions of the past, present and future, but he also failed to identify the regulative features of their thinking and action".

Personal construct theory addresses itself to a person's perceptions of the properties of objects and persons but it does not describe what that person feels to be required of him in his dealings with others. For example, a nurse may construe superficial similarities between many of her patients, thus leading one to conclude that she has stereotyped perceptions of those in her charge. However, further examination would be necessary to discover what kind of behaviour she felt was appropriate in dealing with people in possession of such characteristics. Personal construct theory does not address a person's subjective knowledge of the social rules which govern his everyday transactions.

Nevertheless, whilst recognizing the limitations of personal construct theory, it is felt that for the purposes of the present study it offers a methodology which dovetails fairly well with Harré's ethogenic approach in that it will permit an examination of nurses' constructions or avowed attitudes over a period of time. Whilst the collection of justificatory accounts will facilitate an "on the spot" examination of attitudes.

#### 5.11.2 Repertory Grid Technique

This technique was devised by Kelly in order to explore a person's personal construct system. It has been chosen for the present study because of its possibility of allowing a pattern of responses given to be seen as a definition of a process independent of the form of words used by the researcher. Fransella and Bannister (1977) who have applied and developed the technique, comment:-

"It is an attempt to stand in others' shoes, to see their world as they see it, to understand their situation, their concerns".

p.5

They suggest that it might best be considered as a particular form of structured interview. They write:-

"Our usual way of exploring another person's construct system is by conversation. In talking to each other we come to understand the way the other person views his world, what goes with what for him, what implies what, what is important and unimportant and in what terms they seek to assess people and places and situations. The grid formalises this process and assigns mathematical values to the relationships between a person's constructs. It enables us to focus on particular subsystems of construing and to note what is individual and suprising, about the structure and content of a person's outlook on the world. Yet the information it gives us is not novel or some peculiar product of our "scientific method". It is a formalised version of the kind of information we are always seeking about each other, the kind of understanding we are always in process of gaining about each other".

p.4

Several forms of repertory grid have been developed but in essence they each have the following characteristics (Bannister and Fransella 1971):-

1. They are concerned with eliciting the relationships between sets of personal constructs either in terms of construing elements or comparing constructs.
2. They are concerned with revealing the construct patterning of an individual and not to relate this patterning to some normative data. Normative data may sometimes be sought as in the Grid Test of Thought Disorder (Bannister and Fransella 1966) but the individual has been the prime focus of grid technique.
3. There is no fixed form or content. The repertory grid is a technique to be adapted to individual requirements, not a test to be followed slavishly.
4. All forms of grid are designed so that statistical tests can be applied to the measurements obtained.

In its original form as devised by Kelly, the technique was called the Role Construct Repertory

Test. The subject was asked to name a number of known persons who fitted certain role titles e.g. mother, teacher you disliked - these were the ELEMENTS. CONSTRUCTS were then elicited by considering 3 elements and asking what way were two alike but different from the third. Elements were written along the top of the grid, constructs down the side. Completing such a grid could take one of several forms:-

1. dichotomous marking

Elements are scored in terms of presence or absence of certain characteristics. This often produces a lop sided grid resulting in spurious associations between constructs. A split-half method (Bannister 1959) may be employed where elements are divided equally between poles of constructs, but this in turn puts a certain degree of constraint on the respondent.

2. rank ordering

Elements are rank ordered in terms of constructs. The main disadvantage of this method is that one cannot assume equal intervals between rankings.

3. rating

Elements are rated according to a predetermined scale in terms of each construct. The advantage of this method is that two or more elements may be given equal rating, thus allowing a greater freedom to the respondent.

5.11.2.1 choice of elements

There are two factors which govern the choice of elements in a grid:-

1. The elements must be within the range of convenience of the constructs to be used. This can be verified by asking a subject to indicate the inapplicability of a construct to an element.

2. The elements must be representative of the pool from which they are drawn in order for the subject to indicate the extent of his construing.

#### 5.11.2.2 elicitation of constructs

Constructs may be supplied by the investigator or elicited from the respondent. Kelly (1955) originally described 6 ways in which constructs can be elicited - the most widespread being the method of triadic comparison described on p.116. There are however, a variety of methods in use today and the triad has been shown to be by no means essential or sacrosanct. Fransella and Bannister (1977) suggest that when thinking about eliciting constructs, we should never forget that "all of us do it all the time, whether in the more structured interview situation or in plain everyday conversation and discussion". The emphasis therefore, is on adaptation of method to the demands of the situation.

#### 5.11.3 Analysis of Repertory Grids

"Although it can be constructed and recorded in one clinical session, or two at most, a single grid may contain as much data as a postgraduate student might not long ago, have collected in the course of a research project for a doctorate. The complexity of the relationships it reveals may well be greater".

Slater (1977) p.53

The analysis of repertory grids has, in recent years, come to be synonymous with computer analysis. Many programmes have been written and Patrick Slater's Grid Analysis Package is now widely used. Although for any one grid, only a small number of measures may be required by the researcher or clinician, there are advantages in having at one's disposal, a complete analysis as it would be a mistake to assume that certain parts of a grid are without psychological interest or significance.

In the present study, analysis will concentrate on a few issues thought to be of particular relevance.

#### 5.11.3.1 identification of the most salient elements

If a certain group or cluster of elements are particularly well defined and together account for a large proportion of the total variation in a grid, then it is to be expected that they will influence the organisation of the construct space to a major degree. It would be useful to know, from the student nurse's perspective, whether or not a few people, perhaps a certain group of people are influential in her personal construct system. If this were so, it would have implications for the other people with whom she deals in her day to day work. For example, if her peer group are particularly influential then her dealings with older people may be less than sympathetic.

#### 5.11.3.2 examination of the constructs

As well as knowing whether or not a particular group of people orientate the student nurse's construct system, it would be valuable to examine the meaning of the constructs used. For example, if old people are particularly influential within a construct system, how they are construed - in what terms are they perceived?

Several studies have used various schemes for the categorisation of constructs. One of the earliest was by Little (1968) who categorised children's and adolescent's personal constructs into:-

- a) psychological constructs concerned with character and personality
- b) physicalistic constructs describing outward appearance
- c) role constructs describing habitual roles, acts or behaviour

Duck (1975) developed this scheme of Little's and included



two additional categories as follows:-

- a) fact constructs concerned with descriptions in terms of characteristics objectively assessable, but not solely related to physical appearance (e.g. married - unmarried)
- b) interaction constructs which focus on behaviour in face to face ongoing social interaction (e.g. shy with people)

Peevers and Secord (1973), who were also interested in the development of person perception, developed the Personal Concept Code. They focussed on the descriptiveness or quality of information which a construct provided, and the degree of personal involvement - whether or not the self was part of the construct's frame of reference. The constructs were categorised according to the following categories and each in turn was also categorised as either "egocentric" or "other-oriented":-

- a) undifferentiating (e.g. he lives around here)
- b) simple differentiating (e.g. they are nice)
- c) differentiating (e.g. she is great at maths)
- d) dispositional (e.g. they are real egotists)

Peevers and Secord were also interested in the 'depth' of construing - the extent to which a construct "exemplifies sophistication of insight and attribution". This required a probe to assign each construct to one of 3 levels according to the level of explanation e.g.:-

- 1. She is mean
- 2. They are usually mean but sometimes can be generous
- 3. He is mean but that is because everyone used to bully him a lot

Level 3 is taken as indicative of "elaboration of a personal theory of human personality and behaviour".

Lifshitz (1974), in a study closer to the present subject matter, examined the effects of professional education on a group of social work students. She found that students used mainly concrete descriptive categories whereas trained social workers had more abstract concerns with themselves, others and their work. Her categories were as follows:-

1. task orientation e.g. diligence, responsibility
2. a description of concrete situations e.g. age, sex, profession
3. abstract intrapsychic characteristics e.g. self-awareness
4. abstract interpersonal or interpsychic characteristics e.g. wish to help others
5. abstract social values e.g. equality, justice etc.
6. intellectual characteristics e.g. abstract thinking
7. affective-egocentric approach e.g. "good to me"

It is expected that a similar examination of student nurses' constructs during the course of training would yield valuable information on characteristic modes of construing. For example, if student nurses construe people in mainly concrete terms, this could have important implications for their interaction with others.

#### 5.11.3.3 identification of elements accounting for most change and the direction of that change

It is to be expected that a student nurse's construct system will change over the course of her training and that her manner of construing persons will change as a result of her various experiences. It would therefore be instructive to know which particular persons or elements account for most of the change. If one particular group is isolated, then it would suggest that her experience with that group has been particularly influential in producing the change. This could be especially relevant if a group of people had undergone either a positive or negative change in terms of the nurse's construing.

#### 5.11.3.4 cognitive complexity/simplicity

Another aspect of change in construing is that a person's construct system can become either more complex or more simple. The term "cognitive complexity/simplicity" was introduced by Bieri (1955) to describe construct systems which were characterised by a greater or lesser degree of differentiation. For example, if one component accounts for a large percentage of the variation in a grid, the researcher or clinician may conclude that the person's thinking is unduly restricted or simple. Conversely, a grid with many more dimensions accounting for the variation may be seen as more sophisticated or complex.

There is, however, a certain degree of confusion prevalent regarding the notion of cognitive complexity/simplicity (Slater 1977). The bi-polar opposite of simplicity is incoherence and the location of complexity on the continuum is therefore problematic. Crockett (1965) has also questioned whether complexity/simplicity characterises a whole person or just his construing with regard to a particular set of elements. Most people have detailed knowledge about a very few areas whilst their knowledge of other areas may be scanty or non-existent. Nevertheless it can be argued that a desirable effect of nursing training would be an increasingly differentiated construct system with regard to person perception. If student nurses' construct systems were found to become more simple as training progressed, then this would suggest that training had not been effective in this regard and one could hypothesize that it had had an adverse effect.

#### 5.12 CONCLUSION

This chapter has examined two approaches to the study of attitudes which appear complementary and well suited to the present task. Traditional attitude scales and questionnaires have been rejected for their inability to explain behaviour in a social context. It is now suggested that a combination of quantitative and

qualitative methods as embodied in the examination of nurses' construing during training by means of repertory grids, and the collection of justificatory accounts from nurses following conversations with patients, may be the most fruitful way to proceed.

## CHAPTER SIX

### ACCOUNTING AND CONVERSATIONAL ANALYSIS

Part I of this chapter describes a pilot study into the collection of justificatory accounts from student nurses in a geriatric unit. In Part II, the level of explanation afforded by the examination of accounts is compared with an interaction process analysis of conversations.

#### PART I - PILOT STUDY OF ACCOUNTING

##### 6.1 INTRODUCTION

###### 6.1.1 Background to the Study - Student Nurses' Perspective

An important consideration in the development of student nurses' attitudes toward old people is their formal training and experience in geriatric nursing. An approach was made to the Director of Nurse Education at a district general teaching hospital with the expressed wish that a future research project would involve student nurses during their geriatric placement. The researcher was given permission to audit a geriatric study block with a group of student nurses. The time was used to examine the formal lecture content of the course and to establish a degree of rapport with the student nurses.

The researcher spent a week with the student nurses in the training school. She participated in the lectures by writing notes, but not by asking or answering questions. Coffee and meal breaks were taken in the company of the students whenever possible in order to facilitate informal conversations.

###### 6.1.1.1 formal course content

Lectures given to students emphasized a decremental model of ageing. Table 6.1 shows the areas and topics covered in the lecture course. Each topic

was covered in approximately one hour. Stress was laid on the physical and mental deterioration of the elderly and the subsequent burden of the elderly on society. The introductory lecture outlined statutory care provisions for the elderly, indicating the proportions of institutionalised old people and reminding the students that the care of this minority group would be demanding in terms of their time and energy. Old people were characterised as "a highly dependent group of people needing skilled care" who were a "strain on tax, rates and central government resources".

Table 6:1 Areas and Topics in Lecture Course

Area	Topic
Socio-economic aspects of ageing	General statistics
	Provision of services
	Provision of housing
	Preparation for retirement
Psychological aspects of ageing	Psychological needs of elderly
	Psychogeriatric illness
Physiological aspects of ageing	Diabetes in elderly
	Parkinson's disease
	Cerebro-Vascular Accidents
Special aspects of the care of the elderly	Falls
	Diet
	Drugs
	Incontinence
Role of professionals	Nurse in psychogeriatric unit
	Social worker
	Occupational therapist
	Physiotherapist
	Primary health care team

Subsequent lectures focussed on specific problems of nursing the elderly such as the management of incontinence and pressure area care. The emphasis in the former was on medical causes of incontinence and little advice by way of nursing management was given. Psychological needs of the elderly were dealt with briefly at the beginning of one lecture. More time was spent on Dementia, a charge nurse from one of the psychogeriatric wards and a consultant psychogeriatrician providing the necessary input.

Overall, the teaching provided was largely non-specialised in terms of geriatric nursing. This was epitomised in the remark of one tutor who prefaced a lecture on the management of incontinence with the words "I'm sure you already know all there is to know about pressure area care". Moreover tutors repeatedly emphasized the strenuous nature of the work the students were about to undertake and frequently warned them that they were going to need lots of energy and patience.

The roles of other professionals in the care of the elderly were well represented. A social worker, dietitian, physiotherapist and occupational therapist, all gave lectures to the students. Whilst these were well received by the student nurses, one of them voiced the concerns of many of her colleagues when she commented "It's all very well all these other people telling us what they have to do, but what we want to know is what we have to do". This was not resolved to the students' satisfaction.

#### 6.1.1.2 group discussions

Two sessions during the week were devoted to enabling students to express their fears, hopes, anticipations etc. of their experience on the geriatric unit. The tutor conducted these sessions with the researcher being in her usual role of non-vocal participant. Areas covered and topics discussed are shown in Table 6.2.

Table 6.2 Areas and Topics in Group Discussions

Areas	Topics
Working enviroment	Ward atmosphere Hours of duty
Patient behaviour	Methods of control Patient responsiveness
Nurse behaviour	Earning respect Attitude to patients
Staff relationships	Student's status Permanent staff
Death and dying	Pain relief Questionable practices

Students were agreed that a friendly ward atmosphere with more time to talk to patients would be welcome. Much discussion centred around the need to be good humoured and cheerful in the face of unacceptable behaviour from patients. Students were divided as to whether or not it was permissible to scold patients "when they behave like children".

Another area of discussion was the perceived depressive nature of the job. One student asked "How do you get job satisfaction from changing wet beds?". Another emphasized the need for some response from patients. In both sessions students raised the matter of their own status within the ward team. They expressed a conflict between the standards taught in school and those practiced at ward level and some concern regarding the nature of their relationship with the permanent untrained staff on the geriatric unit, who, according to hearsay, resented each new



batch of students.

The tutor raised the question of death and dying. Students did not have much to say about this, but the tutor emphasized the alleviation of pain and suffering and that termination of life was never justified. Students were urged to challenge questionable practices if they witnessed them.

#### 6.1.2 Theoretical Background to the Study - Accounting

In accounting, speech is used to interpret and explain acts accomplished by the performance of action-sequences. In rejecting the traditional positivistic scientific paradigm, Harré and Secord (1972) suggest that in their view "...human social life is through and through linguistic, and the best understanding of it can be obtained by the use of linguistic and quasi-linguistic concepts". They argue for taking an individual's own explanation as the prime source of data about his actions. This approach entails a model of man rule-following, capable of monitoring his own self-monitoring. Man's special power of speech enables him to provide commentaries upon and accounts of his performances. The most human of all behaviour, therefore, is the conscious following of rules and intentional carrying out of plans.

It is the person's ability to stand back and comment on his actions that provides this study with its methodology. Accounting is not introspection by another name although some accounts are characteristic of introspection. Rather, accounts are naturally produced in the normal course of social action and in this study they are precipitated and encouraged by the researcher in order to make actions intelligible. It is expected that nurses, in commenting on their conversations with patients will reveal their own intentions, motivations and awareness of how nurses and patients should interact.

Such understanding gained by the use of an intensive method as opposed to a paper and pencil extensive method, depends for its generality and applicability on the representativeness of the subjects chosen. The nurses in this study are from one training school, working at one geriatric unit. From what is known about them, the training school, the geriatric unit and others like them, there seems no reason to consider them atypical. On this matter, Marsh, Rosser and Harré (1978) write:-

"The certainty that the average is a type is paid for by the relatively few properties which are likely to survive a generalizing procedure over many individuals. On the other hand, the detail of the knowledge achieved in the use of the intensive design has to be paid for by the ever-present possibility that the case one chose was not typical. Thus the risk is greater when one adopts the intensive design but the pay-off is correspondingly larger".

p.20

In addition to the examination of nurses' justificatory accounts, certain objective data relating to conversation length, context and content will be reported in order to provide certain points of comparison with other studies, notably that of Wells (1980).

### 6.1.3 Gaining Access

As the researcher had previously visited the geriatric unit with a group of student nurses, she was already known to the Senior Nursing Officer. In a subsequent interview, the researcher explained the details of the research about to be undertaken, and the problem of negotiating permission for the audio-recording of conversations was discussed. The SNO undertook to inform the medical staff concerned and arranged for the researcher to meet the senior members of other personnel in the unit e.g. domestic and portering staff, occupational and physiotherapists.

All these senior members of staff undertook to inform their junior colleagues but the researcher was able to talk personally to many of them before the research began.

The geriatric unit was part of a larger complex which contained geriatric and psychogeriatric beds and some Part III accommodation for the elderly. It was an old workhouse building which, despite upgrading, afforded cramped and difficult nursing conditions in places.

## 6.2 METHOD

### 6.2.1 Design

The 12-hour day shift was divided, for recording purposes, into six 2-hour periods as follows:-

8.00 - 10.00 a.m.  
10.00 - 12.00 m.d.  
12.00 - 2.00 p.m.  
2.00 - 4.00 p.m.  
4.00 - 6.00 p.m.  
6.00 - 8.00 p.m.

Student nurses were recorded for 2 hours each, selected from the six 2-hour periods of the day shift and from Monday to Fridays, according to their availability on off-duty rotas and in conjunction with their scheduled teaching, in an attempt to record one nurse on each of the 2-hour periods.

One male and two female geriatric rehabilitation wards, to which student nurses were allocated for 6 weeks, were used in the study. In addition to recording on these wards, recording also took place in a large day room which served all five wards in the unit. The male ward housed 26 patients; the two female wards housed 19 and 18 patients.

Four student nurses were recorded on the female wards,

two on the male ward.

#### 6.2.2. Subjects

The 6 subjects were student nurses in their second year of training in a school of nursing in a district general teaching hospital. All were female, ages ranging from 19-20 years. In educational background Ss had between 6 and 11 O Level GCEs and up to 3 A Levels. None had any full time work experience prior to commencing nurse training.

#### 6.2.3 Apparatus

Lustraphone radio transmitter and receiver  
FM R608 0.25W power at 174MHz  
Clip on microphone  
Stopwatch  
Two Philips N2213 cassette recorders, one  
modified for use with headphones.  
Memorex 120 tapes

#### 6.2.4 Procedure

Although student nurses were allocated only to 3 wards in the unit, much of the day care took place in a large day room which serviced 5 wards. It was necessary therefore, to seek consent to audio-recording of conversations from all patients and nursing staff in the unit. This was undertaken personally by the researcher over the period of the week prior to the research commencing.

All grades of nursing staff were approached and the purpose of the research explained to them in the following terms:-

"I am interested in the communication between student nurses and patients and wish to do some tape recording in this unit. Do you have any objections to this? I am focussing on the student nurses and would not be interested in any other conversations although there is the possibility that these may be recorded".

All patients were approached and permission was sought in the following terms:-

"My name is Mrs. Fielding and I am from the university. I am doing some research with the student nurses on this unit because I am interested in how they talk to patients. One of the things I am doing with them is some tape-recording. Would you mind if the tape recorder happened to be near you when we were recording?".

This was a geriatric unit, and whilst it was impossible to be certain that all patients had given informed consent, the researcher was personally satisfied that no-one had been coerced into co-operation against their will and that no-one had been upset by the proposal. It was necessary to check frequently for new staff and patients. Visitors to the unit were a rare occurrence. The researcher was able to speak personally to those visiting during a period of recording.

Each student nurse wore the microphone for a total of 4 hours, excluding meal and coffee breaks. The first 2 hours provided a period of adaptation whilst the second 2 hours were recorded on tape in a separate room away from the wards and day room. The nurses were not told that the first 2 hours were for adaptation purposes and for the nurse who was recorded from 8.00 - 10.00 a.m., an adaptation period was provided on the preceding day.

In addition to the audiotape recording, the researcher kept rough notes at 15 second intervals throughout the two hours in order to locate specific conversations for accounting purposes. On completion of recording, the researcher selected 5 conversations to form the basis of accounting sessions. A conversation was arbitrarily defined as a verbal interchange between nurse and patient which lasted 25 seconds or longer, with less than a one-minute break in transmission (Wells, 1980). Each minute of the 2 hour recording was numbered on the written record and 5 numbers

between 0 and 119 were selected from a random numbers table. The conversation in progress at that point, or the first conversation after that point, was selected. In this way, 5 excerpts were chosen for re-recording from the original cassette tape ready for re-playing to the student nurse. Because of the limited amount of time available for accounting, a limit of 5 minutes was imposed on any one excerpt.

As soon as practicable after the recording, either the same day or within 24 hours, the researcher arranged to interview the student nurse. The conversations were played for the student nurse to hear. After hearing each excerpt, the nurse was invited to elaborate on what had been happening and to contribute anything she thought was relevant to the conversation. The researcher responded to her leads and asked for clarification and qualification whenever it seemed necessary.

### 6.3 RESULTS

Thirty accounts were collected on the basis of thirty conversations from 6 student nurses. Difficulties with recording equipment resulted in 10 accounts being lost from 2 student nurses. The following results are based on the 20 remaining conversations and accounts from 4 student nurses.

#### 6.3.1 Conversation Length

Table 6.3 shows that the conversations (excluding those longer than 5 minutes), ranged in length from 1 min. to 4 mins. 58 secs.. The median length of all conversations was 3 mins. 23 secs.. Of the 20 conversations, 5 were longer than 5 minutes in length.

Table 6.3 Length of Student Nurses' Conversations  
(minutes:seconds)

Ss	Conv.1	Conv.2	Conv.3	Conv.4	Conv.5
1	>5:00	>5:00	3:45	1:00	4:50
2	>5:00	4:15	2:30	2:45	4:30
3	1:00	>5:00	3:00	4:58	2:00
6	1:15	1:00	>5:00	2:00	1:15

### 6.3.2 Context of Conversations

This was defined according to the categories used by Wells (1980) and which are based on the principal activity of the nurse during the nurse-patient conversation. They are as follows:-

Physical Care Tasks: The nurse was accomplishing a task of direct physical care such as bathing, commoding, or getting the patient in and out of bed.

Orienting: The nurse was not involved in physical care and was orienting a confused and/or wandering patient, by telling the patient, for example, where and who she was or clarifying some aspect of the environment or care that was causing visible distress.

Socializing: The nurse was not involved in physical care and was talking with the patient about subjects unrelated to hospitalization.

Comforting/

Encouraging:

The nurse was not involved in physical care and was talking with a patient in order to provide

comfort for visible distress such as talking to a crying patient, or to encourage a behaviour the nurse thought necessary such as encouraging the patient to drink more fluid.

Instructing/

Explaining:

The nurse was not involved in physical care and was talking with a patient in order to give instructions or explanations about an aspect of care, such as discussing the need for, and procedure of, having an enema.

Table 6.4 shows the percentages of conversations related to the principal activity of the nurse. As can be seen, the great majority of conversations sampled, took place whilst the nurse was involved in direct physical care with the patient.

Table 6.4 Principal Activity of Student Nurses during Sustained Nurse-Patient Verbal Communication

<u>Categories</u>	<u>No.convs.</u>	<u>% Frequency</u>
Physical care tasks	13	65.0
Orienting	-	-
Socializing	4	20.0
Comforting/Encouraging	-	-
Instructing/Explaining	3	15.0

### 6.3.3 Content of Conversations

The conversations were classified for content according to three categories as used by Wells (1980).

They are as follows:-

Procedural: The content is entirely concerned with the performance of a task.



Personal: The content is not concerned with a task but with a specific patient in a personal way.

Mixed: The content includes both procedural and personal elements.

Table 6.5 displays the findings which show that the majority of conversations were entirely procedural in content.

Table 6.5 Content of Student Nurses' Conversations

Content Category	No.convs.	% Frequency
Procedural	11	55.0
Mixed	4	20.0
Personal	5	25.0

#### 6.3.4 Accounts

Student nurses made a large number of comments which purported to explain their behaviour. These fell into five broad areas and will be reported under the following headings:-

1. Evaluative descriptions of patients
2. Popularity of patients
3. Nurses' intentions in conversation with patients
4. Nurses' feelings in conversation with patients
5. Generalised themes.

##### 6.3.4.1 evaluative descriptions of patients

Student nurses' descriptions of patients provided both contextual information about, and some justification for, the ensuing conversation. In other words, they portrayed the kind of person with whom the conversation was concerned and in some cases this description alone was offered as an explanation for the nurses' behaviour.

Positive characteristics centred around the patient's personality and degree of friendliness. A pleasant personality was highly regarded by nurses particularly if this coincided with the patient being considerate and helpful.

*"She's not inconsiderate of other people".* SO3:5

*"She appreciates you".* SO2:3

*"Nice personality".* SO6:1

*"Very nice person".* SO6:2

*"She's very pleasant".* SO6:1

Negative characteristics, on the other hand, focussed on the demanding nature of patients. Nurses noted that some patients were "quick to moan" and were inconsiderate with regard to other patients. They did not seem to appreciate the demands on the nurses' time.

*"She's very quick to moan about everybody else".* SO6:5

*"Not much patience".* SO6:2

*"She can be inconsiderate to the other patients"* SO3:2

*"She expects priority treatment".* SO1:5

Nurses did, however, demonstrate a degree of insight into patients' feelings and pointed out that some patients were less than happy and contented with their present condition, or had certain particular needs which required to be met. Idiosyncracies of particular patients were also noted by nurses.

*"Her appearance is important to her".* SO1:2

*"She doesn't like being on the hoist".* SO1:3

*"She likes to be buttered up a little bit".* SO1:5

*"She's disheartened by being in here".* SO6:2

*"She'd like to get out and do some gardening".* SO6:2

Other references were made to the ease of management of patients. Nurses identified patients in terms of who could manage themselves, or how much help they required from nurses. They also noted those patients whose demands on them exceeded expectations.

*"She'll do whatever she can to help". SO6:1*  
*"She tries so hard". SO6:5*  
*"She's trying to get us to do more for her". SO3:2*  
*"She doesn't wash herself". SO2:2*  
*"She wants help all the time". SO3:2*

Another way in which nurses described patients was according to their ability to communicate. Nurses noted both those patients who were difficult to communicate with, and those with whom communication was easily possible.

*"You can never understand what she says or wants". SO2:3*  
*"You can't have a sensible conversation with her" SO2:2*  
*"She very rarely talks to anybody". SO6:5*  
*"You can hold a conversation with her". SO1:2*  
*"She's quite interesting to talk to because she can tell you a lot about her background". SO2:1*

Occasionally, descriptions of patients would reveal conflicting evaluations. These evaluations subdivided into two seemingly contradictory statements applying to the same patient. Patients described in this way were seen as having pleasant personalities but requiring a great deal of care.

*"She's a bilateral amputee but she's smashing". SO6:1*

Patients were also described according to their mental status. Nurses noted intelligent patients, those who were confused and disoriented and those who were worried and anxious. They also noted patients who understood about nurses' priorities.

*"She's anxious". SO1:1*  
*"She's quite an intelligent woman". SO3:2*  
*"She understands the situation - that there are only three of us on duty". SO3:5*  
*"She's a bit nutty". SO2:5*

### Summary

Student nurses seemed to evaluate these patients largely

in terms of nursing management. The degree of pleasantness and ensuing co-operation was obviously important in the day to day management of patients. "Trying hard" emerged as a favourable characteristic and problems in communication were evident.

#### 6.3.4.2 Popularity of Patients

Popularity seemed to be an indication of the nurse's willingness to become involved with a patient. Only one patient, who featured in two accounts, was volunteered to be popular and this was because of her jolly nature.

*"She's a very jolly lady, she's always giggling. I've not seen her upset or anything".* SO1:2

Four patients who were said to be unpopular, were deemed to be so either because they grumbled and were inconsiderate, or, because they were difficult for the nurse to manage.

*"She's got a reputation for being a bit of a grumbler and also she's always wanting to be first in everything".* SO1:1

*"She's very heavy and can't do anything for herself, so people don't like looking after her, but she's a nice person".* SO2:1

In the latter example, the patient's pleasant personality could not compensate for her level of dependency and consequent demands on the nurse.

Two patients were considered to be of neutral status in the popularity/unpopularity dimension. These were patients who lacked any distinguishing characteristic.

*"I wouldn't say she is unpopular but she's not one of those that sticks out. She's by no means unpopular. Most people tolerate her and get on with her".* SO1:3

#### Summary

Popularity of these patients seemed to be linked to nursing

management. However, it is possible that overt popularity may depend on "jolliness" in addition to independent status.

#### 6.3.4.3 Student nurses' intentions in conversations

In the main, nurses' overt intentions in conversation with patients centred around the need to accomplish a nursing procedure in the routinised course of events.

*"I was helping her to get dressed". SO1:1*

*"I was washing under her arms for her". SO3:3*

Another class of intentions could be described as "just chatting" which might be entered into to 'pass the time away'.

*"They were sitting there and I asked Miss O if she was going to talk to me and the other ladies were there - they'd just had a reading session - we just started talking". SO6:1*

Later on in this same conversation, a specifically therapeutic intention was volunteered by the student nurse who said of another patient:-

*"I was trying to bring her into the conversation".  
SO6:2*

Not all intentions were directed towards the patient. One nurse who was tired and anxious to go home after an evening duty said:-

*"I wanted to get her off (the toilet) and sat down so I could go home". SO2:5*

When she eventually did help the patient from the toilet back to the dayroom, the patient expressed a wish to be put back to bed, whereupon the nurse tried to persuade her to return to her seat until the night staff arrived. Her intention, evident in the account, speaks for itself:-

*"She didn't want to sit down again and I wanted to get her to bear it for a bit longer". SO2:5*

### Summary

Student nurses' intentions in conversation with these patients were focussed mainly on nursing procedures. Conversations were entered into largely without any specifically therapeutic intention. "Just chatting" emerged as an activity without any underlying therapeutic goal.

#### 6.3.4.4 student nurses' feelings in conversations

Student nurses' reported feelings in conversation with patients gave some clue to the emotional/affective nature of such conversations. A positive feeling was volunteered on only one occasion when a patient had complimented the nurse who commented:-

*"It was nice of her to say it". SO1:5*

Negative feelings were occasionally reported and these often related to the nurse's awareness of her own shortcomings.

*"I wanted to go home...it was the end of the day and I'd had enough". SO2:5*

*"I felt as though I was being told off. I suppose it's because I know I should have gone back first of all and taken her". SO2:4*

Feelings of frustration were noted one one occasion when the constraints imposed by another member of staff had resulted in the nurse giving what she knew to be less than adequate care. She commented:-

*"I felt awful for leaving her until last but the auxiliary said to me 'Don't go in there until she's washed'. Because she will do it under normal circumstances. So I thought if I leave her until last and she wasn't washed, I can go in there and help her". SO1:1*

### Summary

On the whole nurses tended not to report overtly positive feelings in their conversations with patients. There was

some evidence in nurses' accounts that feelings of frustration and irritation were sometimes present during an interaction. There was also the suggestion that these feelings were linked to the non-compliance of patients.

#### 6.3.4.5 generalised themes

From the pilot study data, certain themes emerged which pointed beyond the specifics of individual patients toward attitudes of a more general nature. A major theme related to communication. The implicit assumption in nurses' accounting was that communication, either between nurse and patient, or between patients themselves, was generally beneficial both to the patients...

*"I think it probably does them good to be able to talk to each other. Well, all right, they're talking to us as well, but like to have the group thing". SO6:1*

and perhaps to the nurse...

*"It makes the time go quicker I suppose". SO2:1*

Nurses described what in some cases amounted to almost relief at being able to converse with responsive patients and particularly with those who could contribute substantially to the conversation. When nurses were new to the ward, a common strategy for "being occupied" was to locate an interesting patient and "hang in". One nurse describes it as follows:-

*"The first day I was here, I had quite a long chat with her in the afternoon, and it was such a relief to find someone who could talk back and you could have sensible conversation with. All of us tended to stick with just one or two people on that afternoon and I found I talked to her a lot then". SO1:1*

Frustration was expressed at having to cope with patients who, for reasons of mental confusion or speech impairment, could not perform well in conversations. A relatively high

value was placed on patients with whom nurses could have a "sensible conversation". In describing such a patient, one nurse said:-

*"She's got a nice personality; she's very friendly; she'll do whatever she can to help, to help herself. She's 89 and she's like a 60 year old. She's all there. I suppose it's because she's one of the patients that you can hold a conversation with". SO6:1*

The difficulties of not being able to converse with patients seemed to be accompanied by feelings of frustration, but not by specific nursing strategies. The consequences of poor communication were seen to lead to lack of identification with the patient - it being difficult to familiarise oneself with the patient's background in the absence of verbal communication. The following extracts illustrate this point:-

*"It makes it easier when you can communicate with them on the same level, but I get the impression with Miss N that you're just there as someone to help her and that's it - not somebody to talk to". SO1:5*

*"....because of the language problem it's difficult to get to know her". SO3:5*

Two contrasting attitudes were expressed in situations where patients couldn't communicate effectively, concerning the appropriateness of nurses' efforts at conversation. In the first situation a nurse feeding a patient made little attempt to engage the patient in conversation. In the second situation a nurse took considerable trouble to explain a nursing procedure to a patient who could not respond verbally. The first nurse commented that talking was not necessary as "she couldn't talk back". The second nurse justified her explanation by saying "Well, she's quite bright even though her English isn't very good. She knows what's going on". The patients in these two situations were alike in terms of communicative ability, but differed in terms of mental status. The supposedly confused state of the first patient may have affected



the nurse's decision not to talk.

Another theme in the pilot study accounts related to nurses' perceptions that patients' demands were sometimes excessive. Patients too were aware of and sensitive to the demands made on nurses by respective patients. One nurse, commenting on her dealings with a patient who felt unfairly discriminated against, said:-

*"She said at one point that another lady got on her nerves and was calling out all the time. She's right, they do call out but you can't ignore it".* SO1:1

The nurse felt that this particular patient was either unable, or unwilling, to recognise the priorities with which she had to work. If patients were sensitive to these priorities and gave consideration to other patients, this was appreciated by nurses; but if patients were inconsiderate and wanted attention at times deemed inappropriate, nurses were resentful. The following extracts illustrate these attitudes:-

*"R: Why does nobody dislike her if she's difficult to talk to and she's having trouble with constipation?*

*N: I think she's not inconsiderate of other people, which quite a few patients are. She does understand that there are priorities".* SO3:5

*"No, I wouldn't say she's a popular patient. She can be a bit inconsiderate to the other patients, having had the family running to her every whim 24 hours a day. (...) she's trying to get us to do more for her. When she first came you could see that if she wanted to do something for herself she was quite able - like she walked right down to the lifts with me and now - should you not get another nurse to help you stand me up? (...) Obviously people have come on here at night and two nurses have helped her and she can see that it's done and she wants it all the time".* SO3:2

Some patients seem to have developed strategies which could override the nurses' priority system and this was resented greatly by the nurses. One particular patient, Miss F, adopted a "wearing down" procedure by which she grumbled and moaned about other patients in a manner nurses found impossible to ignore. Two of them commented:-

*"On my first day one of the nurses said to ignore her but she's very difficult to ignore because she goes on and on and you can't really walk away from her". SO6:5*

*"I haven't noticed it on the wards so much 'cos she won't call out, she'll just sit there; she'll just grumble to herself". SO1:1*

There were conditions however, when nurses attitudes to demanding patients were modified. One patient was seen by the nurse as having nothing much remaining in her life and so even though her demands were deemed excessive, the nurse's response was one of pity.

*"I feel sorry for her life - if that's all she's got, well, what is there?". SO3:3*

Another modification of attitude was effected by the personality of patients. Sweetness of character could compensate for excessive demands and if the demands were seen as unintentional and simply part of the person's make up, they were excused and overlooked. The following extracts illustrate these modifications:-

*"...she seemed very demanding and I hurt my back with her trying to get off the toilet and she says 'Oh can you do this nurse, can you do that nurse?' But when you get to know her, you know that she appreciates you for it. (...)  
She is very demanding but she's sweet with it.*

R:How do you mean, she's sweet?

N:I don't know, it's the way she looks.  
She's got a special look about her. It's the way she talks and looks at you". SO3:3

*"With her it's not too bad because you know it's her. You know it's her nature that she's always one step ahead of you. But there's another lady on the ward who does it because she's, she likes to be first (...) and that's more irritating, but with Mabel it's not too bad because you know - it's quite funny - because you know it's her".* SO1:3

It was also evident from nurses' accounts that they had been schooled in certain principles of rehabilitation. They knew that patients were to be encouraged to help themselves and that sometimes this would prove to be a frustrating experience. One nurse described it thus:-

*"I felt sorry for her; I didn't like to leave her, just leave her sitting there with a bowl of water in front of her. I felt I wanted to go in and help her but like Sister says - if they can do something for themselves, hard as it may be to leave them, you have to let them do it - like watching patients get dressed and not doing it for them".* SO1:1

Some dissatisfaction was expressed with current practice and the geriatric unit was compared unfavourably with an orthopaedic unit where rehabilitation was seen to be more vigorous. However, the nurse making this comment concluded that the fault lay in the nurses' shortage of time and inadequate working environment.

*"We've come from \_\_\_\_\_ where the emphasis was on getting them up and home whereas here, although it's supposed to be a rehabilitation ward, they don't seem to push them to get going at all. They don't encourage them to walk. There's a lot of wheelchairs used quite unnecessarily. It's time again, I suppose and the width of the corridors".* SO3:3

However, the benefits of rehabilitation were certainly recognised by the nurses, from simply enhancing the quality of life for patients, to increasing self-confidence. The following extracts illustrate this point:-

*"They're both people who like to do things. They both appreciated it during the nice*

weather when we took them out just round the huts. They were different people when we got them back for their cup of tea". SO6:2

"R: You say she hasn't walked out to the toilet for a few days - she could just be pushed - why do you want her to walk?

N: Because the more she does - I could see her becoming more and more dependent quite rapidly on us. If she could walk, she could stand better, for her own confidence". SO3:4

Nurses' attitudes to "face-work" were revealed in several of their comments, ranging from freely given common social acknowledgments to patient remarking on her "nice dress", to begrudging recognition of a patient's need to be "battered" in order for social interaction to proceed smoothly. The following extracts illustrate these two extremes.

"R: Why did you comment about her dress?

N: Well I liked it, it was nice". SO3:5

"She's got a reputation for blowing things up - like yesterday, Eileen dropped the menu board on her leg - it must have hurt because she's an arthritic patient, but she didn't say "Oh that's all right", she made a real mountain of it. I went and got Sister and Sister said "Oh poor Miss N" and that sort of thing. I couldn't have said that; I didn't see it as that important. Obviously it was painful and Eileen did apologise, but Miss N likes to be battered up a little bit. That's obviously the way she needs to be treated but I don't find it easy to talk to her like that". SO1:2

There was evidence in nurses' accounts that they expected appreciation from patients. One nurse, comparing a particular patient unfavourably with others commented:-

"...the other ladies are so grateful for anything that you do and yet she's not. She never shows her gratitude. Perhaps that's what I want. I don't know". SO2:3

When gratitude was expressed, it could be either accepted, as in the following instance...

"R: How did you react to Mrs. S saying  
you were a nice nurse?

N: Quite chuffed. Makes it worth it when  
someone says something like that". SO2:3

... or belittled as in the following extract:-

"R: How did you feel when she said 'You are  
wonderful - you're the kind ones'?

N: Coming from that lady - again perhaps  
because she was from another ward - I  
thought 'Well, she doesn't really know  
me so perhaps that's why she said it.'".  
SO1:5

It is possible that patients experience a double-bind  
in these circumstances, being expected to compliment  
nurses and yet running the risk that their compliments  
will be rejected.

Overt rudeness to patients was avoided however. It  
was seen as dysfunctional to smooth social interaction.  
One nurse comments:-

"I never say anything rude to any of the  
patients. I think it and I say it to somebody  
else afterwards. Like I could strangle Miss N  
but I try not to say anything rude because I  
don't want to get on her bad side. With her  
it's a day to day thing; one day she'll talk  
to you, the next day she won't. So I don't  
really want to upset her". SO1

Nurses' accounts provided some evidence of their  
attitudes toward rules of the institution which  
affected the care of patients. Some rules were  
readily apparent to the observer, such as the one  
relegating smokers to the dining room and allowing non-  
smokers only in the sitting room. One nurse commented on  
this segregation as follows:-

"There are other ladies out there (in the dining  
room) but I still think she feels left out.  
In fact the first day I was here I said to her  
'Why don't you come and sit in the other room?'  
and she said 'No, I'm not allowed because I'm  
a smoker'. Apparently there is a patient  
committee where they decide these things. OK,  
they say other patients might complain but I

*think it's a bit daft to put the smokers out where you eat. I thought they could have put them in the sun lounge - that wouldn't be so bad".* SO1:1

Other rules were more informal but nonetheless strictly adhered to because of their connection with informal figures of authority. A nurse who was defending her action regarding a patient whom she had not taken to the toilet on request made one rule explicit in the following extract:-

*"R: She sounded a bit disgruntled about being left there...*

*N: Well, she said to me when I was going for my dinner 'Oh will you take me to the loo?' So I said 'Yes, all right then'. but when I was taking patients, we had to do all our own patients first. There's two (nurses) on each ward.*

*R: Did she remember that she'd asked you?*

*N: Yes. They had two nurses doing all their patients. It was two nurses to each ward. We do our own patients. The general thing down there is to do your own patients and then help everyone else".* SO2:4

This rule (underlined) originated from the permanent untrained staff on the unit who, although officially junior to the students, had a great deal of experience and dictated practice to a large extent in the absence of trained staff. The official rule was that all nurses should care for all patients irrespective of ward assignment.

Another rule concerned the organisation of work. Implicit in the daily routine was the expectation that the "heavy" work would be accomplished in the morning. One nurse beginning to react against this bemoaned:-

*"Well, there was a lot of pressure; there were only three of us on this morning so we had to keep going and getting further on to the end and it would have been nice to sit down and do it properly but it would have taken us 'till about 3-o'clock".* SO3:3

This same nurse, whilst feeling harrassed and frustrated at the constraints imposed on her by this rule of labour, saw her way out in compensating tactics later in the day:-

*"...in the afternoon you can perhaps make up for it, when you take her out to the toilet - that sort of thing". SO3:3*

Nurses' attitudes toward the nursing demands of patients were hinted at in their assessment of patients' popularity (see p.138). More generally, the easier patients were, and the fewer nursing demands they presented, the more acceptable this was to nurses.

*"She's all right to look after; she's easy to cope with; she can stand up all right and do the things you tell her to. I don't sort of dread going to look after her, like I do some of them". SO2:2*

The inability or failure to meet nursing demands could lead to uncomfortable feelings for the nurse:-

*"R: Did you feel put on the spot when she was talking to you?*

*N: Yes, I felt as though I was being told off. I suppose it's because I know I should have gone back first of all and taken her". SO2:4*

There was evidence in the nurses' accounts that "trying hard" was a desirable characteristic of patients. Telling a patient she was trying hard was seen as rewarding in itself.

*"R: She said at one point 'I'm a nuisance' and you said 'No you're not, you're trying hard'. You could have said 'Yes, you are a nuisance'*

*N: Well she might have appeared to be a nuisance if I'd nursed her a bit more, but to me she wasn't (...) she struggles along and she did it very well". SO1:5*

Furthermore, a patient who seemed to try hard might merit preferential treatment:-

*"Miss L walks like this with her knees cracking*

*all the time. She tries so hard.  
I didn't see why she should have to walk  
all the way round". SO6:5*

Finally, humour was accepted as a good thing for both nurses and patients to indulge in.

*"R: Was there any special reason you said to her 'You don't want to show your kneecaps?"*

*N: Not really, just making her laugh.*

*R: Why did you want to make her laugh?*

*N: Cheer everyone up". SO2:3*

#### 6.4 DISCUSSION

As can be seen from the results presented, a great variety of data has emerged from the pilot study. However, it would be spurious to claim any consistent findings on the basis of such a small study. The purpose of the pilot study was primarily to provide an opportunity for the researcher to become familiar with the use of the radio equipment and to establish a general procedure for accounting.

Nevertheless, the pilot study could be expected to point to some relevant items which might emerge more clearly in the main study.

##### 6.4.1 Length of Conversations

The median length of conversations (3 mins. 23 secs.) is substantially longer than the mean reported by Wells (1980) - 1 min. 28 secs.. This could be effected by the relatively large proportion (25%) of conversations which were longer than 5 minutes in total length. The method of selecting conversations from a 2 hour recording meant that there was a greater likelihood of longer conversations being represented in the sample. However, as this was deemed to be of benefit to the accounting procedure, the method was to be maintained. The alternative would have been to have numbered each conversation and then to have



selected randomly. The identification and numbering of conversations in this manner would, however, have required fuller transcripts than it was possible to make at the time of recording, and so the accounting procedure would have been undesirably delayed.

#### 6.4.2 Context of Conversations

The majority of conversations (65%) took place whilst the nurse was involved in physical care tasks. No conversations were sampled whilst nurses were "orienting" or "comforting/encouraging". This could be due to the small number of conversations in the pilot study, but an inter-judge reliability measure on the main study data would be appropriate.

#### 6.4.3 Content of Conversations

The majority of conversations (55%) were entirely procedural in content. Again, an inter-judge reliability check would be appropriate on the data in the main study.

#### 6.4.4. Accounts

The results from the accounting procedure have been discussed as they were presented. It is to be expected that those areas identified as being important in the nurse-patient encounter - the nurse's evaluation of the patient, her perception of his popularity, her intentions, and feelings towards the patient, will be elaborated in the main study.

#### 6.4.5 A General Procedure for Accounting

As a result of the pilot study, a semi-structured procedure was developed which would ensure a certain degree of comparability across accounts, but which would allow the exploration of specific items within individual accounts. The main elements of this procedure were as follows:-

Following the playback of each conversation a series of questions were put to the student nurse -

1. DO YOU REMEMBER THAT?

This question aims to establish the occasion and bring it to the attention of the student nurse.

2. WHAT CAN YOU TELL ME ABOUT \_\_\_\_\_ (name of patient)?

It was apparent from the pilot study that student nurses possessed a great deal of information, "official" and otherwise, about patients. This question is aimed at eliciting their evaluative descriptions of patients.

3. HOW POPULAR WOULD YOU SAY S/HE IS?

4. WHY?

It seemed from the pilot study accounts that student nurses considered some patients to be more likeable than others. These questions are aimed at establishing the basis for liking or disliking.

5. WHY DID YOU SAY \_\_\_\_\_ ?

Many conversations contained instances where the nurse's motives or reasons for her comments were not apparent. There were also occasions when the comment she made was only one of a range of alternatives. This question is aimed at the uncovering of any background information and at the establishment of reasons, motivations etc..

6. DID YOU HAVE ANY PARTICULAR INTENTION IN MIND?

It had become apparent during the accounting sessions in the pilot study that student nurses were not always aware of pursuing goals in their activities. This question therefore, is aimed at establishing the existence/non-existence of overt aims or goals in a particular conversation.

## 7. HOW WERE YOU FEELING AT THE TIME?

This question is aimed at establishing the presence or absence of affect toward a patient and to clarifying the emotional state of the student nurse at the time of the conversation.

Depending on the nature and content of the conversation, supplementary questions may be used to deal with any particular aspect as it arises.

It was apparent from the pilot study accounting sessions that the audiorecordings were successful in recalling the occasion for the student nurses. There could not, of course, be an independent check that what they were recalling as their intentions, motivation, feelings etc. were actually present at that time in question but their responses indicated that they were not unduly concerned with the image they presented. They did not seem to be trying to manipulate their self-characterisation in a desirable direction for the benefit of the researcher.

## PART II - CONVERSATIONAL ANALYSIS vs. ACCOUNTING

### 6.5 INTRODUCTION

In Chapter 4 a number of systems for categorising verbal interaction were reviewed. Some focussed on content whilst others concentrated on form and/or function of utterances. The limitations of those which considered context only were recognised. The emphasis in the present study is on how nurses talk to patients rather than what they talk about, although it is recognised that choice of topic may well influence manner of speech. Of those systems which deal with the form or function of conversations, the study of form alone is seen as fruitless - none of the studies deals with this in isolation e.g. Macleod Clark (1981) links form to encouraging or discouraging behaviours, but her system would not be suitable for the present study as it is designed only

for nurses' responses to patients' cues and not for the whole range of conversations.

Of the remaining studies which deal with the function/process of conversations, Borgatta (1962) seems the most elaborated and comprehensive and is preferred to inventories of desired/undesired behaviour which require the specification of what therapeutic behaviour is or ought to be, and the consequent necessity to judge interactions "as if" the intentions of the speaker were explicit. In order to test out the utility of a categorisation system with the data from the present study, it was decided to analyse a number of conversations from the pilot study data and to compare the information gained from categorisation with the justificatory accounts.

#### 6.6 PROCEDURE

In order to define the points of comparison as sharply as possible, it was decided to identify those instances in nurses' accounts when specific items of interaction were being justified. From the 20 conversations in the pilot study, this yielded 12 extracts.

The transcripts of conversations which contained these extracts were coded by the researcher according to Borgatta's IPS and then the three sets of information, the extract from the conversation, the IPS code and the account were set side by side. It is recognised that coding of conversations by one person alone is not adequate if a proper analysis is being undertaken. However, the present exercise focussed on the level of explanation offered by categories in comparison with accounts. A reliability check is therefore not considered to be essential for this purpose. The 12 instances will now be considered in turn.

## 6.7 COMPARATIVE ANALYSIS OF BORGATTA IPS AND ACCOUNTS

6.7.1 Context: *The nurse is accompanying a patient from the dayroom to the toilet.*

### Conversation Extract

### Borgatta IPS

P: *I am a nuisance aren't I?* 15 *Personal Inadequacy*  
N: *No you're trying hard, that's something.* 2 *Raising Status*

### Account

R: *She said at one point "I am a nuisance" and you said "No you're not, you're trying hard". You could have said "Yes you are a nuisance".*

N: *Well she might have appeared to be a nuisance if I'd nursed her a bit more, but to me she wasn't. All I'd been told was that she could do a lot for herself so we took her into the toilet and she struggled along and she did it very well. So as I could see she wasn't a nuisance.*

There does not appear to be any mismatch here between the functional categories of the IPS and the student nurse's account. There does, however, seem to be an elaboration of meaning in the account. "Trying hard" is an important concept to nurses - the patient obviously fulfills the nurse's expectations therefore despite the "bother" of taking an unfamiliar patient to the toilet, the patient was not a nuisance - she had not placed excessive demands on the nurse.

6.7.2 Context: *The nurse is helping a patient back from the toilet.*

### Conversation Extract

### Borgatta IPS

N: *You don't want to show your kneecaps do you?* 1 *Social acknowledgment*  
P: *No I'm not seventeen any more.* 1 " "

Account

R: Was there any special reason you said to her  
"You don't want to show your kneecaps?"

N: Not really, just making her laugh.

R: Why did you want to make her laugh?

N: Cheer everyone up.

Again, there is no direct mismatch between the functional categories and the nurse's account, but "social acknowledgment" does not really capture the nurse's stated aim of wanting to "cheer everyone up". There is an elaboration of meaning in the account.

6.7.3 Context: The nurse is attending to a patient in the toilet who seems upset.

Conversation Extract

Borgatta IPS

P: Well I called and called.

17 Antagonism,  
Confrontation

N: Don't worry about it.  
You see there's only two  
nurses on for each ward  
and we're busy.

2 Shows solidarity  
18 Ego defensiveness

Account

R: When she said she called and called, you told her not to worry - do you think that would make her feel any better?

N: I think so, yes, because she could be feeling a bit guilty (at having wet herself).  
Someone should have answered her even if I wasn't there. She's out in the sun lounge - either they'd or ignored her - I don't know.

R: Did you feel put on the spot when she was talking to you?

N: Yes, I felt as though I was being told off. I suppose it's because I know I should have gone back first of all and taken her.

There is an extensive elaboration of the functional categories in this account. What is described as "ego defensiveness" in the IPS coding is seen as hiding an admission of guilt which only becomes evident in accounting. The justification of action (or lack of it) is made by an appeal to the responsibility of others in the account, whereas in the conversation, the nurse excuses herself to the patient by saying how busy they are - an appeal to a shared mythology.

6.7.4 Context: The nurse is helping a patient to dress.

Conversation Extract

Borgatta IPS

N: This is a lovely dress  
isn't it?

1 Social acknowledgment

P: Yea.

5 Shows agreement

N: Lovely and soft.

1 Elaboration

Account

R: Why did you comment about her dress?

N: Well I liked it, it was nice.

A straightforward correspondence exists between the IPS scoring and account. No tactics are being used; it is a simple response which requires no elaboration.

6.7.5 Context: It is almost the end of the evening shift and the nurse is attending to a patient in the toilet.

Conversation Extract

Borgatta IPS

N: Go back and sit down and  
you'll go up to your ward  
in about five minutes.

7 Suggests solution

P: Oh that will be dreadful to go back and sit down again.	14 Disagrees
N: Only for five minutes.	6 Procedural suggestion
P: I've been in there a long time	14 Disagrees, maintains contrary position
N: Yes, well it's only for five minutes more.	4 Acknowledges
Five minutes more and then the night staff will come and take you to bed.	6 Procedural suggestion " "

### Account

R: Did you have any reason for saying the night staff would be coming?

N: Well she didn't want to sit down again and I wanted to get her to bear it for a bit longer.  
I wanted to get her off and sat down so I could go home.  
It was the end of the day and I'd had enough.

In this extract, the nurse's hidden motives become apparent in the account. It could not be deduced from the IPS alone that the nurse was in fact attempting to manipulate the patient's behaviour for her own ends. The nurse justifies this by an appeal to tiredness and deserved rest.

6.7.6 Context: The nurse is assisting a patient to dress in the morning.

### Conversation Extract

### Borgatta IPS

N: Are you ready or are you ready?	13 Direct eliciting
P: I am. (says something about needing help)	11 Gives information 15 Personal inadequacy
N: You can balance well. I've seen you walk	2 Shows solidarity 18 Asserting own authority



Account

N: When she first came you could see that if she wanted to do something for herself she was quite able - like she walked right down to the lifts with me and now "should you not get another nurse to help you to stand me up?" I said to her "Well you've walked down" - all I did was support her arm. Obviously people have come on at night and two nurses have helped her and she can see that it's done and she wants it all the time.

There is no mismatch between functional categorisation and account in this extract, but it is important to know why the nurse is "asserting own authority". This becomes evident in her account. Her knowledge of the patient leads her to believe that she is more capable than it appears. Therefore a justification is made by an appeal to professional judgement.

6.7.7. Context: The nurse is settling a patient into a chair.

Conversation Extract

Borgatta IPS

N: You must be putting on weight, 8 Gives opinion  
those poppers are coming undone<sup>12</sup> Draws attention  
P: I should think with all the 8 Gives opinion  
diarrhoea I've had I'd have  
lost a stone.

Account

R: Did you have any particular purpose in talking about her putting on weight?

N: Well it was just to take the conversation off that particular moment - and obviously she likes to talk about herself so...and at the same time she was swearing she was going to the floor and I was just trying to...I mean she can do it perfectly well, and I think she knows she can.

When the account of this extract is considered, a hidden agenda becomes apparent which is not evident in the IPS coding at all. The nurse is not only "giving opinion" and "drawing attention"; she is trying to distract the patient in order to accomplish a task. A justification is made by an appeal to tactics of distraction in the service of professional judgement.

6.7.8 Context: The nurse is settling a patient into a chair.

Conversation Extract

Borgatta IPS

N: I'm going to walk you out to the toilet when you go around lunchtime.	11 Gives information
That's another thing I've not seen you do for the last couple of days do you know that?	17 Confrontation
P: Well you see, when the thing's been missing they couldn't walk me.	10 Redirected aggression
N: Sure, I understand that, but you used to walk down to the lift and back didn't you?	4 Acknowledges 17 Confrontation
P: I don't remember that.	15 Withdrawal
N: Ooh, I remember.	17 Sarcasm
P: You mean when I was in before?	13 Direct eliciting
N: No!	14 Disagrees
You walked down to the lift last week with me.	17 Confrontation
I can understand you not doing it without your tripod, so I'll have a search around for your tripod and we'll take it from there.	4 Acknowledgement 6 Procedural suggestion

Account

R: You say she hasn't walked to the toilet for a few days - she could just be pushed - why do you want her to walk?

N: Because the more she does - I could see her becoming more and more dependent quite rapidly on us. If she could walk, she could stand better, for her own confidence.

Again, no mismatch is apparent, but the reason behind the confrontation becomes evident in her account. A justification is made by an appeal to therapeutic principles.

6.7.9 Context: The nurse is explaining to the patient that she is about to have a rectal examination.

Conversation Extract

Borgatta IPS

N: All right Mary.	1 Common social acknowledgment
Nurse wants to have a look at your bowels.	11 Gives information
She's going to have a look up your back passage.	11 Elaboration
Just a little feel 'cos we think you might be constipated.	8 Gives opinion
Like we did last time.	11 Elaboration
All right?	1 Social acknowledgment
P: Yea.	4 Understands

Account

R: Any particular reason you were telling you were going to come?

N: Yes, she understands, she doesn't mind, it sounds sort of frightening the way I put it there but she understands exactly.

R: You could just not have told her.

N: Well, she's quite bright even though her English isn't very good. She knows what's going on.

Again, the account gives an elaboration on the reasons for action. Justification is made by appealing to professional judgement.

6.7.10 Context: The nurse is responding to a patient's request in the dayroom.

Conversation Extract

Borgatta IPS

N: What, back up the chair?	13 Asks for opinion
P: Just to the back a bit dear.	6 Procedural suggestion
N: How's that?	1 Implicit eliciting

Account

R: You could have said to her "Well you'll have to push yourself back".

N: She's got such tiny legs and low chairs are hopeless for getting them up - they can't push themselves back - when she sits up just her toes are touching the floor. She wouldn't have been able to manage it.

Again, no mismatch, but when challenged, the nurse defends her action in the account.

6.7.11 Context: The nurse is talking with a group of patients in the dayroom.

Conversation Extract

Borgatta IPS

N: What did your children do?	13 Direct eliciting
P: Mine?	1 Social acknowledgment
N: What did your children do?	12 Repeats
P: My daughter is a stenographer..	11 Gives information
N: A?	1 Implicit eliciting
P: A stenographer and my son is an engineer, a motor engineer.	12 Repeats 11 Gives information
N: Oh yes.	4 Understands
Have you got any grandchildren?	13 Direct eliciting

P: Yes, four	11 Gives information
N: Have you?	4 Acknowledges
P: One boy and one girl in one family and one boy and one girl in the other family.	11 Elaborates
N: Oh lovely.	1 Friendly gesture
How old are they?	13 Direct eliciting
P: (radio very loud) and the boy - a little devil, is 5 years old. My two other granddaughters, one's 20 and one's 17.	11 Gives information 11 Elaborates
N: Ooh, there's quite a difference in their ages then. (audible yawn)	8 Gives opinion

#### Account

R: What were you trying to do?

N: Bring her into the conversation.

R: Did she look left out of it?

N: Well she sat there sort of just looking around her, I suppose because Miss O and Miss P were talking about their work and she did say when the auxiliary asked her "Where did you work?" she said "I never worked" and so the auxiliary said to her "Why not?" and I think that really shut her up and I think embarrassed her. She just sat there and kept looking at Miss O, so I got up and moved her wheelchair so that she was more part of the group and she was able to prompt Miss O - things she knew because Miss O had told her before. She'd moved out of Southampton when she got married but she could join in when they started talking about the air raid shelters and that. I suppose it was so I could bring her into the conversation a bit more.

R: You could have ignored her.

N: Mm but Mrs. P does tend to repeat herself...  
 she knows she's doing it and she wants to say  
 something else but she doesn't know what she  
 ought to be saying. She kept bringing the  
 thing back to work and Mrs. H - she did look  
 embarrassed actually.

R: So you felt you had to do something?

N: Yes.

In this extract, the nurse's intention only  
 becomes evident in the account.

6.7.12 Context: Patients are sitting round the table  
 ready for lunch, space is tight and one patient wants  
 to go to the toilet.

Conversation Extract

Borgatta IPS

N: Where are you going?	13 Direct eliciting
P: The toilet, where is it?	11 Gives information
	13 Direct eliciting
N: Over there	11 Gives information
Can I push you in a bit more	1 Implicit eliciting
Miss F please?	
P2 No I can't, my chair's....	14 Disagrees
N: Well this lady's got to	17 Antagonism,
get past.	confrontation
Just lift your arm up.	Procedural suggestion
P2 She must do what we all do	14 Maintains contrary
and go round.	position
N: Yes, but she's got to walk	14 Disagrees
and you go in a chair.	
Lift your arm up.	6 Procedural
Lift your arm up.	12 Repeats
P: Can I get through?	13 Direct eliciting
N: That's the only distance we	11 Gives information
can give you.	
P: Oh I shall have to go round.	8 Opinion
N: It's a bit too far for her to	8 Opinion
walk I think.	

P:	And I've got to get back	5	Agreement
	haven't I?		
N:	Yes	5	Agreement
	Miss F, wait until she's	17	Antagonism, demanding
	walked back.		
P:	It's just here isn't it?	1	Implicit eliciting
N:	Yes	5	Agreement
	There we are.	1	Acknowledgment
P:	Thank you	1	"
N:	Straight out there	1	"

### Account

N: I'm afraid I'm not very keen on Miss F I must admit

R: What makes you say that?

N: She's very quick to moan about everybody else, whatever anybody else does - they're an absolute nuisance but you're expected to do this do that what you. On my first day one of the nurses said to just ignore her because she goes on and on and you can't really walk away from her. Miss L is a very tiny lady and she'd just sat down - she does this every single time - no I don't want to go to the toilet - I'm just going to sit at the table - and then when she gets to the table she starts asking the ladies on the table - where's the toilet? And then she'll get up and walk around. But Miss F was in the way and didn't want to be pushed in because it was squashing her arm and so I said if you hold your arm up - but she let it flop you see - so I held her arm and pushed her in and put the brake on, but as Miss L was walking back she started pushing her wheelchair back just in spite I think - just the fact that she has to be moved for somebody else. Miss L walks like this with her knees cracking all the time - she tries so hard - I didn't see why she should have to walk all the way round but Miss F said that we have to but she's in a wheelchair which is a bit different. I had to move a couple of wheelchairs and lift her frame over but then she carried on on her own. I didn't want Miss F to move back because she would

*have been disturbed when she was eating her dinner - for her benefit really. But she wasn't very happy, said Miss L was a blooming nuisance, always does it, I think everyone finds her a bit trying really because she's very very abrupt and she always looks very very sad. She sits there all day and very rarely talks to anybody - occasionally to John Smith.*

There is an extensive elaboration of meaning evident in the account in this extract. A justification is made by the nurse judging the legitimacy of patients' claims, something which is not apparent from the IPS coding.

## 6.8 DISCUSSION

A series of comparisons have been made between the accounts offered by student nurses and the IPS scoring system of Borgatta (1962). Generally speaking, the IPS scoring system identifies the function of utterances made, such as "gives information" or "disagrees". This type of descriptive analysis may be useful in identifying patterns of interactions which are problematic for example. What such a descriptive approach does not do, however, is provide an explanation for the interaction. This can only be achieved by the examination of accounts given in response to a challenge.

The conversation cannot be used to explain itself. If, as is the case in the present study, an explanation of behaviour is sought, then an analysis which deals only with process or function is inappropriate. Additional information is required, and in this case is sought, from the student nurses involved in the conversations.

## 6.9 SUMMARY

This chapter has reported a pilot study of student nurses' attitudes toward old people using an accounting methodology; accounting has been compared with an interaction process analysis of conversation in terms



of the level of explanation offered by each and it has been demonstrated that accounting produces an extensive elaboration of meaning and lays bare the intentions of the speaker which might otherwise go unnoticed. In the following 2 chapters, the main study, using an accounting methodology will be reported and discussed.

## CHAPTER SEVEN

### MAIN STUDY: OBJECTIVE CONVERSATIONAL DATA

#### 7.1 INTRODUCTION

The pilot study carried out in the geriatric unit had enabled the researcher to familiarise herself with the recording equipment and to establish a more standardised procedure for accounting.

However, it was not the case that student nurses only encountered old people in the geriatric unit. Informal conversations with students during the course of their geriatric placement indicated that the students themselves felt that experience in geriatric nursing as a speciality was somewhat redundant.

It was their opinion that they had already done more than enough geriatric nursing on other wards and that the medical wards had been "full of geriatric patients anyway".

This distinction between types of old people who are also patients in hospital had not been made in the studies reviewed in Chapter 2. However, a common - sense approach indicates that nurses deal with at least 3 types of old people as patients: there are old people who are patients in a medical (or other ward; there are old people who are also in a medical (or other) ward but who are also considered to be "geriatric" by the nursing staff; and there are old people in geriatric units who, by definition, are geriatric patients.

It seemed desirable, therefore, that the main study should take account of these distinctions. In order to do this a medical unit was identified to which student nurses were allocated during the course of their training. The unit in question was part of a district general teaching hospital and comprised 4 thirty bedded wards which catered for male and female patients on each ward. It was a modern building which created difficulties for the use of the radio equipment until a suitable location for receiving

the transmission could be found.

Student nurses in this particular school gained experience on medical wards at the beginning and at the end of their training, and whilst it was not feasible to carry out a longitudinal study, a cross-sectional comparison was possible between first and third year student nurses. The geriatric placement only took place in the second year of training. Therefore a study was planned to take place in the medical and geriatric units where student nurses experienced those relevant parts of their training.

## 7.2 METHOD

### 7.2.1 Design

Three groups of student nurses were involved in the study as follows:-

1. First year student nurses working in the medical unit (n=10)
2. Second year student nurses working in the geriatric unit (n=11)
3. Third year student nurses working in the medical unit (n=8)

Four types of patients were involved in the study as follows:-

1. Younger patients, below retirement age (65 and under for men, 60 and under for women) in the medical unit.
2. Older patients of retirement age (66 and over for men, 61 and over for women) in the medical unit who were not considered to be "geriatric" by student nurses.
3. Patients of retirement age in the medical unit who were considered to be "geriatric" by the student nurses.
4. Geriatric patients in the geriatric unit.

The number of these different types of patients involved in the study could not be specified beforehand as it was neither possible, nor considered desirable, to constrain the nurse's activities by determining the patients with whom she should converse.

#### 7.2.1.1 recording schedules

In the geriatric unit, the 12 hour day shift was divided for recording purposes into six 2 hour periods as follows:-

8.00 - 10.00 a.m.	12.00 - 2.00 p.m.	4.00 - 6.00 p.m.
10.00 - 12.00 m.d.	2.00 - 4.00 p.m.	6.00 - 8.00 p.m.

Student nurses were recorded for two hours each, selected from the six 2 hour periods of the day shift and from Mondays to Fridays according to their availability on off duty rotas and in conjunction with their scheduled teaching, in an attempt to provide an even spread of recording over the 12 hours of the day shift.

In the medical unit, recording was only permitted during the morning because of the greater possibility of uninformed personnel or visitors coming to the unit outside these hours. Therefore, the morning shift was divided for recording purposes into two 2 hour periods as follows:-

8.15 a.m. - 10.15 a.m.
10.15 a.m. - 12.15 p.m.

Because of time constraints imposed by nursing management, student nurses were recorded for both morning sessions, on different occasions according to their availability on off duty rotas, in conjunction with their scheduled teaching and from Mondays to Fridays.

#### 7.2.1.2 settings

In the geriatric unit, one male 26 bedded ward and two female 19 and 18 bedded rehabilitation wards were used. In addition to recording on these wards, recording also took place in a large dayroom which served all 5 wards in the unit. The transmission of nurse-patient conversations was received and recorded in a separate room away from the dayroom and ward areas.

In the medical unit, 4 mixed sex 30 bedded wards were used. The transmission was received and recorded on a fire staircase adjacent to the wards in question.

#### 7.2.2 subjects

The 29 subjects were student nurses undergoing general nurse training in a district general teaching hospital. They were comprised of three groups as follows:-

1. First year student nurses (n=10) in their first medical ward placement.
2. Second year student nurses (n=11) in their geriatric ward placement.
3. Third year student nurses (n=8) in their second medical ward placement.

Biographical details are given in Appendix F. All student nurses working on the units in question at the time of study, were approached and invited to participate by the researcher. The total population for the three groups was 12, 13 and 11 respectively. Those students not included had declined the researcher's invitation.

#### 7.2.3 Apparatus

Lustraphone radio transmitter and receiver (FM R608  
0.25W power at 174 MHz)  
Clip on microphone  
Stopwatch

Two Philips N2213 cassette recorders, one modified  
for use with headphones  
Memorex 120 cassette tapes

#### 7.2.4 Procedure

##### 7.2.4.1 obtaining consent in the geriatric unit

In the geriatric unit, consent to audiorecording of conversations was sought from patients and staff in the following terms:-

PATIENTS     "My name is Mrs. Fielding and I am from the university. I am doing some research with the student nurses on this unit because I am interested in how they talk to patients. One of the things I am doing with them is some tape-recording. Would you mind if the tape recorder happened to be near you when we were recording?"

STAFF         "I am interested in the communication between student nurses and patients and wish to do some tape-recording in this unit. Do you have any objections to this? I am focussing on the student nurses and would not be interested in any other conversations although there is the possibility that these may be recorded. Any information I may receive will be treated in the strictest confidence and no-one will be identifiable in my final report".

As in the pilot study, the researcher was satisfied that no patients were upset by her proposal, although in many cases informed consent was unattainable. Frequent checks were made for new staff and patients and if visitors were likely to be present during a recording, the researcher was able to explain the research to them personally.

Student nurses were approached personally by the researcher who explained the research to them in terms of being interested in "how student nurses and patients interact". The need to wear a radio-microphone was discussed and it was emphasized that students would have the opportunity to discuss the recordings with the researcher afterwards.

#### 7.2.4.2 obtaining consent in the medical unit

In the medical unit, consent to audio-recording of conversations was sought from patients and staff in the following terms:

PATIENTS     A letter was given to each patient explaining the purpose of the research in terms of how nurses talk to patients. The voluntary nature of the patient's participation was stressed; confidentiality was assured and in addition the researcher talked to each patient to ascertain that there was a willingness to co-operate.

STAFF         All staff (medical, domestic and nursing) received a letter explaining the purpose of the research in terms of nurse-patient communication. The researcher's desire not to disrupt their work was emphasised; confidentiality was assured and an open invitation to discuss the research was given.

Student nurses were approached personally by the researcher and invited to participate in the project. Before each recording, checks were made for new patients and staff.

#### 7.2.4.3 recording

Each student nurse wore the microphone for a total of 4 hours excluding meal and coffee breaks. The first 2 hours provided a period of adaptation whilst the second 2 hours were recorded on tape. The nurses were not told that the first 2 hours was for adaptation purposes and for the nurse who recorded for the first 2 hours of the day, an adaptation period was provided on the preceding day.

In addition to the audiotape recording, the researcher

kept rough notes at 15 second intervals throughout the 2 hours in order to be able to locate specific conversations for accounting purposes. On completion of recording, 5 conversations were selected randomly to form the basis of accounting sessions.

#### 7.2.4.4. accounting

As soon as practicable after recording, either the same day or within 24 hours, the researcher arranged to interview the student nurse. The conversations were played for the student to hear. After hearing each one, the interview proceeded according to the following format:-

1. Do you remember that?
2. What can you tell me about \_\_\_\_\_ (name of patient)?
3. How popular would you say she/he is?
4. Why?
5. Why did you say \_\_\_\_\_?
6. Did you have any particular intention in mind?
7. How were you feeling at the time?

Additional questions were asked depending on the particular conversation.

At the end of the accounting sessions in the medical unit, each student nurse was asked the following question:-

"Of the patients we have talked about today, do you think any of them would be more appropriately cared for on a geriatric ward?"

### 7.3 RESULTS

The results will be presented and discussed in two parts. Firstly, in the remainder of this chapter we will consider those "objective" data resulting from the conversations, relating to conversation length, context and content. Secondly, in Chapter 8,



the analysis of accounts will be presented and discussed.

### 7.3.1 Conversations with Types of Patients

Two hundred and thirty five (235) accounts were collected on the basis of 235 conversations from 29 student nurses and their patients. Those conversations in the geriatric unit were, by definition, conversations between nurses and geriatric patients. In the medical unit, conversations between nurses and younger patients, older patients or "geriatric" patients. The spread of conversations sampled, involved all types of patients but not in any representative proportion as no attempt was made to pre-select patients or conversations. Table 7.1 indicates the spread of types of patients involved in the study in the medical unit.

Table 7.1 Number of Conversations with Different Types of Patients in the Medical Unit

Student group	Young Male	Young Female	Old Male	Old Female	"Geriatric" Male	"Geriatric" Female
First Year (n=10)	20	11	21	32	7	9
Third Year (n=8)	24	4	24	8	5	15

A conversation was defined as "a verbal interchange between nurse and patient lasting 25 seconds or longer with less than a one-minute break in transmission" (Wells 1980). This definition was chosen in order to avoid a large number of extremely short interchanges which, it was felt, would not be particularly helpful for accounting purposes. However, it must be recognised that the resulting sample of conversations will not reflect the true nature of the total amount of nurse-patient verbal communication but will be a selected sample. The sampled extract from any one conversation in the present study was limited to 5 minutes. It was not possible

therefore, to determine the absolute length of a small number of the conversations, or to determine mean length. Table 7.2 shows the number and percentage of conversations sampled, whose total length exceeded 5 minutes.

Table 7.2 Conversations Lasting Longer than 5 Minutes

	Student Group	Hospital Unit	Number Conversations	Percentage of Total Convs.
First Occasion	1st Yr.	Medical	5	10.0%
Second Occasion	1st Yr.	Medical	1	2.0%
	2nd Yr.	Geriatric	5	9.1%
First Occasion	3rd Yr.	Medical	2	5.0%
Second Occasion	3rd Yr.	Medical	0	0

Table 7.3 however, indicates the median length of student nurses' conversations with patients.

Table 7.3 Median Length of Nurse-patient Conversations

Student Group	Hospital Unit	Median Length of Conversations	
		First Occasion	Second Occasion
1st Yr.	Medical	1min. 28.5 secs.	1 min. 13.0 secs.
2nd Yr.	Geriatric	2 mins.40.0 secs.	(not applicable)
3rd Yr.	Medical	1 min. 48.0 secs.	1 min. 15.5 secs.

It seems that student nurses in the geriatric unit were likely to have longer conversations with their patients than were students working in the medical unit. However, patients in the medical unit include younger, older and "geriatric" patients. Table 7.4 shows a breakdown of median lengths of conversations with older and "geriatric" patients in the medical unit.

Table 7.4     Median Lengths of Conversations with Older  
and "Geriatric" Patients in the Medical Unit

	Student Group	Median Lengths of Conversations	
		Older Patients	"Geriatric" Patients
First Occasion	1st Yr.	1 min.23.0 secs.	2 mins. 50.0 secs.
Second Occasion	1st Yr.	1 min. 6.5 secs.	1 min. 38.0 secs.
First Occasion	3rd Yr.	1 min.50.0 secs.	1 min. 54.0 secs.
Second Occasion	3rd Yr.	42.0 secs.	1 min. 2.0 secs.

As there is some variation between median lengths on first and second occasions it would be unwise to assume that observed differences in median lengths are linked to different patient types. Even if that were the case, the findings may not have any psychological relevance as those patients perceived as "geriatric" in the medical unit and those patients in the geriatric unit, may necessitate nurses having longer conversations with them by virtue of their differential nursing needs.

### 7.3.3. Context of Conversations

As in the pilot study, context was defined according to the categories used by Wells (1980) and which are based on the principal activity of the nurse during the conversations as follows:-

1. PHYSICAL CARE TASKS: The nurse was accomplishing a task of direct physical care such as bathing, commoding, or getting the patient in or out of bed.
2. ORIENTING: The nurse was not involved in physical care and was orienting a confused and/or wandering patient by telling the patient, for example, where and who she was or clarifying some aspect of the environment or care that was causing visible distress.

3. **SOCIALISING:** The nurse was not involved in physical care and was talking with the patient about subjects unrelated to hospitalization such as a newspaper story or a television programme.
4. **COMFORTING/ENCOURAGING:** The nurse was not involved in physical care and was talking with a patient in order to provide comfort for visible distress such as talking to a crying patient, or to encourage a behaviour the nurse thought necessary such as encouraging the patient to drink more fluid.
5. **INSTRUCTING/EXPLAINING:** The nurse was not involved in physical care and was talking with a patient in order to give instructions or explanations about an aspect of care, such as discussing the need for, and procedure of, having an enema.

A 10% random sample of the conversations were categorised by the researcher and an additional judge working independently. An interjudge reliability level of 83.3% was achieved. The remainder of the data were categorised by the researcher. Tables 7.5 and 7.6 show the numbers and percentages of conversations related to the nurses' activity.

Table 7.5 Frequency of Conversations related to Nurse's Principal Activity

	Student Group	Phys. Care	Orient.	Social.	Comf./Enc.	Inst./Expl.	TOTAL
First Occasion	1st Yr. Medical	31	4	6	7	2	50
Second Occasion	1st Yr. Medical	34	2	5	7	2	50
	2nd Yr. Geriatric	32	6	14	3	-	55
First Occasion	3rd Yr. Medical	25	1	2	7	5	40
Second Occasion	3rd.Yr. Medical	31	1	1	2	5	40

Table 7.6 Percentage Frequency of Conversations related to Nurse's Principal Activity

	Student Group	Phys. Care	Orient.	Social.	Comf./ Enc.	Inst./ Expl.	TOTAL
First Occasion	1st Yr. Medical	62.0	8.0	12.0	14.0	4.0	100
Second Occasion	1st Yr. Medical	68.0	4.0	10.0	14.0	4.0	100
	2nd Yr. Geriatric	58.2	10.9	25.5	5.6	0.0	100.2
First Occasion	3rd Yr. Medical	62.5	2.5	5.0	17.5	12.5	100
Second Occasion	3rd Yr. Medical	77.5	2.5	2.5	5.0	12.5	100

In order to ascertain whether or not any differences prevailed in nurses' principal activity between the two occasions, 2 x 2 chi-squared tests of association were carried out on data from 1st and 3rd year groups after categories other than Physical care had been combined.\* For the 1st year group,  $\chi^2 = 0.18$ , d.f. 1, n.s. For the 3rd year group,  $\chi^2 = 1.64$ , d.f. 1, n.s.. Consequently, only those data from the first occasion was used in subsequent analysis.

In order to make the three groups strictly comparable one needs to consider morning conversations only in the geriatric unit and separate the patient types in the medical unit, remembering of course that this reduces the total number of conversations considered in the geriatric unit (see Tables 7.7 and 7.8).

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\* It is recognised that each subject contributes more than once to these data. However, as each conversation was sampled randomly it is unlikely that the data are dependent in the same way as if subjects were making repeated choices between alternatives.

Table 7.7 Frequency of Morning Conversations related to Principal Activity of Nurse (first occasion only)

Student Group	Hospital Unit	Patient Type	Phys. Care	Orient.	Social.	Comf./ Enc.	Inst./ Expl.	TOTAL
1st Yr.	Medical	Younger	10	-	2	1	-	13
		Older	17	4	3	5	2	31
		"Geriat"	4	-	1	1	-	6
2nd Yr.	Geriat- ric.	Geriat.	15	1	3	1	-	20
3rd Yr.	Medical	Younger	7	-	-	-	3	10
		Older	10	-	1	4	2	17
		"Geriat"	8	1	1	3	0	13

Table 7.8 Percentage Frequency of Morning Conversations related to Principal Activity of Nurse

Student Group	Hospital Unit	Patient Type	Phys. Care	Orient.	Social.	Comf./ Enc.	Inst./ Expl.	TOTAL
1st Yr.	Medical	Younger	76.9	-	15.4	7.7	-	100
		Older	54.8	12.9	9.7	16.1	6.5	100
		"Geriat"	66.7	-	16.7	16.7	-	100.1
2nd Yr.	Geriat- ric	Geriat.	75.0	5.0	15.0	5.0	-	100
3rd Yr.	Medical	Younger	70.0	-	-	-	30.0	100
		Older	58.8	-	5.9	23.5	11.8	100
		"Geriat."	61.5	7.7	7.7	23.1	-	100

The numbers in some of the cells are too small to make a test of association feasible, but there is some suggestion that conversation with patients whilst carrying out physical care was the most likely occurrence in both medical and geriatric

units with all types of patients.

A further breakdown of conversations in the geriatric unit indicates that student nurses were more likely to converse with patients whilst carrying out physical care during the mornings and to a lesser extent in the evenings. In the afternoons conversations whilst socialising were increasingly likely (see Table 7.9).

Table 7.9 Frequency of Conversations related to Principal Activity of the Nurse and Time of Day in the Geriatric Unit

Time of Day	Phys. Care	Orient.	Social.	Comf./ Enc.	Inst./ Expl.	Total
Morning (8-12)	15	1	3	1	-	20
Afternoon (12-4)	9	1	8	2	-	20
Evening (4-8)	8	4	3	-	-	15

#### 7.3.4 Content of Conversations

As in the pilot study, the categorisation system was derived from Wells (1980) as follows:-

1. PROCEDURAL: The communication was concerned with the performance of a task.
2. PERSONAL: The communication was concerned with a specific patient in a personal way.
3. MIXED: The communication entailed both procedural and personal aspects.

A 10% random sample of the conversations were categorised by the researcher and an additional judge working independently. An interjudge reliability level of 100% was achieved. The remainder of the data were categorised by the researcher. Tables 7.10 and 7.11 show the frequency counts for all conversations.

A 2 x 3 chi-squared test of association was carried out on the data from 1st year student nurses and no statistically significant differences were observed between first and second occasions ( $\chi^2 = 2.21$ , d.f. 2, n.s.). For the data from 3rd year student nurses it was necessary to combine the Personal and Mixed categories before a 2 x 2 chi-squared test could be performed. No differences were evident between first and second occasion ( $\chi^2 = 0.28$ , d.f.1 n.s.). Consequently only those data from the first occasion were used in subsequent analysis.

Table 7.10 Frequency of Conversations in relation to Content

	Student Group	Hospital Unit	Content of Conversations			TOTAL
			Procedural	Personal	Mixed	
First Occasion	1st Yr.	Medical	31	5	14	50
Second Occasion	1st Yr.	Medical	35	7	8	50
	2nd Yr.	Geriatric	18	15	22	55
First Occasion	3rd Yr.	Medical	32	2	6	40
Second Occasion	3rd Yr.	Medical	29	5	6	40

Table 7.11 Percentage Frequency of Conversations in relation to Content

	Student Group	Hospital Unit	Content of Conversations			TOTAL
			Procedural	Personal	Mixed	
First Occasion	1st Yr.	Medical	62.0	10.0	28.0	100
Second Occasion	1st Yr.	Medical	72.0	14.0	16.0	100
	2nd Yr.	Geriatric	32.7	27.2	40.0	99.9
First Occasion	3rd Yr.	Medical	80.0	5.0	15.0	100
Second Occasion	3rd Yr.	Medical	72.5	12.5	15.0	100



In order to achieve a greater degree of comparability it is necessary to consider morning conversations only in the geriatric unit and to separate the types of patients involved in the medical unit, remembering once again that this inevitably reduces the total number of geriatric unit conversations considered (see Tables 7.12 and 7.13).

As the expected frequencies for several cells would be less than 5 even if categories were combined, a test of association is not feasible. However, it would seem that entirely Procedural conversations were more likely with "geriatric" patients in the medical unit than in the geriatric unit and that student nurses in the geriatric unit were more likely to engage in Personal conversations than students in the medical unit were with any type of patient.

In both the medical and the geriatric units, the majority of morning conversations were about procedures or tasks. This is to be expected as during the morning a great deal of nursing procedures are carried out, the time being mostly taken up by the routines of serving breakfasts, making beds, getting patients up etc.. Table 7.14 indicates that in the afternoon, conversations in the geriatric unit tended to be Mixed, whilst entirely Personal conversations were most likely to occur in the evenings. The small frequencies involved however, mean that caution should be exercised in interpretation.

Table 7.12 Frequency of Morning Conversations related to Content (first occasion only)

Student Group	Hospital Unit	Patient Type	Content of Conversations			TOTAL
			Procedural	Personal	Mixed	
1st Yr.	Medical	Younger	6	2	3	11
		Older	20	3	9	32
		"Geriatric"	5	0	2	7
2nd Yr.	Geriatric	Geriatric	10	5	5	20
3rd Yr.	Medical	Younger	6	0	1	7
		Older	15	1	4	20
		"Geriatric"	11	1	1	13

Table 7.13 Percentage Frequency of Morning Conversations  
related to Content (first occasion only)

Student Group	Hospital Unit	Patient Type	Content of Conversations			TOTAL
			Procedural	Personal	Mixed	
1st Yr.	Medical	Younger	54.5	18.2	27.3	100
		Older	62.5	9.4	28.1	100
		"Geriatric"	71.4	-	28.6	100
2nd Yr.	Geriatric	Geriatric	50.0	25.0	25.0	100
3rd Yr.	Medical	Younger	85.7	-	14.3	100
		Older	75.0	5.0	20.0	100
		Geriatric	84.6	7.7	7.7	100

Table 7.14 Frequency of Conversations in the Geriatric Unit  
related to Content and Time of Day

Time of Day	Procedural	Personal	Mixed	Total
Morning (8-12)	10	5	5	20
Afternoon (12-4)	3	4	13	20
Evening (4-8)	5	6	4	15

## 7.4 DISCUSSION

### 7.4.1 Conversation Length

The median length of conversations in the geriatric unit (2 mins. 40 secs.) is somewhat longer than the mean length of conversations reported by Wells (1980). She found a mean length of 1 min. 28 secs. in her study. Computation of the median as opposed to the mean in the present study does not account for the difference as the mean length of geriatric unit conversations is calculated to be 2 mins. 35 secs. when those conversations lasting longer than 5 minutes are counted as being only

5 minutes in total length. The explanation may possibly lie in the different methods of tape-recording used in the two studies. It could be argued that Wells' method was potentially more reactive, the researchers being physically present armed with clip-boards, stop watches and tape-recorders underneath white coats, whereas in the present study, the researcher was in another part of the hospital during the recording process.

Alternatively, the subject groups in the two studies may account for the difference. Wells' smaller sample (n=8) included pupil nurses, trained and untrained staff as well as student nurses. It may be that the student nurses in the present study have similar lengths of conversation to those student nurses in Wells' study, but the small numbers involved do not make comparisons of this sort worthwhile. On the other hand, the longer length of conversation observed in the present study may reflect an increased emphasis on communication within the nursing profession during the 5 years which separate the data collecting in the two studies.

The median length of conversations in the medical unit (1st Yrs. 1 min. 28.5 secs; 3rd Yrs. 1 min. 48 secs.) with all types of patient approximates that reported by Macleod Clark (1981) with student nurses and surgical patients (1 min. 8 secs.). Macleod Clark considered her estimate to be "generous" as "each interaction was timed from the first utterance in an exchange until the final one and included any period of silence when both participants were still present". This would have included a number of conversations shorter than 25 seconds which were excluded in the present study.

It has already been noted that the interpretation of any observed differences in median lengths of conversations with different types of patients within the present study is problematic. Common sense would suggest that degree of dependency is a relevant factor in determining the length of a conversation and in the present study, those

conversations which exceed 5 minutes in length, invariably occurred when a lengthy procedure was being undertaken e.g. bathing which necessitated prolonged nurse-patient interaction.

#### 7.4.2 Context of Conversation

The study by Wells (1980) from which the categorisation system was derived, recorded nurse-patient conversations for day-time periods from 9.00 a.m. to 5.00 p.m.. Her study affords some opportunities for comparison, albeit limited, with the present study. Table 7.15 indicates the principal activity of nurses during conversation with geriatric patients in both studies.

Table 7.15 Comparison of Present Study with Wells (1980)  
Principal Activity of Nurses during Conversation  
with Patients in Geriatric Units

Study	Phys. Care %	Orient %	Social %	Comf./ Enc. %	Inst./ Expl. %	Total No. Convs.
Present	58.2	10.9	25.5	5.5	-	55
Wells	75.3	9.4	5.3	4.1	3.8	517

Although it is apparent from both studies that nurses seem more likely to communicate verbally with patients whilst giving physical care, there are two main differences in the results. Firstly, a smaller percentage of conversations whilst giving physical care in the present study, and a larger percentage of conversations whilst socialising. There are several possible reasons for these discrepancies.

Firstly, the differences in the two studies: the 8 nurses in Wells' study were not only student nurses, but included pupil nurses, trained and untrained nursing staff; the present study considers student nurses only. The inclusion of untrained staff may be responsible for

the increased amount of conversations in the physical care category as nursing auxiliaries often carry out a large proportion of physical care (Wells 1980). The present study also included some evening conversations which are not included in Wells' study. It could be expected that in the evening, when the bulk of the day's work is accomplished, more socialising and less physical care would take place. However, this is not borne out by the present study (see Table 7.9) when afternoons seemed to be the most likely time for socialising.

Secondly, the physical environment in which the two studies were carried out: Wells' study took place in a ward which included a dayroom as part of its facility. In the present study, the dayroom to which patients were transported was separate from the ward area and student nurses did not normally remain on the ward once the patients were out of bed. They were required to accompany patients to the dayroom and so were placed in a situation with an increased potential for socialising and a decreased likelihood of physical care.

#### 7.4.3 Content of Conversation of Conversations

Table 7.16 shows the percentage frequency of geriatric unit conversations compared with Wells (1980). As can be seen, there are certain discrepancies in the Procedural and Mixed categories. However, Wells reports difficulties in recording which resulted in only 9.4% of all observed verbal communication being content analysed. In such circumstances, comparisons are spurious as it is not known in what way the conversations which were "lost", differ from those analysed.

Table 7.16 Percentage Frequency of Content of Geriatric Unit Conversations compared to Wells (1980)

Study	Procedural %	Personal %	Mixed %	Total No. Convs.
Present	32.7	27.2	40.0	55
Wells (1980)	54.1	25.0	20.8	(?49)

Very few entirely Personal conversations were noted in the medical unit (see Tables 7.12 and 7.13). This may reflect a differing emphasis between the two units - in the geriatric unit there was the expectation that nurses would spend time in conversation with patients to a degree that was not present in the medical unit.

#### 7.5 CONCLUSION

This chapter has considered the more "objective" data arising from the audio-recording of nurse-patient conversations in a geriatric and a medical unit. The following chapter will discuss the accounts produced by the student nurses upon being confronted with the recording.

MAIN STUDY: ACCOUNTING

8.1 INTRODUCTION

The pilot study showed certain areas to be of special interest when nurses are talking with patients. These areas which were outlined in Chapter Six are now elaborated not only in relation to nurses and patients in the geriatric unit, but also in relation to the different types of patients and nurses of differing levels of experience in the medical unit.

8.2 EVALUATIVE DESCRIPTIONS OF PATIENTS

Accounts were examined for instances where nurses described the patients with whom they had conversed. These descriptions were mostly given in response to the question "What can you tell me about Mr/Mrs \_\_\_\_\_?" and provided the personal context for the nurse in which the conversation took place.

8.2.1 Positive Characteristics

Positive characteristics were noted amongst all types of patients in both medical and geriatric units, comments focussing as in the pilot study on the patient's personality and degree of friendliness. Pleasantness, cheerfulness and friendliness were appreciated by all nurses but were noted considerably less amongst those patients who were deemed to be "geriatric" in the medical unit. Within the medical unit itself, very few of these "geriatric" patients were seen as in possession of positive characteristics compared to the other medical patients. It could be that two different scales of "positiveness" are operating here. In the geriatric unit, when compared to each other, some geriatric patients are seen in a positive light, whereas in the medical unit, when compared to other medical patients, very few "geriatric" patients are evaluated positively.

A distinction is made here between a positive evaluation

and degree of popularity. This distinction is one employed by the student nurses themselves in their accounting. A positive evaluation does not necessarily guarantee popularity (which will be reported shortly) because evaluation does not necessarily entail involvement with the person being evaluated, whereas for the student nurses, popularity seemed to imply a willingness or enjoyment at being in the presence of, or caring for, a certain patient.

Some of the positive characteristics perceived by student nurses had patronising overtones particularly when related to old and "geriatric" patients and most especially by first year student nurses describing older patients in the medical unit. The following examples illustrate this point:-

*"N: She's a very sweet little old lady -  
I can't think of much to say about her".  
S19(2)2*

*"N: I think he's lovely. He's like a  
gentle giant sort of thing".  
S30(2)4*

*"N: She's a really sweet little lady...(she's)  
...got quite a short little neck and it's  
(the collar) rubbing...she's a really  
lovely lady".  
S34(2)5*

None of the patients so described in the above examples were particularly "little" in the physical sense compared to their peers. What the adjective "little" does in such instances is rather to convey information which diminishes a person's stature in a condescending manner. There were no instances of younger patients being described in this way. Likewise "sweet" was often used to describe older or geriatric patients, but never applied to younger ones.

### 8.2.2 Negative Characteristics

Negative characteristics were perceived almost entirely amongst older and geriatric patients in both units and were related to what nurses felt were unnecessary



grumbles and demands. The only younger patient to be described negatively was a man who tended to annoy the other patients with his chatter and so was possibly a "second hand grumbler" in the sense that he caused others to grumble.

In the geriatric unit negative characteristics related mainly to the patients' desire to get something done at the wrong time for the nurse. One patient in particular had a reputation amongst the nursing staff for always wanting to be given priority. This irritated some staff members. Similarly another patient who always anticipated the nurse's actions was described as demanding in the following extract:-

*"N: She's very demanding..."*

*R: In what way?*

*N: Once you've done things for her she's OK, but she'll sort of tell you everything she wants to be done, you're going to do it anyway but she'll tell you beforehand. Such as "Let me down slowly" and all this sort of thing. Once you've done everything for her she's happy. She doesn't like to wait really, she wants things done now".*

S16 1

Anticipating the nurse's actions resulted in the patient being seen as demanding. The nurse's confidence in her own knowledge of what she had to do was continually being undermined. A similar process happened with another patient in the medical unit who was also deemed to be "geriatric". The student nurse made the following comments:-

*"N: I wouldn't say she was exactly demanding but she's hospitalised - you know, she's always buzzing - whenever there's a buzzer, we all know it's Mrs. G so there's lots of routines centre around her if you know what I mean....I think sometimes people get a little bit annoyed by her because she's always buzzing and asking to be put back to bed just before you're going to do her or something like that".*

S25(1)4

It seemed for the student nurse to be instructed by a patient was not only irritating (a reversal of normal roles), it was also disturbing, particularly for this first year student nurse talking about an older medical patient:-

*"N: He knows a bit too much - he's too hospitalized. And to a new nurse it's a bit - well to me it was a bit off-putting, to be told by a patient how to do something. But you just have to accept it, he's part of the furniture here and you just have to get on, in fact you can ask him a question..."*

*R: He knows a lot?*

*N: He does, he knows too much - like he knew what size wardrobe I had in my bedroom in the nurses' home. I was with him when I came back from coffee and I was saying I'd been away from home for two years and had a lot of stuff and the wardrobe and chest of drawers I had wasn't big enough and he said 'Yes, I know they're just not big enough'. I mean it's as if he's been over there and into my room".*

S22(2)5

This particular patient who knew too much it seemed, had been in the ward for several months and as the nurse herself said, was "part of the furniture". It was the student nurse who was the newcomer - as with the previous examples - she was the one who needed to be "shown the ropes" rather than the patient.

### 8.2.3 Conflicting Evaluations

Not only positive or negative evaluations of patients were made by the student nurses but also seemingly conflicting evaluations. These particular patients were seen as having positive personality characteristics which weighed against a tendency to be unco-operative or difficult to manage. The following extracts serve as examples of this phenomenon:-

*"He's very demanding at times but a very likeable man".*

S15:4

*"She's a very nice lady but she tends to - she's got a very low pain threshold and she tends to be a bit precious even though she's not getting a lot of pain with it".*

S19(2)1

*"He's a bit demanding at times but he's very pleasant with it so you don't sort of feel - I don't know - I like him. I think he's nice".*

S27(2)5

These patients, whether consciously or unconsciously, had the ability to make demands of the nurses, which, if coming from other patients, would result in a negative evaluation. They were skilled in the art of "being a patient" without becoming totally compliant. Over-politeness in patients was not welcomed by nurses. On several occasions, student nurses would remark that it was the "characters" of the ward who received the most attention and were best known despite their sometimes non-compliant nature. Such patients seemed to be skilled operators at working the system to their own advantage without incurring the displeasure of the nursing staff.

#### 8.2.4 Mental Status

Student nurses often described patients by referring to their mental status as perceived by the nurses. Problems (for the nurse) of mentally confused patients loomed large in both medical and geriatric units, but particularly in the latter. Patients were described in global terminology as being "a bit out of touch" or "not really with it". Patients in the geriatric unit were considered to be more confused and unstable than medical patients of any age and the loss of mental powers was one of the factors often instrumental in defining a patient as "geriatric" rather than medical. The following extracts illustrate this point:-

*"You can't really class people as geriatric. It conjures up this senile old person".*

S34

*"I associate geriatrics with senile dementia... mental capacities going downhill".*

S33

*"Well, he's quite old, he's quite with it, no he's not (geriatric)".*

S27

*"Er...no, definitely not (geriatric) because he's a very intelligent man".*

S27

Nevertheless, despite it being such an important aspect of care in the geriatric unit, the terms used to describe it were largely nonspecific. This also applied to both old and "geriatric" patients in the medical unit. When the mental status of younger patients was in doubt, an attempt at explanation was often made by the nurse. For example, one patient's "awful moods" were attributed to his brain tumour - in the geriatric unit, such behaviour could easily become "aggression".

Mental status was also important for nurse-patient communication and nurses often proceeded to relate what the patients' mental status implied for subsequent communication. A student nurse commented about one confused patient:-

*"I tried to do a mental test score on her the other night and she burst into tears! How am I supposed to talk to somebody who keeps bursting into tears?"*

The nurse did not know how to deal with this patient's apparent confusion and this lack of knowledge is something to which we shall return later in discussion.

#### 8.2.5 Verbal Communication

Verbal communication featured prominently in nurses' descriptions of patients, particularly in the geriatric unit where communication with patients was stressed as a particularly important activity for student nurses. Those patients who were "easy to talk to" and who had a stock in trade of stories and reminiscences were often singled out by the student

nurses when "talking to patients" was expected. But many patients had difficulties in communication such as deafness or aphasia and were limited in their verbal repertoire and student nurses frequently commented on these in their descriptions of patients. The following extracts illustrate these points:-

*"She's quite an elderly lady. She's ever so nice - very easy to talk to really".*

S10:1

*"Well, she's a Polish lady and there is a language barrier so that's maybe why I sounded a bit 'all right dear?' but I always find it difficult to communicate with her..."*

S09.1

*"He's a nice old man. He walks with a stick. The only conversation you can have with him is about his grandchildren or him wanting to go to the toilet. That's all he converses really".*

S11.3

This last point, that of the limited conversational abilities of patients, was shared by many of the student nurses in the geriatric unit. Some of them compared geriatric patients unfavourably with psychogeriatric patients on this matter. It seemed that the diminished mental status of many psychogeriatric patients released the student nurses from the taxing burden of finding a suitable conversational topic. In a group discussion following their placement on the geriatric unit, one student nurse expressed her feelings and those of her colleagues succinctly:-

*"You could talk to the psychogeriatric patients and neither of you would be making any sense but with geriatric patients conversation was so limited".*

Similar problems were noted amongst the "geriatric" patients in the medical unit and to a lesser extent amongst the older medical patients. However, there did not seem to be the same expectation in the medical unit that student nurses would engage in "talking to

patients" as a special activity and possibly for this reason, limited conversational repertoires were not noted.

#### 8.2.6 Ease of Management

Finally, one of the most important factors in evaluation for all student nurses and all types of patients was ease of management. All student nurses indentified those patients who tried hard. "Trying hard" was much appreciated by nurses and sometimes negative effects would be tolerated if there was evidence that the patient was making a real effort. For example, a patient who had a cerebro-vascular accident with right-sided paralysis often fell over in his effort to move around. This was undoubtedly difficult for nurses to cope with but was justified in the following manner:-

*"He's had a CVA and he likes to do a lot for himself, does too much sometimes, tries to get up and falls over. He's a very nice man, very pleasant. He's got speech difficulties. He's trying to get his speech back".*

S27(2)2

Within the medical unit there was more expectation of dependency on the part of older and "geriatric" patients. Often surprise would be expressed at these patients who "managed" whereas younger patients who "managed" roused no comment. The extent of dependency was an important feature contributing to the definition of patients as "geriatric" in the medical unit as the following examples illustrate:-

*"She's geriatric because she couldn't look after herself. She would be a lot of work at home".*

S23

*"Yes, he could definitely be classed as geriatric. He can't do anything for himself. He needs total care".*

S23

These medical patients who were defined as "geriatric" presented particular problems of dependency to the student nurses and for the first year student nurses this seemed to be perceived as the patient's fault and generalised to the other older patients. This did not seem to be so for the third year student nurses who emphasised the patients' need of special care rather than apportioning blame. First year student nurses were somewhat overwhelmed by dependent patients either because of this inexperience and lack of skill or because of the division of labour within the ward. However, their perception was of patients who were capable of achieving more and trying harder than they were willing. The following extracts serve as illustrations of this:-

*"I can't say I like her very much - she's really stubborn and difficult sometimes. Later on today when I was trying to give her her lunch, she wouldn't answer me or open her mouth. I was getting really frustrated and annoyed. So I dislike her even more than I did before".*

S18(2)1

*"Oh she's got all sorts - diarrhoea and well, I don't know what to make of her. I mean she can do a lot - she can do most things for herself but if you're there she won't do it. She forgets very easily what she's supposed to be doing. You have to tell her to "eat your soup" and unless you stand there and tell her to take another mouthful, she wouldn't. She needs constant prodding".*

S23(2)4

### 8.2.7 Discussion

In giving their evaluative descriptions of patients, nurses did not relate much by way of personal information about patients. Those idiosyncracies that were mentioned were mainly sympathetic reflections on a patient's particular situation and did not vary as a function of patient type or unit. It seemed from the accounts given that nurses only knew the people for whom they were caring, as patients in a hospital ward. Whilst this might be perfectly reasonable and appropriate in a medical unit, it has far reaching implications for

patients in the geriatric unit. Firstly, a lack of knowledge of personal details about a patient, means that the possibilities for casual conversation are limited. The student nurses were obviously aware of this and tended to concentrate their attention on patients with a story to tell. They remarked that some patients had only one conversation and once they had exhausted that topic, the situation became uncomfortable. Secondly, this lack of knowledge of personal details about patients meant that when nurses attempted to talk to patients, they found themselves constantly asking questions of the "What did you do when you were young?" variety. The nurses found this rather artificial and noted that if other students also employed this tactic, then patients were being required to relate the same information to each subsequent group of students at 6/7 weekly intervals.

What seemed to be missing was some opportunity for student nurses to become familiar with those in their care as people with individual histories. The only documents available to nurses were the medical case-notes and therefore the information gleaned from them related primarily to the clinical condition which might or might not be strictly relevant to their continuing stay in hospital.

"Talking to patients" was encouraged in the geriatric unit, but in a certain way - as something to engage in particularly when there was nothing else to do. This had unfortunate repercussions. Firstly, nurses saw it as a separate activity and not one which was basic to most nursing activity; secondly, because it was viewed as a separate activity, nurses' deficiencies in conversational skills were even more apparent. When trying to converse with patients the student nurses would find themselves in situations in which their conversational skills were wholly inadequate. As has been mentioned earlier, "talking to patients" was rated very highly by both nurse tutors in the training school and by the student nurses themselves.



The purpose of "talking to patients" however, was not made explicit by the tutors, but the student nurses had their own ideas as to its purpose. One of these was to learn about the patients, not in the sense of taking a history, but learning about them as individuals and thereby enabling them to feel more individual in an institution which tended to diminish individuality. It is to be regretted therefore, that they were not given the opportunity to develop and practise skills which could have helped them to realise this goal.

From their descriptions of patients in both units, it seems that the "geriatric" patients in the medical unit were viewed in the least positive light. The implications of this are considerable if one remembers that medical policy is for geriatric patients to be cared for alongside medical patients in general medical units (Hall 1973; DHSS 1976). These "geriatric" patients in the medical unit were often segregated from other patients in rooms furthest from the nurses' station. This was because the rooms within visual supervision distance were needed for more acutely ill patients. It was recognised by nursing staff that the "geriatric" patients' needs were different from those of other patients, but placed alongside other medical patients they were in effect treated in a minimal fashion - rather than receiving different care, they were simply given less of what the medical unit had to offer. Student nurses, and indeed other nursing staff, were aware of this and lamented the fact that these patients weren't really being cared for appropriately. It was generally felt that on a busy medical ward there was insufficient time to devote to lengthy rehabilitation of a minority group of patients who might show a minimal amount of improvement anyway. Nurses felt that they should, on the medical unit, devote their efforts to the care of acutely ill patients who would return to their homes when cured.

This basic dichotomy in philosophy of care for short term acute vs. long term chronic patients is one which

has been recognised for some time (Arie, 1971) but it is one which must be dealt with in a practical sense if further integration of general medical and geriatric services is deemed to be desirable. On the evidence of the present study, it seems that "geriatric" patients are not benefiting as a result of being cared for in a medical unit because the organisation of care is focussed in another direction. Furthermore, it may not be possible to integrate medical and geriatric services successfully if the characteristics and inclinations of staff attracted to each specialty are basically dissimilar.

### 8.3 POPULARITY OF PATIENTS

Accounts from all student nurses were examined for estimations of patients' popularity. These were mostly given in response to the question "How popular would you say \_\_\_\_\_ is?" or they emerged in the account following a particular conversation.

The majority of patients involved in the conversations were considered to be popular by student nurses. There were no discernible differences between first and third year student nurses in this regard. However, a greater proportion of "geriatric" patients in the medical unit were considered unpopular than younger or merely older patients. Similarly in the geriatric unit, although most patients were deemed to be popular, a substantial proportion were thought to be generally unpopular.

#### 8.3.1 Popular Patients

##### 8.3.1.1 positive appeal

Popular status seemed to depend generally on patients appearing to be "pleasant", "friendly", "sociable" and "cheerful". However, patients in the geriatric unit, "geriatric" patients and older patients in the medical unit were often deemed to be popular because

of their "appealing" nature. Certain characteristics seemed to arouse positive feelings in the student nurses and gave rise to reasons for popularity such as the following:-

*"N: He's very deaf, he's a nice old man too. He's quite popular.*

*R: Why?*

*N: He's pleasant, always nice. Quite a character really. He's a real sweetie you know, a typical grandad. Dodders around you know".*

*S11:5*

*"R: How popular would you say she was?*

*N: Very popular I think, I think she appeals because she's got a lovely face. She's really sweet".*

*S30(1)2*

*"R: How popular would you say she was?*

*N: I think most people like Freda.*

*R: Why?*

*N: She's just the sort of sweet typical old lady who can't do very much for herself and needs you a lot to do things for her. Also as well because she does speak occasionally but it's very difficult. Occasionally it comes out really clear but it's few and far between, so she can't start shouting or complaining or anything".*

*S36(1)4*

These somewhat patronising reasons for popularity may have unfortunate side-effects for the patients concerned if the student nurse is thereby drawn into giving more help than is required simply because the patient is "appealing". Such over indulgence would not be compatible with the aims of rehabilitation but would foster dependence. The following conversations from which the three previous quotes were extracted will now be examined for any evidence which would support such a thesis.

## First Conversation

The nurse approaches Mr S in the toilet.

*"N: You finished Mr S?  
Where's your hearing aid?*

*P: I have finished I think.*

*N: Your hearing aid - is it not working?*

(Mr S answers the nurse's question but she appears either not to have heard or ignores his reply and focusses on the hearing aid with a leading question).

*P: (mumbles something)*

(The sound of whistling can be heard as the hearing aid is tuned).

*N: You can hear now can't you?  
Is that better?  
Can you hear me?*

(The nurse still does not acknowledge that Mr S has answered her original question and persists in ascertaining that he can hear her).

*P: Yes.*

(Mr S confirms that he can indeed hear the nurse).

*N: Good, now you've not finished yet then?  
Have you finished yet?  
Have you finished yet?  
Have you finished in the toilet?  
(aside) No I don't think he has".*

S11.5

(The nurse fails to get any response from her repeated questioning. It is fairly clear from the first leading question that she doesn't think he has finished and indeed she states this opinion to someone else and terminates the conversation without any further response from Mr S).

It is apparent from this conversation that Mr S was given very little autonomy. His response to the nurse was ignored (for whatever reason) and in recalling this conversation, the nurse expressed her belief that even with his hearing aid on, Mr S was still very deaf. When asked if the repeated questioning had made her feel frustrated, she replied "No, not really, he gets there in the end". However, on this occasion Mr S didn't "get there" and it was the nurse who decided that he had not "finished" and that the conversation could end.

### Second Conversation

The nurse approaches Mrs H who is lying in bed. It is late morning.

*N: Hello Ethel!  
Hello Ethel!  
All right my love?  
Hello!*

*P: Hello darling.*

(The nurse gains Ethel's attention by a series of greetings).

*N: How are you?*

*P: My head...*

*N: Have you got a bad head my love?*

*P: Mm.*

(After an open question by which the nurse inquires of Ethel's feelings, Ethel responds by indicating something about her head. The nurse immediately assumes she has a bad head and leads Ethel into confirmation of this. Terms of endearment are being used by both nurse and patient).

*N: Mm, you do feel a bit hot don't you?  
When did this come on, was it just this morning?  
Was it just this morning you had a bad head?  
Oh dear.  
You're all right otherwise aren't you?  
Are you all right otherwise?*

*P: Yes.*

*N: That's good.*

(The nurse tries to ascertain, somewhat unsuccessfully, the duration of the bad head and any other symptoms. She asks a series of questions without waiting for a reply).

*P: I just feel a bit wizzy.*

*N: A bit wizzy?*

*P: Like you're going to....I want to keep nice and warm.*

(This patient was observed by the researcher never to want to get out of bed. Whichever nurse approached her to help her to get up and to make her bed, she always protested that she needed to stay in bed and keep warm. She seemed happiest when she could persuade a nurse to put her back to bed where she could curl up in the blankets and doze off to sleep).

*N: You're nice and warm as it is aren't you?  
You're lovely and warm - like a heater!*

*P: I like it really hot.*

*N: You like it really hot?  
Shall we put the blanket up a bit higher...  
I'm going to have to make your bed...*

(The nurse ventures to explain her purpose).

*P: My boy...said he'd come...he gets hold  
of me...right tight...*

*N: Gives you a hug.*

(Ethel either doesn't hear, or ignores the nurse's stated purpose and proceeds to fantasize about a relative. The nurse seems won over and joins in).

*P: Lets me know I'm there.*

*N: Aah!*

P: Yes.

N: A bear hug, that's it.

P: Oh he loves to do that.

N: That's good.

P: Doesn't like to know his mum's in bed.  
Last night....

N: Mm.

P: Sometime, through the night while we were...  
she's getting better as I know her...

N: Mm.

P: ...but she's rather...I don't know how to  
describe her really...

(The fantasy continues with the nurse making understanding noises which encourage the patient to continue).

N: Mm, I'm going to have to make your bed up  
my love.

P: I was a bit frightened of her at first.

N: Were you?  
Oh dear.

P: I'm still frightened of her".

S30(1)2

(The nurse finally reiterates her intention to make the bed but it is still resisted by Ethel).

The nurse appears to have difficulty in this conversation in managing the patient. This could either be because the patient is "appealing" - she has a "lovely face" and is "really sweet" and the nurse may not know how to insist on her co-operation, or, it could be because the symptoms complained of were genuinely confusing the issue. In considering whether or not Ethel was a "geriatric" patient, the nurse said "she's obviously psychologically upset" and so it seems that in this instance the nurse was responding not only to the "lovely face" but also to the signs of confusion.

### Third Conversation

The nurse is feeding Mrs L at lunch time.

*N: Oh Freda, is it starting again?  
Can you show me where it hurts?*

*P: (groans)*

(The patient shows signs of being in pain and the nurse tries to locate the source of discomfort).

*N: Let's have a look.  
Is it going off again now?*

*P: (groans)*

(The nurse is still trying to interpret the patient's groans).

*N: Oh dear.*

(She sympathises with Freda).

*N: Gone?  
Yes.*

(She satisfies herself that the pain has gone).

*N: Let me give you a bit more ice cream.  
I've got some jelly here, would you like  
a bit of jelly?  
No.  
You've got sticky lips now haven't you?"*

S36(1)4

(The nurse continues feeding Freda her lunch).

This conversation highlights the problems nurses experience in communicating with aphasic patients. In recalling this conversation, the nurse said "I feel a bit lost and helpless with her because she can't tell you exactly where it hurts or what it's like, so it's difficult - you've got to try and watch her all the time and get what you can out of her and guess what's going on". Because of this it is



not possible to conclude that the patient's appealing nature has influenced the nurse to encourage dependence. The nurse seems well aware of the patient's physical problems and the steps she (as a nurse) must take to cope with them.

#### 8.3.1.2 ease of communication

Patients with whom it was easy for nurses to converse were popular - they made the working day more pleasant and were often useful in "settling in" other patients with their friendly chatter. Being able to converse with a patient seemed to help nurses to accomplish various procedures more easily. This is perhaps best illustrated by the following account from a nurse who had particular difficulty in talking to a patient she was bathing in the geriatric unit:-

*"Before then it was very hard work - I was having to get him out of the bath, make sure his arms weren't caught, make sure he was on the hoist properly, pull him out, make sure he didn't catch his feet, get him dry quickly and get some clothing on him. And I was trying to do that quickly so that he didn't get cold, didn't hurt himself. And then about that time - I'd got his vest on, I'd got his shirt on and I was starting to dry his legs and put his pants on again - I tried to start up the conversation you see, and I asked a question. I thought about it and thought I'll ask if he's got any relatives coming in, so I asked him and he said "No, don't think so" so I thought "Right, fine (laughs) carry on".*

S08:4

#### 8.3.1.3 humour

In a similar manner, patients who were jovial, quick with witty repartee, even cheeky, were popular with the student nurses. However, only one patient in the geriatric unit was popular because of his sense of humour and another was popular because he amused a lot of people by his idiosyncratic behaviour. None of the "geriatric" patients in the medical unit was popular because of their sense of humour whereas it was commonplace for the other patients, both younger

and older, to be so considered. However, when denoting patients as "geriatric" or not, humour did not feature in nurses' decisions.

#### 8.3.1.4 trying hard

The amount of effort a patient was seen as being willing to expend influenced his popularity to a fair degree. The ability to achieve something did not seem to be as important as the willingness to try. The following examples illustrate this point:-

*"...does a lot for herself, tries ever so hard. She's a credit she really is".*

S17.5

*"She's very popular I think...because she says how bored and depressed she is and because she's so willing and she's fighting it you know and really getting on and helping herself...".*

S21(2)5

As with humour, this was something which differentiated the geriatric patients in both units from the merely older patients. It was the older patients (and some of the more seriously ill younger patients) who were perceived as being popular because of their willingness to try.

#### 8.3.1.5 nuisance value

Finally, the degree of nuisance a patient caused was seen to influence his popularity. This feature was evenly spread amongst all patient types and in both units. These patients were deemed to be popular because they caused so little trouble as in the following example:-

*"I'd say she was a fairly popular patient with the staff as well....she's not much trouble, she only asks for what she really needs. She's quite content to sit in her chair all day although she must be feeling bloody awful at times".*

S18(2)2

### 8.3.2 Unpopular Patients

A minority of patients were considered to be unpopular for a number of reasons, but, as mentioned earlier, geriatric patients in both units were well represented in this minority group. The reasons for their unpopularity were largely the opposite of reasons for popularity.

#### 8.3.2.1 general unpleasantness

Firstly, there were those who were generally unpleasant - those who grumbled, who were difficult or inconsiderate as in the following examples:-

*"No, it depends - I think most people have probably got a soft spot for the Admiral but I wouldn't say he was popular...first impressions, people who don't know him think he's difficult. They're frightened by his temper".*

S15:1

*"She's all right while you're with her, but when you walk away, she's got this habit of chundering under her breath, particularly in the mornings when you tell her to get dressed".*

S07:4

#### 8.3.2.2. communication difficulties

Difficulties in communication were also associated with unpopularity. On the medical unit this problem was increased by the practice of grouping longer stay elderly patients in one room on each ward. These rooms were the furthest away from the nurses' station as described earlier. Student nurses often commented on the fact that these rooms were very quiet, the patients were often stroke patients in need of intensive rehabilitation and there was a tendency for patients in these rooms to be labelled as "geriatric". One nurse described the effect as follows:-

*"...that room anyway just tends to be - you just go down there - get them up and they're*

just sort of left. I think it's terrible really. Bed 1 - Mrs R is going to tomorrow. I think she'll be a lot better off there because there's no occupational therapy for them here and they tend to be a little bit forgotten...they're sort of old and don't do a lot. I mean when you go down there you can guarantee there'll be dead silence in there. They even took the television out and put it in another man's room, so they've got absolutely nothing down there now - it's a shame. And they seem to have them all in one room so there's no conversation at all, they can't even talk to somebody... that room's just like a morgue".

S28(1)1

Even patients who were not labelled as "geriatric" could be tainted with a degree of unpopularity simply be being in these rooms as is shown with the following patient who was considered to be unpopular despite her positive characteristics:-

*"...she's down in that room, people don't tend to go down there, but she's very chatty once you get talking to her".*

S28(1)2

#### 8.3.2.3 not trying

A definite lack of effort or an unwillingness to try resulted in two "geriatric" patients in the medical unit being considered unpopular, whilst a similar small proportion of patients were unpopular because of the nuisance they caused:-

*"...she keeps you talking when you've got things to do. She's more of a burden really - everyone thinks if they've got to go in there, they'll be ages, that sort of attitude".*

S29(2)2

#### 8.3.3. Discussion

It was apparent from the accounts that if not all patients were deemed to be outright popular, it was a minority who judged to be overtly unpopular. In

the main, these were the "geriatric" patients in both units. It seemed that these patients either did not, or could not, fulfill the nurses' expectations in terms of being able to communicate easily, being always pleasant and cheerful, and being easy to manage. This study confirms the findings of Stockwell (1972) who concluded that nurses enjoyed caring for patients who fulfilled the following criteria:-

"Were able to communicate readily with the nurses.  
Knew the nurses' names.  
Were able to joke and laugh with the nurses.  
Co-operated in being helped to get well and expressed determination to do so".

p.46

The fact that "geriatric" patients were amongst the least popular patients could have serious consequences if nurses spent the minimal amount of time with them. In the medical unit, this appeared to be the case. Nurses themselves reported that the patients in the end rooms - those often considered "geriatric" - received little attention. However, Stockwell reported that the patients in her study who had "practically no verbal contact with nurses or other patients for hours at a time", were neither popular nor unpopular. The accounts from student nurses in the present study would support this finding as many nurses suggested that that it was the "characters" of the ward who received most attention, whilst a large proportion of the patient population went unnoticed. Whilst there is not the objective evidence to support it, the impression from the geriatric unit at least, was that a small proportion of patients accounted for most of the verbal interaction.

Popularity of patients was also linked to a patronising attitude on the part of the student nurses. Certain characteristics which some patients possessed seemed to arouse protective and indulgent responses in nurses. Patients who conformed to the "sweet old granny or

granddad" stereotype were popular with nurses but it may not have been to their advantage. In the first conversation reported on p.202, the nurse makes a decision for Mr S which he seems quite capable of making for himself - indeed he does make the decision but it is ignored by the nurse. In the second conversation (p.203), it is not clear whether Ethel is in fact using her 'confusion' to achieve her own ends - she only seems to become confused when the nurse suggests making her bed. But prior to this, the nurse again takes responsibility from her by interpreting and suggesting symptoms which Ethel may have clarified had she been given the chance. This kind of communication - using leading questions - is one which was common to many nurses and with many patients however. In the third conversation (p.206), the patient's inability to speak meant she was more dependent on the nurses. This particular nurse, however, seems to realise the implications of this although it is not known what effect the use of questions have on such a patient who cannot reply.

The question of autonomy and dependence is one which has been linked to attitude in the research literature. Kogan (1961) reported that a positive attitude to old people was positively correlated with a high nurturance score. People showing signs of dependence would, therefore, elicit a nurturing response in those with a positive attitude towards them. The nature of the popularity of some of the patients in the present study is perhaps indicative of a need for further research in order to determine to what extent certain characteristics of patients may result in them being deprived of autonomy and independence. The need to encourage independence was one need of which nurses were made aware in their lectures. They were warned of the temptation to "do things for" patients instead of adopting a more passive supervisory role. The student nurses, however, were often working within a set routine, the requirements of which meant that there was a limited amount of time to accomplish

certain tasks before incurring the bad feelings of other staff members. The line of least resistance lay in "doing things for" patients rather than persisting in time consuming rehabilitation which interfered with the unofficial policy of "getting all the patients to the dayroom as soon as possible".

#### 8.4 NURSES' INTENTIONS IN CONVERSATION WITH PATIENTS

Accounts were examined for evidence of nurses' intentions in conversation with patients. These were either given in response to the questions "Did you have any particular intention in mind? Why did you say \_\_\_\_\_?", or they were volunteered spontaneously in the course of an account being given.

##### 8.4.1 Procedural Intentions

There were a number of differences to be observed in nurses' intentions as they related them, but the overriding impression was of intentions being focussed primarily on the accomplishment of a nursing task or procedure. This was most evident in the medical unit where student nurses' work was mostly taken up with the performance of procedures or set routines such as "doing the washes", "giving the medicines", "doing the observations". Consequently, nurses perceived their intentions in terms of the accomplishment of these procedures or routines as in the following examples:-

*"Well (I was) just taking her dress off, getting her ready for her bath".*

*S18(2)2*

*"Well I just came in to do her observations".*

*S18(2)3*

*"Well I was finishing the observations off and making sure the fluid charts were up to date".*

*S28(2)5*

#### 8.4.2 Intentions of Explanation, Information Giving and Instruction

In the geriatric unit, these procedural intentions were balanced by intentions to give information, instruction, explanation to patient. These kinds of intention were of course apparent in both units but in the medical unit were largely the prerogative of the third year student nurses. Because of their seniority, these nurses were often involved in the giving of information and instruction to patients - tasks which the more junior first year nurses were not able to undertake. These explanatory intentions were often of a kind similar to the following:-

*"I had to explain to the patient that I'd put her back to bed and she could have a sleep as it wasn't worth her getting washed and dressed before she had her bath".*

S12:1

#### 8.4.3 Intentions of "Just Chatting"

In the geriatric unit, "just chatting" was a commonly stated intention. The reader will perhaps recall that in the nurses' formal lectures before embarking on this part of their course, talking to patients was rated highly as an activity in its own right and nurses were encouraged to do this. Moreover, the student nurses themselves expected that there would be more time for talking to patients - something they felt was perhaps lacking in other areas. One student nurse had expressed it thus:-

*"It will be nice to have the time to talk to them. We've never had time to talk to patients before...I think that talking to them will be the majority of our work".*

#### 8.4.4 Therapeutic Intentions

However, when student nurses expressed their intention to "just chat", it was in the absence of any specific



goal. Only two of the conversations recorded in the geriatric unit had any overtly therapeutic aim underlying them. Although student nurses had been told that talking to patients was a good idea, they had not been given any indication as to what such conversations were meant to achieve, nor were they given any indication as to how such conversations might be carried out. A closer look at the two "therapeutic" conversations should be useful at this stage.

### First Conversation

The student nurse is bathing Mr J and has almost finished. She had just returned from finding his clean clothes...

*"N: Hello Mr M, oh I'm calling you Mr M now  
Mr J!  
Are you ready to come out Mr J?"*

(After an initial greeting, the nurse asks a closed question. This is acceptable in instances where specific information is required. No response is heard however, which suggests that the patient assumes that the nurse has perceived his "readiness").

*N: Righto.  
I'm just going to lift the chair back and  
wi'll lift you out of the bath.*

(The nurse explains what she is about to do but uses a plural pronoun "we" when she really means "I").

*N: Nothing to worry about.*

(This may be reassuring to the patient but the nurse has not ascertained what he is worried about if indeed he is worried. If he is not worried he may begin to worry at this point).

*N: Just lift you up a little bit.  
There we are.  
Just let the water drain away.  
You hang on to that.*

*That's it.  
Comfortable still?*

*P: Yes.*

(A series of comments and directives follow with a leading question as to the patient's comfort. The patient's response is minimal).

The sound of bath water draining out of the bath can be heard.

*N: That's a noisy plug hole isn't it?*

*P: Yes.*

*N: Right, you're nearly dry now.  
If you lean back I'll pull you away from  
the bath.  
That's it.  
Lovely.  
Now if you lift your feet up...  
Lovely.  
Well done.  
That's it.  
Can you lean forward for me a little bit...  
...and I'll dry your back.  
Are you dry on top now are you?  
Pop your vest on before you go along the  
corridor.  
Can you slip your arm through there Mr J?*

*P: Yes.*

(With a series of comments, suggestions, praises, the nurse tries to get Mr J dressed).

*N: That's it.  
Leave go of the towel.....leave go of the  
towel.  
It's all right....it'll fall on to you.  
That's it.  
Push your hand through here.  
Towel's all right there.  
Push through...push...push hard.  
There.  
All right?  
Still dry on your legs are you?*

(At this point, the nurse was aware that Mr J wasn't talking very much and so she tries to start up a conversation. Later in the account she admitted hating "horrible silences" and feeling embarrassed by them).

N: Have you got anybody coming to see  
you today have you?

P: I don't think so.

N: You don't think so?" S07:

(The conversation ends at this point).

When questioned about this afterwards, the nurse  
said:-

*"I didn't know what to say. You see I  
hoped that - you start a conversation -  
someone once told me that the art of  
conversation is to ask a question, antic-  
ipate the answer and have the answer ready  
for the answer. I just had the question  
and then I had nothing".*

The student nurse's lack of skill in conversation and  
her awareness of her own limitation is only too  
apparent in this example. She could of course have  
continued the conversation by simply asking Mr J why  
nobody was coming to see him. But when confronted  
with this, another issue surfaced:-

*"R: You could have said 'Why isn't anybody  
coming to see you?'*

*P: Mm, but that could have been embarrassing  
because he might have said that nobody  
loves him or something. That was  
embarrassing because you have to think of  
a question before putting your foot into  
it. I might have embarrassed myself by  
finding out something that he doesn't want  
to talk about. I might get him upset- he  
might burst into tears or not like me for  
it".*

This student nurse is not only in the position of feeling  
she needs to know how to initiate and sustain a  
conversation, she also realises that if she is successful  
she may uncover emotional topics with which the patient  
and herself would be unable to cope.

## Second Conversation

The second "therapeutic" conversation took place in the afternoon. The nurse was putting curlers into one patient's hair and was talking to another patient who was waiting to be put back to bed. The nurse's stated intention was to "keep her occupied whilst she was waiting".

*P1: I'm supposed to lie on the bed but  
I shan't have time.*

*N: No.  
How do you feel?*

(Mrs. C's routine has been disrupted - she has been told she is going home. She raises the matter with the nurse who accepts her comment and asks how she feels with an open question).

*P1: I feel all right dear.*

*N: Have you had visitors?*

*P2: Eh? I didn't have visitors...*

*P1: I've had Edna my daughter.*

*N: No, Mrs C.*

*P2: Yes, she had.*

(The nurse inquires about Mrs C's visitors - the patient whose hair is being curled interprets the question as directed to her and responds accordingly. She is corrected by the nurse and then effectively excluded from the triad).

*P1: I had my daughter - I was glad to see her -  
she said I'm going home this weekend.*

*N: Oh.*

*P1: Saturday I think she said.*

*N: Where do you come from then Mrs C?*

(The patient seems to be offering a cue here about her uncertainty at going home. It is not picked up

by the nurse who proceeds to initiate a more general interchange. Later in the conversation, the patient offers the same cue...).

P1: ...well she told me I was going home.

N: Oh.

P1: I didn't know I'd been here that long.

N: Yes.

P1: I thought out for six weeks, in for two.

N: I won't see you go.

(Again the patient's cue is not picked up by the nurse who again comments in a more general way).

P1: Won't you?

N: No, I've got....

P1: Oh nurse...  
I'm quite happy here.

(The patient's protestations of happiness could be another cue).

N: You go on Monday don't you?

P1: I don't know whether I'll go on Saturday or...

N: I think it's Monday.

P1: Oh I'd like to know for certain.

(The patient has earlier mentioned the possibility of going home on Saturday. Now the nurse mentions Monday and Mrs C makes her worry more explicit).

N: Yes.  
Oh you'll know, don't worry.

(By telling her not to worry, the nurse effectively glosses over Mrs C's anxiety).

P1: I thought she said tomorrow.

N: *Fri...no what is tomorrow?*

P1: *Thursday.*

N: *Possibly.  
You'll find out anyway.*

(Mrs. C's anxiety is not diminished however and she persists, only to have her worry brushed aside once more).

P1: *She said 'I'll see you tomorrow'. I said 'OK Edna'.*

P2: *What day is it today nurse?*

N: *It's Tuesday today.*

P1: *Tuesday?*

N: *Yes, I thought it was Wednesday as well.*

(Mrs C reiterates what she has been told. The second patient tries to clarify what day of the week it is and it is clear that Mrs C has been slightly confused).

P1: *I've been quite happy here...*

N: *That's good.*

P1: *...with all of you.*

(There is the hint again that Mrs C doesn't want to hurt the nurse's feelings by appearing too anxious to leave).

P1: *Makes me tired.*

N: *Eh?*

P1: *I hate this waiting.*

N: *Yes.  
Shouldn't be for long.*

(Mrs C's persistence receives another blanket reassurance from the nurse. Later in the conversation, the theme recurs...)

P1: *This time has gone quick.*

N: *Do you find?*

P1: *Since I've come back.  
I stared at her - I said 'Coming home?'  
She said 'Yes'. I said 'Well I hadn't  
reckoned on it'. I haven't counted  
the length of time I've been in.*

N: *Is he all right your son-in-law Mrs C?*

(But once again, any cues are ignored in favour of another line of questioning).

In this conversation, the nurse did not seem to be aware of the patient's anxiety, nor did she recognise the cues offered. This interpretation is ratified by her account where she said "I don't think she'd tell you if she wasn't happy". As a great deal of the conversation consisted of Mrs C trying to communicate her unhappiness, it can only be concluded that the nurse could not recognise the signs.

In both "therapeutic" conversations in the geriatric unit, deficiencies were observed. The nurses' awareness of these deficiencies and their possible remedies will be taken up for discussion later. However, in both these instances the deficiency seemed to reside in the nurse rather than the patient. Neither patient was aphasic or deaf which might be expected to cause certain difficulties in conversation.

Student nurses in the medical unit did have therapeutic intentions in conversation with patients, mainly with patients who were older but not considered "geriatric" and similar deficiencies were observed. Although nurses had positive therapeutic intentions, they did not always seem in possession of the necessary conversational skills. First year student nurses seemed to fare rather better than their senior colleagues in carrying out ordinary conversation with patients. This might possibly be due to patients seeing them as being more available for conversation than the third year student nurses. They seemed to be the readier

conversationalists and would engage quite freely in casual conversation with patients. Nevertheless, with both groups of student nurses, specific therapeutic intentions were not carried out with the necessary conversational skills.

#### 8.4.5 Intentions to Comfort/Reassure

In addition to the specific use of conversation to achieve a therapeutic goal, there were intentions to reassure, comfort or simply to cheer up patients. In the main these were observed in the medical unit with older and "geriatric" patients, but, as with the therapeutic intentions, conversational skills were again often lacking which resulted in discrepancies between intentions and achievements.

#### 8.4.6 Discussion

It would be true to say that for most of the nurses in the study, their acts in conversation with patients were, to them, non-problematic, and therefore simple explanations were offered such as "getting her out of bed", "giving him his medicine". Persistence in questioning on such occasions was regarded quizzically by student nurses. It was perhaps one instance when they, as participants, expected the researcher, by virtue of her belonging to the same profession, to share their implicit understanding of situations. Any evidence that she did not do so would have damaged her credibility in their eyes, but the general issue of maintaining good relationships whilst obtaining justificatory accounts will be taken up for discussion in the final chapter.

Student nurses' intentions in conversation with patients, were, in the main, related to the particular task in hand. The few "therapeutic" intentions indicated that the students did not normally view their conversations as instruments with which to achieve a goal. "Just chatting" presented a number of opportunities to student nurses which were not developed to their full potential



because the nurses were often unaware of the occasion as an opportunity for care to be given via "talk", and even if they were aware of the occasion's potential, recognised their own deficiencies in conversational skills. "Getting started" was one of these deficiencies and as with the first conversation reported on p.215, the "wrong" closed question was often asked and the nurses unwittingly foreclosed the conversation.

It was expected that the expressive aspect of nurses' activity would be best seen in nurses' accounts of their intentions in conversation with patients. In many instances nurses did not appear to be acting in accord with any conscious recognition of any particular aim, but rather seemed to be responding to the needs of the moment. They did not themselves then, describe their actions with any expressive adverbs. On only one occasion did a nurse claim to be trying to do something "tactfully". In retrospect, the manner of questioning may not have been appropriate for the uncovering of this expressive dimension of activity. An additional question asking "how" the intention was carried out, may have been more successful.

## 8.5 NURSES' FEELINGS IN CONVERSATION WITH PATIENTS

Accounts were examined for evidence of nurses' feelings whilst talking to patients. This was either given in response to the question "Can you say how you were feeling at the time?" or volunteered spontaneously in the course of an account being given.

This was a difficult question for many nurses and was answered at a number of levels - from the very superficial "I was hungry" to the more sensitive areas of expressing frustration and irritation with patients.

### 8.5.1 Positive Feelings

Most of the time nurses claimed to have positive feelings in their conversations with patients, even though these positive

feelings were mainly a simple response of "quite happy" or "fine". Nurses' feelings seemed to be related, not so much to individual patients or types of patients, as to situations. For instance "getting all the work done" gave rise to positive feelings as did "having a chat" or joking with patients.

#### 8.5.2 Feelings of Frustration

"Being rushed" however, gave rise to feelings of frustration and shortage of time appeared to be a common theme as in the following examples:-

*"Well I knew the transport was coming at four. It was coming early and I had to write the Kardex up when I'd finished with Mary. I was trying to sort of rush to get the curlers in".*

S16:5

*"Well (I was feeling) in a bit of a rush because the lunches were up and I wanted to get her finished".*

S18(1)1

Feelings of frustration also resulted when nurses were unable to meet certain needs of patients. For example one student nurse terminated a conversation with an elderly female patient in the medical unit quite abruptly when she couldn't understand what the patient was trying to say. When questioned about this she replied:-

*"Because, well I didn't want, well I was slightly embarrassed that I couldn't understand her, I was getting frustrated because I wanted to know what she was saying and couldn't".*

S23(1)5

Whilst this particular instance might have been avoided had the nurse been more skilled in communication techniques, there were occasions when feelings of frustration appeared to be unavoidable because of the patient's condition as in the following example:-

*"You feel a bit helpless, I mean she's had Stemetil and all sorts and I know when I was on nights we were giving her various painkillers and Stemetil and things and none of it seemed to be really doing an awful lot. And you feel helpless in that sort of situation".*

S36(1)3

### 8.5.3 Negative Feelings

Overtly negative feelings were in the minority but when they did occur seemed to be related to the non-compliance of patients. Encounters with patients who did not behave in an appropriate manner could give rise to negative feelings in nurses. In the following example, a female patient in the geriatric unit had been extremely restless:-

*"Well, I'd spent about two hours trying to tell her to sit down and she'd started getting very restless. By the evening she was just getting worse. We nearly had to sit on her by the end of the evening... You feel just like a record. You feel as if you're on at them all day... I always hope that I would never get like some of the patients. I mean their relatives don't want them - they're dumped half of them... Sometimes I think well if this is what I'm coming to I hope someone is kind enough to put me down".*

S17:2

Although the student nurse understood that the patient was confused, her behaviour, as evidenced by the conversation, was entirely custodial and it could be argued that a more constructive approach would not only have been more useful to the patient, but could have reduced the nurse's negative feelings. The feelings seemed to be linked to the need, as perceived by the nurse, for constantly "keeping on" at the patient, but the "keeping on" really consisted of repeated messages to "sit down" in the absence of any other orientation. The nurse also resorted frequently to joking messages to nearby colleagues within earshot of the confused patient. This is illustrated by the following extract from the conversation:-

*"N: Sit down Ruby!*

*P: No.*

*N: I give up.*

*N2: If you're goint to walk anywhere, walk to the dinner table.*

*N: She's going to school.*

*N2: Oh.*

*P: That one will cost...*

*N2: Cost you about a tenner.*

*N: It's cheaper to go by bus Ruby.*

*P: That will...it's...*

*N: (laughing) Crushed skull...multiple fractures  
...oh God...sat on by Miss G.*

*P: (mumbles incoherently)*

*N: The day I retire I'm going to give myself  
an IM Diamorphine".*

*S28(1)2*

There is no indication in this conversation that the student nurse knows how to cope with a severely confused patient and yet plenty of evidence that it is giving rise to distress on the part of both nurse and patient.

In another example, a younger patient in the medical unit asked to be taken to the toilet just as lunches were due to be served:-

*"P: Can you get me the chariot dear?*

*N: It's lunch time!*

*P: I know, I'm sorry.*

*N: I'll just finish taking Wilfred's pulse  
and I'll be with you.*

*P: I'm trying to help you.  
I'm only trying to help you, that's all".*

*S31(2)5*

When questioned afterwards the student nurse replied:-

*"Oh I was just thinking it was typical of patients to wait until lunch time...I was probably slightly annoyed with him for asking to go then".*

S31(2)5

#### 8.5.4 Discussion

It was obvious when nurses were asked about their feelings that this was an area they were unused to reflecting upon. On a large proportion of occasions nurses felt that there was nothing remarkable about their feelings in conversation with patients. This was to be expected as most of the conversations were neutral in affect and only occasionally touched on an emotive topic for either nurse or patient. The non-compliance of patients, however, aroused negative feelings or feelings of frustration. Patients who do not behave as they are expected to, or who fail to fit into the routine cause problems for the nurse. The manner in which she deals with them is crucial. From the example quoted on p.226, it was not apparent that the nurse had the relevant skills at her disposal and consequently she responded to the patient in a manner which was likely to exacerbate the situation. The question of orientation of confused patients is one on which nurses had certain opinions. If a patient was not normally in a confused state, then efforts would be made to orientate her. However if confusion had become a patient's usual state, then nurses would not necessarily feel obliged to make any attempts to orientate her to her surroundings.

*"It would depend who it was and what they were talking about really. If it was Bertha - she's often confused so you would just carry on. But with Mrs N - she's comatous most of the time, so I'd try to trail off on to something else".*

S28(1)2

#### 8.6 CONCLUSION

The justificatory accounts produced by student nurses in response to questioning gave rise to a wealth of rich

data. In their evaluations of patients, nurses showed their appreciation of compliance and there was some evidence of stereotyping in their descriptions and attributions. "Little old ladies" and "nice old men" caused the least disruption and were therefore the most popular. Student nurses did not appreciate non-compliant patients who disrupted the established nursing routines. Some patients were able to disrupt routines however, or make demands on nurses without being considered unpopular, by virtue of their intrinsically pleasant personalities or by their willingness to "try hard" even if they did not succeed.

Signs of mental confusion often stigmatised an elderly patient as "geriatric" and beyond medical help, whereas similar "symptoms" in a younger person would more likely be deemed to be pathological.

Student nurses responded positively to those patients who could communicate easily. They saw little problem in colluding with patients in their confusion, but experienced more difficulty in conversation with rational patients who had limited conversational repertoires.

Nurses' intentions in conversation with patients were mainly concerned with the accomplishment of nursing procedures. By and large, nurses did not use conversations to achieve therapeutic ends, and on the few occasions when this was attempted, their deficiencies in conversational skills became apparent. This led to feelings of frustration on the part of the nurses who were not able to manage the patients effectively.

The examination of nurses' accounts has shown that nurses attribute certain characteristics both to patients in the geriatric unit and to "geriatric" patients in the medical unit. Dependency, mental confusion and an inability to care for oneself featured heavily in these attributions. In the next chapter, student nurses' perceptions of old people will be examined as they change and develop over the course of training, in an attempt to conceptualise the perceptual framework within which nurse-patient interaction takes place.

## CHAPTER NINE

### AN EXAMINATION OF STUDENT NURSES' PERCEPTIONS OF OLD PEOPLE

#### 9.1 INTRODUCTION

The examination of student nurses' justificatory accounts following their conversations with patients has helped us to understand their perspective in what constitutes a major part of nursing activity, namely, conversation. There remains, however, the broader picture of nurses' perceptions as they change and develop during the course of their training. What preformed constructions of old people does the student nurse bring to the nurse-patient interaction? Do these constructions change during training? Are they positive or negative and in what aspects? These are the questions to which this chapter is addressed.

It was decided to use Kelly's repertory grid methodology in order to study student nurses' perceptions and changes in perception of old people during the course of their three year training programme. A major benefit of repertory grid methodology was seen to be the facility for using the subject's own language and terms of description. For this reason constructs would be elicited from subjects rather than supplied.

The major focus of interest was to be the student nurses' perceptions of old people. However, in order to judge whether or not perceptions were specific to old people, other points of comparison would be necessary. Therefore elements to be rated would include children, young people and middle aged people in addition to the old people.

In order to counteract one criticism of attitude questionnaires i.e. that judgments on terms like "old people" are global and not grounded in a practical

example, all the elements would be specific persons known to the subject.

The training period for student nurses is three years; the time available for the study considerably shorter. A combined cross-sectional and longitudinal design would capitalise on both the time available and the need to measure change over a period of time.

Analysis of any repertory grid can lead to a number of measurements which are more or less useful for a variety of clinical or research purposes. In the present study, analysis will be limited to the following:-

#### 9.1.1 Identification of the Most Salient Elements

The most salient element in a construct system can be identified by considering the percentage of the variation for which it accounts. A relatively large percentage indicates that the element is important in determining the orientation of the construct system whether or not that element is perceived negatively or positively. The most salient group of elements will be identified for each group of students.

#### 9.1.2 Examination of Constructs

An examination of the verbal labels used by nurses to describe people of different ages would be illuminative in respect of their perceptions of old people. For this reason constructs will be categorised according to the system by Lifshitz (1974) who studied changes in perception of social work students and their supervisors. It is to be expected that usage of the concrete descriptive category would diminish as training progressed and students saw people in increasingly abstract terms.

#### 9.1.3 Identification of the Elements Accounting for Most Change

This can be achieved by comparing grids from two occasions



in order to assess which group of elements has changed most in the construct system and how it has changed with respect to construct ratings. In other words, if old people as a group are responsible for most of the change in a construct system one would need to know how they are construed on each occasion.

#### 9.1.4 Cognitive Complexity/Simplicity

Chetwynd (1974) suggests that cognitive complexity can be operationally defined in terms of the explanatory power of the first component in a grid. The simplest grids are the ones where the first component accounts for the highest proportion of the variation. A change in complexity can therefore be ascertained by comparing grids on two occasions using the same constructs and elements. It is to be expected that most nurses will, as a result of their training, show an increasingly differentiated construct system as they progress through their three year course.

### 9.2 METHOD

The design employed is described by Campbell and Stanley (1963) as the "recurrent institutional cycle design". They suggest that it is appropriate in situations where an institutional process is continually being presented to a new group of respondents and where there is no facility for the researcher to control who is exposed to the experimental variable. In the present study, the institutional process is the three year nurse training programme and the experimental variables are the three separate years of that training which include experience in various fields as follows:-

Year 1:	Surgery or Medicine	13 weeks
	Medicine or Surgery	13 weeks
	Paediatrics	13 weeks

Year 2:	Operating Theatre	13 weeks
	Orthopaedics/Accident	
	and Emergency	13 weeks
	Geriatrics	13 weeks
Year 3:	Mental Health/Maternity	13 weeks
	Surgery or Medicine or	
	Gynaecology	13 weeks
	Surgery or Medicine or	
	Gynaecology	13 weeks

Four samples of student nurses randomly drawn from four cohorts, were used in a combined cross-sectional and longitudinal recurrent institutional cycle design and the times of measurement of the four groups were superimposed on the three year training programme as shown in Table 9.1.

Measurement takes place therefore, immediately before clinical experience ( $T_0$ ), and after paediatrics ( $T_1$ ), after geriatrics ( $T_2$ ) and at the end of the training course ( $T_3$ ). Groups A, B and C are measured on two occasions with an intervening period of twelve months.

Table 9.1 Times of Measurement of Student Nurses during Course of Training

Groups	TIME OF MEASUREMENT			
	$T_0$ Surgery or Medicine Medicine or Surgery Paediatrics	$T_1$ Operating Theatre Orthopaedics/A and E Geriatrics	$T_2$ Mental Health/Maternity Surgery or Medicine or Gynaecology Surgery or Medicine or Gynaecology	$T_3$
A	X	X		
B		X	X	
C			X	X
D				X

Campbell and Stanley (1963) point out that this design fails to control for maturation. In the field of person perception this is particularly important as any observed change might plausibly be explained in terms of an increase in sophistication which any group of that age might undergo in similar circumstances. For this reason, two additional groups of teacher training students were sampled from two cohorts to compare with student nurses at  $T_0$  and  $T_3$  as follows:-

GROUPS	TIME OF MEASUREMENT (TIME DURING TRAINING)	
	$T_0$	$T_3$
TT1	X	
TT2		X

Teacher training students were selected because it was thought that they, as a student body, would have relatively little experience of old people during the course of their training.

This design aims to test the effect of Years 1, 2 and 3 of nurse training on the student nurses' personal constructs regarding person perception. In order that any results might be interpretable, the following comparisons would need to be made whenever possible:-

1. Group A Time 0 and Group TT1 Time 0

It is expected that the two groups will be similar with regard to person perception at the commencement of training. If they are not, then a career selection effect is suggested.

2. Group B Time 1 and Group A Time 1

It is expected that these two groups of student nurses will be similar with regard to person perception. If they are not, then a testing effect on Group A is suggested.

3. Group A Time 0 and Group A Time 1

Subject to the result of comparison 2, this should show the effect of Year 1 on person perception.

4. Group C Time 2 and Group B Time 2

It is expected that these two groups of student nurses will be similar with regard to person perception. If they are not, then a testing effect on Group B is suggested.

5. Group B Time 1 and Group B Time 2

Subject to the result of comparison 4, this should show the effect of Year 2 on person perception.

6. Group D Time 3 and Group C Time 3

It is expected that these two groups of student nurses will be similar with regard to person perception. If they are not, then a testing effect on Group C is suggested.

7. Group C Time 2 and Group C Time 3

Subject to the result of comparison 6, this should show the effect of Year 3 on person perception.

8. Group D Time 3 and Group TT2 Time 3

It is expected that these two groups will be dissimilar with regard to the perception of old people and children. If they are not, then a maturation effect may be suggested, but the following comparison also needs to be made.

7. Group A Time 0 and Group D Time 3

This comparison will show any cumulative changes occurring over the training period which have not been detected at an earlier stage, but it is

recognised that it does not control for cohort effects. If comparison 8 shows the two groups to be equal in the absence of any change in the earlier comparisons or cumulative in comparison 9, then it can be concluded that training has not affected person perception. If comparison 8 shows the two groups to be equal in spite of observed change in earlier comparisons, then it will not be possible to attribute such change to the specific training of student nurses.

#### 10. Group TT1 Time 0 and Group TT2 Time 3

If a change is shown in comparison 9, then any similar change in this comparison would substantiate the hypothesis that the effect is due to maturation.

#### 9.2.2 Subjects

Subjects were 44 student nurses randomly sampled in 4 groups from 4 cohorts of nurses in training at a district general teaching hospital and 19 teacher training students from a college of higher education. These latter subjects were not randomly sampled but volunteered for the exercise. The groups were comprised as shown in Table 9.2.

Table 9.2 Subjects in Groups

GROUPS	TIME OF MEASUREMENT			
	T <sub>0</sub>	T <sub>1</sub>	T <sub>2</sub>	T <sub>3</sub>
A	n=12	n=9		
B		n=12	n=8	
C			n=10	n=9
D				n=10
TT1	n=10			
TT2				n=9

Biographical details of Ss are given in Appendix G. It can be seen from the above table, that 3, 4 and 1

Ss respectively from Groups A, B and C were lost to the study. Five Ss "dropped out" of their course while 3 transferred to other courses in other parts of the country.

#### 9.2.3 Apparatus

Repertory grid forms (see Appendix H).  
6cm x 8cm cards.

#### 9.2.4 Procedure

Subjects were asked to name 4 children known to them personally, 3 young people of similar age to themselves, 4 middle aged and 4 old people known to them. Middle aged people were defined as "people of your parents' age" and old people as "people of your grandparents' age". They were asked to write one name on each of 15 cards. These cards, together with one labelled MYSELF, were then shuffled. Cards were dealt out in threes and the subject was asked to state "a way in which two of the people are the same, but different from the third" or to "pick the odd one out and say why they are the odd one out". Triads were formed with cards in succession until the subject began to repeat constructs and was unable to think of new ones. These constructs will be referred to as First Time constructs. The subject was then required to rate each element on each First Time construct using a 7 point scale.

On the second test occasion (12 months later), for Groups A, B and C, subjects were first reminded of the elements to be used. The procedure for eliciting constructs was then repeated as on the first occasion. These constructs will be referred to as Second Time constructs. Finally, any First Time construct which was not reproduced on the second occasion, was added to the grid before the subject was asked to rate each element as before.

On the first occasion, from 5-12 First Time constructs

were elicited per subject, (Mean = 8.8). On the second occasion, from 4-12 Second Time constructs were elicited per subject, (Mean = 7.9). Of the 204 Second Time constructs elicited from Groups A, B and C, 4.9% (10) were reproduced from the first occasion.

### 9.3 RESULTS

#### 9.3.1 Identification of the Most Salient Elements

Grids from each group of students were analysed using the PREFAN programme from Slater's Grid Analysis Package (GAP). For Groups A, B and C, only those Second Time constructs were included in the second occasion analysis and only data from those Ss present on the second occasion is included in the first occasion analysis. The PREFAN programme is suitable for the group analysis of grids which are aligned by element but not by construct. Although the individual people filling the element titles were different in each case, it was thought that the elements were aligned conceptually i.e. elements 1-4 were children in each case, 5-8 were young people in each case etc., and that it was therefore permissible to analyse them in this way.

Tables 9.3 and 9.4 indicate the mean percentage variation accounted for by each set of elements for each group. The most salient set of elements for each group of students can be seen by considering the largest mean percentage variation in each group.

The comparisons outlined on p.233 were made with respect to each set of elements in each group of students (i.e. Children elements in Group A compared with Children elements in Group B) with the following results:-

Table 9.3 Mean Percentage Variation of Elements on First Measurement Occasion for each Group

G R O U P S   O F   E L E M E N T S					
Groups	Time*	Children	Young People	Middle aged People	Old People
A (n=12)	0	25.41	21.52	20.34	31.32
B (n=12)	1	27.52	19.85	23.54	28.92
C (n=10)	2	28.26	18.40	27.03	26.30
D (n=10)	3	25.51	20.84	24.62	29.02
TT1 (n=10)	0	29.24	19.00	25.46	26.30
TT2 (n=9)	3	26.44	23.02	19.45	31.04

\*Time during training

Table 9.4 Mean Percentage Variation of Elements on Repeated Measurement Occasion for Groups A, B and C

G R O U P S   O F   E L E M E N T S					
Groups	Time*	Children	Young People	Middle aged People	Old People
A (n=9)	1	26.87	21.68	22.31	28.80
B (n=8)	2	25.84	23.48	23.15	27.54
C (n=9)	3	26.83	21.61	25.33	26.22

\*Time during training



1. Group A Time 0 and Group T1 Time 0

Independent t-tests between each set of elements for each group of students revealed no statistically significant differences as follows:-

Childrens elements  $t=1.11$ , d.f. 20, n.s.

Young People elements  $t=0.91$ , d.f. 20, n.s.

Middle aged People elements  $t=1.84$ , d.f. 20, n.s.

Old People elements  $t=2.01$ , d.f. 20, n.s.

These results confirm expectations that both groups at the onset of training would be equal in this respect.

2. Group B Time 1 and Group A Time 1

Independent t-tests between each set of elements for each group of students revealed no statistically significant differences as follows:-

Children elements  $t=0.16$ , d.f. 19, n.s.

Young People elements  $t=0.54$ , d.f. 19, n.s.

Middle aged People elements  $t=0.38$ , d.f. 19, n.s.

Old People elements  $t=0.05$ , d.f. 19, n.s.

These results confirm expectations and rule out a repeated testing effect for Group A.

3. Group A Time 0 and Group A Time 1

Dependent t-tests between each set of elements on each occasion revealed no statistically significant differences as follows:-

Children elements  $t=0.57$ , d.f. 8, n.s.

Young People elements  $t=0.59$ , d.f. 8, n.s.

Middle aged People elements  $t=0.77$ , d.f. 8, n.s.

Old People elements  $t=1.62$ , d.f. 8, n.s.

These results show no change as a result of Year 1.

4. Group C Time 2 and Group B Time 2

Independent t-tests between each set of elements for each group of students revealed no statistically significant differences as follows:-

Children elements  $t=0.66$ , d.f. 16, n.s.

Young People elements  $t=1.67$ , d.f. 16, n.s.  
Middle aged People elements  $t=0.94$ , d.f. 16, n.s.  
Old People elements  $t=0.36$ , d.f. 16, n.s.  
These results confirm expectations and eliminate the possibility of a repeated testing effect for Group B.

5. Group B Time 1 and Group B Time 2

Dependent t-tests between each set of elements on each occasion revealed no statistically significant differences as follows:-

Children elements  $t=0.33$ , d.f. 7, n.s.  
Young People elements  $t=0.95$ , d.f. 7, n.s.  
Middle aged People elements  $t=0.23$  d.f. 7, n.s.  
Old People elements  $t=0.50$ , d.f. 7, n.s.  
These results show no change as a result of Year 2.

6. Group D Time 3 and Group C Time 3

Independent t-tests between each set of elements for each group of students revealed no statistically significant differences as follows:-

Children elements  $t=0.36$ , d.f. 17, n.s.  
Young People elements  $t=0.34$ , d.f. 17, n.s.  
Middle aged People elements  $t=0.26$ , d.f. 17, n.s.  
Old People elements  $t=1.01$ , d.f. 17, n.s.  
These results confirm expectations and eliminate the possibility of a repeated testing effect for Group C.

7. Group C Time 2 and Group C Time 3

Dependent t-tests between each set of elements on each occasion revealed no statistically significant differences as follows:-

Children elements  $t=0.84$ , d.f. 8, n.s.  
Young People elements  $t=1.06$ , d.f. 8, n.s.  
Middle aged People elements  $t=0.90$ , d.f. 8, n.s.  
Old People elements  $t=0.85$ , d.f. 8, n.s.  
These results show no change as a result of Year 3.

8. Group D Time 3 and Group TT2 Time 3

Independent t-tests between each set of elements for each group of students revealed no statistically significant differences as follows:-

Children elements  $t=0.18$ , d.f. 17, n.s.

Young People elements  $t=0.64$ , d.f. 17, n.s.

Middle aged People elements  $t=1.58$ , d.f. 17, n.s.

Old People elements  $t=0.63$ , d.f. 17, n.s.

These results confound expectations and, subject to the following comparisons, suggest no change as a result of either training or maturation.

9. Group A Time 0 and Group D Time 3

Independent t-tests between each set of elements for each group of students revealed no statistically significant differences as follows:-

Children elements  $t=0.22$ , d.f. 20, n.s.

Young People elements  $t=0.99$ , d.f. 20, n.s.

Middle aged People elements  $t=1.65$ , d.f. 20, n.s.

Old People elements  $t=0.84$ , d.f. 20, n.s.

These results confirmed that there had been no change as a result of training and/or maturation.

10. Group TT1 Time 0 and Group TT2 Time 3

Independent t-tests between each set of elements for each group of students revealed no statistically significant differences as follows:-

Children elements  $t=0.60$ , d.f. 17, n.s.

Young People elements  $t=1.16$ , d.f. 17, n.s.

Middle aged People elements  $t=1.84$ , d.f. 17, n.s.

Old People elements  $t=0.77$ , d.f. 17, n.s.

These results support the findings in the above comparisons that no change has taken place during training.

Summary

In the absence of any observed change, it seems that neither training nor maturation has had an effect on the most salient group of elements. With the exception

of Group C at Time 2, Children and Old People remain the most salient group of elements throughout the training period.

### 9.3.2 Examination of Constructs

Grids were analysed individually by the INGRID programme from GAP. In groups A, B and C, only those data from subjects present on both test occasions was used and on the second occasion, only second time constructs were examined.

A 10% sample (75) of the total number of constructs was categorised by 2 judges using the system of Lifshitz (1974). A fuller description of the categories was used by the judges as follows:-

1. Task orientation - any reference to ways in which a person deals with life or work in a practical sense e.g. diligence, responsibility, being carefree, dependency on others, having particular interests.
2. Concrete situations - any reference to what a person is or is not in an undisputable sense e.g. sex, profession, age, physical characteristics.
3. Abstract intrapsychic characteristics - any reference to a person's state of mind or personal well-being e.g. self awareness, being happy, lonely, being a particular type of person.
4. Abstract interpersonal or interpsychic characteristics - any reference to a person's skills, deficits or abilities in an interpersonal situation e.g. good conversationalist.
5. Abstract social values - any reference to a person's concern for these e.g. wanting fair play, justice.

6. Intellectual characteristics - any reference to a person's intellectual ability or orientation e.g. abstract thinking, serious minded.
7. Affective-egocentric approach - any reference to a person with links to self e.g. good to me, I know well.

Working independently, an inter-judge reliability level of 64% was achieved. This was considered to be unacceptably low. The combination of categories 3 and 4 raised the reliability level to 74.7% but this was still not considered to be an acceptable level.

It was decided to adopt the simpler category system of Duck (1975) with the expectation that there would be a reduction in the number of physicalistic and fact constructs and an increase in psychological and interaction constructs during the course of training. Duck's categories are as follows:-

1. Psychological - concerned with character and personality.
2. Physicalistic - describing outward appearance.
3. Role - concerned with habitual roles, acts or behaviour.
4. Fact - describing characteristics objectively assessable but not related to physical appearance.
5. Interaction - concerned with behaviour in face to face ongoing social interaction.

A 10% sample of the total number of constructs was categorised by two judges who, working independently, achieved an interjudge reliability level of 64%. This was still considered to be an unacceptably low level. Although Lifshitz (1974) did not report any reliability levels for her categorisation system, Duck (1975) reports a highly significant inter-judge reliability level (binomial test:  $z = 9.176$ ) between three independent judges. Some of the problems of categorisation of personal constructs will be taken up for discussion later in this chapter.

It was then decided to focus on a dichotomous category system distinguishing psychological from factual constructs as follows:-

1. Psychological Constructs - describing character and personality, including inter and intra personal behaviour.
2. Concrete Factual Constructs - describing objectively assessable states.

It was expected that during the course of training, student nurses would construe people in increasingly psychological terms.

Working independently, two judges categorised a 10% sample of the total number of constructs and achieved an inter-judge reliability level of 91%. The researcher (who was one of the judges) then categorised the remainder of the data. The results are shown in Tables 9.5 and 9.6. The comparisons outlined on P.233 were made with respect to changes in the mean no. psychological and factual constructs over the period of training. Independent and dependent t-tests were used with the following results:-

Table 9.5. Mean Number Psychological and Concrete Constructs on First Measurement Occasion for Each Group

Groups	Time*	MEAN NO. CONSTRUCTS	
		Psychological	Concrete
A (n=12)	0	5.30	1.50
B (n=12)	1	5.50	1.75
C (n=10)	2	4.80	1.40
D (n=10)	3	6.40	1.60
TT1 (n=10)	0	7.70	1.40
TT2 (n=9)	3	4.78	3.40

\*Time during training

Table 9.6 Mean Number Psychological and Concrete Constructs on Repeated Measurement Occasion for Groups A, B and C

Groups	Time*	MEAN NO. CONSTRUCTS	
		Psychological	Concrete
A (n=9)	1	3.78	4.89
B (n=8)	2	3.34	3.09
C (n=9)	3	4.78	3.10

\*Time during training

1. Group A Time 0 and Group T1 Time 0

An independent t-test showed a statistically significant difference between the mean number of psychological constructs used by each group ( $t=2.14$ , d.f.20,  $p.<0.05$ ). This means that the student teachers used more psychological constructs than did the student nurses. An independent t-test revealed no statistically significant difference in the mean number of concrete constructs used by each group ( $t=0.13$ , d.f.20, n.s.). The first result confounds expectations that the two groups would be equal in this respect at the onset of training.

2. Group B Time 1 and Group A Time 1

Independent t-tests revealed statistically significant differences in the mean numbers of psychological constructs ( $t=2.12$ , d.f.19,  $p.<0.05$ ) and concrete constructs ( $t=3.84$ , d.f.19,  $p.<0.05$ ) used by each group. These results confound expectations and suggest a testing effect for Group A which resulted in fewer psychological constructs and more concrete constructs on the second occasion.

3. Group A Time 0 and Group A Time 1

Dependent t-tests revealed no statistically significant difference in the mean number of psychological constructs ( $t=0.86$ , d.f.8, n.s.) but a significant difference in the mean number of concrete constructs ( $t=3.50$ , d.f.8,  $p.<0.05$ ) used by the group on each occasion. This means that on the second occasion, more concrete constructs were used but because of the result of comparison 2 above, it is not possible to conclude that this is due to the effect of the first year of training.

4. Group C Time 2 and Group B Time 2

Independent t-tests revealed no statistically significant differences between the groups in terms of the mean number of psychological constructs ( $t=0.24$ , d.f.16, n.s.) and concrete constructs ( $t=1.35$ , d.f.16, n.s.). These results confirm expectations and eliminate the possibility of a repeated testing effect on Group B.

5. Group B Time 1 and Group B Time 2

Dependent t-test revealed no statistically significant differences between the two occasions in terms of the mean number of psychological constructs ( $t=1.14$ , d.f.7, n.s.) and concrete constructs ( $t=1.87$ , d.f.7, n.s.). These results show no change as a result of Year 2.

6. Group D Time 3 and Group C Time 3

Independent t-tests revealed no statistically significant differences between the two groups in terms of the mean number of psychological constructs ( $t=1.61$ , d.f.17, n.s.) and concrete constructs ( $t=1.85$ , d.f.17, n.s.). These results confirm expectations and eliminate the possibility of a repeated testing effect on Group C.



7. Group C Time 2 and Group C Time 3

Dependent t-tests revealed no statistically significant differences between both occasions in the mean number of psychological constructs ( $t=0.29$ , d.f.8, n.s.) but showed a significant difference in the mean number of concrete constructs ( $t=3.11$ , d.f.8  $p.<0.05$ ). This shows that the effect of Year 3 has been an increase in the number of concrete constructs used on the second occasion.

8. Group D Time 3 and Group TT2 Time 3

Independent t-test revealed no statistically significant differences between the groups in terms of the mean number of psychological ( $t=1.52$ , d.f.17, n.s.) and concrete constructs ( $t=1.63$ , d.f.17, n.s.) These results suggest that at the end of training, student nurses are not dissimilar from the student teachers with respect to the number of psychological and concrete constructs they employ in their construing of people.

9. Group A Time 0 and Group D Time 3

Independent t-tests revealed no statistically significant differences between the two groups in terms of the mean number of psychological constructs ( $t=1.10$ , d.f.20, n.s.) and concrete constructs ( $t=0.14$ , d.f.20, n.s.) These results suggest that over the training period as a whole there have been no appreciable differences in the mean numbers of psychological and concrete constructs employed by student nurses in their construing of people. This comparison however, does not control for cohort effects and therefore does not nullify the difference observed in comparison 7.

#### 10. Group TT1 Time 0 and Group TT2 Time 3

Independent t-tests revealed a statistically significant difference between the groups in terms of the mean number of psychological constructs ( $t=2.31$ , d.f.17,  $p<0.05$ ) but no difference in the mean number of concrete constructs ( $t=1.76$ , d.f.17, n.s.). This means that Group TT2 used fewer psychological constructs and in this were similar to the student nurses at Time 3. Whilst recognising that this comparison does not control for cohort effects, there is the possibility that the difference may be due to the effect of the teacher training course.

#### Summary

There is no support for the expectation that as training progressed, student nurses would construe people in increasingly psychological terms. There is some evidence of an increase in the use of concrete constructs during Year 3 and a tendency to use more concrete constructs on the repeated measurement occasion.

#### 9.3.3 Identification of Elements Accounting for Most Change

In order to detect those elements which were construed most differently on the second test occasion, the DELTA programme from GAP was used. This programme for two completely aligned grids produces a grid of changes by subtracting the first grid from the second before proceeding with a principal components analysis. The grid then shows the extent and direction of changes that have taken place (Slater 1977).

Only groups A, B and C were concerned in this analysis and only those subjects present on both test occasions. Because DELTA deals with completely aligned grids, the constructs analysed were the same on both occasions, Second Time constructs not being used unless

they were repeated from the first occasion. As with saliency of elements, it was decided to consider sets of elements.

Table 9.7 shows that for each group, old people account for most of the observed change.

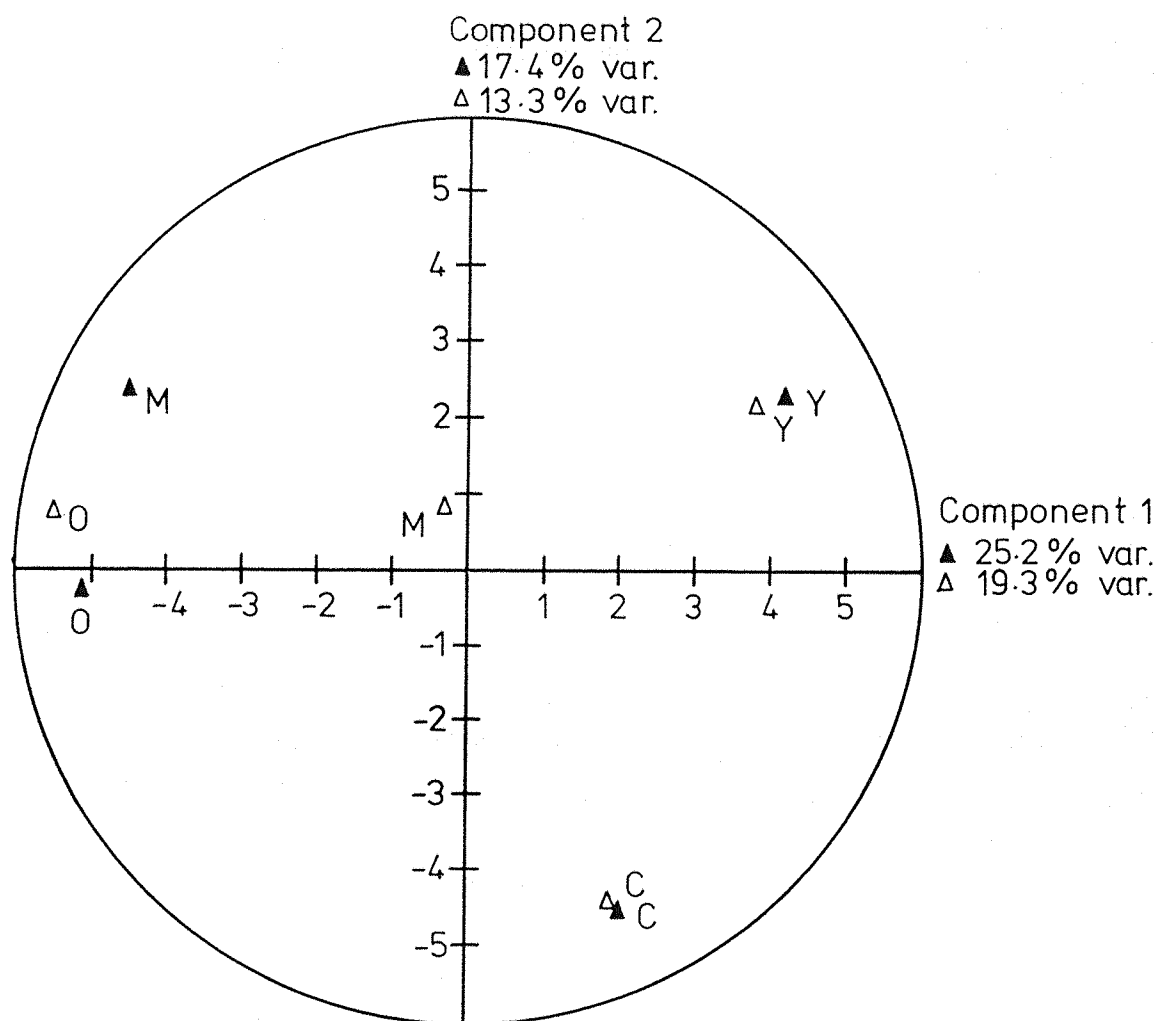
In order to see more clearly the changes in the construct systems of these student nurses, it was decided to use the Principal Components Analysis performed by PREFAN for each group at the first and second measurement points, using First Time and Second Time constructs respectively. A group cognitive map was prepared for each of the three groups showing the placement of elements for the two main components.

Table 9.7 Mean Percentage Variation of Elements for Groups A, B and C (Delta Analysis)

GROUPS OF ELEMENTS				
Groups	Children	Young People	Middle aged People	Old People
A (n=9)	26.86	22.29	21.63	29.23
B (n=8)	23.44	18.32	23.22	35.02
C (n=9)	26.30	20.03	25.75	27.92

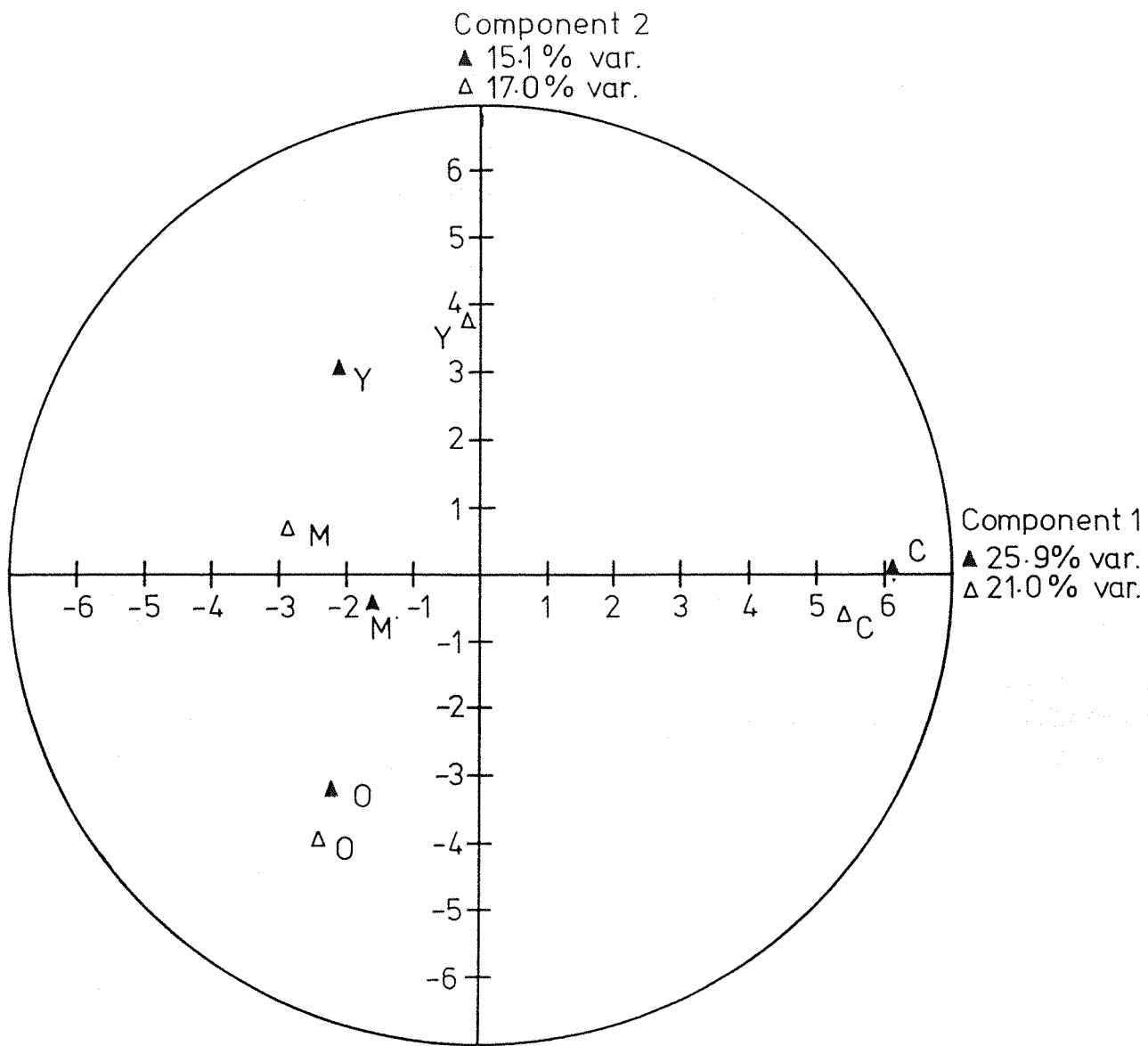
Figures 9.1, 9.2 and 9.3 show these whilst Tables 9.8, 9.9 and 9.10 list the constructs which contribute to the two main components on each occasion. It should be noted that "High rating" and "Low rating" does not necessarily correspond to positive or negative evaluation of elements.

At the commencement of their training, group A differentiate the four sets of elements fairly clearly. Both Old People and Middle aged People are separated from Children and Young People on the basis of the First Component. They are thus viewed as slow, inactive,



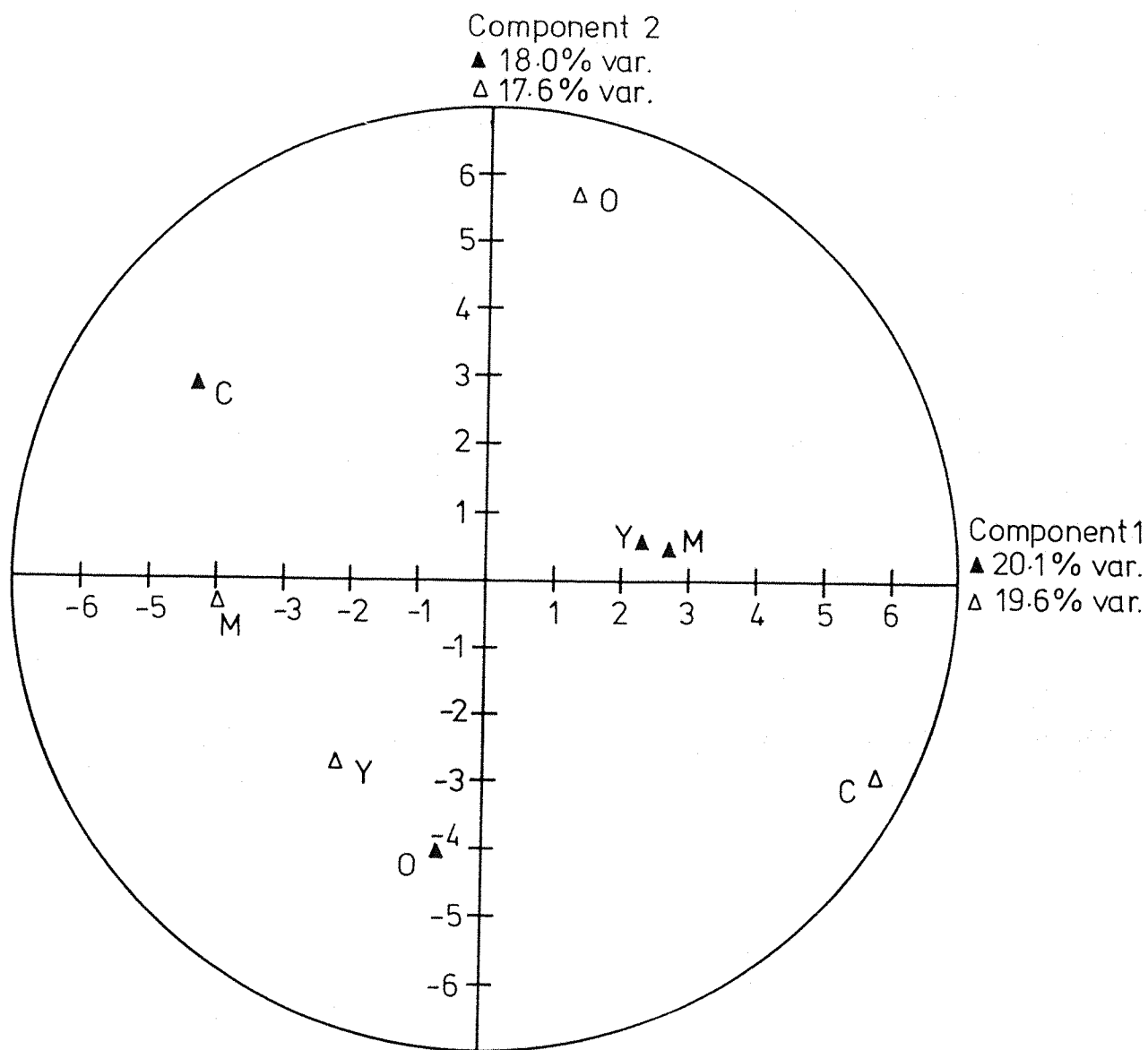
KEY: ▲ - First occasion (time 0)  
 Δ - Second occasion (time 1)  
 C - Children  
 Y - Young People  
 M - Middle Aged People  
 O - Old People

Fig. 9.1 Group A placement of elements with first two components  
on both measurement occasions



KEY: ▲ - First occasion (time 1)  
 Δ - Second occasion (time 2)  
 C - Children  
 Y - Young People  
 M - Middle Aged People  
 O - Old People

Fig. 9.2 Group B placement of elements with first two components on both measurement occasions



KEY: ▲ - First occasion (time 2)  
 Δ - Second occasion (time 3)  
 C - Children  
 Y - Young People  
 M - Middle Aged People  
 O - Old People

Fig.9.3 Group C placement of elements with first two components  
on both measurement occasions

Table 9.8 Group A Main Constructs contributing to Components 1 and 2 (the construct with the highest loading taken from each S, presented in order of highest loading)

TIME 0		TIME 1	
COMPONENT 1		COMPONENT 1	
High rating	Low rating	High rating	Low rating
Is happy and carefree	Not happy and carefree	Hasn't had long illness	Has had long illness
Is not slow	Is slow	Is still learning	Not still learning
Is in a learning position	Not in learning position	Doesn't live alone	Lives alone
Is active	Not active	Hasn't had to fight for everything	Has had to fight for everything
I relate to as an equal	I don't relate to as equal	Is always on the go	Takes life more seriously
Is fun to be with	Is demanding	Doesn't go to church	Goes to church
Is outgoing	Prefers home	Went to same school as me	Didn't go to same school
Leads an active life	Doesn't lead active life	Is outgoing	Is not outgoing
Willing to have a go at anything	Weights things up a lot		
COMPONENT 2		COMPONENT 2	
High rating		High rating	
Low rating		Low rating	
Knows a lot	Doesn't know a lot	Is independent of others	Dependent on others
Helps other people	Doesn't help other people	Same profession as me	Not same profession
Has responsibilities	Doesn't have responsibilities	Is always fussing	Lets things alone
Is not moody	Is moody	Has had a career	Hasn't had a career
I see often	I don't see often	Is full of adventure	Is timid and shy
Is independent	Is dependent	Is very calculating	Doesn't look before leaping
Is not musical	Is musical		
Is not related to me	Is related to me	Is independent of parents	Dependent on parents
		Is mature	Immature
		Is retired	Not retired

Table 9.9 Group B Main Constructs contributing to Components 1 and 2 (the construct with the highest loading taken from each S, presented in order of highest loading)

TIME 1		TIME 2	
COMPONENT 1		COMPONENT 1	
High rating	Low rating	High rating	Low rating
Is not influenced by others	Influenced by others	Is more of a friend	I look up to
Is self centred	Not self centred	Is still at school	Not still at school
Not concerned/aware	Is concerned/aware	Is still at school	Works
Is dependent on others	Independent of others	Doesn't have responsibilities	Has responsibilities
Inconsiderate of others	Is considerate of others	" "	" "
Related to me	Not related to me	I treat as a child	I treat as an adult
Not old fashioned, set in ways	Old fashioned, set in ways	Is not clever	Is clever
Not determined	Is determined	Is affected by circumstances	Is down to earth
COMPONENT 2		COMPONENT 2	
High rating	Low rating	High rating	Low rating
Has fast pace of life	Has slow pace of life	Has an involved social life	Is withdrawn and quiet
Ridiculous sense of humour	Sarcastic sense of humour	I can have a good chat	Is proper and polite
Is approachable	Is sharp and abrupt	Is still working	Is retired
Connected with life here	Not connected with life here	Is bubbly	Is quiet and placid
Not shy or reserved	Shy and reserved	I see regularly	Haven't seen for a long time
Is easy going	Is anxious	Not a lot of experience	Lot of experience in war
Doesn't have settled home environment	Settled home environment	Is not clever	Is clever
Is quiet, keeps to self	Is outgoing	Follows everyone else	Is strong minded



Table 9.10 Group C Main Constructs contributing to Components 1 and 2 (the construct with the highest loading taken from each S, presented in order of highest loading)

TIME 2		Time 3	
COMPONENT 1		COMPONENT 1	
High rating	Low rating	High rating	Low rating
I am friendly with	I am not friendly with	Lacks experience	Is very worldly
Is mature	Is not mature	Is still at school	Not still at school
Worries about future	Lives for the moment	Is not professionally qualified	Is professionally qualified
Has good business sense	Doesn't have business sense		
I am very fond of	I am not fond of	I don't know well	I know well
At top of their profession	Not at top of profession	Blunders	Is a perfectionist
Has high level of education	Not much education	I've not had time to develop relationship with	Have had time to develop relationship with
Is talkative	Is not talkative		
Is vivacious	Is insipid	Is immature	Is mature
		Is selfish	Is not selfish
		Is optimistic	Is pessimistic
COMPONENT 2		COMPONENT 2	
High rating	Low rating	High rating	Low rating
Is vivacious	Is insipid	Isn't lively	Is lively
Leads active life	Doesn't lead active life	Is well travelled	Not well travelled
Lacks experience	Is very worldly	Is not a student	Is a student
Has lots to look forward to	Not much to look forward to	Is lonely	Is not lonely
Is lively	Is not lively	Is serious	Is fun loving
Is extravert	Is introvert	Is married	Not married
Few life experiences	Many life experiences	Has found what they want in life	Is unpredictable
Related to me	Not related to me		
Lives with a family	Lives alone	Is not selfish	Is selfish

preferring home and being demanding. Component 2 tends to separate Children from all other elements on the basis of their not knowing a lot, not having responsibilities and being dependent. After one year, the isolation of Old People is even more clear cut on the First Component and they are perceived in terms of having had long illnesses, not still learning and living alone. Children also retain their position of separation on the Second Component largely in terms of their continued dependence on others.

After one year of training, Children in Group B are separated from the other elements on the basis of the First Component. They are thus viewed as being beyond the influence of others, self centred, unconcerned and unaware, and again, in a position of dependency on others. On the Second Component, Old People and Young People are at opposite ends of the pole. Young people are characterised as leading a fast pace of life, having a ridiculous sense of humour and being approachable. Old people in contrast were seen as having a slower pace of life, a sarcastic sense of humour and being sharp and abrupt. On the second occasion, after two years training, the position of the elements relative to each other has changed very little. Children are perceived as friends who have no responsibilities and who are treated in a different manner to adults. Old people are now seen as withdrawn and quiet, proper and polite, placid but also strong minded. It should be remembered that this group have had the most recent experience of geriatric nursing along with group C at their first measurement point.

After two years training, group C identify themselves as Young People closely with Middle aged People who tend to be separated from other elements on the basis of the First Component. This means that they see themselves and their peers and Middle aged People whom they know, to be mature, as worrying about the future and having a good business sense. Old People, who are separated from other elements by the Second Component

are perceived as insipid, not leading an active life, being worldly but not having much to look forward to. On the repeated measurement occasion, at the end of their training, Young People in group C are slightly less closely identified with Middle aged People whilst Old People are still separated from other elements by the Second Component and are perceived as not being lively, being lonely and serious, having found what they want in life and not being selfish.

### Summary

Old People elements account for most of the observed change in student nurses' construct systems. The first component separates them from Young People elements during the first year of training, whilst in the second year Children elements appear to be the most distinctive on the basis of the first component. In the third year the first component separates Young People and Middle aged People elements from Children and Old People.

#### 9.3.4 Cognitive Complexity/Simplicity

In order to assess whether or not student nurses' construct systems had become more complex during the course of their training, grids from all subjects were analysed using the INGRID programme from GAP. For groups A, B and C, First Time constructs and Second Time constructs were analysed on the first and second occasion respectively. The percentage variation accounted for by the first component was identified in each case. Tables 9.11 and 9.12 show the mean percentage variation for each group at each measurement point. The comparisons outlined on P.233 were made with the following results:-

Table 9.11 Mean Percentage Variation of First Component  
for each Group on First Measurement Occasion

Group	Time*	% var. 1st Component
A (n=12)	0	49.22
B (n=12)	1	50.40
C (n=10)	2	55.16
D (n=10)	3	47.02
TT1 (n=10)	0	45.89
TT2 (n=9)	3	50.02

\*Time during training

Table 9.12 Mean Percentage Variation of First Component  
on Repeated Measurement Occasion for Groups A,  
B and C

Group	Time*	% var. 1st Component
A (n=9)	1	42.24
B (n=8)	2	52.06
C (n=9)	3	47.11

\*Time during training

1. Group A Time 0 and Group TT1 Time 0

An independent t-test revealed no statistically significant difference in mean level of cognitive complexity between the two groups ( $t=0.96$ , d.f.20, n.s.) This result confirms expectations that the two groups would be equal in this respect at the onset of training.

2. Group B Time 1 and Group A Time 1

An independent t-test revealed no statistically significant difference in mean level of cognitive complexity between the two groups ( $t=1.37$ , d.f.19, n.s.). This result shows that repeated measurement has not affected Group A.

3. Group A Time 0 and Group A Time 1

A dependent t-test showed a statistically significant difference between mean levels of cognitive complexity between the two measurement points ( $t=2.60$ , d.f.8,  $p<0.05$ ). This means that on the repeated measurement occasion, after one year of training, Group A's construct systems were more complex.

4. Group C Time 2 and Group B Time 2

An independent t-test revealed no statistically significant difference in mean level of cognitive complexity between the two groups ( $t=0.44$ , d.f.16, n.s.). This means that repeated measurement had not affected Group B.

5. Group B Time 1 and Group B Time 2

A dependent t-test showed no statistically significant difference between mean levels of cognitive complexity between the two measurement points ( $t=0.41$ , d.f.7, n.s.). This result shows no change in cognitive complexity as a result of Year 2.

6. Group D Time 3 and Group C Time 3

An independent t-test revealed no statistically significant difference in mean level of cognitive complexity between the two groups ( $t=0.02$ , d.f.17, n.s.). This means that repeated measurement has not affected Group C.

7. Group C Time 2 and Group C Time 3

A dependent t-test showed a statistically significant difference between mean levels of cognitive complexity between the two measurement points ( $t=3.47$ , d.f.8,  $p.<0.01$ ). This means that on repeated measurement, after the third year of training, Group C's construct systems were more complex.

8. Group D Time 3 and Group TT2 Time 3

An independent t-test revealed no statistically significant difference in mean level of cognitive complexity between the two groups ( $t=0.47$ , d.f.17, n.s.). This suggests that the changes observed in the student nurses' groups cannot be attributed to their particular training and are more likely due to the effect of maturation.

9. Group A Time 0 and Group D Time 3

An independent t-test revealed no statistically significant difference in mean level of cognitive complexity between the two groups ( $t=0.45$ , d.f.20, n.s.). This result suggests that overall, there has been no change in cognitive complexity in student nurses' construct systems. As this comparison does not control for cohort effects however, and as there has been some observed change in earlier comparisons, the result may be indicative of a cyclical effect.

10. Group TT1 Time 0 and Group TT2 Time 3

An independent t-test revealed no statistically significant difference in mean level of cognitive complexity between the two groups ( $t=0.18$ , d.f.17, n.s.). This result shows no change between the two groups but does not control for cohort effects and in the light of observed changes in the student nurses' groups, may be indicative of a cyclical effect.

## Summary

There is evidence of an increase in cognitive complexity during the first and third years of training but not during the second year. The cross sectional comparison indicates no overall change in complexity and it is suggested that these results may be indicative of a cyclical change in complexity.

## 9.4 DISCUSSION

### 9.4.1 Identification of the Most Salient Elements

It has been shown that all groups had either Old People or Children as the most salient sets of elements. If only one set of elements had been consistently the most salient, then this would have suggested that these elements were particularly influential in the individual's construct systems. As it is however, the interpretation of the observed results is somewhat problematic. The elements were chosen for their relative position on a continuum stretching from childhood to old age. It is perhaps this aspect which is reflected in the results, as Old People and Children are the endpoints of that continuum, rather than any other characteristics of these elements which make them particularly salient. It may be that the constraints imposed by the researcher in the choice of elements has predetermined the results in this way.

One way of avoiding this problem might be to sample a wide range of persons known to the subject and to include them all as elements before ascertaining their ages from the subject when the grid has been completed. This would probably lead to more complications in analysis however, as subjects would not necessarily contribute equal numbers of old people, young people etc., but if a large enough grid were completed, sizes could perhaps be made comparable by random elimination of elements.

#### 9.4.2 Examination of Constructs

The difficulties as experienced in the categorisation of constructs is a problem which has not been touched upon in the repertory grid literature. Lifshitz (1974) presents no reliability data and reports that the experimenter alone assigned constructs to categories. In view of the low inter-judge reliability level established in the present study, her findings must be viewed with reservations. In practice it was extremely difficult to make decisions between some of the categories. For example, should a construct relating to dependency be categorised as "task orientation" or "abstract intrapsychic characteristic"? Dependency on others may be a state of mind as much as a physical disability.

Whilst more clarification of certain constructs at the point of elicitation would have aided categorisation, problems would still have remained. Some constructs were descriptions of other people's apprehensions of the elements rather than direct descriptions of the subjects e.g. Is well loved. Some constructs could be assigned to two categories, one for each pole, when idiosyncratic "opposites" were elicited e.g. Is well loved - Is outspoken. Only the simplest of schemes, a dichotomous category system, was successful in the present study in achieving a respectable inter-judge reliability level.

The comparisons which were made showed that at the beginning of training student teachers used more psychological constructs than did student nurses. Unfortunately, the literature relating to the developing construct system concentrates on children and adolescents (Brierley 1967; Little 1968) and so little is known about the continuing development into adulthood. However it might be possible to explain the observed difference between the two student groups in terms of their different educational backgrounds in preparation for their respective courses. Student teachers may have included more arts subjects than student nurses and the



latter may have taken more science subjects than the former. However, it is only in the psychological constructs that the two groups differ and the most plausible explanation probably lies in the fact that the student teachers were slightly older, with more educational qualifications and more work experience than the student nurses. They might thus be considered a more "mature" group.

Group C's use of concrete constructs increased significantly over the third year of training. However, in the absence of any change in the number of psychological constructs it is not possible to conclude that this is necessarily a detrimental change. There was a tendency for Groups A, B and C to produce more concrete constructs on repeated measurement. A possible explanation for this might be a decrease in motivation on the second occasion and a consequent production of superficial concrete constructs at the expense of psychological discriminations.

The two student groups were similar to each other at the end of their training and the evidence suggests that it is the teachers rather than the nurses who have changed.

What seems to be missing from the personal construct theory literature is any normative data regarding proportions of constructs of certain types. This undoubtedly reflects the clinical bias of much of the research undertaken when the emphasis is on idiographic change rather than normative comparisons. Nevertheless, the clinical field is not the only one where repertory grid methodology has application and the establishment of some normative data would be a distinct advantage. The collection of normative data would, however, be extremely difficult as the question "normative for what purpose?" must always be asked. Proportions of types of constructs may well be related to the elements used in any particular grid.

#### 9.4.3 Identification of Elements Accounting for Most Change

Old People accounted for most of the observed change in Groups A, B and C over the two measurement occasions. A consideration of the constructs used by Group A which specify Old People in particular (see Component 1, low rating on Table 9.8) indicate a generally negative evaluation on both occasions. It is recognised however, that each subject has contributed only one construct to this analysis and therefore a construct may seem particularly idiosyncratic and "out of place" at times. Group B, on the other hand, seem to modify their occasional negative evaluations which are seen in constructs on the first occasion to a more positive evaluation on the second occasion (see Component 2, low rating on Table 9.9). Group C likewise, show an occasionally negative evaluation of old people on their first measurement occasion which is modified on the second occasion (see Component 2, low rating and high rating at Time 2 and Time 3 respectively).

Overall, this is perhaps indicative of a general modification of negative attitudes where they exist, but it is not until Time 2 that overtly positive attitudes begin to appear e.g. Group B at Time 2 characterise Old People as having a lot of experience in the war, being clever and strong minded; Group C at Time 2 include being very worldly, having many life experiences among their constructs characterising Old People. It must be remembered however, that in a group analysis such as this, each subject contributes only one construct to each component. It would be possible theoretically to examine the grids of individuals, to categorise their constructs as either positive, negative or neutral and thus to determine the nature of an individual's construing of old people.

It is between Time 1 and Time 2 that student nurses are allocated to the geriatric unit. It would be

interesting therefore, to look at individual nurses over this particular time period in more detail. The data collected in the present study is, however, insufficient for detailed case studies largely because little is known about the specific elements in an individual's grid i.e. Element number 13 is an Old Person in each case but it may be a grandmother or a next door neighbour, someone seen often or infrequently, or someone with whom one shares a home. For a case study, such information would be essential in order for the interpretation of results not to seem trivial.

#### 9.4.4 Cognitive Complexity/Simplicity

It is apparent from the observed results that student nurses' construct systems change with regard to cognitive complexity over the period of their training. It is not possible to conclude, however, that this is due to their specific training as the student teachers appear to be similar to student nurses in terms of cognitive complexity at the end of their training. The results do not support the hypothesis that student nurses' construct systems would become increasingly differentiated (more complex) as they progressed through training. Changes in complexity were observed in Groups A and C in the first and third year of training but there was no overall change which suggests a cyclical effect. It is however, reassuring that training has not resulted in more simple construct systems as this would limit a person's ability to perceive the behaviour of others in a multidimensional way. The ability to do this is of advantage to the nurse in her perception of patients and should help to guard against stereotyping. Adams-Webber (1969) showed that the more cognitively complex a person's system was, the more accurate he was in identifying the constructs used by his partner. This has implications for nurses if as their construct systems become more complex, they are better able to interpret patients' behaviour.

A word of caution is needed at this point however. Bannister and Fransella (1971) point out that cognitive complexity/simplicity is not a trait of which a person possesses a fixed amount. A person may well be extremely cognitively complex in relation to jazz music for example, but simple when dealing with modern art. The student nurses' construct systems in the present study have changed in complexity in relation to the elements in question. Whether or not this would generalise to patients in hospital is a matter for empirical determination. It would also be useful to know to what extent the observed changes are due to particular experiences in training and a more detailed analysis with more frequent measurements and a suitable control would be necessary in order to answer that question.

#### 9.5 CONCLUSION

This study has taken an overall look at the changes in nurses' perceptions of people of different ages over the three year training period. Four aspects of this have been considered. Firstly, it has been shown that, given the procedure outlined in this study, Old People and Children were the most salient elements in determining the nurses' construct systems. If this is so, then it has implications for the nurse's experience in caring for these age groups in hospital. If these elements are categorised most distinctly in a nurse's experience, then her behaviour toward these age groups may be similarly distinctive.

Secondly, it has been shown that student nurses do not construe people in increasingly psychological terms as they progress through training. There is some evidence from this study that during the final year of training, their construing becomes more concrete. The effect of repeated measurement on the production of concrete constructs cannot, however, be ruled out, but what is apparent from this study is that training per se does not result in more psychologically orientated person perception.

Thirdly, it has been shown that Old People account for most of the observed change in student nurses' construct systems. This suggests that attention toward the student nurse's experience with old people should not be limited to the geriatric placement but should be considered throughout the training period as a whole.

Fourthly, it has been shown that training is ineffective in producing an increasingly differentiated construct system and it is suggested that cyclical changes may be taking place. These may be due to particular experiences during training but this is a matter for empirical determination.

At the beginning of this thesis, it was suggested that nurses were reluctant to make a career in geriatric nursing. In the following chapter, a study is described which seeks to provide some additional information regarding student nurses' experience in geriatric nursing and subsequent career choices.

## CHAPTER TEN

### EXPECTATIONS AND REVIEW OF TRAINING: CAREER CHOICES

#### PART I - PILOT STUDY

##### 10.1 INTRODUCTION

So far, data have been presented relating to the student nurse's perceptions of old people and her conversations with them in hospital. If, as was suggested in Chapter 1, recruitment of trained nursing staff for geriatric nursing is difficult, and nurses are choosing not to make geriatric nursing their career, it would seem important to know what factors influence their choice of career; what experiences during training have been influential; and what they hope to gain by way of reward from their future career. In other words, what are their reasons for choosing or rejecting a career in geriatric nursing?

It was thought that data on this particular issue would be a valuable addition to the present study, contributing to a more complete picture of the student nurse's experience with old people in hospital. In order to assess those factors which determine student nurses' career choices and to gain their evaluation of their training in general and geriatric nursing in particular, it was decided to focus both on nurses at the end of their training and on nurses at the beginning of their training. The latter have expectations which influence their experience of various specialities, whilst the former will already be making plans for their chosen career.

The limited amount of time available for this part of the study necessitated a questionnaire approach. However, it was still considered desirable to allow the subjects as much freedom as possible in responding. Therefore, open ended questions were to be used whenever possible.

A small pilot study was carried out with student nurses at the end of their training. The pilot study is reported in Part I of this chapter and the main study succeeds it in Part II.

## 10.2. METHOD

### 10.2.1 Design

A questionnaire was administered to student nurses in the final 3 months of their 3 year training programme on one occasion only.

### 10.2.2 Subjects

The subjects were 10 student nurses, a convenience sample from a single cohort of student nurses undergoing general nurse training. All were female aged from 20-25 years, median age = 22 years. Educational background: from 5-11 GCE O levels Median = 7  
from 0-3 GCE A levels Median = 2

### 10.2.3 Questionnaire

A questionnaire was designed with seven questions as follows:-

1. Now that you have reached the end of your training, which parts have you enjoyed most and why?
2. What have you enjoyed least and why?
3. What are your immediate plans for your career?
4. What would you most like to do, given the ideal circumstances?
5. Do you see yourself with a long term future in nursing? Where?/Why not?
6. Looking back on your training, how do you feel about your geriatric experience?
7. Would you consider a career in geriatrics? Why?/Why not?

The questions were devised by the researcher to elicit information from the student nurses regarding their feelings about their training in general, their geriatric nursing experience in particular and their choice of future work.

#### 10.2.4 Procedure

The researcher introduced herself to the student nurse and explained that the purpose of the interview was to ask questions about her feelings on completion of her training. Confidentiality was assured. The researcher proceeded to ask the student nurse the questions and wrote down her responses.

### 10.3 RESULTS

#### 10.3.1 Q1. Now that you have reached the end of your training, which parts have you enjoyed most and why?

Student nurses mentioned between 1 and 5 parts each, the average being 2.6 parts. Table 10.1 shows those parts of training mentioned by student nurses in response to Q1 and the frequency with which each part was mentioned by the sample.

Table 10.1 Parts of Training Enjoyed Most

<u>PART OF TRAINING</u>	<u>FREQUENCY OF MENTION</u>
Accident and Emergency	1
Geriatrics	3
Gynaecology	0
Maternity Care	4
Medicine	4
Mental Health	0
Operating Theatres	1
Orthopaedics	2
Paediatrics	2
Surgery	2
Third Year Wards*	6

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\*It is recognised that this is a collective term but the importance of its inclusion becomes apparent when the reasons given in support of responses are considered.



Third Year wards, Maternity Care and Medicine account for 56% (14) of mentions. Those nurses who mentioned Third Year wards cited their increased self-confidence in support of this response. In the final months of their training they had grown in confidence and had welcomed a greater share of responsibility. As one student phrased it:-

*"I felt confident, I had more responsibility and I knew what I was doing".*

Nurses mentioning Maternity Care and Medicine also referred to their self-confidence in these areas. It seemed as though the amount of responsibility they were expected to shoulder was equal to the amount they felt able to take. One nurse who mentioned Maternity Care felt that this experience in her second year was at a "good point" during her training, when she had enough but not too much responsibility. The same nurse also mentioned Third Year wards because at that time she felt more confident and enjoyed the responsibility of working with junior students and taking some part in their teaching.

#### 10.3.2 Q2 What have you enjoyed least and why?

Student nurses mentioned from 1-3 areas, an average of 1.5 areas each. Table 10.2 shows those parts of training mentioned by student nurses in response to Q2 and the frequency with which each part was mentioned by the sample.

Table 10.2 Parts of Training Enjoyed Least

PARTS OF TRAINING	FREQUENCY OF MENTION
Accident and Emergency	0
Geriatrics	1
Gynaecology	0
Maternity Care	1
Medicine	2
Mental Health	0
Operating Theatres	7
Orthopaedics	1
Paediatrics	2
Surgery	1

It can be seen that a dislike of Operating Theatres accounts for the largest proportion (46%) of mentions. The reasons given in support of this related to the perceived nature of the work which was described as "boring". The nurses did not like the lack of patient contact in this area and there was a feeling that it wasn't really nursing. One nurse mentioned that she didn't like the other staff who worked there.

Only one nurse mentioned Geriatrics in response to this question. She felt that the care given in the geriatric unit was not of a high standard, that the facilities were inadequate and that the permanent staff were lacking in enthusiasm and treated the unit as merely a convenient place to work.

#### 10.3.3 Q3 What are your immediate plans for your career?

Table 10.3 shows that the majority of the student nurses intended to remain in the hospital and gain staffing experience on the general and orthopaedic wards.

Table 10.3 Student Nurses' Immediate Plans on Completion of Training

IMMEDIATE PLAN	No. NURSES
To work on Surgical Ward	3
To work on Medical Ward	3
To work on Orthopaedic Ward	2
Don't know yet	2

#### 10.3.4 Q4 What would you most like to do, given the ideal circumstances?

Student nurses found the 'ideal' situation difficult to conceptualise or separate in a meaningful way from their actual plans.

10.3.5 Q5 Do you see yourself with a long term future in nursing? Where?/Why not?

Table 10.4 shows that the majority of student nurses did foresee a long term involvement for themselves in nursing.

Table 10.4 Student Nurses' Perceptions of Long Term Involvement in Nursing

RESPONSE	No. NURSES
Yes	7
No	1
Probably	2

Their responses to the second part of the question are shown in Table 10.5. The only nurse to respond negatively to this question reported that she was "fed up" with nursing - she felt she was misused and was treated as "just an extra pair of hands" particularly on night duty.

Table 10.5 Responses to Q5 showing areas of Long Term Involvement

LONG TERM FUTURE	No. NURSES
Community Nursing	2
Geriatric Nursing	2
Some Chronic Area	1
Abroad	1
Area Unspecified	2

10.3.6 Q6 Looking back on your training, how do you feel about your geriatric experience?

Three nurses gave an overtly positive response to this question, one nurse gave a negative response, whilst the majority (6) gave a mixed response.

Positive responses centred mainly around the patients with 2 nurses commenting that they liked old people. The work however, was mainly seen in negative terms - fixed routines, boring, poor standard of care. Moreover, staff were perceived as having the "wrong frame of mind", being unenthusiastic, lethargic and using it as a convenient place to work. Student nurses noted that the building and facilities were inadequate and one nurse commented on the "horrifying death rate". Nevertheless, many nurses were willing to recognise the potential for improvement in this specialty and commented on its value and humanitarian worth.

10.3.7 Q7 Would you consider a career in geriatrics?  
Why?/Why not?

One nurse responded positively to this question and nine negatively. Those responding negatively qualified their answers by saying they would consider working in geriatrics for a limited period of time but not for a whole career. The only nurse prepared to give an unqualified "yes" to this question, had worked as an auxiliary in the geriatric unit prior to training, and saw it as an area of great potential - she felt there was more to be done as the patients were more dependent, needing "total care". She intended to work part-time when married.

10.4 DISCUSSION

10.4.1 Q1 Now that you have reached the end of your training, which parts have you enjoyed most and why?

It would have been possible to limit a student nurse's response to one area of training she had enjoyed most. This would have restricted most nurses (7 out of 10) who had no clear preference for one particular area and for whom one choice would have been difficult to make. Rank ordering of different parts of training would not have overcome this problem. It was decided to

allow nurses more than one choice with the recognition that the overall results would be influenced unequally by individuals. This was considered of less importance than allowing the nurses to compare those areas they had enjoyed and to discriminate between them. Oppenheim (1979) considers the problem of multiple mention codes and suggests that there are no difficulties in turning such data into percentages even though the sum will exceed 100 per cent.

Assessing statistical significance, however, is problematic since the data are not independent. Oppenheim suggests a way round the lack of independence by using a 2 x 2 chi-squared test on the number of respondents in certain category against all those who did not respond in that way. The test would be performed on the number of cases and not on the number of responses. However, this approach assumes an equivalence between students' responses which may not be justified in the circumstances. It was decided to retain the possibility of multiple mention responses but not to try to assess statistical significance.

Self-confidence and responsibility featured heavily in student nurses' responses to this question. If this is confirmed by the main study, it could have implications for the placement of certain experiences in the training programme.

#### 10.4.2 Q2 What have you enjoyed least and why?

Those matters of analysis discussed above, also have relevance for this question.

It is interesting to note that only one nurse cited Geriatrics in response to this question. The majority response of Operating Theatres and the student nurses' descriptions of the work as "boring" may well reflect the understandably limited nature of their involvement in this area. It is also placed in the second year of their training when some of them may be ready to shoulder

more responsibility than they can be given in the Operating Theatre.

10.4.3 Q3 What are your immediate plans for your career?

Because of the limited variety of responses to this question, it is not clear whether nurses are excluding geriatrics or merely responding to offers in general areas. The main study should throw light on this area.

10.4.4 Q4 What would you most like to do, given the ideal circumstances?

Because of the unsatisfactory responses to this question, it was decided to exclude it from the main study.

10.4.5 Q5 Do you see yourself with a long term future in nursing? Where?/Why not?

It is interesting that responses to this question show nurses to be interested in non-acute areas of nursing for a long term involvement. If this is confirmed by the main study, it may well reflect the concern voiced by some students of their desire to marry and raise a family. Their long term involvement therefore, includes their potential domestic responsibilities.

10.4.6 Q6 Looking back on your training, how do you feel about your geriatric experience?

Many of the comments here focussed on the staff working in the geriatric unit. If this is also shown to be of concern in the main study, it may have implications for the potential involvement of permanent staff in the teaching of student nurses on the unit. The work was seen as "boring" and "routine" - there may be scope for a more structured educational programme taking place on the unit.

10.4.7 Q7 Would you consider a career in geriatrics?  
Why?/Why not?

It is apparent from responses to this question that student nurses were not willing to consider a whole career in geriatric nursing. If this is confirmed in the main study, it has important implications for the recruitment of motivated trained staff to work in geriatric units.

10.4.8 Modifications as a result of the Pilot Study

With the exception of Q4, the questionnaire had proved to be useful in eliciting the comments and evaluations of student nurses regarding their training and future career choices. It was thought that the questions could be adapted for students at the beginning of training, but that individual interviews would be unduly time consuming with a larger number of subjects. Therefore, in view of the time available and the apparently unambiguous nature of the questions, it was decided to administer the questionnaire to nurses in a classroom setting with the researcher present in order to answer any queries which might arise.

PART II - MAIN STUDY

10.5 INTRODUCTION

As a result of the pilot study, it was decided to modify the questionnaire by omitting the questions relating to student nurses' ideal plans and by adapting the questions for a group of nurses at the onset of training. Instead of a series of face to face interviews, the questionnaires were to be administered in a group classroom setting. It was hoped in this way to be able to gather more data relating to student nurses' expectations and perceptions of their training in general, their geriatric nursing experience in particular, and their future career choices.

## 10.6 METHOD

### 10.6.1 Design

A cross sectional design involved two groups of student nurses, one in Introductory Block (Group A) and one in Final Study Block, (Group B) on one occasion only.

### 10.6.2 Subjects

Group A consisted of 26 Ss (24 female, 2 male). Their ages ranged from 18-30 years, median = 19 years.

Educational background: from 5-12 GCE O Levels, Median = 7.5  
from 0-3 GCE A Levels, Median = 0

Group B consisted of 40 Ss (37 female, 3 male).

Their ages ranged from 20-33 years, median = 21 years.

Educational background: from 3-10 GCE O Levels Median = 7  
from 0-2 GCE A Levels Median = 1

### 10.6.3 Apparatus

The two questionnaires are shown in Appendix I.

## 10.7 RESULTS

Group A Q1 Which parts do you expect to enjoy most and why?

On average nurses mentioned 3 areas (range 1-6) as being those they expected to enjoy most. Table 10.6 shows those parts of training mentioned by student nurses in response to this question and the frequency with which each part was mentioned by the sample.

Table 10.6 Parts of Training Group A. Expect to Enjoy Most

PART OF TRAINING	FREQUENCY OF MENTION
Accident and Emergency	15
Geriatrics	4
Gynaecology	4
Maternity Care	16
Medicine	3
Mental Health	3
Operating Theatres	9
Orthopaedics	4
Paediatrics	15
Surgery	4
	278



Maternity Care, Accident and Emergency and Paediatrics account for 59.7% of all mentions. The reasons given in support of those areas related mainly to the characteristics of the work as anticipated by these student nurses. Maternity Care was seen as being intrinsically interesting and held a certain fascination for the students.

*"I will gain a greater understanding of the female body".*

Accident and Emergency was also seen as interesting but in addition was expected to be exciting and "never boring".

*"Needs quicker thinking and immediate action".*

Paediatrics, on the other hand, was mentioned mainly because of the patients involved. The student nurses who cited paediatrics in response to this question, found children and young babies "fascinating" and because of their helplessness perhaps, nurses thought this area to be most worthwhile.

*"I enjoy children - they have their future lives in front of them. They have something to look forward to".*

Group B Q1 Now that you have reached the end of your training, which parts have you enjoyed most and why?

On average nurses mentioned 1.9 areas (range 1-4) as being the most enjoyed. Table 10.7 shows those parts of training mentioned by student nurses in response to Q1 and the frequency with which each part was mentioned by the sample.

Table 10.7 Parts of Training Group B have Enjoyed  
Most

PART OF TRAINING	FREQUENCY OF MENTION
Accident and Emergency	11
Geriatrics	4
Gynaecology	0
Maternity Care	9
Medicine	10
Mental Health	3
Operating Theatres	4
Orthopaedics	4
Paediatrics	12
Surgery	14
Third Year Wards	5

Surgery, Paediatrics, Accident and Emergency and Medicine account for 61.8% of mentions. The reasons given in support of these related mainly to work characteristics as perceived by the student nurses and also to the rewards they had received in these areas. Surgery, Paediatrics, Accident and Emergency and Medicine were all enjoyed because of the fast pace of work in these areas, and because of the high turnover of patients. Work offered in these areas was seen as "varied", "interesting" and a "challenge". The rewards nurses received were mainly to do with seeing patients recover and go home.

*"Speed of recovery".*

*"You can see progression".*

*"Can see results - they go home quicker and better than when they came in".*

Those nurses citing Paediatrics in response to this question mentioned, in addition to those reasons already reported, the fact that they enjoyed caring for and being with children.

Another reason common to Surgery, Accident and Emergency

and Medicine, but not to Paediatrics, was the ward atmosphere and the benefit of good staff relationships.

Group A Q2 Which parts do you expect to enjoy least and why?

On average, student nurses mentioned 1.4 areas (range 0-3) as being those they expected to enjoy least. Table 10.8 indicates these areas and the frequency with which they were mentioned by the sample.

Table 10.8 Parts of Training Group A Expected to Enjoy Least

PARTS OF TRAINING	FREQUENCY OF MENTION
Accident and Emergency	3
Geriatrics	9
Gynaecology	1
Maternity Care	1
Medicine	0
Mental Health	13
Operating Theatres	6
Orthopaedics	0
Paediatrics	4
Surgery	0

Mental Health and Geriatrics and Operating Theatres account for 75.7% of all mentions. The reasons given in support of these responses related mainly to those aspects of the work and characteristics of the patients involved as were anticipated by the student nurses.

Mental Health was seen as a "frightening" area in which to work and one which would require a great deal of physical stamina and patience. Geriatrics likewise was seen to be very demanding.

*"I expect a lot of mopping up will have to be done. Also the generation gap may be a problem. Senility and confusion is also something I would not find easy to cope with effectively".*

Mental Health, Geriatrics and Operating Theatres presented great threats to these student nurses. They were not sure that they possessed the resources with which to cope.

*"I am not sure whether or not I can take all the blood, watching amputations etc."*

*"I don't know if I would have the patience in dealing with the elderly - little experience".*

The patients in these areas were also seen very much as unknown quantities. Nurses expressed concern at not knowing what they (the patients) would be like and consequently they were unsure of their own responses.

*"Rather frightening - those (patients) that might not be aware of what was happening to them".*

*"I am unsure of what will be involved in caring for these patients".*

Group B Q2 What have you enjoyed least and why?

On average student nurses mentioned 1.1 areas (range 1-3) as being enjoyed least. Table 10.9 indicates these areas and the frequency with which they were mentioned by the sample.

Table 10.9 Parts of Training Group B Enjoyed Least

PARTS OF TRAINING	FREQUENCY OF MENTION
Accident and Emergency	1
Geriatrics	5
Gynaecology	1
Maternity Care	3
Medicine	8
Mental Health	1
Operating Theatres	5
Orthopaedics	4
Paediatrics	12
Surgery	3
First Year Wards	3

Paediatrics, Medicine, Geriatrics and Operating Theatres accounted for 65.2% of all mentions. The reasons given for dislike of these areas were varied, but one which was common to all concerned poor staff relationships. Nurses had not enjoyed working in these areas partly because the staff there had made them feel unwelcome and there had been a "bad atmosphere". Paediatrics, although enjoyed by 30% of the group (see Table 10.10) was also enjoyed least by the same proportion (30%) (see Table 10.11).

Table 10.10 Parts of Training Mentioned by Groups A and B in response to Q1  
(Percentage of Subjects mentioning each part)

PART OF TRAINING	GROUP A (n=26)	GROUP B (n=40)
Accident & Emergency	57.7	27.5
Geriatrics	15.4	10.0
Gynaecology	15.4	0.0
Maternity Care	61.5	22.5
Medicine	11.5	25.0
Mental Health	11.5	7.5
Operating Theatres	34.6	10.0
Orthopaedics	15.4	10.0
Paediatrics	57.7	30.0
Surgery	15.4	35.0
Third Year Wards	-	12.5

Table 10.11 Parts of Training Mentioned by Groups A & B in response to Q2  
(Percentage of Subjects mentioning each part)

PART OF TRAINING	GROUP A (n=26)	GROUP B (n=40)
Accident & Emergency	11.5	2.5
Geriatrics	34.6	12.5
Gynaecology	3.8	2.5
Maternity Care	3.8	7.5
Medicine	0.0	20.0
Mental Health	50.0	2.5
Operating Theatres	23.1	12.5
Orthopaedics	0.0	10.0
Paediatrics	15.4	30.0
Surgery	0.0	7.5
First Year Wards	-	7.5

In this case, the nurse's self confidence was at risk - one student reported having felt totally unable to cope with sick children and many students mentioned the distress occasioned by suffering children.

*"Sick and dying children were difficult not to get involved with".*

Those nurses who had not enjoyed medicine reported that they had found it to be slow and lacking in positive intervention. One nurse also commented that "most patients do not fully recover".

Geriatrics was perceived as "heavy and tiring" with "no interesting outlets". Nurses found the experience "boring, tedious and too long". One nurse also commented on the lack of interest on the part of permanent staff in the area.

Operating Theatres also affected some nurses' self confidence as "they did not know much". They also found the work to be "boring" with little patient contact.

A larger percentage of student nurses in Group A (34.6%) expected not to enjoy geriatrics than did those student nurses in Group B (12.5%) who reported that they had not enjoyed Geriatrics (see Table 10.11).

Group A Q3 What are your immediate plans (if any) for your career when you finish your training?

Table 10.12 shows that 38% (10) of nurses envisaged proceeding to further training. A further 27% (7) were undecided as to their choice of speciality whilst another 23% (6) had already earmarked Surgery, Medicine and Paediatrics as their chosen areas.

Table 10.12 Group A's Immediate Plans on Completion of Training

IMMEDIATE PLANS	FREQUENCY OF MENTION
No immediate plans	1
Area undecided	7
Overseas work	4
Surgery or Medicine	2
Surgery	1
Paediatrics	3
Armed Forces	1
Further training	10

Group B Q3 What are your immediate plans for your career?

Table 10.13 shows that 50% of nurses (20) were opting for immediate experience in either medical or surgical nursing. A further 17.5% (7) were also seeking staffing experience but were undecided as to the specific area. Another 8 nurses had chosen various specialities and 5 had other plans, one to leave nursing for a few months, two to complete secondments in Psychiatry and two to travel abroad. None were planning to return to Geriatric nursing.

Table 10.13 Group B's Immediate Plans on Completion of Training

IMMEDIATE PLANS	FREQUENCY OF MENTION
Medicine	10
Surgery	3
Medicine or Surgery	7
Area undecided	7
Gynaecology	2
Orthopaedics	2
Operating Theatres	1
Neurology	1
Paediatrics	2
Other	5

Group A Q4 Do you see yourself with a long term future in nursing? Where?/Why not?

Table 10.14 indicates that 88.5% (23) of Group A foresaw a long term involvement for themselves in nursing. None answered negatively to this question.

Table 10.14 Group A's Perceptions of Long Term Involvement in Nursing

LONG TERM FUTURE	No. NURSES
Yes	23
No	0
Probably	2
Uncodable	1

Table 10.15 shows that 61.5% (16) had no clear indication as to what direction their career might take at this stage in their training.

Table 10.15 Group A's Estimate of Area of Long Term Involvement in Nursing

AREA	No. NURSES
Area unspecified	16
Maternity Care	2
Paediatrics	1
Community nursing	3
Accident & Emergency	2
Administration	1
Uncodable	1

Group B Q4 Do you see yourself with a long term future in nursing?

Table 10.16 indicates that 72.5% (29) of the sample saw a long term involvement for themselves in nursing. Only 3 nurses answered negatively to this question.



Table 10.16 Group B's Perceptions of Long Term Involvement in Nursing

LONG TERM FUTURE	No. NURSES
Yes	29
No	3
Probably	7

\*One nurse omitted this question

Table 10.17 shows that 45% (18) had no clear indication of which direction their career might take. Five nurses saw only a part-time commitment for themselves as supplementary to marriage and a family, whilst 10 felt they wanted to specialise in the acute areas. Only one nurse indicated a commitment to geriatric nursing in the long term as owner of a private nursing home.

Table 10.17 Group B's Estimate of Area of Long Term Involvement in Nursing

AREA	No. NURSES
Area unspecified	18
Acute areas	10
Community nursing	5
Geriatrics	1
Other	1

\*5 nurses indicated part-time work rather than an area.

Group A Q5 How do you feel about working in the geriatric unit?

From Table 10.18 it can be seen that 69.2% (18) of Group A reported either negative or mixed reactions.

Table 10.18 Group A's Feelings about Working in the Geriatric Unit

RESPONSE	No. NURSES
Positive	8
Negative	8
Mixed	10

Although equal numbers of nurses reported positive and negative responses, those reporting positive responses emphasised the fact that the elderly need nursing care as much as any other group and that "we'll all be old one day" rather than seeing in geriatric nursing any special qualities.

The overtly negative responses emphasised the perceived depressing nature of both the work and the patients. They expressed again their doubts about being able to cope.

*"Apprehension - because of the general impression of a geriatric patient i.e. death, grumpy, incontinent. Not much job satisfaction".*

Those nurses reporting mixed reactions also perceived in geriatric nursing many undesirable characteristics but were, nevertheless, willing to "have a go".

Group B Q5 Looking back on your training, how do you feel about your geriatric experience?

From Table 10.19 it can be seen that 50% (20) of the sample reported mixed reactions.

Table 10.19 Group B's Feelings about their Geriatric Experience

RESPONSE	No. NURSES
Positive	11
Negative	9
Mixed	20

For those nurses responding positively, most of the comments related to the nurses' evaluation of the work itself.

*"I enjoyed this and found that looking after old people is worthwhile, a great deal of patience and understanding is required".*

*"Very interesting, learnt a lot about basic nursing care and treatment of patients as individuals.*

*"It was a worthwhile experience and has helped me to understand caring for a long-term geriatric on a medical ward, for example a stroke patient".*

For those nurses responding negatively and for those with mixed reactions, there was an overriding time dimension - nurses feeling that the amount of time allotted to this experience was excessive.

*"It was basically too long. Geriatrics experience is gained on general medical wards and 13 weeks allocation seems to be a time waster..."*

*"Enjoyable although the time allocated was too long - ceased to learn anything after 6 weeks".*

*"Valuable, but 3 months is enough".*

Group A Q6 Would you consider a career in geriatric nursing? Why?/Why not?

Table 10.20 shows that 57.7% (15) of the sample answered this question negatively.

Table 10.20 Group A's Consideration of a Career in Geriatric Nursing

RESPONSE	No. NURSES
Yes	6
Possibly	3
No	15
Uncodable	2

There was also a feeling that time spent in geriatric nursing was time wasted in terms of one's career but

also in terms of energy which could be spent on those who had a chance of complete recovery.

*"There is less hope of the patient ever recovering and in many cases the patient will spend the rest of his or her life there".*

*"I want to work with people you can really help to recover instead of making the last months of life comfortable".*

Those nurses who reported that they would consider a career in geriatric nursing had mostly had previous experience of some kind with old people which they had enjoyed.

Group B Q6 Would you consider a career in geriatrics?  
Why?/Why not?

Table 10.21 shows that 65.0% (26) of the sample answered negatively to this question. Of the remaining 14, 10 specified certain conditions which would need to be met for them to consider such a career.

Table 10.21 Group B's Consideration of a Career in Geriatric Nursing

RESPONSE	No. NURSES
Yes	4
Possibly	10
No	26

Most of the responses to this question related to the value placed on geriatric nursing by the student nurses. They felt that little experience was to be gained by working on a geriatric ward, particularly when newly qualified. As one nurse commented:-

*"When newly qualified you need to work on a ward that is going to give you a better insight into acute illnesses".*

Geriatric nursing was seen as lacking in interest, variety and challenge. Characteristics of the work featured in some of the comments, nurses rejecting the possibility of a career in geriatric nursing because it was "depressing", "too heavy" and "too routine".

Two nurses felt they had little to contribute to geriatric nursing, whilst another two emphasised the lack of reward in the field. Referring back to their geriatric nursing experience during training, they commented that they "did not find the work showed much in the way of results".

Four nurses gave an unqualified positive response to the question. Their comments are quoted in full:-

*"Enjoy nursing the elderly. Parents own a rest home".*

*"It would be satisfying and a challenge and someone has to look after old people even though they may be difficult".*

*"I have previous experience and have enjoyed it tremendously. I like the type of nursing and care involved".*

*"Because I get on quite well with old people and they need the very basic nursing skills".*

## 10.8 DISCUSSION

Q1 Which parts do you expect to enjoy most and why?  
Which parts have you enjoyed most and why?

It is clear from Group A's responses to Q1, that the student nurses at the beginning of their training are looking for excitement, interest and challenge from their work. The areas they were most looking forward to - Maternity Care, Accident and Emergency and Paediatrics - were all areas in which they could expect a high level of activity and drama. It is interesting to note therefore, that the areas Group B had enjoyed most - Surgery, Paediatrics and Accident and Emergency - were similarly characterised by the

student nurses as places where the pace of work was fast and lively.

At the beginning of training then, it would seem that the student nurse is looking toward the more acute areas to fulfill her expectations of her nursing training. This expectation, which may be in the nature of a self-fulfilling prophecy, is realised during the course of training when nurses derive most enjoyment from areas which offer these characteristics of action and challenge.

Q2 Which parts do you expect to enjoy least and why?  
What have you enjoyed least and why?

When anticipating their training, it is clear from Group A's responses to this question, student nurses feel a great deal of anxiety about certain areas. These are the areas of which they know least. Both Mental Health and Geriatrics raised the spectres of patients with abnormal qualities and the nurses found this prospect alarming. There is perhaps, an argument here for experience of those areas early in the nurses' training. Whether this would serve to decrease or increase anxiety is a matter for empirical determination, but it would seem to be unwise to ignore the feelings nurses reported in anticipation of these areas.

The fear of Operating Theatres is one which must be common to many nurses at the beginning of their training. The eminently reasonable apprehension at the thought of observing operations with the tension this involves could perhaps be reduced by an early explanation of the student nurse's role in the Operating Theatre.

It is interesting to note that at the end of training, the major reason for dislike of an area seems to be the poor staff relationships which prevail in some areas. Student nurses are always at somewhat of a disadvantage in their work on the wards. They are

always in the position of newcomers to the ward team and as such are only integrated in that team by permission of the permanent staff. In some areas this is accomplished more successfully than in others. The fact that 30% of Group B disliked Paediatrics and that 50% of these nurses mentioned staff relationships as a major reason for their dislike indicates the importance of this for the student nurse.

Paediatrics, of course, had an additional major feature - namely the caring for sick children and of those nurses who had not enjoyed Paediatrics in Group B, 75% of them mentioned how difficult they had found this to be. It was upsetting and demanded involvement. The role conflict which ensued was compounded by the fact that many such children had parents in the hospital to care for them and consequently the nurse's role was ill defined.

Geriatrics, on the other hand, could not help but fail to live up to the student nurses' expectations for enjoyment of an area. "Pointless" and "futile" were descriptions which might have been alleviated if nurses' experience in the unit had been more structured. They perceived it as "very heavy, tiring, no interesting outlets".

Q3 What are your immediate plans (if any) for your career when you finish your training?  
What are your immediate plans for your career?

Responses of both groups of student nurses to this question indicate an intention on the part of the majority to pursue a career in the acute specialities. None intended to seek work in the geriatric unit. Group B mentioned a wide range of areas and so it seems that nurses are intentionally excluding geriatrics as a possibility. Whilst a large proportion of Group A, who are just commencing training, are understandably not specific in their plans, the areas which are noted are, again, the acute areas.

Q4 Do you see yourself with a long term future in nursing? Where?/Why not?

It is apparent that almost all the student nurses anticipated a long term involvement for themselves in nursing. For most nurses in Group A, this was in the far distant future and had not yet been conceptualised in any clear manner. What is perhaps more suprising is that 45% of Group B still had no clear indication of the direction of their career although they were at the end of their training. There is perhaps a need here for some career counselling for these student nurses who are at a crucial point in their careers. Five of the nurses in Group B were intending to marry in the near future and for each of these, nursing had taken on a secondary significance as a part-time activity to be fitted into their new domestic routine. The only possibility of any interest in geriatric nursing came from one nurse who wanted to run a private nursing home. One can only speculate as to whether her primary motives were altruistic or financial!

Q5 How do you feel about working in the geriatric unit? Looking back on your training, how do you feel about your geriatric experience?

The responses of student nurses in Group A revealed a great deal of apprehension concerning work in the geriatric unit. A resignation to its inevitability characterised the positive statements whilst stereotyped perceptions of the geriatric patient and the work abounded in the negative and mixed responses.

A similar proportion of student nurses in Group B reported negative or mixed responses. Although nurses who had enjoyed it felt that they had learned a great deal about "basic nursing care", the majority of nurses felt that it did not offer enough as a speciality in its own right. The qualities it demanded according to these nurses, were "patience" and "understanding" rather than the professional skills



of a qualified nurse.

Q6 Would you consider a career in geriatric nursing?  
Why?/Why not?

The responses to this question of student nurses in both groups reveal the relative value placed on the well being of an old person as against a younger person. The students at the beginning of their training felt that effort expended on the elderly could be spent to greater advantage on younger patients. If the standard against which health is measured is an absolute one, then this is undoubtedly true, but definitions of health and perceptions of who is healthy vary in reality (Field 1976). The desire of nurses to see "complete recovery" in all their patients is not only a logical impossibility, but is inappropriate with certain classes of patients who have the odds, in the guise of age, stacked against them.

At the end of training, 10% of Group B would consider a career in geriatric nursing. A further 25% would consider it if the conditions were favourable. From a visual inspection of the data, no association could be seen between consideration/rejection of a geriatric nursing career and most/least enjoyed areas of training, or responses to the geriatric nursing experience. It would seem, therefore, that reasons for rejecting this area as a career have little to do with experiences during training.

#### General Considerations

It is recognised that the change in technique of administering the questionnaire between pilot study and main study has resulted in a certain loss of specificity in nurses' responses. Nurses were more vague in writing their comments than they were in relating them verbally to the researcher. However, this is thought not to have altered the general direction of the results and in some cases nurses were very specific

in their written comments.

The deliberate lack of precoding nurses' responses by forced choice questions is considered an advantage in a study of this size. Nurses were able to qualify their Yes/No responses in ways which might not otherwise have been elicited. In retrospect, however, it would have been useful to gain nurses' evaluations of all parts of their training, not only the most and least enjoyed areas. A more balanced continuum of evaluations would then have been obtained which might have provided a baseline for the nurses' future career choices. This could be achieved by using the different parts of training as elements in a repertory grid and either eliciting constructs by comparisons or providing those constructs given in response to the first two questions of the questionnaire.

#### 10.9 CONCLUSIONS

This chapter has considered student nurses' expectations of, and responses to, their geriatric nursing experience and has examined their reasons for choosing/rejecting a career in that field.

It is apparent from this study that student nurses do not expect to enjoy geriatric nursing. At the beginning of their training, Group A revealed considerable doubts and anxieties both about the nature of the work and their own ability to cope. At the end of their training period, over a third of Group B reported that they had not enjoyed geriatric nursing. They described the work as "boring" and taxing of their physical strength. Consequently, none had made any immediate plans to work in the field on completion of training. Geriatric nursing as a possibility in the future was entertained by a minority of nurses but was not seen as an area which would help them to further their careers in the short-term. It was considered to have too little of valuable experience to offer to be useful in this regard. This study confirms the

suggestions in Chapter 1, that geriatric nursing holds little attraction for nurses. The implications of this for the profession will be taken up in the final chapter.

## CHAPTER ELEVEN

### CONCLUDING DISCUSSION

#### 11.1 INTRODUCTION

In the course of this thesis certain issues have been raised which merit further discussion. This concluding chapter considers these issues which relate first of all to the methods employed in the study and secondly to the subject area, and goes on to outline certain recommendations in the light of these considerations.

#### 11.2 ISSUES RAISED BY METHODOLOGIES

##### 11.2.1 Accounting

Harré and Secord (1972), in outlining "new methodological directions" for the study of attitudes place a high value on the necessity to untangle affective evaluation and ranking. They suggest that this issue has been ignored by many researchers in the past and set out a procedure by which this aim might be achieved. The procedure begins with a "situation in which each of the participants acts out or avows an attitude in a genuine context of commitment". It proceeds to the prompting of justifications by challenges to the attitude displayed.

##### 11.2.1.1 defining the situation

Certain difficulties were encountered with this format in the present study, the first of which concerns the situation in which the attitude is acted out or avowed. The particular behaviour in question was the nurse's conversation with a patient. As a single item of behaviour, this cannot be divided into situations as of itself. Rather it constitutes a part, albeit sometimes a major part, of many particular situations. For this reason, it was perhaps unwise to focus on conversations alone without the prior identification

of the total "situation" which may have taken the form of "helping the patient to dress", "bathing the patient" or "doing the medicines".

However, as it was seen in the present study, "talking to patients" did seem to be an identifiable activity in its own right even though it was not engaged in for much of the time. Focussing on the situations in which "talking to patients" was the prime activity might have approximated a more easily identifiable situational context than was the case. All of the conversations which comprised the data base were randomly sampled in an effort to exclude researcher bias in the selection of conversations for accounting purposes. This move, however, effectively eliminated the possibility of any "situations" being deliberately focussed upon. Consequently many of the conversations were "purposeless" in the nurse's terms - she could not always give a clear indication of her intentions as the conversation was often just a small part of a much wider activity. Harré (1978) maintains that the situation is the "taxonomically prior category" within which intentions can be perceived.

The justifications which were elicited on the basis of these conversations then, is somewhat general and not specifically focussed upon the disentangling of evaluation and ranking issues, but nevertheless has some value in helping us to understand the nurse's experience in caring for patients.

It is recommended for any future study using accounting for the examination of attitudes, that time should be spent on the identification of "situations". The work of Argyle, Furnham and Graham (1981) on situations, which has burgeoned since the data collection period in the present study, should be particularly useful in this regard. In their book they report an experimental study in which subjects were required to rate various goals for three situations according to how compatible goals were with various social roles. The subjects were occupational therapy students and the three

situations were:- a small party or gathering; complaining to a neighbour about constant noisy disturbance; nursing someone who is physically unwell (could be at home in bed). Argyle et. al. report that a key goal in the nursing situation appeared to be the nurse "looking after" the patient. The only conflict emerging was when the goals "looking after self" and "well-being of patient" coincided.

It is to be regretted that Argyle and his colleagues did not include nurses and patients (?) as subjects in this experiment - indeed the subjects seem to have been a convenience sample of students attending a course on social skills training. However, they make an interesting point which merits further consideration. It is suggested that conflict in the nurse-patient situation lies in the nurse's concern for her own well-being. Whilst their recommendation for greater medical precautions to protect nurses is rejected as quite unwarranted by this reported study, the nurse's need to protect herself in the nurse-patient encounter has also emerged in the present study. The reader will recall the student who attempted to initiate some meaningful conversation with Mr. J. in the bath. She failed miserably and was acutely aware of the fact. But her account of her failure revealed a very real concern for herself.

*"I might have embarrassed myself by finding out something that he doesn't want to talk about. I might get him upset - he might burst into tears or not like me for it".*

S08:4

One of the patient's goals in the study by Argyle et.al. related to obtaining information. This was seen as having little to do with nurse's goal of "looking after herself". This rather suprising finding probably reflects the fact that the subjects were not nurses as it would seem to have obvious links - if a patient requests information which the nurse is not authorised to give, then this can impinge directly on her need

to "look after herself".

The approach adopted by Argyle and his colleagues in determining the goals and interrelationships between goals and social roles is a promising one however, providing that recommendations for conflict reduction etc. are based on in-depth studies of particular professional groups and results derived from one grouping are not unjustifiably extrapolated to another.

#### 11.2.1.2 the timing of the challenge in a 'real-life' situation

The second difficulty which was encountered in the present study is essentially a practical one. There is a need in a study of this kind for the challenge to be put to the participant as soon as possible. Harré and Secord (1972) write:-

"The investigator must take an active role at this point, whether the commitment has been engineered or has occurred in some natural situation, since the criterion for the partition of attitudes at this point depends upon the creation of a justificatory context, and this is achieved by the participant's attitude being challenged".

p.310

It was explained in Chapter 5 that interruption of the nurse's activity was highly undesirable and that in order to "recreate" the activity a short time later audio recordings were made by means of a radio microphone. It was necessary to replay these recordings to the nurse as soon as possible afterwards in order that she would be able to remember the occasion and also to minimise the amount of reconstruction that might take place before the interview. Because of this, the challenge to the nurse took place without the benefit of full transcriptions of the conversations and when, eventually, full transcriptions were obtained, certain items came to light which had passed unchallenged.

A larger research budget might help overcome this problem (!) but the prior identification of "situations" would decrease the likelihood of important issues being overlooked. The use of videotape in order to capture non-verbal as well as verbal aspects of the situational behaviour may also be useful in this regard.

#### 11.2.1.3 maintaining good relationships

The third problem encountered is one which is common to many research situations but which is exacerbated in the particular procedure advocated by Harré and Secord (1972). It concerns the need to maintain both the researcher's credibility and her good relationship with the respondent while at the same time providing a justificatory context by challenging the action observed. In the present study, the participants knew that the researcher belonged to the same professional group as themselves. They rightly expected, therefore, that she would share a knowledge base with them. The asking of "why?" to certain items was therefore regarded quizzically and a fine line had to be trodden between obtaining the relevant information and not appearing to want to "trick" respondents. The motivation of student nurses on the second occasion was sometimes noticeably lower than previously. This could have been due to their perceiving the exercise as "strange" and somewhat useless, or their feeling understandably threatened at having their actions challenged in that way. This latter point, however, does not throw doubt on the validity of their accounts as nurses did not seem to alter their accounts in order to present themselves in a more desirable light. This confirms the experience of other researchers (Faulkner 1980; Macleod Clark 1981) who, using audio and video tape recordings, likewise found the methods to be essentially non-reactive.

When asked how they felt the wearing of the microphone had affected their behaviour students generally commented



that they did not actually forget its presence but that they were mostly too busy to think about it much. None of those participating in the study disconnected the microphone at any time although they were shown how to do so and reassured that they could do so if they felt uncomfortable at any time.

#### 11.2.1.4 generation of research issues

A positive advantage of the method, however, lies in the uncovering, during the process of accounting, of relevant issues which, if not able to be pursued at the present time, are fertile areas for future research.

The use of first names for example, by nurses when addressing patients: it is clear that there are some patients who are always addressed by first name and some who are never so addressed. Nurses' accounts suggest that when a patient has been in hospital for a long time then first names are used. However, some patients were called by their first name from the beginning of their stay in hospital and although no nurse could remember a patient being specifically asked about preferred form of address, most were sure that they were carrying out the patient's wishes. How do nurses determine a patient's form of address then, and what is the effect on the patient? Do familiar first names serve to enhance the relationship between nurse and patient? Does an insistence on formal address help to preserve the patient's dignity or keep him at arm's length?

Another area highlighted in the present study is concerned with the possibility of over-indulgence of "appealing" patients. It was apparent from nurses' descriptions of patients that stereotyped images prevailed in certain instances. It is suggested that the use of the word "just" in nurses' descriptions serves to limit a patient's attributes to those congruent with the stereotype e.g. "He's just a nice old man".

It was also apparent from nurses' accounts that some patients were popular because of their appealing attributes e.g. kind faces, little legs etc.. It was suggested in Chapter 8 that such patients may be at a disadvantage if nurses are tempted to give more help than is beneficial for rehabilitation purposes. Further research could clarify this issue.

The strategies employed by nurses in "talking to patients" also merits further research. This is particularly necessary if nurses are to be encouraged and taught to communicate effectively. Very few strategies, other than the "what did you do when you were young" strategy, were observed in the present study but many "blocking" tactics (Macleod Clark 1981) were used, albeit unwittingly, which had the effect of curtailing what might have been a beneficial interchange. For example, in the following conversation between a student nurse and a male patient in the geriatric unit, the nurse effectively "blocks" the conversation even though she afterwards admitted that she felt the patient was in need of something.

Mr. A. is becoming agitated in his chair.

*N: What's the matter?*

*P: (mumbles)*

*N: Sorry?*

*P: (mumbles again)*

*N: You're all right aren't you?*

*P: No.*

*N: No?*

*P: (more mumbles)*

*N: Do you want to sit up a bit?*

*No?*

*You're fine".*

*S09: 4*

Macleod Clark (1981) suggests that nurses control conversations in this way. That this may be so is obviously true, but the data from the present study suggest that it is the lack of an alternative strategy which determines the conversation in most instances - control by default.

11.2.1.5 the role of accounts in the explanation of conversations

It was apparent from those instances examined in Chapter 6 that the collection of accounts contributed a great deal to the understanding of what is going on in conversations, compared with a process analysis of conversation. The meaning of a piece of behaviour is often far from obvious. For example, the reader may recall the nurse who was comforting a patient who had wet her pants, but who was also in the process of convincing herself that she really was too busy to have taken the patient to the toilet earlier.

*"N: Don't worry about it.  
You see, there's only two nurses on for  
each ward and we're busy".*

*...*

*P: Well I couldn't hold it any more.*

*N: Well don't worry.  
It's not your fault really.  
It's ours.  
But we're just so busy.  
We've got so many people to do at once and  
they're bursting to go at once.  
That's the trouble".*

S02:4

When confronted with this conversation later, the nurse commented:-

*"I felt as though I was being told off. I  
suppose it's because I know I should have  
gone back first of all and taken her".*

But the meaning that this episode has for the nurse

is also important in terms of any recommendations that may be made. Recommendations, if they are to be implemented successfully must "make sense" to the people concerned. Therefore, any recommendations on the basis of the above example, for instance, must take account of the rules of the situation in which the nurse acts. She has a formal responsibility to "look after" the patient's needs. But there are informal rules operating also:-

*"The general thing down there is to do your own patients and then help everyone else".*

If the informal rule is ignored in recommendations, then no amount of restructuring the formal rules will change what actually happens to the patient.

#### 11.2.1.6 implications for attitude research

It is the belief of the author that attitudinal studies which focus on simple behavioural or attitudinal items do not contribute to our understanding of the situations within which attitudes are expressed. For example, the distinction between personality attributes and demands on the nurse, which emerged in nurses' evaluative descriptions of patients, would not have been uncovered by either single approach. The reader may recall that certain patients were described in both "positive" and "negative" terms e.g.

*"R: What sort of person is she?*

*N: (laughs) Very demanding - she's very sweet- I like her but - you sort of have to tell her, tell her what for, several times during the day really".*

S21(2)2

This patient was indeed "demanding", she demanded attention many times during the day and an observational study would have reported that nurses had many dealings with her in which they "told her what for".

*N: Mrs. H. What's the matter?*

*P: I want to go to the toilet.*

*N: Well go on then.*

*P: I'm...not...I'm slipping...*

*N: Well what did you get up for then?*

*If you're going to fall over.*

*Not much point in getting up is there?*

It is hard to imagine what would constitute an appropriate attitudinal item to represent the nurse's "general" response to Mrs. H., because it was apparent from the nurse's account that her response was in part dependent on the extent of her demands.

The collection and analysis of accounts does not restrict responses by the method imposed in an artificial manner, but rather enables the situational variances in response to emerge as valid explanations.

The use of the subject's own language as a resource in explanations was valuable in the present study. Harré and Secord (1972) comment on the importance of evaluative/ranking distinctions and this has already been discussed. Accounting as a methodology can facilitate the making of these distinctions by permitting the subjects to describe objects or people in their own terms. This again, was particularly evident in nurses' evaluative descriptions of patients when the use of justificatory accounting enabled the nurse not only to evaluate the patient on a popular-unpopular dimension, but to attribute particular characteristics to patients within that dimension, and to set the limits within which those characteristics would count as contributing to the evaluation. For example, one older patient in the medical unit was described as popular because she was generally "pleasant". The nurse, however, went on to suggest limitations to her popularity.

*"I think sometimes people get a little bit annoyed at her because she's always buzzing and asking to be put back to bed just before*

*you're goint to do her or something like that. And also she could possibly do more for herself really, we think. She doesn't try that hard so, you know - I think she's content to sit back a bit although she's quite a pleasant lady".*

S25(1)4

It is suggested therefore, that the use of accounting in the present study is a pointer to attitude research in the future and that future studies should not neglect to capitalise on the subject's own ability to articulate evaluative/ranking distinctions. It is recognised that the present study does not go far enough in this respect and that the reason for this is largely due to the absence of situational definition discussed earlier.

#### 11.2.2 Ethics of Tape Recording Conversations

In the planning and execution of the study, the ethical aspects of tape recording conversations were highlighted. Copp (1981) writes:-

"Informed consent, vastly different from mere compliance or consent, is an integral part of nursing research. The elderly have the right to know the purpose of the research proposed; the credentials of those involved; the methods which will be employed to protect their identity, their bodies, their peace of mind; and what demands will be made on them if they elect to participate in the research".

p.194

These sentiments are often difficult to translate into practice when dealing with long term institutionalised patients, which is not to say that they should not be put into practice. However, in the present study, despite careful explanation by the researcher to each patient, no-one refused to participate, which might on first consideration be occasion for rejoicing. During the course of the study, one patient was overheard to comment to a nurse that "listening in to somebody else's conversation" was an intrusion on their privacy.

This patient was one of the more gregarious patients in the geriatric unit and yet she had felt unable to refuse the researcher's request. The problem of over compliance, particularly in institutionalised subjects, is extremely complex. The responsibility of the researcher in this regard cannot be overemphasised.

### 11.2.3 Repertory Grids

The employment of repertory grid technique enables the researcher to capitalise on the respondent's primary resource in describing and evaluative objects of people, namely their own language. However, a prior consideration in the use of repertory grids is the careful naming of elements and the elicitation of constructs.

#### 11.2.3.1 the naming of elements

In the present study, elements were chosen to represent various age groups. It was thought that by having 4 of each age group chosen, any tendency to stereotype people of certain ages would become apparent. To a degree this has been successful in that most respondents perceived people in the same age group in similar terms. However, what was not controlled in the present study was the extent of personal involvement with each element. This could be important with regard to certain characteristics if a negative or positive evaluation depends on the extent of personal involvement. It would be advisable therefore, in any future study using this approach, to control for extent of involvement.

#### 11.2.3.2 the elicitation of constructs

The construction of a repertory grid is a process which can be more or less interactive. In a clinical situation, the therapist may be actively involved in enabling the client to clarify or even formulate his constructs, and the very process of constructing a

grid may be a therapeutic endeavour. In a research project such as the present one, it is obviously desirable to limit the researcher's influence to a minimum. Yet this has consequences for the elicitation of constructs. In the present study, no prompts were given to respondents other than the stated instructions. A question as to whether the response given was an important distinction would no doubt have eliminated some of the lower level constructs but would also have cast doubt on the validity of other constructs and may have confused respondents as to what was really expected of them. There is no easy solution to this problem but the role of the researcher in the elicitation of constructs is an important one.

#### 11.2.3.3 problem of generalisation

At the outset, the purpose of using repertory grids to examine student nurses' perceptions of people of different ages was to ascertain the perceptual framework within which the nurse-patient conversation took place. There is, of course, no means of direct generalisation from elements in the repertory grid to patients on the wards, but some evidence that certain constructs may be common to both situations. For example being "dependent on others", being "slow" often characterised old people for student nurses. It would be a logical progression from the present study to examine nurses' construing of old people in hospital and of "geriatric" patients in general wards as well as geriatric patients in geriatric units to determine what special characteristics mark off the groups from each other.

#### 11.2.3.4 complementary methods

Another reason for the choice of repertory grids in the present study was that it was deemed a complementary method to accounting. This is still believed to be so and the extent to which they might usefully be combined is a matter for empirical investigation.



When attempting to examine nurses' attitudes toward patients in a situation where the expression of attitude is likely to vary with the many situational factors and characteristics of various patients, case studies of nurses over many situations and with many types of patients could be a useful approach. The use of accounting for the clarification of concepts could then be a first step in the drawing up of grids which might distinguish relevant "types" of patients. Marsh, Rosser and Harré (1978) utilised such an approach in their study to establish the significance of items of clothing worn by football fans.

They hypothesised that the "gear" worn by fans had some symbolic function which communicated specific attributes to other fans. By combining and separating items of "gear" in pictures, Marsh and his colleagues were able to elicit a number of factors from fans as to expectations of behaviour based on the "gear" worn by an individual.

It would be possible, although not attempted in the present study, to link repertory grids and accounting more directly. Completed grids could be obtained from nurses about patients in their care focussing particularly on the medical "geriatric" vs. older patient. If conversations were recorded and accounts obtained, it could be possible to match intentions with "types" of patients and to see whether or not a particular "type" of patient was always treated in a particular manner by that nurse. An identification of a particular style of interaction with particular types of patients might be a useful beginning for anyone seeking to modify his or her interaction with a patient.

In the present study, the two methods are used for slightly different purposes. The repertory grid technique was employed to examine the constructs of "old people" of which nurses were in possession and to detect changes in the way old people were construed

as the nurses progressed through training. It was a macro level approach and as such cannot be directly compared with nurses' accounts of conversations with patients - the micro level approach. Time constraints also necessitated different nurses being involved in each aspect. Ideally, they would have been the same. Furthermore, the task of the nurse in each methodology was somewhat different. Using the repertory grid technique, the nurse was required to make distinctions between persons. These distinctions could be of any nature whatsoever. Using the accounting procedure, the nurse was responding to her conversation with a patient and was not, therefore, describing a patient without reference to any particular context but with reference to the very specific context of the nurse-patient encounter. In retrospect, it may have been more fruitful to align the methodologies more overtly. For example, the nurse could be required to produce constructs on the basis of "my conversation with..." as opposed to the elements being persons only.

Nevertheless, both methods are commended as permitting the use of the subject's own language in formulating explanatory concepts.

### 11.3 ISSUES RELATED TO STUDENT NURSES' ATTITUDES TOWARD OLD PEOPLE

In her foreword to *Care of the Aging* (Copp 1981), Thelma Wells warns of the innocent sounding opinion that nursing care of the old is 'just good basic nursing'. She writes:-

"This comment typically arises from two sets of false assumptions:  
(1) that aging is a time of illness and incapacity and (2) that nursing's major role is providing total care to dependent people".

The decremental model of ageing which underlies these assumptions was undoubtedly the one presented to student nurses via their lecture course. It would

not be true to say that nursing was presented as "providing total care to dependent people" as very little was indicated as to nursing's specific role in the care of the elderly at all.

Student nurses were given a great deal of information on the contribution of other health professionals to the care of the elderly but were not given any clear indication of what their role might be except in the most global terms such as "letting patients help themselves", and "not doing everything for them". The inadequacy of basic nursing education programmes has been recognised by the World Health Organisation (1976). Their report suggested that:-

"Care for the elderly in hospital and community settings requires, among other things, a thorough knowledge of the process of aging and of the psychological, sociological and health-oriented aspects of care - indeed, of its person-oriented rather than its disease-oriented aspects".

p.409

Whilst the educational component observed in the present study could not be said to be overtly disease-oriented, it was only person-oriented in a non-specific way. Student nurses were not given full or accurate information regarding the process of ageing for example. References which were made during the course of lectures to research material were not cited fully and facts were sometimes exaggerated.

In addition, the assessment of the elderly person was placed clearly in the medical context and a consultant physician taught this part of the course. No mention was made of nursing assessment and the nursing process as a means of assessment, planning and evaluation was not being used in the unit at the time of the study.

As regards nurses' anxieties, these were explored in discussion but little was done by tutors to alleviate anxiety by outlining their role in the care of the elderly.

The time in the geriatric unit was divided into two main parts - psychogeriatric and geriatric with one week being spent in the community. The student nurses met with their clinical teacher each week in the unit, usually for an hour during an afternoon. The researcher was not part of these sessions and so cannot comment on their content. But from the comments made by student nurses in discussion after the geriatric placement and from the results of the questionnaire study, it did not seem that they felt they had undergone an educational experience.

On the whole, nurses at the end of their training period felt that geriatric nursing had little to offer as a speciality. But there was some evidence that those nurses just beginning their training were anxious about working in the geriatric unit, not because they thought it was going to be "boring", but because they didn't know what it had to offer. However, second year student nurses who were about to work in the unit, had already decided that caring for the elderly was non-specialised work and as such, of little interest. They commented that they had cared for many old people already as the general wards were "full of them". It is suggested that, and the accounts of nurses support this suggestion, their experience of caring for old people in general wards, was not helpful in creating a positive attitude towards geriatric nursing. Those patients deemed to be "geriatric" in the medical unit were not being cared for in a specialised manner and therefore student nurses were not looking forward to "more of this" in the geriatric unit. It was interesting to note that some third year students commented that certain patients would be "better off" in the geriatric unit. Their experience of geriatric nursing had at least convinced them of the benefit of specialised geriatric care even if they at least did not wish actively to participate in it.

This reflection on the potential of specialised nursing care for the benefit of the elderly may link with

the tentative modification of negative attitudes after the geriatric placement, noted in the repertory grid study. Whilst it is not possible conclusively to attribute a causal role to the geriatric placement in this, it is an aspect of the study which merits further investigation, and a case study approach has already been suggested.

It is apparent from this study that student nurses were not planning to make their career in geriatric nursing. The recent White Paper "Growing Older" (D.H.S.S. 1981) confirms the suggestion made earlier regarding nursing recruitment:-

"Nursing levels in departments of geriatric medicine have improved considerably over the country as a whole, but they continue to cause concern, with severe problems in some districts and unit. Only about half the total nursing staff in departments of geriatric medicine are qualified, and an adequate level of supervision of unqualified staff is not always possible".

p.54

Whilst there will always be potential recruits among married nurses wishing to work part-time, there is a considerable need for the speciality to be made more attractive to the student nurse so that she does not immediately reject it as a possibility on completion of training.

Finally, there is much to be desired in the way student nurses communicate with patients. It was apparent from the analysis of student nurses' accounts, that their conversations with most patients on most occasions were carried out in the absence of any specifically therapeutic goals. In part this probably reflects the fact that data collection was not "situationally" based but must also indicate the neglect of conversations as a therapeutic tool. The students had received no educational input at all on this aspect of care, thus pointing to a deficiency noted by Wells (1980) who wrote:-

"Nurse-patient verbal communication was a visible sign of the nurse-patient relationship, and it was found to be limited and not very meaningful".

p.124

This does not imply, however, that nurses were not concerned about communication. It seemed to be the case that even when they wanted to achieve a specifically therapeutic goal, they did not have the conversational skill at their disposal.

#### 11.4 IMPLICATIONS AND RECOMMENDATIONS FOR NURSING

##### 11.4.1 Education

As a result of this study it is suggested that a more structured geriatric component to general nursing education is required. Wells (1980) concluded that the nurses in her study were "a product of a training system that taught them a series of tasks and neglected to provide adequate information about care of the elderly". The paucity of specialised nursing knowledge imparted to student nurses in the present study has implications for the quality of care these nurses are capable of giving. The relationship between knowledge and care is an interesting area currently being investigated by Montague (1982). The lack of information imparted also implies that nurse tutors themselves are not knowledgeable about geriatric nursing. There is a school of thought (Roberts 1977) which questions whether indeed geriatric nursing is a speciality in its own right and whilst it would not be argued by this author that certain principles are not common to all aspects of nursing, the development of research into the process and effects of ageing, and into the nursing care of elderly people, has created a body of knowledge about which it is important that nurses should know. Unfortunately, on the basis of the present study, we cannot conclude that Pinel's (1976) prophecy has yet been fulfilled. He wrote:-

"Although student nurses are at last undertaking geriatric experience in their training, the tutors often have no background of geriatric nursing of their own to pass on. However, in time the situation will be self-remedying as the student nurses of today become the staff nurse, ward sisters and tutors of tomorrow".

p.1603

The results of the questionnaire study in this thesis suggest that very few student nurses see anything of value in geriatric nursing as a career. It is largely viewed as an area where the primary requirement is for a workforce. It is unlikely that these students, who do not feel they have learnt anything of value during their geriatric placement, will become the enlightened tutors of tomorrow.

The urgent need is for a restructuring of the student nurses' experience in geriatric nursing. This is likely to be well received by the students themselves. The reader may recall the students' comment about how helpful it was to be told what other professionals did in the absence of what the nurse had to do. Objectives which the nurse herself can evaluate during the course of the experience, might serve to direct her expectations away from the rewards of acute medical areas to more appropriate individualised patient goals. For example, it is now 20 years since Norton and her colleagues (1975) first published their study of geriatric nursing problems in hospital. This study, whilst lip service is paid to it as a milestone by the profession, has still to be translated into everyday practice. Yet it offers the basis for nursing interventions over a wide range of care - the assessment and grouping of patients, the care of equipment, the provision of clothing, the management of pressure sores. The work already done by researchers such as Norton et al (1975), Wells (1980) provides a basis for the restructuring of nursing education but in order to effect this restructuring, nurse tutors must become more conversant with recent advances in geriatric nursing and must develop ways of incorporating these advances into

the content of the courses they teach.

It was also apparent from the present study that there is a need for teaching communication skills to nurses. This has been highlighted by other researchers (Faulkner 1979; Macleod Clark 1981) and will not be elaborated here. Suffice it to say there was a deficiency in terms of what nurses were expected to do (talk to patients) and what they were equipped to do.

#### 11.4.2 Practice

As regards nursing practice, the impression gained from the present study was of a picture, in the geriatric unit at least, little removed from what Baker (1978) describes as a "routine geriatric" style of nursing. This entails the provision of a basic standard of care to meet patients' minimal needs. This was recognised by the student nurses themselves who commented that it was "too routine", "monotonous" and that "nothing happened". Their time in the geriatric unit was compared unfavourably with that spent in the psychogeriatric unit where treatment was seen to be more "active" in terms of reality orientation programmes, electro-convulsive therapy and drug regimes. There was little evidence from nurses' accounts that they had adequate opportunity to assess patients as individuals and to plan accordingly. It was often noted by nurses that particular patient was "for rehabilitation", but as far as can be judged on the basis of this study, such rehabilitation as was carried out by the nurses was indistinguishable from one patient to the next.

In the medical unit rehabilitation was seen as an optional "extra" which some patients obviously needed but which was not the purpose of the medical ward at all. The following extract illustrates this:-

*"She's a geriatric case, she's confused, she's got dementia and she really needs no medical looking after at all. It's*



*just a case of getting her up, dressing her, feeding her, the sort of thing that could be done on a geriatric ward really".*

S19

The implementation of the nursing process with individualised assessment, planning of care, delivery of care and subsequent evaluation would have done much to break down the "routine geriatric style". In order to implement the stages of the nursing process with elderly patients, nurses will need to learn to listen to what old people want out of life in hospital, and goals will need to be set from that perspective. For long term geriatric patients, this will entail the rejection of the acute curative model of care and its replacement with a model focussing on the integrity of the individual. Carlson and Wiseman (1981) suggest that the hospice movement has potentially great benefits when applied to the care of the elderly, with its emphasis on total wellbeing and the involvement of patient and family in decision making.

An important point which the present study has highlighted concerns the policy regarding "geriatric" patients in medical wards. That some patients are informally defined as "geriatric" was suggested by Baker (1978). This study confirms her findings. The subjective definitions depended upon the student nurses' perceptions of characteristics which indicated dependency, senility, chronic untreatable disease and confusion as in the following example:-

*"I associate "geriatrics" with old people, bed-ridden people, people you find hard to talk to, mental capacities going downhill".*

S33

These patients were often grouped together in the ward and, to a certain extent, were regarded as "illegitimate patients" as it was recognised that they had needs which were not being met on an acute medical ward.

*"This is not a long stay place for disabled persons...I thought this was an acute medical ward".*

S22

Indeed it was felt by some nurses that their needs could not and should not be met on an acute medical ward.

Whether or not appropriate nursing care can be given to a variety of patients in one ward, is a matter for empirical determination. There will inevitably be problems of provision of services of different kinds e.g. occupational therapy, which may not be economically viable for a few patients in each unit. In the meantime it is suggested that early nursing assessment of elderly patients in medical wards should take place and there be a recognition of the limitations of rehabilitative care given in such wards so that appropriate resources are directed toward elderly long term patients.

#### 11.4.3 Research

This study has implications for nursing research in general and attitude research in particular. There has been a tendency for attitude research in nursing to utilise questionnaire and observational approaches which this thesis maintains are in themselves inadequate. It is important that any applied discipline such as nursing, should not in its research neglect the conceptual and theoretical problems which are to be found in its constituent parts. An acceptance of a questionnaire to do the job of collecting data ought to rest upon the understanding and intellectual acceptance of how questionnaires are developed and what the results represent. It is not clear from the nursing research into nurses' attitudes that this is the case. Questionnaires have been used by nurse researchers as a short cut to the explanation of behaviour. This they were never meant to achieve, and, it is maintained, cannot achieve. The temptation to use them for this purpose however, is fuelled by their inexpensive application and quick results.

Likewise, observational studies and conversational analysis cannot throw light on the reasons behind the actions observed. It would appear that a new approach is required and indeed has been utilised in this study. It is encouraging that other researchers have come to similar conclusions. Melia (1981) writes of her

study:-

"...student nurses' actions cannot be taken at face value. There are other factors, social contextual factors in operation which might affect what a nurse does. It seemed a logical progression, therefore, to move from observation of the students to a research method which allowed some insight into their construction of nursing".

p.697

Melia went on to conduct informal, unstructured interviews with students.

The relationship between qualitative and quantitative methods is one which has encouraged polemic on both sides. Nursing research, although still in its infancy compared with other disciplines, has taken shelter in the quantitative stable presumably in the belief that "numbers can't lie". It is suggested however, that although numbers as of themselves may not lie, the concepts which they purport to represent may be in need of radical revision, and nurse researchers should not resort to those unrevised concepts simply because there is a recognised means of measurement.

The present study is an attempt to break with that tradition and to discover how far an alternative method can be taken.

## APPENDIX A

### Two Commonly Used Attitude Measurement Tools (Chapter 1)

#### Attitudes Toward Old People Scale (Kogan 1961)

Kogan's OP scale consists of 17 paired negative and positive statements about old people which fall into 7 categories as follows:-

##### Residential Aspects

- 1 Negative: It would probably be better if most old people lived in residential units with people of their own age.
- 1 Positive: It would probably be better if most old people lived in residential units that also housed younger people.
- 5 N: Most old people tend to let their homes become shabby and unattractive.
- 5 P: Most old people can generally be counted on to maintain a clean, attractive home.
- 12 N: In order to maintain a nice residential neighbourhood, it would be best if too many old people did not live in it.
- 12 P: You can count on finding a nice residential neighbourhood when there is a sizeable number of old people living in it.

##### Discomfort and Tension

- 2 N: There is something different about most old people: it's hard to figure out what makes them tick.
- 2 P: Most old people are really no different from anybody else: they're as easy to understand as younger people.
- 8 N: Most old people make one feel ill at ease.
- 8 P: Most old people are very relaxing to be with.

##### Variation Among Old People

- 11 N: If old people expect to be liked, their first step is to try to get rid of their irritating faults.
- 11 P: When you think about it, old people have the same faults as everybody else.

- 13 N: There are a few exceptions, but in general most old people are pretty much alike.
- 13 P: It is evident that most old people are very different from one another.

### Intergenerational Relations

- 9 N: Most old people bore others by their insistence on talking about the "good old days".
- 9 P: One of the most interesting and entertaining qualities of most old people is their accounts of their past experiences.
- 10 N: Most old people spend too much time prying into the affairs of others and giving unsought advice.
- 10 P: Most old people tend to keep to themselves and give advice only when asked.
- 16 N: Most old people are constantly complaining about the behaviour of the younger generation.
- 16 P: One seldom hears old people complaining about the behaviour of the younger generation.

### Dependency

- 4 N: Most old people would prefer to quit work as soon as pensions or their children can support them.
- 4 P: Most old people would prefer to continue working just as long as they possibly can rather than be dependent on anybody.
- 17 N: Most old people make excessive demands for love and reassurance.
- 17 P: Most old people need no more love and reassurance than anybody else.

### Cognitive Style and Capacity

- 3 N: Most old people get set in their ways and are unable to change.
- 3 P: Most old people are capable of new adjustments when the situation demands it.

6 N: It is foolish to claim that wisdom comes with old age.

6 P: People grow wiser with the coming of old age.

#### Appearance and Personality

14 N: Most old people should be more concerned with their personal appearance; they're too untidy.

14 P: Most old people seem to be quite clean and neat in their personal appearance.

15 N: Most old people are irritable, grouchy, and unpleasant.

15 P: Most old people are cheerful, agreeable, and good humoured.

Finally Item Pair 7 does not readily cluster with others:-

7 N: Old people have too much power in business and politics.

7 P: Old people should have more power in business and politics.

The respondent is required to indicate the extent of agreement or disagreement with each statement via a 6 category likert scale. The negative and positive mean scores are made comparable by subtracting the positive mean from 8.00. Higher mean values thereby indicate more unfavourable attitudes for both positive and negative items.

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Tuckman-Lorge Attitude Questionnaire (Tuckman and Lorge 1953).

The questionnaire consists of 137 statements classified into 13 categories. Two statements from each category are included here, and the total number of statements in each category is included after the category title.

1. Conservatism (14)

They are set in their ways.

They like old songs on the radio.

2. Activities and Interests (9)

They vote for the political candidate who promises the largest old age pensions.

3. Financial (6)

They are unproductive.

They worry about financial security.

4. Physical (27)

They need less sleep than younger people.

They never fully recover if they break any bone.

5. Family (13)

They spoil their grandchildren.

They get no sympathy from their relatives.

6. Personality Traits (14)

They are kind.

They have few friends.

7. Attitude Toward the Future (5)

They think the world is headed for destruction.

They are anxious about the future.

8. Best Time of Life (5)

They are in the happiest period of their lives.

They have a chance to do all the things they want to.

9. Insecurity (20)

They get upset easily.

They have a high suicide rate.

10. Mental Deterioration (14)

They are absent minded.

They are not useful to themselves or others.

11. Sex (4)

They should not marry.

They have no interest in the opposite sex.

12. Interference (3)

They are in the way.

They are a nuisance to others.

13. Cleanliness (3)

They never take a bath.

They are careless about their table manners.

The respondent is required to indicate whether he is in general agreement (yes) or general disagreement (no) with each statement. The score is the number of "yes" responses.

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## APPENDIX B

### Glossary of Terms Describing Nurses (Chapter 2)

#### Registered Nurse (RN)

A general American nursing qualification which is the basic requirement for most further specialisation. It is generally considered to be the equivalent of the State Registered Nurse (SRN) in England and Wales.

#### Licensed Practical Nurse (LPN)

A general American nursing qualification which is more practically orientated than the RN. It could be considered the equivalent of the State Enrolled Nurse in England and Wales.

#### Nursing Assistant (NA)

A person working under qualified nursing supervision who has no formal qualifications.

#### State Registered Nurse (SRN)

The general nursing qualification in England and Wales which is the basic requirement for most further specialisation.

#### State Enrolled Nurse (SEN)

A general nursing qualification in England and Wales of a practically oriented nature. Educational entrance requirements are lower than for the SRN.

#### Auxiliary Nurse (AN)

A person working under qualified nursing supervision who has no formal qualifications.

## APPENDIX C

### Some Communication/Interaction Schemes (Chapter 4)

#### Scale of levels of Responding (Bugental 1953)

This scale is used to describe "the degree to which the subject matter of what one participant says accords with what was previously said by the other".

- Level I.      Passive : No variation from the preceding response. Simple agreement, bridging, requests for clarification.
- Level II.     Responsive : Normally replying and contributing to the discussion. Answers to questions.
- Level III.    Developing : Addition of new aspects of topic but staying directly with the point of the referent response. Explanation, illustration, etc.
- Level IV.     Diverging : Changing the emphasis of the direction of the discussion rather clearly but without completely changing the topic. Bringing in explicitly related but tangential material.
- Level V       Changing : No explicit connection to the topic of the preceding speech is evident.
-

## Categorisation System of Spring and Turk (1962)

The written record of nurses' communication is first divided into "verbal units" i.e. a complete sentence or portion of a sentence that expresses a complete thought. The following 6 scoring categories are then applied. The scores within each category range from "most therapeutic" to "least therapeutic".

### A. Approach (to patient)

1. Moderately directive.
2. Directive.
3. Laissez-faire.
4. Other.

### B. Level (at which interaction is responded to)

1. Conceptual.
2. Inferential.
3. Clarification.
4. Superficial.
5. Allied to non-patients.

### C. Topic

1. Psychological feelings, attitudes, values.
2. Physical feelings and care.
3. Historical, current or future events, plans, situations, people.
4. 1, 2 or 3 as applied to therapist or staff.

### D. Focus

1. On the patient.
2. On others than patient or therapist.
3. On the therapist.

### E. Consistency

1. Consistency or appropriate inconsistency.
2. Inconsistency.

### F. Sentence Structure

1. Statements and indirect questions.
2. Exclamation and other.

This inventory contains 30 situations typically encountered by nurses in their interactions with patients. Nurses' response to the situations are categorised as follows:-

- Type I: A reply which indicates the nurse's awareness that the person involved is experiencing an unmet need or a problem, and conveys a concern to understand the nature of his difficulty. It encourages verbalization, and conveys a willingness to listen. It seeks to promote reduction of stress experienced by the patient (or family members) and stimulates him to use his own resources in solving his problem.
- Type II: A reply which indicates the nurse's awareness that the person involved is experiencing a problem and conveys sympathy and reassurance based upon explicit content of the conversation, exclusive of the real nature of the problem. It seeks to promote the person's well being by accepting his feelings and by creating superficial reassurance, but does not encourage verbalization of his real problem nor stimulate him to use his own resources in its resolution.
- Type III: A reply which indicates the nurse's awareness that the person involved is experiencing a problem and conveys an intent to investigate the problem. It seeks to promote discussion but inquires into tangential aspects of the problem and overlooks cues to identify its real nature. It seeks to promote the person's well being by acquiring further information but because of the nature of the enquiry, does not promote resolution of the problem.
- Type IV: A reply which indicates the nurse's awareness that a need is being expressed by the person involved but conveys a lack of intent to promote

verbalization of his problem. Instead, it seeks to explain, justify, or defend the nurse's point of view or those with whom she identifies - or to give advice. It denies opportunities to consider the position of the person with whom she is interacting and offers rational responses which tend to avoid exploration of his problem.

Type V: A reply which indicates the nurse's awareness that a need is being expressed by the person involved and conveys rejection or denunciation of the need. It seeks to change the subject or to show disapproval of his point of view. It focuses on relief of the nurse's stress and/or allows for verbalization of the nurse's disapproval of the person with whom she is interacting, and thus denies to him an opportunity to explore his problem and to use his own resources in its resolution.

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## Tool to Characterize Verbal Behaviour (Johnson 1964)

Ten major categories of verbal behaviour were identified:-

1. Fact expression.
2. Asking for fact expression.
3. Feeling expression.
4. Asking for feeling expression.
5. Directives.
6. Formulation.
7. Asking for formulation.
8. Acknowledgments.
9. Unknown.
10. Exploitatatives.

The major categories of feeling expression and formulation were subdivided as follows:-

### Feeling Categories

1. Statements about self
  - a) Emotional
  - b) Physical
2. Statements about others
  - a) Emotional
  - b) Physical

### Formulation Categories

1. Statements pertaining to the situation
  - a) Involving feelings
  - b) Not involving feelings
2. Statements pertaining to self
  - a) Involving feelings
  - b) Not involving feelings
3. Statements pertaining to the patient
  - a) Involving feelings
  - b) Not involving feelings

4. Statements pertaining to others
  - a) Involving feelings
  - b) Not involving feelings

---

Identifiable Verbal Techniques or Behaviours  
(Macleod Clark 1981)

Behaviours were identified which could encourage or discourage patients from conversing:-

Encouraging or Reinforcing

- (i) Asking questions - open or closed (when appropriate)
- (ii) Encouraging patient to continue e.g. go-ons, uh-hs.
- (iii) Using reflection/mirroring
- (iv) Recognising and responding positively to cues, direct, indirect or implied questions.

Discouraging or Blocking

- (i) Asking closed or leading questions.
- (ii) Missing or recognising but responding negatively to cues, direct, indirect or implied questions by use of cliché, maintaining superficiality, changing topic or subject, avoidance.

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Developing Interactive Skills (Therapists) Dowling 1977)

Fifteen major categories of conversation were identified:-

1. PROPOSING - a behaviour which puts forward a new concept, suggestion or course of action (and is actionable).
2. BUILDING - a behaviour which extends or develops the actions, proposals, comments, and/or contributions of self or another.

3. SUPPORTING - a behaviour which involves a conscious and direct declaration of support or agreement with another person or his concepts.
4. DISAGREEING - a behaviour which involves a conscious and direct declaration of difference of opinion, or criticism of another person's concepts.
5. DEFENDING/ATTACKING - a behaviour which attacks another person or defensively strengthens an individuals own position. Defending/attacking behaviours usually involve overt value judgements and often contain emotional overtones.
6. OPEN - a behaviour which involves self exposure of the individual by disclosure of personal experiences or feelings or admitting mistakes or inadequacies, providing that these are made in a non-defensive manner.
7. TESTING UNDERSTANDING - a behaviour which seeks to establish whether or not an earlier contribution has been understood.
8. INTEGRATING - a behaviour which summarizes and integrates the content of previous discussions or considerations.
9. ELICITING - a behaviour which seeks facts, opinions, or clarification from another individual or individuals.
10. GIVING INFORMATION - a behaviour which offers facts, or clarification to other individuals.
11. SHUTTING OUT - a behaviour which excludes, or attempts to exclude, another group member (e.g. interrupting; talking over).
12. BRINGING IN - a behaviour which is a direct and positive attempt to involve another group member.
13. CHALLENGING - a behaviour which is intended to provoke the expression of a response at a feeling level (e.g. anger, sadness) which otherwise would remain unexpressed.
14. ENLARGING - a behaviour which expands or enlarges the meaning of a previous contribution by interpreting or providing awareness of underlying dimensions.
15. POINTING OUT - Pin-pointing a specific verbal or non-verbal dimension of another's behaviour that is taking place without being commented upon.



## APPENDIX D

### PERSONAL CONSTRUCT THEORY - FUNDAMENTAL POSTULATE AND ELABORATIVE COROLLARIES

#### Fundamental Postulate

"A person's processes are psychologically channelized by the ways in which he anticipates events".

#### Construction Corollary

"A person anticipates events by construing their replications".

This corollary introduces the notions of construing and replication. Construing means "placing an interpretation" on certain stimuli. Man is not seen responding to stimuli but to the interpretation of stimuli. Replication of events occurs when man abstracts recurrent themes in his interpretation. Kelly (1963) writes:-

"Thus the concept of a day is erected along the incessant stream of time - a day which is, in its own way, like other days and yet clearly distinguishable from the moments and the years".

p.53

Man is therefore able to anticipate events because he construes some sameness amongst them.

#### Individuality Corollary

"Persons differ from each other in their construction of events".

Here, Kelly is simply stating that although all share certain experiences and environments, each person develops a unique view of the world based on his personal construction of experience.

### Organization Corollary

"Each person characteristically evolves, for his convenience in anticipating events, a construction system embracing ordinal relationships between constructs".

This is Kelly's formal statement of the notion that constructs are inter-related. Within a person's construction system there may be many levels of ordinal relationships; some constructs will subsume others; those in turn will subsume still more. Each system is however, built for a person's own convenience in anticipating events.

### Dichotomy Corollary

"A person's construction system is composed of a finite number of dichotomous constructs".

Here, Kelly is specifying the formal properties of a construct: it is a discrimination which represents an awareness of some similarity and contrast amongst a series of elements. It is important to note that a construct is not equivalent to its verbal label, and many constructs cannot be verbalised. A construct is distinguished from a concept, however, in terms of its bipolarity and personal nature i.e. by saying an apple is crisp I am saying it is not mushy. The most important aspect of constructs is their anticipatory nature; they are the means by which we are able to predict and anticipate events.

### Choice Corollary

"A person chooses for himself that alternative in a dichotomised construct through which he anticipates the greater possibility for extension and definition of his system".

Here, Kelly is assuming that when a person has to make a choice, he will favour the alternative which promises to provide the best basis for the anticipation of subsequent events. The development of a person's

construction system involves elaboration through:-

- a) extension - the reaching out to increase the range of the constructs by exploring new ideas which are only very partially understood.
- b) definition - the confirming in greater detail those aspects of experience which have been fairly actively construed.

#### Range Corollary

"A construct is convenient for the anticipation of a finite range of events only".

This is a formal statement of the notion that constructs are limited in their applicability to certain elements. Few, if any, are relevant to everything.

#### Experience Corollary

"A person's construction system varies as he successively construes the replication of events".

Kelly acknowledges here that people change, but change does not necessarily occur because of new events; it is the successive construing of events which results in change.

#### Modulation Corollary

"The variation in a person's construction system is limited by the permeability of the constructs, within those range of convenience the variants lie".

A construct is permeable to the extent that it can absorb new elements into its range of convenience. Over-precision in construing then could lead to a very narrow, restricted view of the world.

#### Fragmentation Corollary

"A person may successively employ a variety of construction subsystems which are interentially incompatible with each other".

This is a formal statement of the idea that at different times in our life we may think quite differently. Hence the notion that new constructs in different subsystems may not be directly derived from old constructs in old subsystems but may be newly developed within a larger system.

#### Commonality Corollary

"To the extent that one person employs a construction system which is similar to that employed by another, his psychological processes are similar to those of the other person".

This corollary acknowledges the potential similarity between persons in terms of similarly construed events. Construing superficial similarity between people would lead to stereotyping.

#### Sociality Corollary

"To the extent that one person construes the construction processes of another he may play a role in a social process involving the other person".

This corollary is of great significance in our understanding of other people. Rather than saying that one person must construe a situation in the same way as another for mutual understanding to be created, this corollary maintains that in order to play a constructive role in a social process with another person, he must effectively construe the other person's outlook.

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APPENDIX E

Details of Subjects in Accounting Pilot Study (Chapter 6)

Subject No.	Age	GCE O Levels (inc. CSEs)	GCE A Levels
O1	20	6	1
O2	20	6	1
O3	20	8	-
O4	20	5	-
O5	19	11	3
O6	20	8	1

## APPENDIX F

### Details of Subjects in Accounting Main Study (Chapter 7)

#### First Year Student Nurses in Medical Unit

Subject No.	Age	GCE O Levels (inc. CSEs)	GCE A Levels
18	19	8	3
19	19	10	-
21	21	6	-
23	19	7	-
24	19	6	2
27	19	7	-
29	19	8	2
30	20	9	1
33	20	7	2
34	18	8	-

#### Second Year Student Nurses in Geriatric Unit

Subject No.	Age	GCE O Levels (inc. CSEs)	GCE A Levels
7	20	9	-
8	20	8	1
9	20	9	-
10	21	9	-
11	20	5	1
12	20	14	-
13	20	6	-
14	20	10	1
15	20	8	2
16	20	9	1
17	20	8	1

#### Third Year Student Nurses in Medical Unit

Subject No.	Age	GCE O Levels (inc. CSEs)	GCE A Levels
22	21	6	-
25	20	6	2
26	21	6	1
28	21	6	1
31	20	11	3
32	20	7	1
35	22	6	1
36	21	6	1

APPENDIX G

Details of Subjects in Repertory Grid Study (Chapter 9)

GROUP A

Subject No.	Age (on first occasion)	GCE O Levels (inc. CSEs)	GCE A Levels
01	18	12	-
02	18	7	-
03	18	5	-
04	18	5	-
05	19	5	-
06	18	8	1
07	18	5	-
08	19	7	2
09	25	5	-
10	21	6	-
11	18	6	-
12	18	7	-

GROUP B

Subject No.	Age (on first occasion)	GCE O Levels (inc. CSEs)	GCE A Levels
13	20	7	-
14	19	7	-
15	19	9	-
16	19	5	-
17	20	6	-
18	27	6	-
19	19	6	2
20	22	6	-
21	23	7	-
22	21	8	-
23	19	14	2
24	19	6	-

GROUP C

Subject No.	Age (on first occasion)	GCE O Levels (inc. CSEs)	GCE A Levels
25	21	7	-
26	23	8	2
27	21	8	2
28	20	6	-
29	20	5	-
30	21	8	3
31	21	6	2
32	24	6	-
33	22	8	2
34	20	8	2

GROUP D

Subject No.	Age	GCE O Levels (inc. CSEs)	GCE A Levels
35	23	6	-
36	21	5	-
37	21	13	-
38	24	-	-
39	22	7	4
40	21	10	1
41	22	5	-
42	21	9	-
43	21	6	-
44	21	8	-

GROUP TT1

Subject No.	Age	GCE O Levels (inc. CSEs)	GCE A Levels
TO1	18	8	3
TO2	19	9	3
TO3	22	7	3
TO4	19	8	2
TO5	25	10	2
TO6	20	6	3
TO7	18	5	2
TO8	18	10	3
TO9	18	10	3
T10	27	5	3

GROUP TT2

Subject No.	Age	GCE O Levels (inc. CSEs)	GCE A Levels
T11	23	6	2
T12	21	8	1
T13	20	5	1
T14	20	8	2
T15	21	8	1
T16	21	9	1
T17	20	9	2
T18	21	12	2
T19	22	8	1



Form Used in Completion of Repertory Grids (Chapter 9)

INSTRUCTIONS: FILL IN ROW BY ROW. DO NOT OMIT ANY SQUARES. ONLY USE NUMBERS 1-7.

## APPENDIX I

### Questionnaires Used to Assess Geriatric Nursing Experience and Career Choices (Chapter 10)

#### INTRODUCTORY BLOCK STUDENTS' QUESTIONNAIRE

This questionnaire is part of a wider study which is concerned with student nurses during their training.

Any information you give will be treated with the strictest confidentiality. No names are requested and so your answers will be anonymous. This study is not part of your assessment and there is no obligation to take part. However, your willing co-operation in this matter would be greatly appreciated.

There are no right or wrong answers to the questions - the emphasis is on what YOU really think and feel at this early stage in your training. Please try to answer all the questions as honestly as you can.

During the course of your 3 year training, you will gain experience in the following areas:-

Surgery  
Medicine  
Paediatrics  
Operating Theatres  
Orthopaedics  
Accident and Emergency  
Geriatrics  
Mental Health  
Maternity Care  
Gynaecology

1. Which parts do you expect to enjoy most and why?
2. Which parts do you expect to enjoy least and why?

3. What are your immediate plans (if any) for your career when you finish your training?
4. Do you see yourself with a long term future in nursing?  
Where?/Why not?
5. How do you feel about working in the geriatric unit?
6. Would you consider a career in geriatric nursing?  
Why?/Why not?

Biographical Details

Age:

Educational Qualifications:

Professional Qualifications:

Previous work experience:

Any other comments:

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YEAR 3 STUDENTS' TRAINING REVIEW QUESTIONNAIRE

This questionnaire is part of a wider study which is concerned with student nurses during their training.

Any information you give will be treated with the strictest confidentiality. No names are requested and so your answers will be anonymous. This study is not part of your assessment and there is no obligation to take part. However, your willing co-operation in this matter would be greatly appreciated.

There are no right or wrong answers to the questions - the emphasis is on what YOU really think and feel at this stage in your training. Please try to answer all the questions as honestly as you can.

### YEAR 3 STUDENTS' TRAINING REVIEW INTERVIEW SCHEDULE

1. Now that you have reached the end of your training, which parts have you enjoyed most and why?
2. What have you enjoyed least and why?
3. What are your immediate plans for your career?
4. Do you see yourself with a long term future in nursing?  
Where?/Why not?
5. Looking back on your training, how do you feel about your geriatric experience?
6. Would you consider a career in geriatrics?  
Why?/Why not?

### Biographical Details

Age:

Educational Qualifications:

Professional Qualifications:

Previous Work Experience:

Miscellaneous Comments:

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