UNIVERSITY OF SOUTHAMPTON

AN INVESTIGATION OF STUDENT NURSES'

ATTITUDES TOWARD OLD PEOPLE IN

HOSPITAL

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ABSTRACT

FACULTY OF SOCIAL SCIENCES

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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.

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*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	1951	1966	1971	1977/78 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.

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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 progress-
> ive 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".

<div align="right">p.48</div>

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 Auxilaries (D.H.S.S. 1981) (see Table 1.5).

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

GRADE TITLE	TOTAL NO. WHOLE TIME EQUIVALENTS
Registered Nurses	2381.7
Enrolled Nurses	2085.0
Nursing Auxilaries	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 over-
> strained, 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 enviroment 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".

<div align="right">p.6</div>

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 hospital-
ised 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 biassed 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 sugg-
ested 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 inadaptable 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
Lives ey (1974) which investigated attitudes toward

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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 gen-
erally 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 experimential
> 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

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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.

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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,
1971)   and After Course

Level of Interest		BEFORE COURSE		AFTER COURSE	
		No.	Percent.	No.	Percent.
Major interest	6	O	–	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	O	11	6.79	23	14.28
No answer	–	2	1.23	O	–
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

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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

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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 posit- ively 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 <u>British Studies</u>

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 <u>all</u> 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. <u>KOGAN'S OLD PEOPLE SCALE IN THE NURSING LITERATURE</u>

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 employ ed 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 suprising.

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 interpret-
ation. 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
concensus 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 occurence 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 <u>as if</u> 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 <u>USE OF THE CONCEPT</u>

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".

<div align="right">p.427</div>

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".

<div align="center">p.428</div>

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

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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 individ-
ual studies (Gale and Lives ey, 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 bi-
polar 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 manœuvres.

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 biassed, 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 phenomemon 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

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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 critcism 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".

p.119

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 quesion 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 generalisab-
ility 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."

<div align="center">p.51</div>

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".

<div align="right">p.624</div>

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 Selltiz, 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 method-
ology 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 validat-
ional 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
Selltiz, 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.

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 enviroment 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 enviroment 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".

<div align="right">p.362</div>

3.7.4.2 <u>Situational factors</u>

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 suprising 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

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(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 -

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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 enviroments 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; Magnuss on, 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 superceded by research which emphazises 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".

<div align="center">p.199</div>

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 critisizes 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".

<div align="center">p.222</div>

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
succintly 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

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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 straight-
forward. 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 app-
> ropriate 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 samescorer,
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 them 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".

<div align="center">p.308</div>

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 categ-
ories 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, concurrance, 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
    agression
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 conver-
sation 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.

Moores 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 <u>intention</u>
to shut out present, and does the action have the <u>effect</u>
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 <u>Summary</u>

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".

<div align="right">p.227</div>

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.

CHAPTER FIVE

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 <u>should</u> be done, not
describe how it <u>is</u> done.

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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 observ-
> ations".

<div align="center">p.67</div>

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 ofestablishing by the trained
> delicacy of eye, ear, and touch a corres-
> pondence between the explicit predictions
> of science and the actual experience of
> our senses to which these predictions shall
> apply".

<div align="right">p.31</div>

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 ines-
capably 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

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like any other, existing without personal regard for its enviroment, but as a being whose <u>personal</u> 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 inter-
> preting. 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".
>
> p.8

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."

<div align="right">p.76</div>

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 indentification 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 colleaugues 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, meaningful-
ness and propriety". Accounts may include implicit

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

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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 inter-
pretation 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 qualit-
atively 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 reconstruc-
tion. 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 reployed 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 manoevred 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 occuring
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".

<div align="center">p.247</div>

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:-

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"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 part-
icular 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".

<div align="center">p.4</div>

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.

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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 "exemp-
lifies 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 character-
   istics 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 <u>cognitive complexity/simplicity</u>

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. Coversely, 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 <u>CONCLUSION</u>

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 institution-
alised 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 commentar-
ies 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,

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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

Categories	No.convs.	% Frequency
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.

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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 <u>generalised themes</u>

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

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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 know s 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

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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 them-
> selves, 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*

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*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 a patient remarking on
her "nice dress", to begrudging recognition of a
patient's need to be "buttered" 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
buttered 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. <u>The general thing
> down there is to do your own patients and
> then help everyone else</u>".* 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 <u>all</u>
nurses should care for <u>all</u> 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

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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

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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*   2 Raising Status
   something.

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*   1 Social acknowledgment
   your kneecaps do you?

P: *No I'm not seventeen any more.*   1   "   "

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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?

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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   14 Disagrees
   back and sit down again.

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   4 Acknowledges
   minutes more.
   Five minutes more and then the   6 Procedural suggestion
   night staff will come and take   "   "
   you to bed.

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

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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 <u>why</u> 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. <u>*Context*</u>: *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 12 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*

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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.	11 Gives information
My two other granddaughters, one's 20 and one's 17.	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 haven't I?	5	Agreement
N:	Yes	5	Agreement
	Miss F, wait until she's walked back.	17	Antagonism, demanding
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

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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 utter-
ances 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

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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 activ-
ities 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 possibil-
ity 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

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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	O	O

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.

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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 conv-
ersations 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
     enviroment 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   <u>Percentage Frequency of Conversations related</u>
<u>to Nurse's Principal Activity</u>

	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, x^2 = 0.18, d.f. 1, n.s. For the 3rd year group, x^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).

* 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.	Geriatric.	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.	Geriatric	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 (x^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 (x^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 | | | |
			Procedural	Personal	Mixed	TOTAL
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 | | | |
			Procedural	Personal	Mixed	TOTAL
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 comparibility
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 | | | |
			Procedural	Personal	Mixed	TOTAL
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

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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 coat s, 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

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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 conver-
sations 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 it s
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 characteris-
tics 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*

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*"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".*

<div align="right">*S33*</div>

*"Well, he's quite old, he's quite with it, no
he's not (geriatric)".*

<div align="right">*S27*</div>

*"Er...no, definitely not (geriatric) because
he's a very intelligent man".*

<div align="right">*S27*</div>

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
<u>medical unit</u>. When the mental status of youger 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 <u>geriatric</u>
<u>unit</u>, 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 <u>Verbal Communication</u>

Verbal communication featured prominently in nurses'
descriptions of patients, particularly in the
<u>geriatric unit</u> 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

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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 psychoger-
iatric 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

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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*

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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

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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 under-
standing 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".

<div align="right">*S30(1)2*</div>

(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 genuinly 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".*

<div align="right">S08:4</div>

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

<div align="center">207</div>

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 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 <u>both units</u> 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 <u>medical unit</u> 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".

<div align="right">

S28(1)1

</div>

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".*

<div align="right">

S28(1)2

</div>

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".*

<div align="right">

S29(2)2

</div>

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 perogative
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.*

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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?"   *SO7:*

(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 <u>could</u> 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 posit-
ive

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"*.

<div align="center">

S31(2)5

</div>

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 converstations 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 compus
mentus most of the time, so I'd try to trail
off on to something else"*.

<div align="center">

S28(1)2

</div>

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 collu ding 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.

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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	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 TIME OF MEASUREMENT
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.

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3. <u>Group A Time O and Group A Time 1</u>

   Subject to the result of comparison 2, this
   should show the effect of Year 1 on person
   perception.

4. <u>Group C Time 2 and Group B Time 2</u>

   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. <u>Group B Time 1 and Group B Time 2</u>

   Subject to the result of comparison 4, this should
   show the effect of Year 2 on person perception.

6. <u>Group D Time 3 and Group C Time 3</u>

   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. <u>Group C Time 2 and Group C Time 3</u>

   Subject to the result of comparison 6, this should
   show the effect of Year 3 on person perception.

8. <u>Group D Time 3 and Group TT2 Time 3</u>

   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. <u>Group A Time O and Group D Time 3</u>

   This comparison will show any cumulative changes
   occuring over the training period which have not
   been detected at an earlier stage, but it is

recognised that it soes 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

	TIME OF MEASUREMENT			
GROUPS	T_0	T_1	T_2	T_3
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. <u>Group A Time 0 and Group TT1 Time 0</u>

   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. <u>Group B Time 1 and Group A Time 1</u>

   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. <u>Group A Time 0 and Group A Time 1</u>

   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. <u>Group C Time 2 and Group B Time 2</u>

   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 O 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 O 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 <u>Examination of Constructs</u>

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 con-
structs 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

		MEAN NO. CONSTRUCTS	
Groups	Time*	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

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Table 9.6   Mean Number Psychological and Concrete
            <u>Constructs on Repeated Measurement Occasion</u>
            <u>for Groups A, B and C</u>

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. <u>Group A Time O and Group TT1 Time O</u>

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. <u>Group B Time 1 and Group A Time 1</u>

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 O 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 const-
ructs 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 O 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. <u>Group TT1 Time O and Group TT2 Time 3</u>

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.17p.$<$0.05) but no
difference in the mean number of concrete const-
ructs (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 differ-
entiate 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,
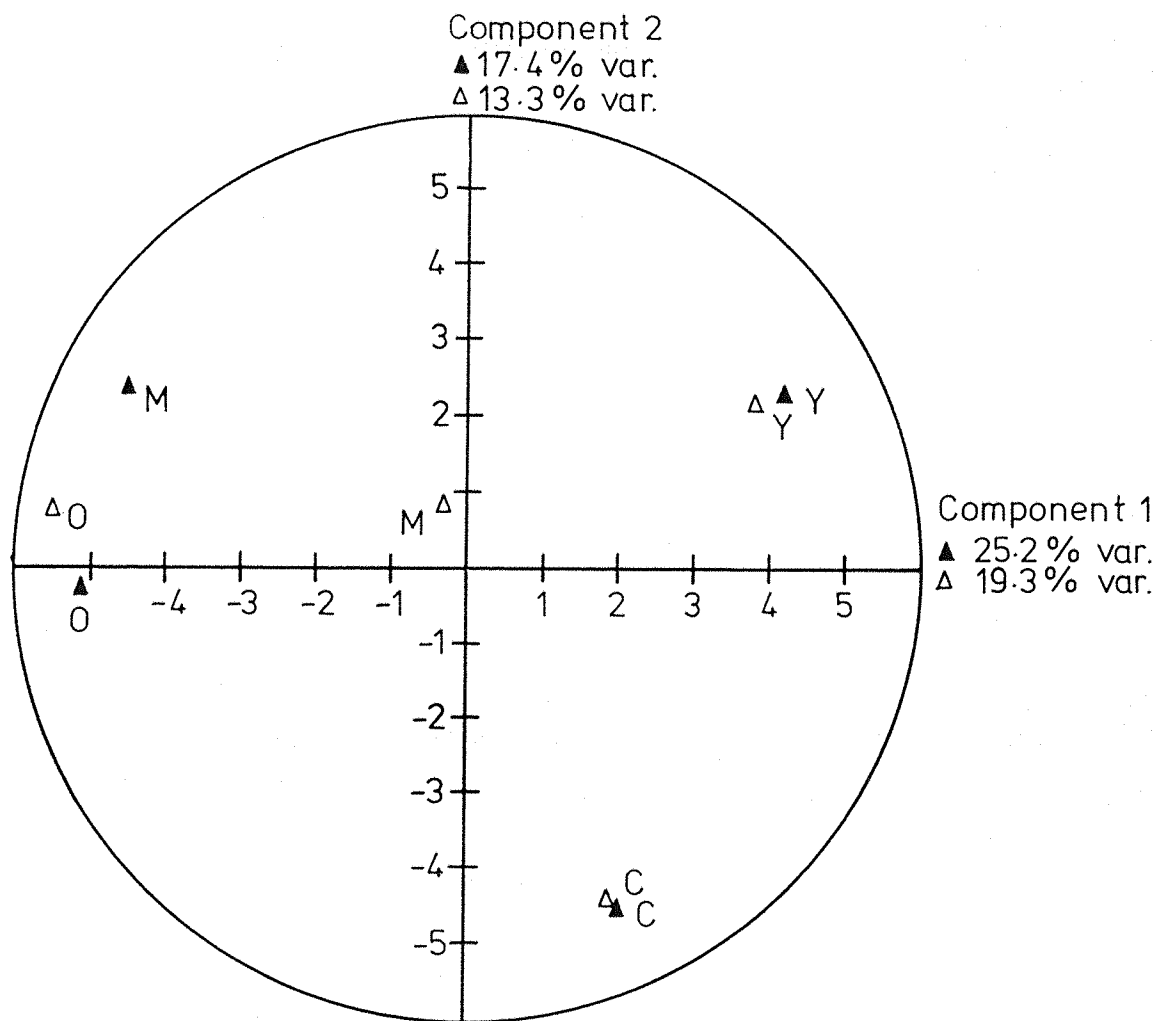
KEY: ▲ - First occasion (time 0)
△ - Second occasion (time 1)
C - Children
Y - Young People
M - Middle Aged People
O - Old People

Fig. 9.1   Group A placement of elements with first two components
on both measurement occasions
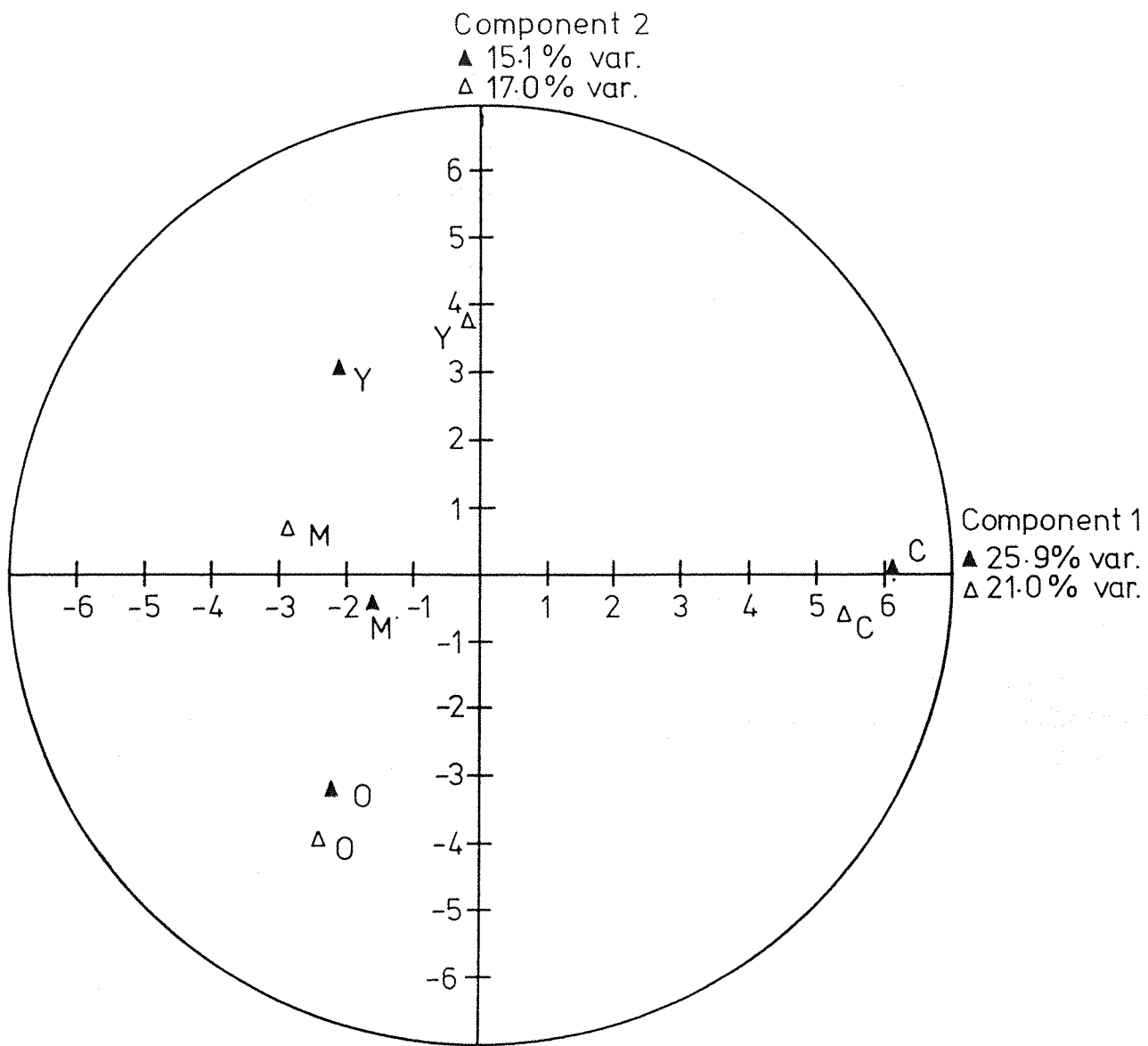
KEY: ▲ – First occasion (time 1)
△ – Second occasion (time 2)
C – Children
Y – Young People
M – Middle Aged People
O – Old People

Fig. 9·2 Group B placement of elements with first two components on both measurement occasions
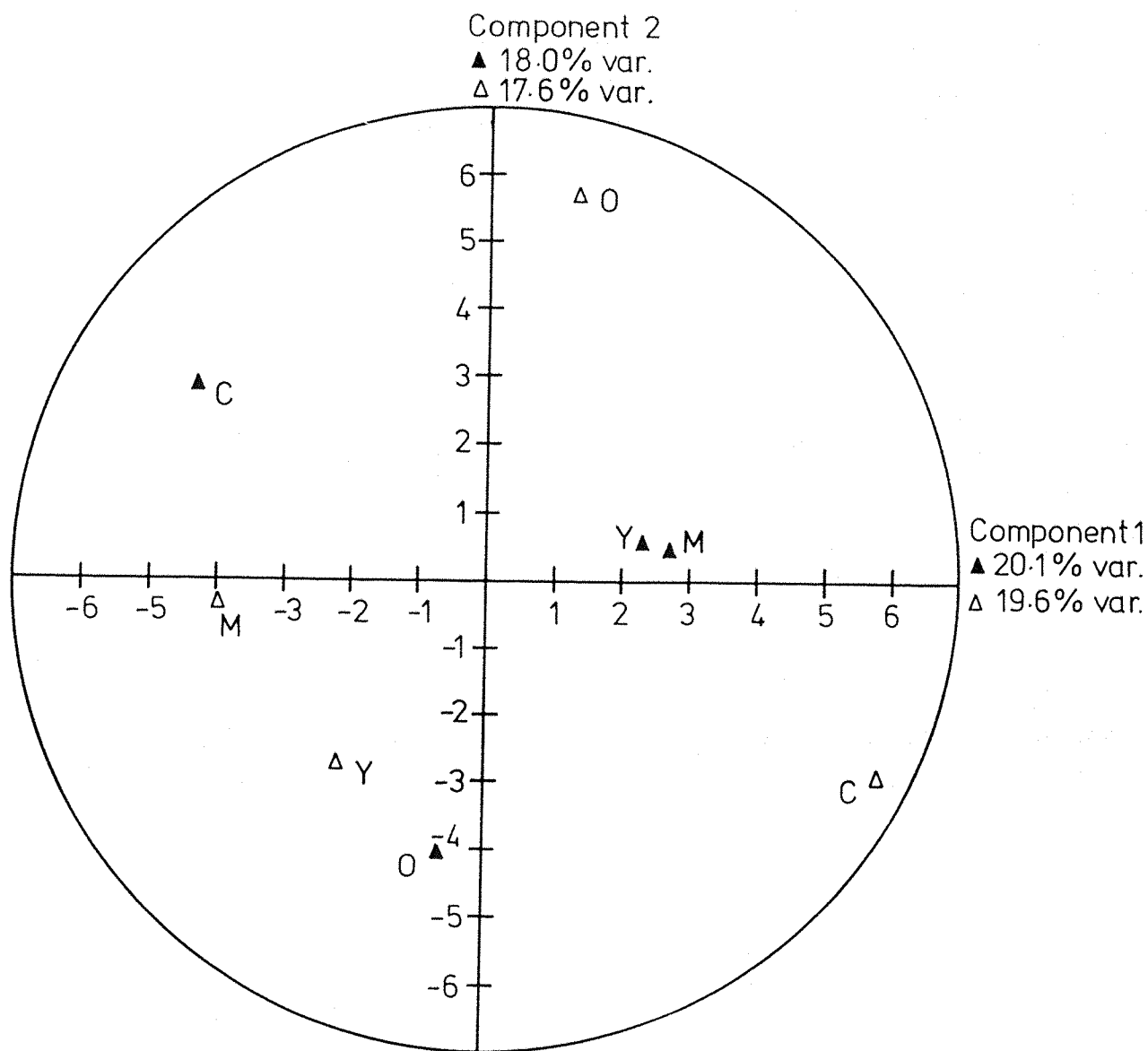
KEY: ▲ – First occasion (time 2)
△ – Second occasion (time 3)
C – Children
Y – Young People
M – Middle Aged People
O – Old People

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 O
COMPONENT 1

High rating	Low rating
Is happy and carefree	Not happy and carefree
Is not slow	Is slow
Is in a learning position	Not in learning position
Is active	Not active
I relate to as an equal	I don't relate to as equal
Is fun to be with	Is demanding
Is outgoing	Prefers home
Leads an active life	Doesn't lead active life
Willing to have a go at anything	Weighs things up a lot

COMPONENT 2

High rating	Low rating
Knows a lot	Doesn't know a lot
Helps other people	Doesn't help other people
Has responsibilities	Doesn't have responsibilities
Is not moody	Is moody
I see often	I don't see often
Is independent	Is dependent
Is not musical	Is musical
Is not related to me	Is related to me

TIME 1
COMPONENT 1

High rating	Low rating
Hasn't had long illness	Has had long illness
Is still learning	Not still learning
Doesn't live alone	Lives alone
Hasn't had to fight for everything	Has had to fight for everything
Is always on the go	Takes life more seriously
Doesn't go to church	Goes to church
Went to same school as me	Didn't go to same school as me
Is outgoing	Is not outgoing

COMPONENT 2

High rating	Low rating
Is independent of others	Dependent on others
Same profession as me	Not same profession
Is always fussing	Lets things alone
Has had a career	Hasn't had a career
Is full of adventure	Is timid and shy
Is very calculating	Doesn't look before leaping
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

COMPONENT 1

High rating	Low rating
Is not influenced by others	Influenced by others
Is self centred	Not self centred
Not concerned/aware	Is concerned/aware
Is dependent on others	Idependent of others
Inconsiderate of others	Is considerate of others
Related to me	Not related to me
Not old fashioned, set in ways	Old fashioned, set in ways
Not determined	Is determined

COMPONENT 2

High rating	Low rating
Has fast pace of life	Has slow pace of life
Ridiculous sense of humour	Sarcastic sense of humour
Is approachable	Is sharp and abrupt
Connected with life here	Not connected with life here
Not shy or reserved	Shy and reserved
Is easy going	Is anxious
Doesn't have settled home enviroment	Settled home enviroment
Is quiet, keeps to self	Is outgoing

TIME 2

COMPONENT 1

High rating	Low rating
Is more of a friend	I look up to
Is still at school	Not still at school
Is still at school	Works
Doesn't have respon-sibilities	Has responsibilities
Is considerate of others	
I treat as a child	I treat as an adult
Is not clever	Is clever
Is affected by circumstances	Is down to earth

COMPONENT 2

High rating	Low rating
Has an involved social life	Is withdrawn and quiet
I can have a good chat	Is proper and polite
Is still working	Is retired
Is bubbly	Is quiet and placid
I see regularly	Haven't seen for a long time
Not a lot of experience	Lot of experience in war
Is not clever	Is clever
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
COMPONENT 1

High rating	Low rating
I am friendly with	I am not friendly with
Is mature	Is not mature
Worries about future	Lives for the moment
Has good business sense	Doesn't have business sense
I am very fond of	I am not fond of
At top of their profession	Not at top of profession
Has high level of education	Not much education
Is talkative	Is not talkative
Is vivacious	Is insipid

COMPONENT 2

High rating	Low rating
Is vivacious	Is insipid
Leads active life	Doesn't lead active life
Lacks experience	Is very worldly
Has lots to look forward to	Not much to look forward to
Is lively	Is not lively
Is extravert	Is intravert
Few life experiences	Many life experiences
Related to me	Not related to me
Lives with a family	Lives alone

Time 3
COMPONENT 1

High rating	Low rating
Lacks experience	Is very worldly
Is still at school	Not still at school
Is not professionally qualified	Is professionally qualified
I don't know well	I know well
Blunders	Is a perfectionist
I've not had time to develop relationship with	Have had time to develop relationship with
Is immature	Is mature
Is selfish	Is not selfish
Is optimistic	Is pessimistic

COMPONENT 2

High rating	Low rating
Isn't lively	Is lively
Is well travelled	Not well travelled
Is not a student	Is a student
Is lonely	Is not lonely
Is serious	Is fun loving
Is married	Not married
Has found what they want in life	Is unpredictable
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:-

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Table 9.11 <u>Mean Percentage Variation of First Component</u>
<u>for each Group on First Measurement Occasion</u>

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 <u>Mean Percentage Variation of First Component</u>
<u>on Repeated Measurement Occasion for Groups A</u>,
<u>B and C</u>

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. <u>Group A Time 0 and Group TT1 Time 0</u>

An independent t-test revealed no statistically
significant difference in mean level of cognitive
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. <u>Group B Time 1 and Group A Time 1</u>

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. <u>Group A Time O and Group A Time 1</u>

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. <u>Group C Time 2 and Group B Time 2</u>

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. <u>Group B Time 1 and Group B Time 2</u>

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. <u>Group D Time 3 and Group C Time 3</u>

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 signif-
icant 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 O 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 O and Group TT2 Time 3

An independent t-test revealed no statistically signif-
icant 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.

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 emements 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

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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 psych-ological 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.

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 under-
going 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

PART OF TRAINING	FREQUENCY OF MENTION
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

*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 <u>Do you see yourself with a long term future</u>
           <u>in nursing? Where?/Why not?</u>

Table 10.4 shows that the majority of student nurses
did foresee a long term involvement for themselves
in nursing.

Table 10.4 <u>Student Nurses' Perceptions of Long Term</u>
            <u>Involvement in Nursing</u>

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" particul-
arly on night duty.

Table 10.5 <u>Responses to Q5 showing areas of Long</u>
            <u>Term Involvement</u>

LONG TERM FUTURE	No. NURSES
Community Nursing	2
Geriatric Nursing	2
Some Chronic Area	1
Abroad	1
Area Unspecified	2

10.3.6 Q6 <u>Looking back on your training, how do you feel</u>
           <u>about your geriatric experience?</u>

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 <u>Would you consider a career in geriatrics?
Why?/Why not?</u>

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 <u>DISCUSSION</u>

10.4.1 Q1 <u>Now that you have reached the end of your
training, which parts have you enjoyed
most and why?</u>

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 <u>What are your immediate plans for your</u>
           <u>career?</u>

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 <u>What would you most like to do, given the</u>
           <u>ideal circumstances?</u>

Because of the unsatisfactory responses to this question,
it was decided to exclude it from the main study.

10.4.5 Q5 <u>Do you see yourself with a long term future</u>
           <u>in nursing? Where?/Why not?</u>

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 <u>Looking back on your training, how do you</u>
           <u>feel about your geriatric experience?</u>

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

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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   <u>Now that you have reached the end of your</u>
              <u>training, which parts have you enjoyed</u>
              <u>most and why?</u>

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 O-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	O
Mental Health	13
Operating Theatres	6
Orthopaedics	O
Paediatrics	4
Surgery	O

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 <u>What have you enjoyed least and why?</u>

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 <u>Parts of Training Group B Enjoyed Least</u>

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	O
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
alloted 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 <u>Which parts do you expect to enjoy most and why?</u>
<u>Which parts have you enjoyed most and why?</u>

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 Accidennt and Emergency - were similarly characterised by the

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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 <u>What are your immediate plans (if any) for your
    career when you finish your training?</u>
    <u>What are your immediate plans for your career?</u>

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 <u>maintaining good relationships</u>

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 arms' 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".

<div align="right">S09: 4</div>

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".
>
>   SO2:4

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".

<div align="right">

S25(1)4

</div>

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".

<div align="right">

p.194

</div>

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 overemph-
asised.

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 elic-
itation 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

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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".

<div align="center">p.54</div>

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:-

<div align="center">315</div>

"Nurse-patient verbal communication was
a visible sign of the nurse-patient relationship,
and it was found to be limited and not very
meaningful".

<div align="center">

p.124

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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 under-
taking 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".*

<div align="center">

S19

</div>

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".*

<div align="center">

S33

</div>

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".*

<div align="right">

S22

</div>

Indeed it was felt by some nurses that their needs
could not and should not be met on an acute medical ward.

<div align="center">

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</div>

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.

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 giv ing 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.

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. <u>Mental Deterioration</u> (14)

They are absent minded.

They are not useful to themselves or others.

11. <u>Sex</u> (4)

They should not marry.

They have no interest in the opposite sex.

12. <u>Interference</u> (3)

They are in the way.

They are a nuisance to others.

13. <u>Cleanliness</u> (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.

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.

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 willing- ness 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, jusfity, 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.

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. Exploitatives.

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 cliche, maintaining superficiality, changing
      topic or subject, avoidance.

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 <u>conscious and direct</u> declaration of <u>support or agreement</u> with another person or his concepts.

4. DISAGREEING - a behaviour which involves a <u>conscious and direct</u> declaration of <u>difference of opinion</u>, or <u>criticism</u> of another person's concepts.

5. DEFENDING/ATTACKING - a behaviour which <u>attacks another person</u> or <u>defensively strengthens</u> an individuals own position. Defending/attacking behaviours usually involve overt value judgements and often contain emotional overtones.

6. OPEN - a behaviour which involves <u>self exposure of the individual</u> by disclosure of <u>personal experiences or feelings or admitting mistakes or inadequacies</u>, providing that these are made in a non-defensive manner.

7. TESTING UNDERSTANDING - a behaviour which seeks to establish <u>whether</u> or not <u>an earlier contribution has been understood</u>.

8. INTEGRATING - a behaviour which <u>summarizes</u> and integrates the <u>content of previous discussions</u> or considerations.

9. ELICITING - a behaviour which <u>seeks facts, opinions, or clarification</u> from another individual or individuals.

10. GIVING INFORMATION - a behaviour which <u>offers facts, or clarification</u> to other individuals.

11. SHUTTING OUT - <u>a behaviour which excludes</u>, or attempts to exclude, another group <u>member</u> (e.g. interrupting; talking over).

12. BRINGING IN - a behaviour which is a <u>direct and positive attempt to involve</u> another group <u>member</u>.

13. CHALLENGING - a behaviour which is intended to provoke the expression of <u>a response at a feeling level</u> (e.g. anger, sadness) which otherwise would remain unexpressed.

14. ENLARGING - a behaviour which <u>expands</u> or <u>enlarges</u> the meaning of a previous contribution by <u>interpreting</u> or <u>providing awareness of underlying dimensions</u>.

15. POINTING OUT - Pin-pointing a <u>specific verbal or non-verbal dimension of another's behaviour</u> that is taking place without being commented upon.

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 enviroments, 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 anticip-
atory 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 experince 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".

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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.

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

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

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
O1	18	12	–
O2	18	7	–
O3	18	5	–
O4	18	5	–
O5	19	5	–
O6	18	8	1
O7	18	5	–
O8	19	7	2
O9	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
T1O	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

APPENDIX H

Form Used in Completion of Repertory Grids (Chapter 9)

NAME ....

DATE ....

KEY:
7 = VERY DEFINITELY YES
6 = DEFINITELY YES
5 = YES
4 = NEITHER YES OR NO
3 = NO
2 = DEFINITELY NO
1 = VERY DEFINITELY NO

ELEMENTS

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

LEAVE BLANK

CONSTRUCTS

INSTRUCTIONS: FILL IN ROW BY ROW. DO NOT OMIT ANY SQUARES. ONLY USE NUMBERS 1-7.

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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:

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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