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Psychiatric/Mental Health and Surgical Nurses' Perceptions of Problematic Behaviour

by

William N. Leddy

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Nursing

Faculty of Nursing

Edmonton, Alberta
Fall, 1993

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled Psychiatric/Mental Health and Surgical Nurses' Perceptions of Problematic Behaviour, submitted by William Norman Leddy in partial fulfillment of the requirements for the degree of Master of Nursing.

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Olive Yonge

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Diane Buchanan

Michael W. Gillespie

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July 9, 1993

Date

DEDICATION

This thesis, which marks the culmination of my master's level coursework and research, would never have been realized without the help of others. To that end, I dedicate this work to the members of my family.

Kathy, my wife, understood as a nurse does, whenever I had to be away for long hours, on many weekend days. My elder son Stephen, when asked what I would have when I was finished with this work, replied, "More time to play with us!" And my younger son Matt, when hearing the first vignette from the questionnaire read aloud, said, "She's crazy, dad!" To these people, who helped me keep my focus and my morale during all the stages of my master's program, I offer my humble thanks.

ABSTRACT

The defining of problematic behaviour varies among cultures and different groups within a larger society. Nurses who work in varying settings have quite different foci in their perceptions, possibly extending into the perceptions of what constitutes problematic behaviour and its recommended management. This might partially explain why the psychological problems of some patients in acute physical care areas have received insufficient attention. Among psychiatric/mental health and surgical nurses, what are the perceptions of problematic behaviour? In this descriptive study a modified ten-vignette questionnaire designed by Flaskerud regarding problematic behaviour was completed by 30 psychiatric/mental health nurses and by 39 surgical nurses at the University of Alberta Hospitals. Differences between group means (from rating scale items) were examined through analysis of variance and repeated measures t-tests, with alpha set at .05. A two-factor analysis was also carried out. In general, no significant differences were found between the two groups' ratings of the seriousness of the behaviours or need for management. The psychiatric/mental health nurses did rate themselves significantly higher in terms of confidence for helping the persons in the vignettes. Qualitative analysis was applied to the responses to open-ended questions. There were some differences in the terminology and types of suggestions given by the respective groups of nurses. Implications include: the use of nurse referral or consultation systems in the planning of certain clients' care; inservice education given to nurses; onsite management of patient behaviour; and assessment carried out at the time of patient admission.

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RATIONALE

Psychiatric/mental health nursing has as its major focus the mental well-being of the individual (Haber, Leach, Schudy, & Sideleau, 1982; Stuart & Sundeen, 1987). This focus makes it distinct from other areas of nursing which, while recognizing the importance of psychosocial needs, focus more on the physiological integrity of the client. There has been some lack of success in nursing, in meeting the mental health needs of clients (English & Morse, 1988; Flaskerud, 1984). In a care area which has a physical focus, for instance a hospital surgery unit, nurses are concerned primarily with the physiological functioning of the client, where routines of care and expectations of a particular recovery pattern take precedence. Ongoing education for the nurses, as well as the expectations of the nurses' performance, will very often be centered on the physical care of the client. Therefore, these nurses may not be optimally oriented to recognize and manage mental disorders (the terms mental illness and mental disorder will be used interchangeably). Conversely, in a hospital psychiatric ward, the nurses will see the client's mental state as their primary focus, and may not be oriented to deal with many physiological concerns.

The nursing process, used in all areas of nursing, is based on the scientific method. A problem is perceived, hypotheses are formed, interventions occur, and results are noted and evaluated. This practice has been, overall, quite effective. In a case where a client's mental health needs are not satisfactorily met, the problem-solving process can be examined to determine the nature and the extent of the care deficit. The basic difficulty may be found at the beginning of the nursing process--with the perception of a problem. Perception involves the sensing, organizing, and interpreting of data (Murray & Huelskoetter, 1987). The interpretation component in particular is preceded by one's formation of values; these in turn are heavily influenced by one's culture and education (Gove, 1989; Scheff, 1966). So a mental health or psychiatric problem may be perceived by the client, the nurse, both, or neither.

In client care, a problem can occur in making decisions about the nursing approach that will be used. If nurses disagree, tensions will rise, inconsistent psychosocial care may be given to the client, the therapeutic alliance may be severed, and there will be dissatisfaction with nursing care. Or perhaps problems exist with a client's behaviour, but that behaviour is not perceived by the client or the caregiver as reflecting a mental disorder, and so help is never sought. An example would be a subtle case of depression which may not be recognized by nurses working in a physical care area, and so an option such as consulting a psychiatric/mental health nurse would not be considered. The client's behaviour might be misinterpreted and unwittingly, a nontherapeutic nursing approach might be instituted. This in turn could alienate the client, and worsen the psychiatric condition. The following sections will deal with research which has been done in the areas that comprise the conceptual focus of this thesis.

Review of the Literature

Nurses - Background and education

The registered nurse in today's North American society completes an education which will ordinarily comprise experience within areas that deal with surgical care,

medical care, psychiatric/mental health care, obstetrical care, and pediatric care. Each area is very different and has its own major focus and expectation of what the nurse will do.

In Canada, nurses who work in the psychiatric/mental health area may have diploma or further educational preparation, such as the postdiploma certificate in psychiatric/mental health nursing offered at Mount Royal College in Calgary, Alberta. In the United States nurse generalists, called psychiatric and mental health nurses, have a baccalaureate degree in nursing (recommended) and make up the majority of nurses working in the psychiatric/mental health area. Psychiatric and mental health nurse specialists have a minimum of master's degree preparation in psychiatric nursing which includes academically-supervised clinical practice (Stuart & Sundeen, 1991, p. 20).

In Canada and the British Empire, an additional designation exists: the Registered Psychiatric Nurse (RPN). The RPN is a graduate of a programme in Psychiatric Nursing, which was formerly of three years' duration and is currently of two years' length. These programmes (and the Registered Psychiatric Nurse designation) exist only in the four western Canadian provinces (H. Mussallem, personal communication, November, 1989) and in England. In Canada, RPN's have their own association. There are some nurses who hold dual RN and RPN credentials. All nurses who specialize and work in the area of psychiatric/mental health nursing will, no matter their background, come to focus on the priorities of their chosen area.

In the day-to-day working with clients, the nurse in psychiatry- mental health becomes skilled in the recognition and interpretation of client behaviours. The nurse also becomes more familiar with different types of psychiatric disorders: etiology, common manifestations, and indications for intervention. Over time, even subtle cues in the behaviour of a client can be perceived by the nurse, and hypotheses may be made about the meaning of the behaviour. This skill is maintained at a high level with increasing experience and ongoing education.

A registered nurse (with diploma or further education) who works in surgery will have had surgical teachings in the nursing programme. An increasing length of time working in this area will allow the nurse to become very skilled in areas such as dressing changes, wound care, postoperative ambulation, and the assessment of wound healing, circulatory status, and pain, among others. This nurse will have completed a psychiatric/mental health rotation in the RN programme, just as the psychiatric/mental health nurse will have had a student clinical posting in surgery. Thus, the two will have a basic knowledge of each others' areas of expertise. For both groups of nurses, the ability to communicate and to form relationships with clients is very important.

Socialization

Individuals are socialized into various roles and settings across the entire life span. Socialization is defined as: "the process whereby individuals acquire the personal system properties-- the knowledge, skills, attributes, values, needs and motivations, cognitive, affective and conative patterns-- which shape their adaptation to the physical and sociocultural setting in which they live" (Inkeles, 1969, pp. 615-616). A person's taking up of an occupation is an example of entering into a new socialization process. A student nurse is socialized into the role of nurse throughout the nursing education programme. Following graduation, the new nurse is socialized into the chosen work area. The longer that a nurse works in a particular nursing area, the stronger will be the influence of that area on the nurse's views. According to Benner (1984), :

> ...organizations operate more like cultures than rationalized organizational charts. Socialization works because there is a taken-for-granted background of assumptions and values that one cannot get completely clear about or make completely explicit...Situational adjustment will cause one to take up many

> practices that embody values one does not recognize or freely choose. (198 ', p. 191)

Through interacting with members of the group, the individual learns role behaviours appropriate to the position within the group. The members of the group, holding normative beliefs about how the role is constituted, use reward and punishment to help the person learn what is appropriate or not for the role (Lum, 1988). Thus in "role taking", the individual comes to self-appraise in terms of others' opinions and thereafter, performs the role accordingly (Brim, cited in Hardy & Conway, 1988). With respect to a learning theory perspective, according to Bandura (1969), identification, imitation, and observational learning all refer to the behaviour modification which results from being exposed to modelling stimuli. The modelling stimuli come from a "role model" who... "possesses certain skills and displays techniques that the individual lacks and from whom, by observation and comparison with one's own performance, the individual can learn" (Kemper, cited in Lum, 1988). After attending to the new learning, the person retains it over time, and responds to reinforcers which may be external, self-administered, or vicariously experienced.

The group into which one is socialized is termed the reference group, which is "... any collectivity, real or imagined, envied or despised, whose perspective is assumed by the individual" (Lum, 1988, p. 257). A normative reference group provides the person with a set of norms and values, as well as specifying the standard for the proper level of performance in the role. It is this reference group which provides the professional socialization to the nurse. One way in which this would occur is the learning of a technical language (Lum, 1988). Society allows a profession to have a monopoly on its practice, based on the idea that lay people do not have the knowledge, judgment, or skills to carry out this job. The profession controls the body of knowledge upon which its practice rests (Lum, 1988).

Benner (1984), studied the process of nurses becoming experts. She noted that only when the nurse had concentrated practice in an area, and gave up some of the rules of practice that were learned in school or earlier in the career, did that nurse become truly expert in that area. Applying this work to psychiatric nursing, Krauss (1987) stated that expertise in this area comes from exposure to a sufficient number of paradigm cases and from experience, and that the depth, richness, and familiarity that underlie expertise come from specialization in the area. Some of these changes in a nurse would come through the socialization process.

Looking at professional socialization in the psychiatric nursing field, it is noted that these nurses are expected to utilize their judgment, knowledge of nursing diagnoses, and knowledge of standard classification of mental disorders as the basis of formulating client care (American Nurses' Association, 1987). The use of standardized psychiatric nomenclature, along with nursing diagnosis, is an indicator of accountability and quality practice among psychiatric nurses (Wilson & Plumly, 1984). The authors go on to describe all its functions:

> Cited raisons d'etre include: facilitating development of the science itself by providing an operationalized, interdisciplinary vocabulary to stimulate research and enhance communication, defining the boundaries of the phenomena to be focused upon, and organizing complex and exhaustive information into a more concrete form by establishing indictive links. (Wilson & Plumly, 1984)

The pitfalls inherent in this process are well documented, with criticism centring about the issues of reliability, labelling, and reliance on the medical model (Gary & Kavanagh, 1990, Wilson & Plumly, 1984).

Mental disorder and Problematic Behaviour

In any society, the behaviour of individuals must meet societal expectations and requirements (norms). Failure to do so is termed *deviance*. The greater the deviance in

a society, the greater the role strain and threat to the society (Edgerton, 1976). One's level of expected social control affects the ability of others to interact with the individual comfortably and predictably. Mental illness is defined in terms of how much this social control is broken down (Clausen, 1971; Scheff, 1966; Vetter, 1972). In this same vein, Sullivan (1953) defined mental illness as "inappropriate interpersonal relationships".

The instances of societal rule breaking which cannot be classified, for example, as bad manners, crime, or drunkenness, are then labelled as mental illness (Gove, 1980; Scheff, 1966). Or, according to Szasz (1970), the role of "mental patient" is *ascribed* to an individual. This seems to be society's method of explaining some of its members' problems in living.

The recognition of mental illness, according to Edgerton (1969), involves firstly the perception: an observer has an initial subjective realization that something is "wrong"-someone is behaving in a "crazy" manner that is irrational, unreasonable, or inexplicable. There is then the verbal expression of this perception, which is called labelling. Action occurs next, in which others adopt new modes of interaction with the labelled person.

The society or cultural group teaches its members which behaviours are to be considered sane or mentally-ill and accordingly places positive or negative sanctions on each, respectively. The behaviours considered to be "sane" are those which best promote the technology, social structure, and ideology of the group (Flaskerud, 1980; Perrow, 1965). Thus, these labels (of mental illness) become legitimized and, being patterns that narrow the range of human choices, are now termed *institutions* (Eaton, 1980). In one classic experiment, volunteer subjects with no psychiatric illness presented themselves at a psychiatric hospital, stating simply that they heard voices. Following admission, displaying no manifestations of mental illness, they were nevertheless treated in a routine manner by all hospital staff as being mentally ill. Only the copatients in the hospital queried whether or not they were in fact mentally ill (Rosenhan, 1990).

The institution of mental illness, in the Western world, has become medicalized, that is, under the care of physicians (Akers, 1985; Eaton, 1980). Thus, mental illness is subject to medical diagnosis and treatment, which might include hospitalization. Medical diagnosis of clients is strongly influenced by their doctors' educational and cultural backgrounds; strong differences in the diagnosis of schizophrenia and depression were demonstrated among psychiatrists from American, British, and Canadian backgrounds (Sharpe, Gurland, Fleiss, Kendell, Cooper, & Copeland, 1974). In this medicalized system, there is belief in modern technology, a mastery over the environment, and some control over destiny (Flaskerud, 1980). Nursing of the mentally ill in hospitals, clinics, and in the community, is a part of this larger system of health care.

"Problematic behaviour" is an expression which does not necessarily connote mental illness. As stated above, that which constitutes mental illness is very open to interpretation, depending upon the person's background. Flaskerud (1980) noted,

> Psychiatric/mental health nursing as it is practiced and taught relies heavily on psychiatric explanations for labeling normal and abnormal behaviour and on psychiatric therapies for managing problematic behaviour. These explanations focus on the view that standardized forms of mental illness exist which are typified by relatively standardized behaviours or symptoms of these illnesses. However, there is evidence that neither the explanations for problematic behaviour nor its management are standardized. (p. 4)

Because this research is based quite closely on that done by Flaskerud, the concept of "problematic behaviour" is carried over from her work.

Attitudes toward mental illness - Mental health professionals

Research has been conducted regarding the attitudes of various health professionals, including nurses, toward mental illness. One group of American psychiatric nurses was found to have more acceptance of a medical paradigm of mental illness, as were psychiatrists, psychiatric social workers, and psychiatric outpatients, compared to clinical psychologists (Morrison & Hanson, 1978). The 23 American psychiatric nurses, 20 psychiatrists, and 40 psychiatric outpatients demonstrated less of an attitude characterizing what the authors referred to as the controversial psychosocial position about "mental illness," compared to 25 social workers and 16 psychologists. The Client Attitude Questionnaire was used. (Morrison & Nevid, 1976).

An Israeli study of nurses, professional staff, occupational therapists, medical students, and patients showed that nurses and patients held more custodial attitudes toward the mentally ill (discouraging autonomy, promoting submission, and emphasizing physical needs) than did the other groups (Rosenbaum, Elizur, & Wijsenbeek, 1976). A group of English nurses showed more authoritarianism (which was related to age, education, and training) in their view of psychiatric treatment. They were studied with social workers and psychiatrists (Pallis, 1978).

Attitudes toward patients and toward the etiology and treatment of mental illness among American psychiatric nurses, psychiatric social workers, psychiatrists, and psychologists were studied by Roskin, Carsen, Rabinel, & Marell (1988). Among the groups, the nurses were found to have the most biologic orientation to the etiology of mental illness, and the lowest scores on the nurturant-empathic approach scale. The possible explanation given for the latter was that nurses have the most intimate, sustained care-giving role for the most severely-ill clients, and these results may reflect a degree of "burnout". Other studies have looked at mental health professionals, including nurses, with regard to their attitudes toward the chronically mentally ill (Mirabi, Weinman, & Magnetti, 1985); attitudes, roles and backgrounds (Blum & Redlich, 1980); and mental health ideology (Del Gaudio, 1976).

Attitudes toward mental illness - Nurses

A group of 100 medical, critical care, and surgical nurses in Miami, Florida were divided into two groups. The experimental group received two hours of time to discuss personality disorders, emotional issues in the medical setting, and individual issues raised by the nurses. This group later showed decreases in social restrictiveness and authoritarianism, as measured by the Opinions About Mental Illness Scale and the Millon Behavioural Health Inventory. Nurses with a history of personal psychiatric exposure also scored lower on these two dimensions (Wilcox, 1987).

The effects of a psychiatric nursing course favourably changed the responses to four out of five scales of the Opinions About Mental Illness Instrument, among 185 nursing students in Georgia (Bairan & Farnsworth, 1989). Another group of students who were tested pre (n= 34) and post (n= 37) psychiatric posting in their nursing programme in Ontario were compared on perceptions, beliefs, and opinions about mental illness, with no significant difference found between the groups (Malla & Shaw, 1987).

The conceptions of a group of 75 nursing students in Virginia about psychiatric patients showed a change in one study; following patient contact, the clients were seen as being less irritable, more socially competent, and less dangerous than before, using the Nurses' Observation Scale for Inpatient Observation (Kish & Hood, 1974). In a California study, 11 student, 8 medical-surgical, and 8 psychiatric nurses were compared on the Opinions About Mental Illness Scale. The psychiatric nurses were shown to be more authoritarian and less adherent to a theory of interpersonal etiology

of mental disorders; they also had more socially restrictive opinions about mental illness (Kahn, 1976).

A six-week training in Louisiana in psychiatric nursing brought about no significant differences in the Opinions About Mental Illness Scale among a group of 15 nonpsychiatric nurses; however, the nurses' aide group (n= 14) later showed a reduction in social restrictiveness (Distefano & Pryer, 1975). In Israel, Weller &. Grunes (1988) studied 95 practical and registered nurses with high, moderate, or no contact with mentally ill patients, using the Attitude Toward Mental Illness questionnaire. Though no differences were found, practical nurses, nurses with less experience, and religious nurses were found to hold the most positive attitudes.

The attitudes of nurses to "difficult" patients were explored by English & Morse (1988) and Podrasky & Sexton (1988). Both of these works made use of vignettes which depicted some of the "difficult" behaviours that were studied. In addition, Gallop & Wynn (1987) noted that nurses and medical residents both identified the same "difficult" patients but the nurses' responses were more personalized and affect-laden, and less objective than those of the residents.

The results of the above studies indicate that exposure to psychiatric nursing tends to bring about a shift in one's perceptions. This type of research in turn supports the belief that particular professional socialization experiences will differentiate the behaviours of the student and later, the graduate nurse.

Identification of mental illness

A number of studies have addressed the identification or rating of psychological disturbances and disabilities by health professionals, including nurses (Asberg, Peris, Schalling, & Sedvall, 1978; Colson & Coyne, 1978; Hardman, Maguire, & Crowther, 1989; Offer, Ostrov, & Howard, 1982; Watson, 1988). In these works, references to nurses are very general. The common practice of reporting research results without differentiating the different health care providers, was also commented upon by Molzahn & Northcott (1989), who called for more specific attention to identifying and comparing the groups involved.

Five "gatekeeper" professions (n= 178) were studied by Coie, Costanzo, & Cox (1975). Respondents (clergy, nurses, physicians, police, and social workers) were asked to evaluate 190 behavioural items for the mental illness implications of the behaviour described in each item. The items, short, third-person descriptions, were largely based on the Minnesota Multiphasic Personality Inventory (MMPI). Public health nurses (n= 36) showed a questionnaire response profile very similar to that of the physicians. The authors noted, "One can see the evidence of the effects of training and professional work roles on mental health judgments" (p. 633).

Within nursing, Davis & Jensen (1988) pointed to the importance of the nurse's ability to identify depression in medical patients, with the optimal method being the use of the Structured Clinical Interview from the DSM-III. A study of 13 nurses, rating 77 long-term hospitalized clients in Tennessee showed that there was no statistically significant difference ($r = .73$, $p > .05$) in the reliability of nurses' reports, whether they were behavioural (for example, descriptions of observed actions) or based on the "medical model" (for example, "schizophrenia") (Lambert, Cartor, & Walker, 1988). Female student nurses (n= 125) in Nigeria responded to 40 items which used semantic differential scales to contrast "normal person", "typical mental case", and "mad man"; the mean scores among these three cases were significantly different, with Cronbach alpha coefficients ranging from .90 to .93 (Jegede, 1976).

A group of 30 hospitalized arthritis patients reported their affective states through the Multiple Affect Adjective Check List (MAACL); 26 of their caregiver RN's then completed the same test as they thought their patients would. The Marlowe-Crowne Social Desirability instrument, one scale of which measures denial, was also

administered. There were no significant differences for patients and nurses, respectively, in all three scales of anxiety (mean 9.07 versus 9.43), hostility (mean 8. 13 versus 7.90), and depression (mean 16.93 versus 18.43). Higher educational levels in the nurses were correlated with increased accuracy in the completing of the instruments (Muhlenkamp & Joyner, 1986).

A study in England of the recognition of psychiatric problems in cancer patients showed that a "specialist nurse" who had extra training in problem recognition and communication with cancer patients could recognize anxiety, depression, and sexual problems in 76% of occurring cases, as compared to 15% for all others who cared for the same clients (Maguire, 1985). In Arizona, a study compared 15 psychiatric, 16 medical, and 18 surgical nurses (3 LPN's were in each of the medical and surgical groups). The nurses completed a detailed questionnaire about concerns and problems in caring for their patients. They estimated the proportion of patients on their units having combined physical and psychiatric problems at 20%, 17%, and 12%, respectively. Thirteen percent of psychiatric nurses, 83% of medical nurses, and 66% of surgical nurses felt substantially or extremely concerned about their ability to adequately provide client emotional care due to lack of training or experience. The authors stated, "Patients with co-existent physical and psychiatric problems...receive suboptimal care by virtue of their behavioural response to physical illness" (Misiaszek, Crago, & Potter, 1987, p. 631).

It is an expectation that nurses will identify actual or potential emotional problems in their clients. The literature reviewed does not consistently point to a measurable difference in the abilities of psychiatric and nonpsychiatric nurses to identify mental illness.

Psychiatric liaison nursing

Nurses have for some time utilized each others' expertise in an unofficial capacity. The utility of this system of referrals became evident in nursing practice and so the process has been formalized in some areas. "Medical-surgical nurses realized their inability to adequately meet the total needs of their patients. They logically turned for assistance to nurses more skilled in certain areas. From this request evolved the psychiatric liaison nursing role" (Nelson & Schilke, 1976, p. 63)

An article describing the use of psychiatric liaison nursing in Michigan states that nurses from nonpsychiatric/mental health areas found medical psychiatric consultations hard to understand due to jargon and had problems using them in nursing care. Therefore, they requested the opinions of psychiatric/mental health nurses. In the specific example given, the psychiatric/mental health nurse consultants work with the requesting nurse and not directly with the client in question. This consultation is based on the belief "...that the consultants should work with the staff's perception of the patient...not to provide an 'expert assessment' of the situation but to work on nursing care problems from the nurse's own frame of reference" (Przepiorka & Bender, 1977, p. 756). In Canada, Newton & Wilson (1990) noted that staff nurses gave an extremely high written satisfaction rating to the psychiatric liaison service in place at the Health Sciences Centre in Winnipeg, Manitoba.

Research - Problematic behaviour and the use of vignettes

Members of different cultures see mental illness differently (Edgerton, 1969; Giger & Davidhizar, 1991; Goffman, 1961; Kiev, 1964; Murphy, 1973; Pedersen, 1981). Though nurses who work in different areas of nursing do not constitute separate cultures, they are socialized differently in their respective work areas and have different experiences and expectations . This is true of surgical as well as psychiatric/mental health nurses.

From her observations of culture, Flaskerud (1984) noted that there seems to be a need for the exploration of culture-specific perceptions of problematic behaviour, and its appropriate management, by nurses who work in mental health/psychiatric settings. The relationship between problematic behaviour and the subsumed concept of mental illness was discussed earlier. Studies of this type have generally been based on specific observations of the researchers, and to date there has not been a replicable quantitative research design or instrument that would allow direct comparisons between groups. Karno & Edgerton (1969) used a questionnaire with a series of vignettes to exemplify behaviours which they believed represented mental illness. These everyday-language items were administered with a questionnaire to 444 Mexican-Americans and 260 Anglo-Americans in California. The 184 Mexican-Americans who completed the interview in English showed perceptions of mental disorder very similar to the Anglo respondents. The remaining 260 Mexican-Americans responding in Spanish tended to express much more traditional cultural beliefs, which were in contrast to those beliefs of the Anglo group (1974).

Two groups of female nursing students in Ontario were asked to respond to three vignettes, which exemplified normal, paranoid schizophrenic, and schizotypal persons (Malla & Shaw, 1987). One student group was entering the nursing programme, and one group had completed two years of nursing education, including the psychiatric/mental health posting. From the vignettes, the degree of perceived mental illness was rated on a seven-point scale. In both groups, significant differences were found in the perceived mental illness ratings among the three vignettes, with the normal at the lowest and the paranoid schizophrenia at the highest. Additionally, the more experienced students showed a statistically higher mean mental illness rating for the paranoid schizophrenia vignette. The authors stated that this group, "...presumably through the influence of instructions and exposure to psychiatric patients, had improved their recognition of signs, symptoms, and severity of mental illness..." (p. 38).

Flaskerud (1979) noted the need for instruments which measure values and attitudes regarding broad psychosocial concepts such as mental illness. Vignettes were seen to exemplify these topics in a way that didn't necessitate defining the topic too narrowly, such that the context might be lost. Accordingly, she created a tool which collected demographic and biographical data from the respondents, as well as their reactions to each of eight vignettes which depicted behaviour believed to reflect mental illness. Three questions followed each vignette: What do you think of this person's behaviour? Do you think that anything ought to be done about it? If so, what? Content validity and interrater reliability were established. The respondents were presented with the questions in a face-to-face interview (Flaskerud, 1980).

Using this tool, Flaskerud (1980) measured the perceptions of problematic behaviour among 50 Appalachians, 50 lay nonAppalachians, and 54 mental health professionals (including nurses) in Chicago. Seven of the eight vignettes showed statistically significant differences between the Appalachians and the other two groups. The former group did not perceive the vignettes as exemplifying mental illness. The latter two groups saw the stories as illustrating neuroses, personality disorders, or psychotic episodes. Nor did the Appalachians tend to recommend psychiatric treatment; either tolerating or punishing the behaviours was suggested instead. The mental health professionals generally saw medication or one of the talking therapies as the route of choice.

A later study compared perceptions of problematic behaviours among 20 Black Baptist Fundamentalists, 28 Native Americans, 32 Chinese Americans, 30 Filipino Americans, 30 Mexican Americans, 18 Appalachians, and 68 mental health professionals (including nurses) from three U.S. states. The instrument described above was used, but this time it included ten vignettes. Overall, statistically significant differences were found between the three groups of mental health professionals and the six groups of minority culture respondents. These differences were in terms of both

the perception of problematic behaviour and the recommendations regarding its management (Flaskerud, 1984). Responses among the minority cultures varied, but they generally identified mental illness much less often, perceiving instead clairvoyance, criminality, spirit possession, immorality, or laziness.

Allen, Graves, & Woodward (1985) compared the perceptions of problematic behaviour by 20 American southern Black female fundamentalists and 20 mental health professionals (inclusing 17 psychiatric/mental health nurses), using Flaskerud's instrument. For nine of the ten vignettes, statistically significant differences were found between the groups, with the mental health professionals identifying mental illness more often. On all ten vignettes, there was a significant difference between the groups regarding the suggested management; the mental health professionals recommended psychiatric treatment more often. Interestingly, neither the fundamentalists nor the mental health professionals identified psychiatric nurses as a resource for managing the problematic behaviour. Such findings suggest that the potential of psychiatric liaison nursing is far from realized.

As seen from the preceding literature, there is more data available about mental health professionals in general, than about nurses; and there is more data about attitudes toward mental illness than there is about its recognition. There appears to be a tendency for people with a greater background in the psychiatric/mental health area to perceive mental illness to a stronger degree. This may be due to the process of professional socialization. However, the literature is inconclusive regarding the perceptions of problematic behaviour or mental illness, of nurses with different backgrounds.

The results of all the above studies have important implications for nursing. As Krauss noted,

> We need to understand the nature of the early warning signals, the soft signs, that psychiatric nurses recognize...Benner's work argues for an increased commitment on the part of psychiatric nurses to grounded, descriptive research that will continue to uncover the components of expert practice... in the context of psychiatric nursing. (1987, p. 14)

The recognition that different people's perceptions of problematic behaviour are at variance means that nurses must use careful assessment and validation to ensure relevant and appropriate care. Flaskerud (1980) called for replication of this research with other minority groups. Indeed, only a few groups have been studied using this research method, and none since the 1985 Allen, Graves, & Woodward article. These previous studies all focused on minority groups within the community, and where comparisons were made, it was with mental health professionals of different disciplines. It would, as a bridging measure, be beneficial to study groups of community members at large, not just the minority groups. No studies compare the perceptions of two different groups of nurses and no research in this regard looking at graduate nurses has been carried out in Canada. The decision was taken to study two groups of nurses, recognizing that these groups are much more similar than those previously studied using Flaskerud's vignettes.

Psychiatric/mental health nurses are experienced in the identification of mental illness in the clinical setting. Does this experience have an influence on their perceptions of various behaviours that may be encountered in everyday life, such as those depicted in the vignettes? The professional socialization of psychiatric nurses could reasonably be expected to cause differences in their responses to the above, in comparison to surgical nurses with no psychiatric nursing experience since studenthood. The choice of surgical nurses in particular will be discussed later.

Following the review of the literature, the research question proposed was: "What are the perceptions of psychiatric/mental health nurses and surgical nurses of problematic behaviour?" A replication study based on Flaskerud's 10-vignette instrument and research design was chosen to answer this research question.

The purpose of this study was to measure and compare the perceptions of problematic behaviour between two groups of nurses: one group who were working in a hospital inpatient psychiatric area and one group working in a surgical nursing unit. The data collected would indicate what the two groups' views were about the treatment of problematic behaviour. This study would advance scientific knowledge by delineating the specific perceptions of nurses and not the more general group of mental health professionals.

The following are operational definitions for terms which are central to this research:

Mental disorder (or mental illness): A clinically significant behavioural or psychologic symptom or pattern that occurs in a person and is associated with distress or disability or with an increased risk of suffering death, distress or disability, or an important loss of freedom; is not an expectable response to a particular event or experience (Wilson & Kneisl, 1992, p. 995).

Norm: A standard of behaviour, achievement, or other, based on measurements of a large group; used for comparison to an individual (Gary & Kavanagh, 1990, p. 1028).
Nurse working in the psychiatric area: A nurse whose duties are concerned primarily with the management of clients with a mental illness and the promotion of their mental health, in a hospital psychiatric inpatient setting. This person might be a registered nurse (RN) with a diploma or B.Sc.N. or higher education, or a registered psychiatric nurse (RPN).

Nurse working in the surgical area: A nurse whose duties are primarily the physical care of clients before and after undergoing a surgical procedure. This person will be a registered nurse (RN) with diploma, B.Sc.N. or higher education.

Perception: The process by which sensory stimuli are organized and given meaning as the person identifies and describes the environment and everything in it. Perception involves sensation of, feelings about, and interpretation of (or the meaning related to) an object or situation in its totality (Murray & Huelskoetter, 1987, p. 52). For this study, perception will be measured as the response to the vignette questionnaire.

Problematic behaviour: That behaviour in a person which is defined by self or others as undesirable and not congruent with a culture's ideology, values, or way of life. In this study, the perception of problematic behaviour is measured by an instrument developed by Flaskerud and modified by this researcher.

METHODS

A cross-sectional descriptive design is the one of choice where little previous knowledge exists about the topic under study (Brink & Wood, 1989). Very little is known about the perceptions of surgical nurses regarding problematic behaviour. Somewhat more data exists about the perceptions of problematic behaviour among student and psychiatric nurses. However, much of it is entwined among the results obtained from a variety of mental health professionals. For this research project, results were compared for two independent groups: psychiatric/mental health and surgical nurses. This study was not a true comparative survey design due to lack of underlying data . Therefore the research question was directed at establishing what the nurses' perceptions were, and not primarily on how they compared.

Three directional hypotheses were proposed: (1.) Nurses working in the psychiatric/mental health area will perceive the behaviours as being of greater cause for concern than will the nurses in the surgical area. (2.) Nurses working in the psychiatric/mental health area will recommend interventions to manage the problematic behaviours more often, and to a stronger degree, than will the surgical nurses. Finally, (3.) the psychiatric/mental health nurses will rate themselves as more confident in helping the person portrayed in the vignette, than will the surgical nurses.

Sample

The target population was those nurses working within the psychiatric/mental health and surgical inpatient areas at the University of Alberta Hospitals, Edmonton, Alberta, Canada. In the psychiatric/mental health area, both RN's and RPN's were employed, whereas no RPN's worked in the surgical area. A mixture of full-time. part-time, and casual status employees worked in both the nursing care areas.

Those participating had to meet the following criteria: being a registered nurse or registered psychiatric nurse; having at least one year of experience in psychiatric/mental health nursing or surgical nursing, respectively; not having worked as a graduate nurse in the other area, for instance a surgical nurse with psychiatric experience was excluded; and having been employed on the unit for a minimum of one year. The nurses were employed in full-time, part-time, or casual capacities. They worked all shifts, of eight or twelve hour durations. Staff, charge, head, and clinical specialist nurses were allowed to participate in the study. Participation was entirely voluntary.

Surgical nurses, as opposed to nurses working in other specialties, were chosen for this research because their area was seen as being very different from that of psychiatry-mental health. For example, in comparison to a medicine area, there may be fewer confused elderly on surgery units. Though hospital stays are short in the surgery area, there are some patients who stay for days, weeks, and perhaps longer, so there would be opportunities for the nurse to get to know the client. There is more of a "normal" day in the surgical nursing unit with its attendant activities such as meals, walking about, visiting, and talking with others, compared to an intensive care unit, where lights are on all the time, and day and night are indistinguishable. Therefore, the surgery and the psychiatric nursing unit are directly comparable on a number of counts in terms of opportunity for client contact, yet they are different enough that two distinct types of nurses can be compared.

Instrument

The instrument was based on one developed by Flaskerud (1984). Ten brief vignettes were presented, describing the behaviours of ten different hypothetical

persons. Following each vignette, a series of standardized questions were asked. The response format was changed (see Appendix A) from that used by Flaskerud, who utilized an interview technique which asked open-ended questions and made no use or suggestion of terms which connoted mental illness. In this study, for each of the vignettes there were four closed-ended questions which were answered by circling the most appropriate number from 1 to 5. The questions were intended to measure those aspects addressed in the hypotheses and so, like Flaskerud, no suggestion of mental illness was used. Additionally, there were three open-ended questions, with enough space provided to write the answer. Personal data collected included age, gender, years of postsecondary education, highest achieved educational qualification, graduate experience in the other area of nursing (surgical and psychiatric/mental health, respectively), years of experience in nursing, and total years' experience in the present-employed area of nursing.

Completion of the questionaire required approximately one hour. The reading level was at a grade 5 to 8 for the questionnaire. Consent was incorporated into the covering letter used to explain the study. Any American references in the vignettes were changed to reflect a Canadian population. This researcher received written permission from Flaskerud to use the vignettes and make modifications to the questions that were asked (see Appendix A).

Questionnaires were distributed in coded plain brown envelopes to the nurses working on the inpatient psychiatric nursing units and the surgical (general, orthopaedic, plastic, and urology) nursing units at the University of Alberta Hospitals. The nurses were permitted to complete the questionnaires at home or at work. They were asked to complete the questionnaires privately, without conferring with others. The time frame for return of the completed items was one month.

The rating scale data was analyzed using an analysis of variance to compare the two group means (with one-tailed alpha at .05), Pearson correlation coefficients, a factor analysis, Cronbach alpha, and a t-test. The open-ended questions comparing the responses of the two groups were analyzed using qualitative methods: transcription, identification of domains, and coding into categories.

Flaskerud (1980) established validity and reliablilty for her tool. The modified tool used in this research was pilot tested with approximately ten members of a mental health nurses' interest group, and their feedback was incorporated into the final format of the questions. With the modifications, Cronbach alpha reliability coefficients were calculated ranging from 0.7254 to 0.9554 among the four closed-ended questions, averaging 0.8905 across all ten vignettes.

As a validity check for this researcher's subjectivity in coding of the long-answer questions, a MN-prepared external reviewer coded a sample of approximately one-quarter of the responses from both groups of nurses. This person's coding had different labels in some cases, saying for example, "psychotic" where this researcher had said "mentally ill." The external reviewer was true to the data and as often as possible used the informants' exact words. Essentially, the external coding yielded the same or very similar categories as those identified in this study. See Appendix N for the classifications generated by the external reviewer.

RESULTS

The psychiatric/mental health nurses returned 33 questionnaires. Three respondents were not included in the sample because of previous surgical experience. Overall, 30 questionnaires were analyzed out of a total of 104 distributed, for a 29% response rate. For the surgical nurses, 42 questionnaires were returned. Three were not included for study because the nurses had previously worked in the psychiatric/mental health area. Of the 121 questionnaires, 39 (32.2%) were analyzed.

Biographical Data

The groups of nurses were very similar in regard to personal data (see Tables in Appendix L). Among the psychiatric/mental health nurses, the vast majority (86.7%) were female, as was the entire group of surgical nurse respondents. Average age among both groups was between 36 and 37 years. They were similar for post-secondary education as well, with means between four and five years and ranges of two to twelve years. The two groups were also roughly equal in terms of years of nursing experience, averaging around 10 to 11 years, and length of work experience in the current practice setting (both groups around eight years). Ninety percent of the psychiatric/mental health nurses were RNs, and 30% were RPNs. Some of these nurses were dually (RPN and RN) qualified. All of the surgical group were RNs. Approximately one quarter of both nurse groups had baccalaureate degrees in nursing. Other educational data for the sample is tabulated in Table L-5 in Appendix L.

Major findings

Quantitative analysis

The psychiatric/mental health nurses felt much more confident than did the surgical nurses in dealing with the behaviours from the vignettes. However, general concern about the behaviours and the perceived need for intervention was not significantly different between the two groups.

To arrive at these overall findings, means were computed for both groups' responses to the questions which utilized five-point rating scales (see Table 1). These questions were as follows: As a nurse, do you think that this behaviour is cause for concern? (question 2); As a nurse, do you think that anything ought to be done about this matter? (question 3); What degree of help do you think this person needs, if any? (question 4); and How confident would you feel in helping this person? (question 6). The items were asked consistently across the ten vignettes (see Appendix A). Pearson correlation coefficients showed a consistent pattern of higher correlations among the responses to questions 2, 3, and 4, across all the ten vignettes. This pattern was also seen, and to an even greater extent, among the replies to question 6. Following from this, four, three, and two-factor analyses were carried out, with the two-factor analysis showing the most definitive results. The responses to question 6 formed the first-identified factor (confidence). The responses to questions 2, 3, and 4 formed the second factor (concern/intervention).

The first factor (Eigenvalue 8.81273), with the only large and significant difference between the two nurse groups, was the source of the largest amount of explained variance (22%) between the two groups. This means that confidence in dealing with the people in the vignettes was the principal difference between the psychiatric/mental health nurses and the surgical nurses, with the psychiatric/mental health nurses exhibiting greater confidence.

The second emergent factor (Eigenvalue 7.82241), that is, the responses to the rest of the rating-scale questions 2, 3, and 4, had a common thread. It was the perception of seriousness or gravity of the portrayed behaviour and its requisite reaction from others. This factor acounted for 19.6% of the variance between the groups. A mean for the psychiatric/mental health and for the surgical nurses was computed for the second factor across all ten vignettes. The two nurse group means were then compared using a t-test. The resulting difference was nonsignificant ($p = .269$). The reasons underlying the main differences that were found will be discussed later.

Details behind the above findings will be discussed next. Comparisons between the groups for each of the questions, using an analysis of variance, were completed. Question 6 (How confident would you feel in helping this person?) produced a large and significant difference in the two group means ($p < .000$). This result supported the directional hypothesis that the psychiatric/mental health nurses would be more confident. The psychiatric/mental health nurses reported a significantly higher degree of confidence in dealing with the type of cases exemplified in the vignettes. Across all ten vignettes, results from question 2 (As a nurse, do you think that this behaviour is cause for concern?) showed no significant difference ($p = .09$) between the psychiatric/mental health and the surgical nurses (who exhibited slightly greater concern). This finding disconfirms the hypothesis that the former group would assess the behaviours as being more cause for concern. Responses to question 3 (As a nurse, do you think that anything ought to be done about this matter?) showed no significant difference ($p = .57$) between the two groups of nurses. According to the expectations of the researcher, the psychiatric/mental health nurses should have had a lower mean, signifying they felt more strongly that something should be done about the behaviour portrayed in the vignette. Results from question 4 (What degree of help do you think this person needs, if any?) showed no significant differences between the two groups ($p = .29$). A higher mean for the psychiatric/mental health nurses would have confirmed the hypothesis that nurses working in the psychiatric/mental health area would recommend a stronger degree of intervention than would the surgical nurses.

One vignette produced results which ran counter to the anticipated trends. Vignette number 5 featured a woman who saw, heard, and communicated with spirits that she said surrounded her. In this instance, there were significant differences ($p < .05$) between the psychiatric/mental health nurses and the surgical nurses' responses for each of the questions 2, 3, and 4. The psychiatric/mental health nurses showed less concern and recommended less in the way of interventions. As will be described, the vignettes portraying spirit phenomena produced notable differences in the groups' open-ended responses as well.

Table 1
Comparison of Means of Psychiatric/Mental Health and Surgical Nurses' Responses to 5-Point Rating Scale Questions for all Vignettes*

Item	Nurse	
	Psychiatric/mental health	Surgical
Scale mean for questions 2,3,4 (concern/intervention) *(second factor)*	4.04	4.16
Question 2 (concern)	4.00	4.18
Question 3 (something to be done about behaviour)	4.22	4.28
Question 4 (degree of help)	3.90	4.02
Question 6 (nurse confidence) *(first factor)*	4.03**	2.13**

* higher score means increasing magnitude; items 2, 3, and 6 rescaled to reflect this
**p< .000. Alpha at .05 two-tailed.

Qualitative Analysis

The long-answer questions supported the data from the rating-scale questions. The type of behaviour in each vignette varied greatly, and the nurses' responses varied accordingly. Five of the vignettes (numbers 2, 4, 6, 7, and 8) portrayed extreme behaviours that suggested severe mental problems, for example hearing voices, having delusions, and acting violently toward other people. For these vignettes, the two groups were very similar in their opinions regarding abnormality, mental illness, and the need for intervention. The other five vignettes in the questionnaire (numbers 1, 3, 5, 9, and 10) did differentiate somewhat more between the two groups in the above regards The answers to the open-ended questions brought out the more subtle differences between the groups. These vignettes showed less clear situations in which there might be more social problems and extenuating circumstances, for example having difficulty coping in daily life, experiencing spiritual phenomena, or being inactive and dependent. When all ten vignettes are considered, the question now emerges as to why the two nurse groups' opinions were so similar. And because there were such similarities, no further statistical analysis in this area was pursued.

In many cases the psychiatric/mental health nurses used more exact terminology or gave more detailed answers. Perhaps the best indicator of this difference between the groups is the frequency with which the surgical nurses used the generic term "counselling", whereas the psychiatric/mental health nurses suggested, for example, group therapy, psychotherapy to explore past personal issues, or a structured treatment program. The psychiatric/mental health nurses appeared to be much more familiar with the type of situations that were portrayed. This familiarity is also consistent with these nurses' greater reported confidence. Their answers tended to reflect what is routinely seen in psychiatric intervention, that is, standard practice.

Results will be reported for each of the vignettes. As previously mentioned, a series of standardized open-ended questions followed each vignette. Question 1 (see Appendix A) asked, "What do you think of this person's behaviour?". Question 5 asked, regarding intervention, "What would you suggest?".

The qualitative analysis included a coding of the responses into numerous categories determined by the data. Later, these categories were collapsed into broader categories. For instance in all the vignettes, for the question about the opinion of the

behaviour, the general concepts of "normal" and "abnormal" emerged, and it was usually possible to collapse the responses into one of these two categories. Within the "abnormal" category, a number of replies were coded under a "mental illness" label, for example psychiatric diagnoses, references to illness, sickness, or lack of touch with reality, and words such as "crazy." The mental illness category did not include personality disorders, though these were still coded as abnormal. A third category called "split" was created for items which did not clearly fall into the other two categories of normal and abnormal. "Split" had a common thread in that the replies were of a certain contradictory or conditional nature. Or, the answer to the question about opinion regarding the behaviour suggested normalcy and the answer to the question about intervention suggested that something be done. These factors made it invalid to classify these replies in the other two categories. The presence of a "split" response suggested that there were conflicting thoughts in the mind of the respondent. A large number of such responses would suggest that the group generally had difficulty in commiting to one clear stand or other. In contrast, for the question about intervention , it was always possible to categorize the responses into "intervention" or "nonintervention."

Vignette 1

Vignette 1 portrayed a woman who claims to see Jesus sometimes and to have healed others, and who at times throws herself on the floor and loudly talks to Jesus and His angels. Very few of either group of nurses thought the behaviour was "normal." Two-thirds of the psychiatric/mental health nurses deemed the behaviour abnormal, compared to about three-quarters of the surgical nurses. About half of the psychiatric/mental health nurses gave replies that connoted mental illness, which was in similar frequency to the surgical nurses (see Table 2). Generally, the psychiatric nurses used more specific or medically diagnostic terms to describe abnormal behaviours. About one-third of the former group gave ambiguous responses which were coded in the "split" category, compared to half this frequency for the surgical nurses.

In both groups, the vast majority recommended intervention (see Table 3). A small number of the surgical group stated that they did not know what should be done, compared to none of the psychiatric/mental health group. Generally, the mental health nurses suggested more numerous and specific types of interventions. For instance, they mentioned categories of help such as the use of inpatient versus outpatient treatment, support from friends, and help from a nurse. Various nursing approaches for the lady in the vignette were also supplied, such as: getting her into therapy, using gentleness, having a nonthreatening manner, orienting to reality, never offering advice, remaining calm, being consistent with her, talking, validating, clarifying, and refocusing her in regard to her beliefs and their effect on her life.

The psychiatric/mental health nurses were much more likely to recommend medical attention, assessment, and medications, in addition to using the children to get their mother to receive help. Though the vignette focused on one character, just under half of both groups expressed concern for the welfare of the children.

Table 2
Percentages of Nurses' Responses to "What do you think of this person's behaviour?", Vignette 1 (woman with religious behaviours)

Category	Nurse	
	Psychiatric/mental health	Surgical
Normal	3.3%	7.9%
Abnormal	66.7%	76.3%
Mentally ill	56.7%	52.6%
Don't know	0%	2.6%
Split	30%	13.2%
Total	100%	100%

Table 3
Percentages of Nurses' Responses to "What would you suggest?", Vignette 1 (woman with religious behaviours)

Item	Nurse	
	Psychiatric/mental health	Surgical
Intervention	96.6%	92.3%
No intervention	3.4%	2.6%
Don't know	0%	5.1%
Total	100%	100%

The following paragraphs will describe the findings in greater detail. Question 1 (opinion of the behaviour) was answered by all of the psychiatric/mental health nurses. One of these nurses thought that the behaviour was within the range of "normal," saying, "Many...TV religious leaders claim to heal people too, I think nothing of her behaviour...could be describing a female Jimmy Swaggart- he does the very SAME things." The surgical nurses (n=38) all responded to question 1 with one exception. Two respondents' answers were rated in the "normal" category, replying with descriptions such as "coping behaviour"; and "appropriate." One response was "I don't know."

Twenty of the psychiatric/mental health nurses gave responses that were categorized as "abnormal." These responses included "hasn't coped", "abnormal", "eccentric", "excessive." A number of responses in the "abnormal" category were coded by this researcher as a "mentally ill" subcategory (56.7% of total n). For this vignette, this category included descriptions like "delusional", "grandeur", "psychotic", "hallucinated", "schizophrenic," and "religiose." These are descriptions that would be found in a psychiatric/mental health nursing textbook used to describe psychopathology.

Vignette 1 portrayed abnormal behaviour in the opinion of 32 surgical nurses. Descriptors used by these nurses included "inability to deal with reality"; "abnormal"; "not coping"; "excessive"; and "odd." The "abnormal" category also included the "mental illness" category descriptors, such as "delusions"; "lost touch with reality"; "hallucinating"; " crazy"; "schizophrenic"; "psychotic"; "unstable"; and "mentally

disturbed." A number of these descriptors were identical to those used by the psychiatric/mental health nurses.

The "split" category represented nine of the psychiatric/mental health nurse respondents; sample responses included: "strange, not unusual... assess further if delusions are involved"; "a coping mechanism, which has potential to escalate"; "committed to religion to find inner peace...to attend outpatient clinic";."as a result of losing husband, I believe that she's histrionic"; "strange, bordering on mental illness... not of great concern except that she may be neglecting her children"; and "unusual coping mechanism- investigation warranted- is she ill?" To some of these nurses, the behaviours were warning signs, not sufficient in themselves to label a person as ill.

The "split" category was assigned to the responses of three surgical nurse respondents. They used descriptors such as: "She has turned to a good source of help, but sounds somewhat fanatical- [needs] counselling"; "religion is OK but not if the children are neglected"; "somewhat unusual- but perhaps is compensating for feelings of worthlessness"; "although her faith is important, she seems to overdo it"; "wierd person-the church should have a stern talk with her-- many religions have members who exhibit this type of behaviour." These nurses seemed ambivalent toward the effect of religion on mental illness.

Question 5 asked what should be done, if anything. There were 29 replies to this question from the psychiatric/mental health nurses, with one missing. There were no replies of "I don't know." Intervention of one type or another was recommended in 28 cases.

All 39 surgical nurses answered question 5 about what should be done. Two stated that they didn't know. One nurse's response was not to intervene, "Unless there is a case of potential harm to herself or her children I would not interfere." Thirty-six surgical nurses' responses were coded in the "intervention" category. The results for the two groups are tabulated in Appendix B.

Vignette 2

This vignette described a suspicious man who had ideas of reference and made threats and committed violent acts against others. The nurses were all definite about their ratings; the man in the vignette was showing abnormal behaviour, and they all felt intervention was required (see Table 4).

A large majority of the psychiatric/mental health nurses saw this abnormality as mental illness, as did the surgical nurses. The psychiatric/mental health nurses used more varied terms to describe this person's behaviour, whether or not they placed him in the "mental illness" category. They made more references that the man was not likely to cooperate with others.

Both groups unanimously felt that some sort of intervention was in order (see Table 5). The psychiatric/mental health nurses recommended certification under the Mental Health Act, the use of medications, hospitalization, and help/therapy/treatment interventions, much more often than did the surgical nurses. This difference might reflect greater familiarity with these treatment modalities. The psychiatric/mental health nurses also recommended help for the wife slightly more often than did the surgery group. This difference, too, might reflect more experience with the routine interventions that are used in this area. Generally, this was one of the vignettes which garnered the most unequivocal data from both groups of nurses.

Table 4
Percentages of Nurses' Responses to "What do you think of this person's behaviour?", Vignette 2 (man with suspicious and violent behaviours).

Item	Nurse	
	Psychiatric/mental health	Surgical
Normal	0%	0%
Abnormal	100%	100%
Mentally ill	83.3%	76.9%
Split	0%	0%
Don't know	0%	0%
Total	100%	100%

Table 5
Percentages of Nurses' Responses to "What would you suggest?", Vignette 2 (man with suspicious and violent behaviours).

Item	Nurse	
	Psychiatric/mental health	Surgical
Intervention	100%	100%
No intervention	0%	0%
Don't know	0%	0%
Total	100%	100%

There were 30 replies to question number 1 from the psychiatric/mental health nurses. One nurse requested more information than the vignette provided. The data from these nurses was all categorized into the "abnormal" category. There were no "normal" or "split" categories emerging from this vignette.

A "mentally ill" category related to 25 of the 30 replies. The terms that were coded for this category included: "paranoid"; "delusional"; "schizophrenia, persecutory type"; "certifiable under the Mental Health Act"; "psychotic"; "hallucinated"; "thought disordered"; "pathological"; "ill"; and "crazy." Other comments not coded in the "mentally ill" category included items such as "dangerous"; "potential"; "insecure"; "homicidal"; "inappropriate"; "abusive"; "scared"; "unpredictable"; and "demented possibly from a tumour."

Among the replies from the surgical nurses (n= 39, with no missing, "I don't know," or "need more information" responses), none fell into categories of "normal" or "split. Thirty responses were categorized as "mentally ill" and were as follows: "paranoid"; "schizophrenic"; "psychotic"; "delusional"; and "neurotic." Other responses (abnormal, but not coded as "mentally ill") included: "dangerous"; "scary"; "inappropriate"; "irrational"; "unstable"; "unacceptable behaviour"; "odd"; "abnormal"; "and "organic."

Item 5 was answered by 29 of the 30 psychiatric/mental health nurses . There was one missing reply, and no replies of "I don't know." All 29 responses fell into the category of "intervention." No one asked for more information.

Question 5 (interventions) for this vignette was answered by all 39 surgical nurses. There were no missing or "I don't know" replies. All the responses fell into the "intervention" category. The breakdown of the interventions specified by both groups, is tabulated in Appendix C.

Vignette 3

This vignette described a young woman with dependent and dramatic behaviours, who was jailed for soliciting on the street and who has difficulty in caring for her two children. The behaviours and circumstances in this vignette are not very straightforward and the results show less agreement among the respondents in general (see Table 6). The psychiatric/mental health nurses were polarized, seeing both normalcy and abnormality more of the time, whereas more of the surgical group's responses were coded in the "split" category. "Immature" was a descriptor used by the psychiatric/mental health nurses more often than the surgical nurses. Generally the psychiatric/mental health nurses used a greater range of terms to describe how they evaluated the character in the vignette. Several commented that often this type of person was not very motivated to change. None of the surgical group had comments in this regard, possibly because they do not recognize behaviour such as this.

Though similar numbers of both groups suggested interventions, the profiles for those suggested interventions were quite different in this vignette (see Table 7). Counselling was recommended by almost one-quarter of the psychiatric/mental health nurses, compared to about two-thirds of the surgery nurses. When no details were added by the respondent, "counselling" was coded as a more generic term. About half of the psychiatric/mental health nurses identified "therapy", versus about one-quarter for the surgical nurses. While this category meant a support group for the surgical nurses, the psychiatric/mental health nurses listed more details: "rehabilitation"; "psychotherapy to improve self awareness, problem-solve, and explore possible past sexual abuse"; "life skills"; and "behaviour therapy."

The psychiatric/mental health nurses were much more likely to suggest certain modes of intervention. They were: therapy, treatment, medications, assessment, "psych," support, and social services. In two areas the groups were very similar: the recommendation of help for the children, and of education for the woman. Some interventions were recommended more often by the surgery nurses. They mentioned the need for a role model or authority figure in a few cases, while the other group never identified this intervention. Financial help was recommended by about one-quarter of the surgery nurses compared to about one-sixth of the psychiatric/mental health nurses. Job training was listed by one-quarter of the surgery nurses, versus very few of the psychiatric/mental health nurses. Overall, the response profiles of the two groups for this vignette are quite different. More psychiatric/mental health nurses were likely to see this as a situation of abnormality requiring treatment, while more surgical nurses tended to see it as a social problem requiring nonpsychiatric type of help. Again, these perceptions may be a reflection of the use of routine procedures in the nurses' respective areas of work.

Table 6
Percentages of Nurses' Responses to "What do you think of this person's behaviour?", Vignette 3 (woman with dependent and dramatic behaviours)

Item	Nurse	
	Psychiatric/mental health	Surgical
Normal	13.8%	2.9%
Abnormal	48.3%	20.6%
Mentally ill	0%	5.9%
"Split"	37.9%	76.5%
Total	100%	100%

Table 7
Percentages of Nurses' Responses to "What would you suggest?", Vignette 3 (woman with dependent and dramatic behaviours)

Item	Nurse	
	Psychiatric/mental health	Surgical
Intervention	96.3%	100%
No intervention	3.7%	0%
Total	100%	100%

Twenty-nine of the thirty psychiatric/mental health nurses responded to question 1. Four replies fitting the category of "normal," were listed as: "not too abnormal considering her emotional and physical hardships"; "is having difficulty caring for herself and her kids- probably hasn't learned the skills"; "her crying is reacting to her situation"; "needs appropriate resources and some parenting skills"; "meets her needs in the best way that she can- is able to relate to her environment." Among the surgical nurses, there were five missing replies (n= 34). Two nurses asked for more informaton. One surgical nurse stated, "This lady's not crazy- she doesn't have psychiatric problems." This was rated as a "normal" response.

An "abnormal" category was seen for fourteen of the psychiatric/mental health nurses. Comments here were: "personality devations"; "decompensating"; "personality disorder, possibly inadequate"; "labile"; "rather severe adaptive responses"; "severely emotionally disturbed"; "some borderline personality features"; "would benefit from psych care." Some of these nurses also questioned the presence of depression, anorexia nervosa, and past childhood abuse. Seven of the surgery nurses responding did so in a way that was coded "abnormal." Comments included: "very disturbed"; "can't cope with life"; "should rule out psych problems"; "needs psych help"; "needs psych counselling"; "needs psych assessment"; "needs psychiatrist." Among these, one reply was categorized as "possibly mentally ill" ("it would be wise to rule out psychiatric problems"); and one was categorized as "mentally ill" ("depressive, unstable, suicidal"). Several replies ("immature and childish"; "brought on by stress and social condition"; "not socially acceptable to society or her children"; and "unstable") were put in the "abnormal" category when the respondent also suggested "psych" help of one sort or another.

A "split" category emerged for eleven.of the psychiatric/mental health nurses. These replies did not explicitly state an opinion of normal or abnormal, and were sometimes nebulous (for example, "unfortunate situation; poor coping"). In a number of replies, while the comments were somewhat noncommittal, there were suggestions of some type of intervention. This was a characteristic used to help determine whether a response was coded "split." Other comments characteristic of this type were "unable to maturely conduct herself successfully in society"; "ineffective coping"; "maturational crisis"; "weak and incompetent"; "poor life skills"; "lonely and desperate for help"; "it is a social problem"; "the streets are full of people like this"; and "chronic low self esteem." Twenty-six of the surgical nurses' responses fell into the "split" category. These included: "a cry for help"; "coping attempts"; "low self esteem"; "insecure"; "immature"; "situational"; "unstable"; "sad." Again, a nurse might not have commented much on the person's behaviour, but may have suggested intervention all the same.

Question 5 regarding intervention was answered by 27 out of 30 psychiatric/mental health nurse respondents. There were no "I don't know" replies. One reply was "no intervention unless requested or unless children suffering from neglect" (a "nonintervention" category). The other 26 replies fell into the "intervention" category.

For question 5, there were four missing responses from the surgical group, which resulted in an n of 35. None of these nurses suggested "no intervention." There were a number of differences between the two groups. Please see Appendix D for these comparisons.

Vignette 4

This was a vignette of a man who thinks that he receives messages into his head through electrical waves, and who repeatedly contacts the government to warn of impending nuclear attacks. The two nurse groups were quite different in their assessment of the man. While all the nurses saw the behaviours as abnormal, the psychiatric/mental health nurses felt that there was mental illness present in a large majority of cases, compared to about two-thirds of the surgical group (see Table 8). More of the psychiatric/mental health nurses commented that they thought the man was harmless, than did the surgical nurses.

Both groups were unanimous about the need for intervention (see Table 9). Six of the psychiatric/mental health nurses suggested a doctor or psychiatrist, while none of the other group did. The surgical group used the "psych" category much more often, for example, "psych help, treatment, counselling." The psychiatric/mental health nurses specifically mentioned both hospitalization and outpatient treatment for the man, as well as various nursing aspproaches, much more often than did the surgical nurses. The biggest difference was that the former group specified the use of medication more than twice as often as did the latter group. Overall, the psychiatric/mental health nurses again showed more familiarity with standard practice and experience nursing clients depicted in this type of scenario.

Table 8
Percentages of Nurses' Responses to "What do you think of this person's behaviour?", Vignette 4 (man who claims to receive electrical messages into his mind).

Item	Nurse	
	Psychiatric/mental health	Surgical
Normal	0 %	0%
Abnormal	100%	100%
Mentally ill	83.3%	69.4%
Split	0%	0%
Total	100%	100%

Table 9
Percentages of Nurses' Responses to "What would you suggest?", Vignette 4 (man who claims to receive electrical messages into his mind).

Item	Nurse	
	Psychiatric/mental health	Surgical
Intervention	100%	100%
No intervention	0%	0%
Total	100%	100%

All of the 30 psychiatric/mental health nurses responded to question 1, and all thought this man was displaying abnormal behaviour. Of these, 83.3% of the responses connoted mental illness ("paranoid delusions"; "psychotic"; "thought disorder"; "paranoid"; "has ideas of reference"; "schizophrenic"; "thought insertion"; "auditorily hallucinating"; "premonitionary ideations"). Descriptors not fitting into the "mental illness" category included "harmless"; "probable resistance to treatment"; "disturbed"; "potential for increased danger if condition worsens"; "a nuisance"; "abnormal"; "odd"; "and lonely, anxious, and/or frustrated."

The surgical nurse group had three missing replies which left an n of 36, all of which fell in the "abnormal" category. Twenty-five (69.4%) of these were in the "mental illness" subcategory, and terms were used as follows: "delusional", "psychiatric disorder", "paranoid", "schizophrenic", "psychotic", "hallucinating." Other descriptors outside of the "mental illness" subcategory were: "abnormal", "potential for danger", "harmless", "a nuisance", "odd", "unstable", "needs psych help", "lonely", "insightless." Two (7.7%) expressed puzzlement at trying to understand what an experience this man must be having.

Question 5, referring to interventions ("What would you suggest?") among the psychiatric/mental health nurses, there were two missing responses, giving an n of 28. Of these, all suggested some sort of intervention. Among the surgical nurses, there were two missing replies and one reply of "???," leaving an n of 36. All suggested some sort of intervention. The frequencies and descriptions of the two groups' suggested interventions are tabulated in Appendix E.

Vignette 5

In this vignette, a woman hears and interprets spirit messages in episodes that last from a few hours to several weeks. Overall, the surgical nurses all saw abnormality, while the psychiatric/mental health nurses were more divided (see Table 10). Of the latter group, more saw the behaviour as representing mental illness.

All the surgical nurses recommended interventions, and a large majority of the psychiatric/mental health nurses (see Table 11). The main differences noted for this vignette were that the surgical nurses recommended the "psych" category more often, as well as assessment, hospitalization, and counselling. The psychiatric/mental health nurses recommended medication more often, as well as "intervention only if..." Additionally, the psychiatric/mental health nurses recommended several items which the surgical nurses did not, namely outpatient services, treatment, support, and neurological assessment. Though the vignette represents behaviour that is out of the ordinary, the psychiatric/mental health nurses were less apt to label and treat it as such. Perhaps this is because they see a number of people with minimal or borderline hallucinatory symptoms who do not receive immediate or intense attention.

Table 10
Percentages of Nurses' Responses to "What do you think of this person's behaviour?", Vignette 5 (woman who hears and interprets spirit messages).

Item	Nurse	
	Psychiatric/mental health	Surgical
Normal	3.3%	0%
Abnormal	73.3%	100%
Mentally ill	70.0%	59.4%
Split	23.3%	0%
Total	100%	100%

Table 11
Percentages of Nurses' Responses to "What would you suggest?", Vignette 5 (woman who hears and interprets spirit messages).

Item	Nurse	
	Psychiatric/mental health	Surgical
Intervention	80.7%	93.3%
No intervention	15.6%	0%
Don't know	3.7%	6.7%
Total	100%	100%

All 30 of the psychiatric/mental health nurses responded to the number 1 question (what they thought of the behaviour). One nurse replied: "Not a lot. Maybe she has spiritual abilities- who knows? Ever heard of Edgar Cayce? Are these experiences causing her or family great distress?" This response was coded as "normal."

The surgical nurse group had four nonresponses and three who indicated "I don't know" in answer to question 1, leaving an n of 32. There were no "normal" or "split" categories emerging.

Twenty-two of the 30 replies from the psychiatric/mental health nurses were coded as "abnormal." A "mentally ill" category emerged in 21 responses. Comments fitting here were: "schizotypal"; "psychotic"; "mood disorder with sensory-perceptual alterations"; "derealization"; "possible catatonic schizophrenia"; "suspect organicity/toxicity as much as psychosis"; "hallucinated"; "mentally ill." Other "abnormal" comments that were not rated as "mentally ill" were:"cause for concern"; "inappropriate"; "odd"; "unusual."

All of the surgical nurses' perceptions of the behaviour were coded "abnormal". Of the total sample, 19 replies were in the "mentally ill" category, with comments such as: "delusional"; "schizophrenic"; "starting to be crazy"; "hallucinated"; "psychotic"; "has lost touch with reality"; "another psychiatry case." Other comments not in the "mentally ill" field were:"cause for concern, but seems to deal with life"; "concerned about suicide"; "could become uncontrollable"; "odd"; "abnormal"; and "inappropriate."

Seven responses from the psychiatric/mental health nurses were coded as "split". Comments here were: "Odd/interesting. I don't know enough about the supernatural nor can I prove it's (sic) existence or disclaim it"; "May be other symptoms too...assess"; "Odd- support and ensure activities with other people"; "A bit bent- help only if same asked for"; "May be hallucinating or having a religious experience- regardless of one's beliefs, it doesn't seem problematic"; and "Behaviour is an attempt to meet her needs-requires outpatient treatment." As with the other vignettes, this category contained conditional or ambiguous replies.

Question 5 regarding what should be done was answered by 27 of the 30 psychiatric/mental health nurses. One indicated "?" and three did not answer the question. Five of those responding gave replies that were coded as "nonintervention." These replies were:"Intervention only if requested"; "need to gather more information"; "I don't believe that much will be accomplished by treating her with meds or hospitalization"; "Explore what these episodes mean to her and what she wants"; "Unless patient is troubled then is no need to interveen (sic) in her life." Suggestions for intervention came from 26 of the psychiatric/mental health nurses.

Question 5 was answered by 29 of the 39 surgical nurses (74.4%). There were two "I don't know" and eight missing replies. All responses were coded as "intervention." These and other responses are summarized in the table in Appendix F which compares both groups.

Vignette 6

In this characterization, a woman neglects her children, is tearful for hours at a time, feels that her deeds have harmed thousands of others, considers suicide, and does not perform personal hygiene. Both groups felt that the behaviour was abnormal (see Table 12) and in need of intervention (see Table 13). The psychiatric/mental health nurses described mental illness and suggested hospitalization, urgent action, help for the husband, support, medication, therapy, and certification much more than the other group. While both groups suggested medical intervention, the psychiatric/mental health nurses mentioned social services and nursing intervention more often. Both groups in similar numbers recommended ECT (electroconvulsive therapy). The surgical nurses used the "psych" category of interventions, as well as counselling and treatment, much more than did the other nurses. Both nurse groups commented on the severity of the problem in roughly equivalent amounts. In this vignette, the particulars are quite clear-cut, and both groups responded accordingly. However, the psychiatric/mental health nurses again show a greater specificity in their response to the situation. Indeed, scenarios such as this are often seen on the psychiatry units.

Table 12
Percentages of Nurses' Responses to "What do you think of this person's behaviour?", Vignette 6 (woman with depressed and nihilistic ideation).

Item	Nurse	
	Psychiatric/mental health	Surgical
Normal	0%	0%
Abnormal	100%	100%
Mentally ill	82.8%	69.4%
Split	0%	0%
Total	100%	100%

Table 13
Percentages of Nurses' Responses to "What would you suggest?", Vignette 6 (woman with depressed and nihilistic ideation).

Item	Nurse	
	Psychiatric/mental health	Surgical
Intervention	100%	100%
No intervention	0%	0%
Total	100%	100%

Question 1 was completed by 29 of the 30 psychiatric/mental health nurses. All 29 were coded as "abnormal." Of the responses, 24 (82.8%) were classified as "mentally ill." The main descriptors were: "suicidal"; "depressed"; "paranoid"; "psychotic"; "catatonic"; "thought disordered"; "schizophrenic"; "delusional." Half of this group (41.4%) also commented on the severity of what was being portrayed: ("very sick"; "this person is in trouble!"; "illness is possibly life threatening"; "major depression"; "severe"; "disabled".

The rest of the responses, though definitely abnormal, were not coded under the "mentally-ill" category. The psychiatric/mental health nurses used the following words:"suicidal"; in danger"; "needs help"; "concerned for the children"; "poor self-esteem"; and "inappropriate."

Among the surgical nurses, there were three missing responses, giving an n of 36. Like the psychiatric/mental health nurses, the surgical nurses all thought that this was abnormal behaviour. Of the total, 25 characterized the woman as suffering from a mental illness. Major descriptors used were: "depressed"; "delusional"; "possibly suicidal"; "paranoid"; "postpartum depression or nervous breakdown"; "schizophrenic." The severity of the disorder was commented upon by 13 of the nurses, who stated, "very depressed"; "needs psychiatric help!"; "profoundly depressed"; "dangerous to herself"; "big problem"; "severe"; and "+++ depressed." The rest of the responses did not specifically connote mental illness. Included were: "suicidal", "concern for the children", "needs help", "potentially dangerous", "poor self-esteem", "odd", "disturbed."

Question 5 ("What would you suggest?") was answered by 28 of the psychiatric/mental health nurses. All suggested an intervention, the commonest being

hospitalization, medications, help for the children, "psych" interventions, and certification under the Mental Health Act.

For the surgery nurses, question 5 was answered by 36 of the 39 respondents. All 36 suggested some sort of action, the main ones being "psych" interventions: hospitalization; counselling; help for the children; medications; and treatment. A more detailed listing of interventions can be found in Appendix G, where the two groups of nurses are compared.

Vignette 7

This vignette portrayed a quiet man who did not trust people, who drank every day, and who on occasion verbally and physically abused his wife and committed other violent acts. Almost every one of the psychiatric/mental health nurses and a large majority of the surgical nurses rated the behaviour as abnormal. Fewer of the psychiatric/mental health nurses' responses were rated "split " (see Table 14). Two-thirds of this same group mentioned alcoholism compared to half the surgical nurses. Just under half of both groups commented about dangerousness. More surgical nurses regarded the man in the vignette as mentally ill; this differs from the other vignettes, where the psychiatric/mental health nurses tended to see more mental illness. A few psychiatric/mental health nurses commented that this sort of situation was common, whereas none of the other group did. All of the nurses in both groups suggested intervention (see Table 15). The term "counselling" was referred to in terms of individual and family. The surgical group mentioned individual counselling much more and family counselling less, whereas the psychiatric/mental health nurses were equally divided in their suggestions for each.

The surgical nurses did not recommend treatment/detoxification nearly as often as the other group. However, similar numbers in both groups specifically mentioned Alcoholics Anonymous. A small number of the psychiatric/mental health nurses mentioned the possibility of the wife's leaving, while the other group did not. The psychiatric/mental health nurse group also recommended the "psych" interventions significantly more than did the other group. The same case was true with regard to "support." While the two groups recommended help for the wife in similar numbers, the psychiatric/mental health nurses recommended help for the family members more often. For this vignette, the surgical nurses seem to be quite well-acquainted with alcoholism and its treatment. The psychiatric/mental health nurses are too; however, they also show more familiarity with its psychosocial concomitants.

Table 14
Percentages of Nurses' Responses to "What do you think of this person's behaviour?", Vignette 7 (man with daily drinking and abusive behaviours).

Item	Nurse	
	Psychiatric/mental health	Surgical
Normal	0%	0%
Abnormal	96.6%	85.7%
Mentally ill	24.1%	28.6%
"Split"	3.4%	14.3%
Total	100%	100%

Table 15
Percentages of Nurses' Responses to "What would you suggest?", Vignette 7 (man with daily drinking and abusive behaviours).

Item	Nurse	
	Psychiatric/mental health	Surgical
Intervention	100%	100%
No intervention	0%	0%
Total	100%	100%

Question number 1 for this vignette was answered by 29 of the 30 psychiatric/mental health nurses. None of the responses were coded as "normal." There was one "split" category response. This nurse described the man as having ineffectual coping skills and low self esteem (not enough to code as necessarily "abnormal"), and then recommended marriage counselling and group therapy. This characteristic of "split" coding is the same as seen in some of the other vignettes.

Thirty-five of the 39 surgical nurses responded to question 1 (opinion of the behaviour). None of the responses were coded as "normal." There were three "split" answers, such as "he does not feel very good about himself and his behaviour reflects this"; "needs to grow up or has low self esteem"; "not too much different from what happens in Edmonton."

Twenty-eight of the psychiatric/mental health nurses gave replies which were coded as "abnormal." Of these, seven were coded as "mentally ill." Descriptors seen were: "depression", "psychotic", "possibly a mental illness," and "mildly schizotypal." Nineteen of the assessments said that the man was alcoholic. Other comments concerned dangerousness, questionable insight, poor self esteem, anger, concern for the wife and family, a personality disorder, and a lack of control.

Thirty-two of the surgical nurse responses were coded as "abnormal." Mental illness ("depressed", "paranoid", "has psychiatric problems", "crazy") was mentioned by ten of the surgical nurses, alcoholism by 20, and abuse/aggression/danger by 15. Other comments included concern for wife and family, the unacceptability and inappropriateness of the behaviour, its commonness, anger, poor self esteem, and the need for treatment only if he would accept and act upon it.

Question 5 asking about intervention was answered by 29 of the psychiatric/mental health nurses. One hundred percent of these fell into the

"intervention" category. The most common ones were treatment/clinic/detoxification, therapy, "psych" interventions, and help for his wife and family.

Five missing responses to question 5 put the surgical nurses' n at 34. All of these suggested some sort of intervention. The replies of both groups of respondents are tabulated in Appendix H.

Vignette 8

Exemplified in this vignette is a young female adult who stopped school after she began being tearful, afraid and withdrawn. She screams nonsense at her parents, and states that she hears voices. In both nurse groups the vast majority identified the behaviour as abnormal (see Table 16). The surgical group had "split" responses more often than the psychiatric/mental health nurses, though these were both in low numbers. The psychiatric/mental health nurses saw mental illness much more often. Both groups recommended intervention almost in total (see Table 17). The psychiatric/mental health nurses suggested the use of medications twice as often as the surgical nurses. The same is true with hospitalization, treatment, use of a doctor/psychiatrist, and support. This former group recommended, more than did the surgical group, that the family receive help and also that they help the girl in the vignette. As has been seen with some of the other vignettes, the surgical nurses used the generic term "counselling" much more often than the other nurses. Also of note is the mention by one of the surgical group that a nurse be used as a helper. In this vignette, a psychotic episode, the psychiatric/mental health nurses in their responses reflected what they see in practice. Almost one-quarter of this group mentioned that the situation appeared to be classic initial or prodromal schizophrenic symptomatology.

Table 16
Percentages of Nurses' Responses to "What do you think of this person's behaviour?", Vignette 8 (woman with withdrawn and hallucinatory behaviours).

Item	Nurse	
	Psychiatric/mental health	Surgical
Normal	0%	0%
Abnormal	96.7%	94.1%
Mentally ill	86.7%	64.7%
"Split"	3.3%	5.9%
Total	100%	100%

Table 17
Percentages of Nurses' Responses to "What would you suggest?", Vignette 8 (woman with withdrawn and hallucinatory behaviours).

Item	Nurse	
	Psychiatric/mental health	Surgical
Intervention	100%	97.0%
No intervention	0%	0%
"??" re: intervention	0%	3.0%
Total	100%	100%

All of the psychiatric/mental health nurses responded to the number 1 question regarding their opinion of the behaviour (n= 30). None found it "normal." One response was coded as "split" in that the behaviour was "unpredictable" and the recommendation was "hospitalization."

Among the surgical nurses, five respondents did not answer question 1, which meant an n of 34. None found the behaviour "normal." Two nurses' answers fit into the "split" description: "withdrawn, needs counselling"; and "certainly needs help... what happened to change her behaviour? Needs therapy, family counselling."

Twenty-nine of the thirty psychiatric/mental health nurses felt that this behaviour was definitely "abnormal." Descriptors included"withdrawing", "depersonalization", "disociative disorder- multiple personality," and "abnormal- she needs help." Mental illness was connoted in 26 of the group. The nurses used terms like: "ill"; "schizophrenic- classic initial symptomatology"; "psychotic- hallucinations, depersonalization"; and "command hallucinations."

Thirty-two of the surgical nurses categorized the behaviour as "abnormal." Descriptors included "abnormal and requires immediate help"; "inappropriate"; "very big emotional problem"; "abused? assaulted? difficulty at school? poor self esteem"; "withdrawn"; "strange- problem"; "split personality?" "problems are due to precipitating events." Mental illness was suggested in 22 of all the replies ("psychotic", "schizophrenic", "hallucinating", "paranoid", "out of touch with reality").

Question 5 regarding intervention was answered by 29 of the 30 psychiatric/mental health nurses; it was recommended in all cases. This same question was answered by 33 of the surgical group. One surgical nurse replied, "??." The remainder of the surgical respondents felt that some sort of intervention was required. A detailed tabular summary of the replies of the psychiatric/mental health and the surgical nurses is presented in Appendix I.

Vignette 9

The character in this vignette is a 45-year-old married male who is moody, unemployed, letting his wife do everything for him, complaining of physical pains, doctor shopping, and taking "nerve medicine". More surgical nurses' assessments of the behaviour fell in the "normal" range with fewer "split" codings, than did those of the psychiatric/mental health nurses. Both groups in similar numbers gave responses that were coded as "abnormal". More psychiatric/mental health nurses indicated that mental illness was present (see Table 18). In both groups, where mental illness was suggested, it almost always centred around depression. A few psychiatric/mental health nurses recommended intervention "only if he was willing to change or get help," versus none of the surgical group. Both nurse groups suggested intervention in all cases. The psychiatric/mental health nurses specified therapy (plain, group, psycho-, or family) much more often than the surgical nurses. This same pattern was also true in the cases of medications, doctor/psychiatrist, and career intervention. The psychiatric/mental health nurses recommended both doctors and psychiatrists, whereas the surgical nurses recomended only psychiatrists.

Half of the surgical nurses recommended counselling (which included exploring problems and talking to the man, as well as the word "counselling" itself), compared to a minimal number of the other group. It is to be noted that there was some overlap in the "counselling" and "therapy" categories.

Two nurses in the surgical group identified suicide as a possible concern. One surgical nurse said the man needed a "kick in the ass" and one other commented that he should be "kicked out of the house."

That the psychiatric/mental health nurses saw less normality, more pathology, and gave more "split" replies suggests two things. Firstly, the vignette is a less well-

defined situation compared to some of the others; elements of it suggest a personality disorder but there may well be some extenuating physical circumstances or a crisis period in his growth and development. Secondly, these nurses see this sort of case more often; the profile of their recommended interventions supports this idea as well.

Table 18
Percentages of Nurses' Responses to "What do you think of this person's behaviour?", Vignette 9 (unemployed man with moody and physically complaintive behaviours).

Item	Nurse	
	Psychiatric/mental health	Surgical
Normal	3.4%	15.2%
Abnormal	79.3%	75.8%
Mentally ill	75.9%	60.6%
"Split"	17.2%	9.1%
Total	100%	100%

Table 19
Percentages of Nurses' Responses to "What would you suggest?", Vignette 9 (unemployed man with moody and physically complaintive behaviours).

Item	Nurse	
	Psychiatric/mental health	Surgical
Intervention	100%	100%
No intervention	0%	0%
Total	100%	100%

Twenty-nine of the 30 psychiatric/mental health nurses answered the behaviour opinion question. One respondent's reply was coded as "normal", saying "I need more info'; perhaps he is moody b/c the pain...trouble with nerves? Expand on this! Is there genuine medical concern with his back, legs and what's cooking with his nerves?" This response could not be sorted into either the "abnormal" or "split" categories.

The surgical group had an n of 33. Five of the responses were coded as "normal". Comments here were "He needs an ego boost and job placement"; "male menopause...needs a kick in the ass!"; "may be something bothering him or he may just be lazy"; "doesn't want to grow old"; and "a lazy bum."

Five of the psychiatric/mental health nurse responses were coded as "split": "unfortunate...needs psychotherapy"; "apathetic...needs group therapy"; "sense of worth is declining...enrollment in a support group"; "lack of energy and physically run down...consult to psych"; "mid-life crisis...could do with antidepressants."

Three surgical nurse responses were coded "split". These, like in the other vignettes, had equivocal elements, for example, "it is a reaction to something, it could be physical...needs counselling to find what he feels is causing his nerve problem"; "poor self esteem...explore why problems with nerves"; "dependent...needs counselling."

Twenty-three replies from the psychiatric/mental health nurses were coded as "abnormal". Comments included, "somatization disorder"; "anxiety disorder";

"dependent personality disorder"; "apathetic"; "passive"; "withdrawn"; and "?drug abuse." Among the "abnormal" responses were 22 "mentally ill" ratings. Descriptors used here included "possibly has a mental illness"; "needs assessment for possible illness...explore feelings, coping skills"; "he is ill & needs treatment...psychotherapy" in three of these 22 cases. The other 19 of the 22 specifically identified depression.

Twenty-five of the responses from the surgical nurses were coded as "abnormal". Descriptors used were expressions such as "irrational problem is causing him the physical pain"; "emotional problems which he translates into physical ailments"; "abnormal"; "psychosomatic, unstable, suicidal"; "needs psych help." Twenty of the surgical group gave replies which were coded as "mentally ill". All of these spoke of depression.

For question 5 concerning what should be done in the case, 28 of the 30 psychiatric/mental health nurses responded. All of their replies were coded as "intervention." The same question was answered by 33 of the surgical nurses, with six not responding. They, too, all suggested "intervention." The responses of both groups of nurses to the intervention question are tabulated in Appendix J.

Vignette 10

The central figure in this account is a rather excitable but friendly 27 year old man who occasionally sees and speaks to his deceased mother. More of the surgical nurses saw the behaviour as being normal, and one person from this group didn't know. More of the psychiatric/mental health nurses thought the man was acting abnormally. About one-third of both groups were of the opinion that the man was mentally ill (see Table 20). A small, similar percentage of each nurse group gave "split" replies.

A large majority of the psychiatric/mental health nurses and all of the surgical nurses felt that something should be done in this case. The almost 15% split between the two groups was the largest encountered in this category. The psychiatric/mental health nurses commented more often about intervention *only if* the man wanted it or if the behaviour became of increasing concern (see Table 21). This group also more often recommended the use of medications. The surgical nurses, on the other hand, recommended counselling and "psych" (psychiatric, psycho-, psych-) interventions much more. One surgical nurse recommended a novel approach: "Have a 'pretend' seance and let him think that his mother is retiring to another sphere & won't be seeing him again."

The details of this vignette are not very clear, compared to some of the others. The man is not functionally impaired day-to-day; his behaviour is not constant and he is not a danger to self or others. Both groups are hesitant to label the behaviour; they see little harm in it, and often comment that grief is a factor here. Also to be noted is that this is the final vignette of a long questionnaire, and perhaps the responses reflect a factor of fatigue from the respondents.

Table 20
Percentages of Nurses' Responses to "What do you think of this person's behaviour?", Vignette 10 (man who sees and communicates with his deceased mother).

Item	Nurse	
	Psychiatric/mental health	Surgical
Normal	7.1%	15.6%
Abnormal	82.1%	71.9%
Mentally ill	32.1%	31.3%
Split	10.7%	9.4%
"?" (don't know)	0%	3.1%
Total	100%	100%

Table 21
Percentages of Nurses' Responses to "What would you suggest?", Vignette 10 (man who sees and communicates with his deceased mother).

Item	Nurse	
	Psychiatric/mental health	Surgical
Intervention	85.2%	100%
No intervention	14.8%	0%
Total	100%	100%

Question 1 which asked for opinions of his behaviour was answered by 28 of the 30 psychiatric/mental health nurses. Two of the replies were classified in the "normal" category, with comments such as "perhaps his mother is appearing to him, maybe he's psychic"; and "...older parents have related these kinds of phenomena in my family and other families. I don't think they are any crazier than the next person."

Thirty-two of the surgical group answered question 1. One wrote "?." Five of the responses were coded in the "normal" category, with comments such as:"it is normal"; "he uses this behaviour to help him cope with life"; "?can be true (?)"; and "OK."

Three psychiatric/mental health nurse responses fell into the "split" category, saying "sometimes people see these kinds of things in grief reactions...he needs to be assessed"; "grief reaction- I would need to know to what degree his ability to function and relate is impaired...needs assessment and counselling if grief is unresolved as it appears to be"; "working in psychiatry, I have learnt that this is cause for concern. But... he could really be experiencing this... needs to talk, [writer wishes to] be around when he goes through these things."

Three surgical nurse replies fell into the "split" category: "unusual but probably not profoundly abnormal or harmful...may benefit from a grieving support group (sic)...needs psych help"; "introvert...meet people> see counsellor"; "perhaps he does see his mother or maybe he's crazy."

The remaining 23 psychiatric/mental health nurses gave answers that were coded in the "abnormal" category. The respondents stated, for example, "out of the ordinary"; "he hasn't dealt with his mom's death"; "dysfunctional grieving"; "inappropriate- needs some reality orientating"; "behaviour is different"; "he's not

dangerous, just strange"; and "eccentric." Nine of these nurses indicated that they thought he was experiencing a mental illness: "depression"; "psychosis"; "auditory and visual hallucinations;:" "?schizophrenic"; "delusional"; and "may or may not have a mental illness."

The remaining 23 surgical nurses gave responses which were judged to be indicative of abnormality. Examples include:"lonely young man not coping well with mother's passing"; "unresolved grief due to loss of mother?"; "odd but harmless"; "...do not feel that 'seeing' his mother is normal"; "not accepting his mother's death." "guilt"; "irrational"; "innapropriate when friends are about!"; "abnormal"; "wierd"; "sad- has not gotten over mother's death." Ten of this group suggested that there was or could be mental illness present. They commented:"needs psychiatric help"; "hallucinating"; "psychiatric problems"; "paranoid schizophrenia"; "psychotic"; "depressed"; "auditory and visual hallucinations"; "unstable...refer to psychiatrist"; and "having delusions both auditory and visual."

Sixteen psychiatric/mental health nurses mentioned grief reaction in their responses. Ten made the point that the man's behaviour was cause for concern or intervention only if he requested it or if there were signs that there were problems in his daily functioning. Twelve of the surgery nurses mentioned grief reaction in one form or other. One nurse mentioned that there should be intervention only if the man wanted it.

Question 5 about interventions was answered by 27 of the psychiatric/mental health nurses. Four of the group said that nothing should be done, or to wait until the behaviour interfered with the man's functioning. The remaining 23 nurses recommended various types of interventions.

The intervention query received responses from 28 of the surgical nurse group. All of those responses received were coded in the "intervention" mode. See Appendix K for a tabular presentation of the replies from both groups.

Summary

As noted earlier, only five of the vignettes showed much difference between the two groups, and even here, those differences were not pronounced. In the three vignettes which concerned spirit phenomena, in two of three cases the surgery nurses were more likely to comment on abnormality. The surgery nurses also recommended more intervention in two of the three cases. The other two vignettes described more social problems, and there was only one notable difference here. That was the psychiatric/mental health nurses' much stronger identification of abnormality in vignette 3 portraying histrionic behaviour, which is more likely to be recognized and dealt with as a therapeutic issue in the psychiatric area.

Five vignettes (numbers 2, 4, 6, 7, and 8) show more straightforward cases of mental illness, which are more likely to have been observed by all nurses in their student psychiatric rotations. The other five vignettes (numbers 1, 3, 5, 9, and 10, mentioned in the previous paragraph) show cases with less clear-cut particulars, and which would be less commonly observed or recognized by student nurses in their psychiatric rotations. These situations would be seen and identified more by nurses who worked in the psychiatric/mental health area. Even among the psychiatric/mental health nurse respondents here, though, there are more disagreements in the assessments of the behaviours.

DISCUSSION

Summary of Major Findings

The main finding of this study is that the psychiatric/mental health nurses felt more confident than did the surgical nurses in dealing with the situations described in the vignettes. The former group also showed more familiarity with standard psychiatric/mental illness diagnosis and treatment. However, both groups had similar perceptions of the seriousness of the situations, and of the degree of intervention required.

Professional socialization has been suggested as an explanation for the hypothesized differences between the nurses. Does this phenomenon indeed explain the observed differences? And what might explain the observed similarities? Professional socialization is a process that includes a number of factors. The first finding of greater confidence among the psychiatric/mental health nurses (consistent with the hypothesis) is not surprising considering their experience, which is one factor in professional socialization. Many of them have long periods of service. Everyday, these nurses see cases such as the ones the vignettes portrayed. Neither is the nurses' greater familiarity with standard psychiatric/mental illness intervention unexpected; it is another factor in professional socialization. These main findings are consistent with those of Misiaszek, Crago, & Potter (1987), who found that considerably fewer psychiatric nurses felt a lack of confidence in responding to clients' emotional problems compared to medical and surgical nurses.

Two of the hypotheses were contradicted, however. The first one stated that, compared to the surgery nurses, the psychiatric/mental health nurses would be more concerned about the behaviour in the vignettes. In fact, these nurses were not. As the psychiatric/mental health nurses see such phenomena daily, perhaps a factor of tolerance or even desensitization results from their routine experience; this might represent one effect of their ongoing professional socialization. They might feel less alarm or concern in these cases, precisely because they have seen that their clients somehow cope with the situation. Do the psychiatric/mental health nurses see the serious side of the behaviour but react without alarm? Or do they have no more insight into the situation than would any other type of nurse? The first explanation is the more probable, although the results of the open-ended questions do not provide definitive answers to these queries. The replies of the psychiatric/mental health nurses showed their greater familiarity with present psychiatric terminology and diagnosis, but because psychiatric diagnosis is such an inexact endeavour, one set of nurses' replies cannot be adjudged superior to the other. It is possible that the psychiatric/mental health nurses do not feel greater concern because they feel confident in dealing with the behaviour. That is, when reading the questionnaire, perhaps their connotation of the term "concern" was more "worry" rather than "identification of abnormality." This connotation may be different from that of the surgical nurses. The tendency to greater accuracy among the psychiatric/mental health nurses in describing the abnormality they saw, lends support to the notion that these nurses' socialization has taught them to more readily identify psychopathology. A good example is vignette 3 (histrionic behaviour) where the psychiatric/mental health nurses commented with more detail and diagnostic language about what they saw as occurring.

The other contradicted hypothesis stated that the psychiatric/mental health nurses would recommend intervention more often, and to a stronger degree, than would the surgical nurses. In the rating scale items, over the ten vignettes the two groups did not differ significantly. There are several possible reasons for this finding. One could be that the psychiatric/mental health nurses routinely see compromised

situations where no intervention occurs, and this scenario continues over time. Perhaps a sense of helplessness or dismay gives way to a degree of resignation that nothing will be done, and perhaps even to the feeling that intervention would be of little use, if not outright counterproductive. Possibly peer pressure as a part of socialization (Bandura, 1969; Hardy & Conway, 1988) influences this feeling in the nurse, who comes to accept the group norm that it is not worth becoming distressed over the situation. Another explanation could be that the psychiatric/mental health nurses routinely see fairly little being done (rightly or wrongly) in the standard management of some situations, and they come to believe that this is the desirable level of intervention. Another possibility is that the surgical nurses are more attuned to psychosocial dynamics than was previously credited, and that they have indeed internalized much of the knowledge and attitudes from their student psychiatric/mental health rotations, a professional socialization process.

These discussions of tolerance, desensitization, and seeing little being done, sound tantamount to a description of occupational burnout. Burnout, however, is characterized by impairment in complex thinking, decline in enthusiasm for work, and decrease in concern for others (Muldary, 1983). It was not in any way evidenced in the responses from either group of nurses. Rather, it may be that the psychiatric/mental health nurses have experienced ongoing professional socialization in which they have adjusted to the perceived realities of the work setting (Lum, 1988). Or, as Benner (1984) described, they have given up some of their earlier-held rules and beliefs in the process of becoming more expert.

In answering the open-ended questions, while the psychiatric/mental health nurses furnished more detail and specificity in their recommended actions, they did not as a whole recommend that more action be taken. In seven of the ten vignettes, there were negligible differences between the groups in the rating frequencies of "intervention" and "nonintervention." However, three vignettes, numbers one, five, and ten, produced a greater difference in this regard. These vignettes all had people experiencing spiritual phenomena. The disparity in the groups could be due to the nurses' personal religious beliefs. Or, because in two of the cases (vignettes five and ten) at least 12% more of the surgical nurses recommended intervention, the psychiatric/mental health nurses may be more reluctant in these cases to suggest interference (it was mentioned earlier that vignette five showed a statistically significant different between the two groups in the quantitative analysis, which was an exception to the rest of the data). A number of clients with religiose ideation are seen in the psychiatric area, and the nurses try to maintain objectivity in dealing with them (Wilson & Kneisl, 1992). This result may be reflective of those nurses' attitudes.

The socialization which determines a nurse's perceptions of problematic behaviour may have been received at the societal, professional or specialty level. All of the hypothesized group differences between mental health professionals and cultural minority groups were accepted in previous research on perceptions of problematic behaviour (Allen, Graves, & Woodward,1985; Flaskerud, 1980, 1984). Obviously, even allowing for the changes here in the question format, the groups were much more different than were the two groups studied in this research, possibly due to socialization at the societal level. Malla & Shaw (1987), using vignettes and rating scales, demonstrated that exposure to psychiatric patients improved the ability of student nurses to recognize signs, symptoms, and severity of mental illness. Their work supports the impact of socialization at the professional level, which may account for some of the similarities found between the surgical and psychiatric/mental health nurses in this study. The confidence difference between the two nurse groups, consistent with Misiaszek, Crago, & Potter (1987), and the psychiatric/mental health nurses' greater familiarity with psychiatric diagnosis and treatment are probably due to socialization at the specialty level. Finally, it is possible that the results cannot be explained by socialization alone. It may be that people with certain types of conceptions regarding

problematic behaviour or mental illness enter into nursing, or into particular nursing specialties.

It was earlier stated that the literature reviewed did not consistently point to a measurable difference in the identification of mental illness by psychiatric and nonpsychiatric nurses. The results of this study are consistent with that statement. There remains, however, a paucity of literature in this area.

Yet another reason for the major findings could be that there are actual differences between the two groups, and the hypotheses are in fact true, but the means of measuring these phenomena are as yet faulty. Polit & Hungler (1991) suggest that the safest interpretation of nonsignificant findings is that they represent a lack of evidence for either the truth or the falsity of the hypothesis. However, some methodological considerations bear discussion. Firstly, it was noted earlier that the content of each vignette had a great effect on the responses. The particular vignettes used here might not be optimal for comparisons within nursing. They were developed "to measure the differing views of behaviour and its management that may exist between psychiatric professionals and various minority groups" (Flaskerud, 1980, p. 4). Half the vignettes were included to measure "normative minority group behaviours" and half to measure mental illness behaviours (Flaskerud, 1984, p. 193). As such, their focus was very broad. Secondly, there is the potential problem of response bias with the use of vignettes (Polit & Hungler, 1991); does the response truly indicate what the respondent's actual behaviour would be? This response bias might explain in particular the lack of difference detected between the two groups in terms of their concern about the portrayed behaviour. To them, ten short stories on paper may not indeed come close to being faced with the real situation. Thirdly, the wording of the post-vignette questions may have failed to elicit the depth and type of information needed to adequately test the hypotheses. This seems to be particularly true in the case of the question "As a nurse, do you think that this behaviour is cause for concern?" Because this study represents research of an exploratory-descriptive type, where there is not a great deal of pre-existing knowledge in this area, the optimal type of questions to test a difference between the two groups have not yet been developed. Lastly, any combination of all the above explanations could be operating upon the observed results.

Limitations of the Study

There are several limitations in the generalizability of these findings. The target population was those nurses who worked within the psychiatric/mental health and surgical nursing areas in a large metropolitan hospital; therefore, the results of this study cannot be generalized further. The sample sizes, while adequate for statistical testing, would benefit from greater numbers to enhance validity. Perhaps certain types of nurses (for example, those with more patience, or who wrote well, or who were interested in research) completed the instrument, and other types of nurses who did not complete it were not represented among the sample. Though there were four men among the psychiatric/mental health nurses, these were the only males; therefore, the findings cannot be generalized to nursing populations having a greater proportion of males. Factors such as cultural group among the nurses were not measured; this might also be a confounding variable.

Some comments, verbal and written, were received regarding the questionnaire. Several respondents thought that it took too long to complete, which affected the number and quality of responses. Indeed, the nonresponse rate was higher for the last several vignettes. Possibly the overall rate of return would be higher if the questionnaire were shorter. Deleting some of the vignettes would have drastic effects on the validity and reliability; asking fewer questions after each of the ten vignettes might be preferable. If the respondents were given a form of remuneration in terms of

money or time off work to complete the questionnaire, the response rate might be higher.

While this questionnaire measures the perceptions of problematic behaviour with both qualitative and quantitative methods, it was the only instrument that was used. The use of two or more questionnaires, or possibly a face-to-face interview technique, may provide a better measure of the data.

Recommendations for Further Research

The first recommendation for research is to replicate this study among psychiatric/mental health and surgical nurses in different hospitals. Modified questions following the vignettes might extract data more germane to the research question. Flaskerud (1980) suggested a rating scale to categorize responses to the vignettes, which was attempted in this research. Perhaps using more guided questions would better compare the knowledge and attitudes of the two nurse groups; for example, giving a menu of interventions from which the respondents could choose, in addition to allowing space for making other suggestions. Face-to-face interviews might appeal to more respondents and might yield more illustrative data, compared to a questionnaire. A comparison group of nurses other than surgical could be tested to see if differences exist among other types of nurses. Nurses who do not work in a hospital setting could be studied as well, and comparisons could be made to hospital nurses. The sample focus of this research was as specific as Flaskerud's was broad. A middle-ground group, such as a general community sample, would bear studying.

It was earlier stated that the socialization which determines a nurse's perceptions of problematic behaviour may have been received at the societal, professional or specialty level. Research would be useful to identify the level at which this influence is strongest, and where there are interactions among the three levels. The culture of the nurse was not addressed in this study. Future research could examine its role in the nurse's perceptions of problematic behaviour.

It would be worthwhile to apply this research to the "gatekeeper" or entry points of psychiatric help, similar to Coie, Costanzo, & Cox (1975). Respondents (for example, clergy, nurses, physicians, police, and social workers) could be compared on their assessments of the behaviours from the vignettes.

The vignettes covered a wide range of problematic behaviour, some of which was due to culture and some to mental illness. Therefore, the data cannot be used to measure the relative tendencies of different types of nurses to identify certain psychopathological phenomena such as psychoses, personality disorders, or mood alterations. Further research may use a series of different vignettes incorporating these phenomena plus accompanying social circumstances, while controlling for culture as a variable.

Implications for Nursing

The findings of this study have some implications for theory development. We need to know more about the comparative effects of socialization within a society, a profession, or a professional specialty upon the perceptions and actions of group members. This knowledge would further help us examine the effects of routine, standardized practice upon groups of workers such as nurses, over time; how do later experiences override the effects of earlier professional socialization, over what time frames and in what circumstances? Benner's (1984) identification of five levels of nursing expertise, from novice to expert, and the nurse's moving beyond earlier-learned rules, could be a useful theoretical basis here.

One serendipitous finding from this study was the frequent comments from both groups of nurses regarding concern for the family members of those portrayed in

the vignettes. This concern seems to demonstrate that both psychiatric/mental health and surgical nurses see situationd from a holistic perspective.

There are implications for nursing practice resulting from this research. This study has not shown great differences between two types of nurses in their perceptions of the seriousness of the portrayed behaviours or their required interventions. However, psychiatric/mental health liaison nursing has been documented to be successful in several applications (Newton & Wilson, 1990; Nelson & Schilke, 1976; Przepiorka & Bender, 1977). Though there appears to be a contradiction here, perhaps the greater confidence felt by the psychiatric/mental health nurses would help to explain the success. It may be that the psychiatric/mental health nurses' greater knowledge of current psychiatric/ mental health diagnosis and intervention, their communication and multidisciplinary consultation skills, or their understanding of the referring group's frustration in dealing with the situation at hand allows them to intervene in a way that is helpful. Or perhaps the party receiving the consultation is very receptive to receiving the assistance at that time. Often when the psychiatric/mental health nurses are consulted by other nurses, it is for their understanding of clinical subtleties, such as identifying and dealing with a personality disorder. The responses to the vignette portraying the woman with the dependent and histrionic behaviours supports this notion.

Though no difference was found from the rating scale items between the two groups of nurses' perceptions of gravity or requisite action from the vignettes, there is not yet reason to assume that psychiatric/mental health nurses and other nurses are equally skilled in the recognition and treatment of problematic behaviour. Indeed, in the responses to the long answer questions, the psychiatric/mental health nurses consistently gave more detailed answers which reflected greater familiarity with psychiatric/mental health intervention. The finding of greater confidence among the psychiatric/mental health nurses supports the idea that this nursing specialty would indeed have something to offer a nurse from another area, where a situation of problematic client behaviour was concerned. Other nurses endeavour to provide optimum psychosocial client care. Perhaps their ability to recognize and intervene in a large percentage of these cases is better than the nurses themselves perceive, and that their confidence in this area (which can be increased) is the limiting factor. Psychiatric liaison nursing or continuing nursing inservice education could be helpful in addressing these issues.

Summary

This study addressed the research question "What are the perceptions of psychiatric/mental health nurses and surgical nurses of problematic behaviour?" The psychiatric/mental health nurses showed more confidence and familiarity with the situations that were presented to them. They did not see them as requiring more concern or intervention, compared to the surgery nurses. This chapter discussed these results in terms of the concept of socialization and noted the limitations of the study. Future research to address these limitations and to further explore nurses' perceptions of problematic behaviour was suggested. Finally, implications for nursing practice and theory were discussed.

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Appendix A
Questionnaire

Psychiatric-Mental Health and Surgical Nurses'

Perceptions of Problematic Behaviour

#___

December 1, 1991

Dear Colleague,

This questionnaire is part of a study to find out nurses' ideas and judgments about different situations that may take place in people's lives. The answers that you give will add to nursing knowledge in this area. I have been to your work area to describe this study to the nurses.

As a graduate student in nursing, I invite you to complete this questionnaire. It will take about 45 minutes of your time. The questionnaire may be completed at coffee or lunch breaks, or it may be taken home. If you have any questions, I would be glad to answer them. My phone number is 456-4165 at home, and 492-6788 at work. Or my thesis supervisor, Olive Yonge, can be reached at 492-2402.

If, as a nurse presently working in psychiatry, you have worked as a registered nurse in surgery within the <u>past ten years</u>, please do not fill in this entire questionnaire. I will not be able to include you in this study. Simply complete question # 1 and return the empty questionnaire to the sealed collection box on your unit. This does not apply to people who were nursing *students* in the past ten years.

No names are used on the questionnaires, only numbers, so no one will know who has completed them when the results are analyzed. These sheets will be coded only by me, the person doing the research. By your answering this questionnaire, I will assume that you have given consent to be part of this research. You do not have to fill this questionnaire out if you do not wish. There are no known risks or gains to you as a result of your giving answers to the questions. Please complete this questionnaire privately and do not talk about your answers with other people.

Results of this study will be shared with the staff at a later date. Notices about this will be posted on your nursing unit. The results that I collect will be used in my Master of Nursing thesis. They may be used at a later time for teaching student nurses.

In advance, thank you very much for taking the time to consider the items in this study. Please fill out the questionnaire by **December 19, 1991**. It can be dropped in the sealed box on your nursing unit.

Yours truly,

Bill Leddy, MN Candidate
Faculty of Nursing
Phone 492-6788

The questionnaire that you are completing will ask you to respond to some short stories about different people. Also, you will be asked some background questions that I will use to help understand more about different nurses' opinions concerning the stories.

1. Do you work in a psychiatry/mental health area? _____
Have you ever worked in the surgical nursing area since first graduating as a nurse? _____ When and for how long?_____

_____

If you have worked in surgery as an RN in the past ten years (student nurse status is exempt here), please do not answer any further questions. Simply return the unanswered questionnaire to the sealed box on your unit. Thank you for your participation to this point-- it does make a difference.

2. How many years of education have you completed since high school?_____

Please check your highest level of nursing education attained:

RN diploma_____

RPN diploma_____

Bachelor's degree (Nursing)_____

Bachelor's degree (other)_____

Master's degree_____

Doctorate_____

Post-nursing specialty diploma_____ Specialty_____

3. Gender: Female_____ Male_____

4. What is your current number of years of nursing experience since first graduating as a nurse?
_____ years.

Now I would like you to read five very short stories about different kinds of people out in society, in order to find out what you, as a nurse, generally think about these situations:

5. This first person is a 42-year-old woman who was married and has five children. Several years ago her husband left her and she doesn't know where he is. Since that time she has become very religious and spends a lot of time each week at church services and prayer meetings. She believes that she has special powers from God. She claims that on many occasions she has seen Jesus surrounded by His angels. She gets very excited and emotional on these occasions. She cries, moans, throws herself on the floor and talks loudly to Jesus and His angels. She says that she has healed other people because of her faith. Her older children feel that she spends too much time on these activities and that she neglects the younger ones.

1. What do you think of this person's behaviour?

2. As a nurse, do you think that this behaviour is cause for concern? Circle one of the numbers below.

1	2	3	4	5
Great concern				No concern

3. As a nurse, do you think that anything ought to be done about this matter?

1	2	3	4	5
Definitely yes				Definitely no

4. What degree of help do you think this person needs, if any?

1	2	3	4	5
No help				Intensive help

5. What would you suggest?

6. How confident would you feel in helping this person?

1	2	3	4	5
Very confident				Not at all confident

7. Do you have any other comments? Please describe.

6. This next person is a 40-year-old man who is married. He is a very suspicious person. Sometimes he thinks that people he sees on the street are talking about him or following him around. A couple of times, now, he has beaten up men who didn't even know him because he thought that they were plotting against him. The other night he began to curse his wife terribly; then he hit her and threatened to kill her because, he said, she was working against him just like everyone else.

1. What do you think of this person's behaviour?

2. As a nurse, do you think that this behaviour is cause for concern? Circle one of the numbers below.

1	2	3	4	5
Great concern				No concern

3. As a nurse, do you think that anything ought to be done about this matter?

1	2	3	4	5
Definitely yes				Definitely no

4. What degree of help do you think this person needs, if any?

1	2	3	4	5
No help				Intensive help

5. What would you suggest?

6. How confident would you feel in helping this person?

1	2	3	4	5
Very confident				Not at all confident

7. Do you have any other comments? Please describe.

7. This is a 24-year-old woman who is unmarried. She looks younger than 24 years-- about 17 or 18 and she speaks in a very soft, young voice. She has had some hard times in her life. Although she is not married, she has two children by different fathers. Right now she lives alone with the children but she has a hard time taking care of them and handling them. She has been arrested twice for soliciting and once for causing a disturbance on the street. Each time that she has been in jail she has become very upset and hysterical-- crying loudly, throwing herself on the floor, and refusing to eat. When she's released, she tries hard to be a good mother but her attempts at it don't last very long and soon she's in trouble again.

1. What do you think of this person's behaviour?

2. As a nurse, do you think that this behaviour is cause for concern? Circle one of the numbers below.

1	2	3	4	5
Great concern				No concern

3. As a nurse, do you think that anything ought to be done about this matter?

1	2	3	4	5
Definitely yes				Definitely no

4. What degree of help do you think this person needs, if any?

1	2	3	4	5
No help				Intensive help

5. What would you suggest?

6. How confident would you feel in helping this person?

1	2	3	4	5
Very confident				Not at all confident

7. Do you have any other comments? Please describe.

8. This is a 42-year-old man who is divorced. His ex-wife and two children live here in Edmonton but he hasn't seen them in years. He thinks that he has special mental powers and that he receives messages through electrical waves that other people can't hear. Most of these messages are about danger to Canada from foreign, communist countries. He tries very hard to get in touch with the Prime Minister of Canada, and the Alberta Premier, to warn them of nuclear attacks. The messages that he hears tell him that Canada is going to be bombed and he tries to warn the government of these attacks. People in government ignore him and don't answer his letters or phone calls.

1. What do you think of this person's behaviour?

2. As a nurse, do you think that this behaviour is cause for concern? Circle one of the numbers below.

1	2	3	4	5
Great concern				No concern

3. As a nurse, do you think that anything ought to be done about this matter?

1	2	3	4	5
Definitely yes				Definitely no

4. What degree of help do you think this person needs, if any?

1	2	3	4	5
No help				Intensive help

5. What would you suggest?

6. How confident would you feel in helping this person?

1	2	3	4	5
Very confident				Not at all confident

7. Do you have any other comments? Please describe.

9. This individual is a 35-year-old woman who is married. She has for the last several years experienced episodes in which she can see figures of spirits standing around her and she can also sometimes hear voices mumbling to her. No one else can see or hear these things. During these experiences she talks in a strange, low-pitched tone of voice and reveals messages from the spirits. These episodes may last anywhere from a few hours to a week. Between them, she carries on her regular activities but is not very outgoing.

1. What do you think of this person's behaviour?

2. As a nurse, do you think that this behaviour is cause for concern? Circle one of the numbers below.

1	2	3	4	5
Great concern				No concern

3. As a nurse, do you think that anything ought to be done about this matter?

1	2	3	4	5
Definitely yes				Definitely no

4. What degree of help do you think this person needs, if any?

1	2	3	4	5
No help				Intensive help

5. What would you suggest?

6. How confident would you feel in helping this person?

1	2	3	4	5
Very confident				Not at all confident

7. Do you have any other comments? Please describe.

Now we'll take a break from the stories and I will ask you a few more questions about yourself.

10. What is your age?_____

11. How long have you worked in your present psychiatry area? _____years

Now, going back to the stories:

12. This is a woman who is 30 years old, married, and has three children. Every day she cries and weeps for hours on end and does not take care of her children. She claims that all kinds of people are accusing her of trying to hurt them. She feels that her thoughts and deeds may have harmed thousands of people. She thinks and talks about killing herself. She sits for hours without moving. She does not bath, wash, comb her hair, or change her clothes.

1. What do you think of this person's behaviour?

2. As a nurse, do you think that this behaviour is cause for concern? Circle one of the numbers below.

1	2	3	4	5
Great concern				No concern

3. As a nurse, do you think that anything ought to be done about this matter?

1	2	3	4	5
Definitely yes				Definitely no

4. What degree of help do you think this person needs, if any?

1	2	3	4	5
No help				Intensive help

5. What would you suggest?

6. How confident would you feel in helping this person?

1	2	3	4	5
Very confident				Not at all confident

7. Do you have any other comments? Please describe.

13. This is a man who is 30 years old, married, and has four children. He is a very quiet man; he does not talk much and he does not trust people like strangers or bosses. He works in a factory but does not have much hope of getting ahead in life. Every night after work he drinks in a bar, sometimes coming home late at night. Sometimes he and his wife argue loudly about his drinking and on occasion during these arguments he hits her. Once when he was very angry with her, he bruised her face badly, broke windows in his apartment, and threw furniture into the street.

1. What do you think of this person's behaviour?

2. As a nurse, do you think that this behaviour is cause for concern? Circle one of the numbers below.

1	2	3	4	5
Great concern				No concern

3. As a nurse, do you think that anything ought to be done about this matter?

1	2	3	4	5
Definitely yes				Definitely no

4. What degree of help do you think this person needs, if any?

1	2	3	4	5
No help				Intensive help

5. What would you suggest?

6. How confident would you feel in helping this person?

1	2	3	4	5
Very confident				Not at all confident

7. Do you have any other comments? Please describe.

14. This is an 18-year-old girl who is in high school. She had always been a moody girl and has never gotten along well with people. A few months ago she began to cry all the time and act afraid of everyday things. She has stopped going to school and stays at home. She screams at her parents, and a lot of the time what she says does not make any sense to them. She has talked about hearing voices talk to her and thinks that she really is somebody other than herself.

1. What do you think of this person's behaviour?

2. As a nurse, do you think that this behaviour is cause for concern? Circle one of the numbers below.

1	2	3	4	5
Great concern				No concern

3. As a nurse, do you think that anything ought to be done about this matter?

1	2	3	4	5
Definitely yes				Definitely no

4. What degree of help do you think this person needs, if any?

1	2	3	4	5
No help				Intensive help

5. What would you suggest?

6. How confident would you feel in helping this person?

1	2	3	4	5
Very confident				Not at all confident

7. Do you have any other comments? Please describe.

15. This is a 45-year-old man who is married and has three children. Although when he was younger he was full of life and a hard worker, now he is moody, stays at home a lot, and does not talk much. He is presently unemployed and complains of trouble with his nerves. He says he has pain in his back and legs and has been to many doctors who have not been able to find much wrong with him but they do give him nerve medicine. His last job as a labourer on a truck dock was, he says, too hard on his nerves. Now he sits at home most of the time, does not talk much, and lets his wife do things for him.

1. What do you think of this person's behaviour?

2. As a nurse, do you think that this behaviour is cause for concern? Circle one of the numbers below.

1	2	3	4	5
Great concern				No concern

3. As a nurse, do you think that anything ought to be done about this matter?

1	2	3	4	5
Definitely yes				Definitely no

4. What degree of help do you think this person needs, if any?

1	2	3	4	5
No help				Intensive help

5. What would you suggest?

6. How confident would you feel in helping this person?

1	2	3	4	5
Very confident				Not at all confident

7. Do you have any other comments? Please describe.

16. This is a man, aged 27, who is not married. Every now and then he sees the figure of his mother, who died a few years ago, standing before him. He then talks to her and she replies to him. People who are with him when he talks to his mother do not see or hear her. He is described by friends as a rather excitable but friendly person.

1. What do you think of this person's behaviour?

2. As a nurse, do you think that this behaviour is cause for concern? Circle one of the numbers below.

1	2	3	4	5
Great concern				No concern

3. As a nurse, do you think that anything ought to be done about this matter?

1	2	3	4	5
Definitely yes				Definitely no

4. What degree of help do you think this person needs, if any?

1	2	3	4	5
No help				Intensive help

5. What would you suggest?

6. How confident would you feel in helping this person?

1	2	3	4	5
Very confident				Not at all confident

7. Do you have any other comments? Please describe.

Thank you very much. You have have completed all the questions and let me tell you once again how much your participation in this study is appreciated. I would also like to remind you that all information that you have given me will be kept confidential.

Bill Leddy

MN Candidate

Appendix B

Percentages of Nurses' Recommendations to "What would you suggest?", Vignette 1 (woman with religious behaviours)

Category	Nurse	
	Psychiatric/mental health	Surgical
Certification (Mental Health Act)	3.4%	0%
"Psych" (psycho-, psych-psychiatric) interventions	46.7%	43.6%
Therapy (incl. therapist, group, psycho-, individual-)	34.5%	43.6%
Doctor/psychiatrist	26.7%	12.8%
Assessment	34.5%	15.4%
Counselling (including counsellor, exploration, grief process work, discussions of...)	20.7%	38.5%
Medications	17.2%	10.3%
Children getting mother to receive help	17.2%	2.6%
Church help	13.8%	15.4%
Nurse wanting more information	6.6%	5.1%
Treatment	3.4%	5.1%
Outpatient	13.8%	0%
Concern for the children	26.7%	38.5%
Help for the children	41.4%	38.5%
Hospitalization	6.9%	7.7%
Nurse	3.4%	0%
Social services	3.4%	7.7%

Appendix C

Percentages of Nurses' Recommendations to "What would you suggest?", Vignette 2 (man with suspicious and violent behaviours).

Category	Nurse	
	Psychiatric/mental health	Surgical
Psych (psycho, psychiatric, psychological) interventions	79.3%	69.2%
Hospitalization	55.2%	37.8%
Medications	44.8%	25.6%
Help/therapy/treatment	41.4%	30.8%
Certification (Mental Health Act)	51.7%	10.3%
Assessment	27.6%	27.0%
Arrest	20.7%	5.4%
Help for wife	20.7%	17.9%
Security measures	13.8%	10.8%
Support	13.8%	0%
Means to get client into therapy	13.8%	2.7%
Approaches to gain trust	13.8%	0%
Doctor/psychiatrist	10.3%	15.4%
Outpatient treatment	3.4%	0%
Counselling	0%	16.2%
Explanation of reality	0%	2.7%
ECT (electroconvulsive therapy)	0%	2.7%
Comments about low likelihood of man to cooperate	17.2%	2.7

Appendix D

Percentages of Nurses' Recommendations to "What would you suggest?", Vignette 3 (woman with dependent and dramatic behaviours)

Category	Nurse	
	Psychiatric/mental health	Surgical
Counselling	22.2%	65.7%
Therapy	51.9%	25.7%
Treatment	11.1%	2.9%
Doctor/psychiatrist	18.5%	5.7%
Medications	7.4%	0%
Assessment	18.5%	11.4%
Psych-, psycho-, psychiatric	40.7%	22.9%
Group help	22.2%	0%
Support	33.3%	20.0%
Social services	55.6%	37.1%
Role model/authority figure	0%	8.6%
Help for the children	37.0%	34.3%
Help at home	18.5%	0%
Outpatient help	11.1%	0%
Education	29.6%	31.4%
Nurse	3.7%	0%
Financial help	14.8%	28.6%
Job training	1.1%	25.7%

Appendix E

Percentages of Nurses' Recommendations to "What would you suggest?", Vignette 4 (man who claims to receive electrical messages into his mind).

Category	Nurse	
	Psychiatric/mental health	Surgical
Treatment	17.9%	8.3%
Medications	50.0%	22.2%
Psych-, psycho-, psychiatric interventions	39.3%	61.1%
Hospitalization	35.7%	22.2%
Nursing approaches	25.0%	11.1%
Further assessment	21.4%	25.0%
Doctor/psychiatrist	21.4%	0%
Outpatient	42.9%	5.6%

Appendix F

Percentages of Nurses' Recommendations to "What would you suggest?", Vignette 5 (woman who hears and interprets spirit messages).

Category	Nurse	
	Psychiatric/mental health	Surgical
"Psych" interventions	15.4%	65.5%
Assessment	26.9%	41.4%
Medications	46.2%	24.1%
Hospitalization	7.7%	24.1%
Counselling	3.8%	20.7%
Therapy	15.4%	17.2%
Doctor/psychiatrist	19.2%	17.2%
Various nursing approaches	0%	10.3%
Help only if requested...	19.2%	6.9%
Outpatient	26.9%	0%
Treatment	19.2%	0%
Support	15.4%	0%
Comments about treatment being of no use	3.8%	0%
Neurological assessment	7.6%	0%

Appendix G

Percentages of Nurses' Recommendations to "What would you suggest?", Vignette 6 (woman with depressed and nihilistic ideation).

Category	Nurses	
	Psychiatric/mental health	Surgical
Hospitalization	78.6%	33.3%
Medications	60.7%	25.0%
Help for children	28.6%	25.0%
Psych-, psychiatric, psycho-interventions	25.0%	61.1%
Certification (Mental Health Act)	25.0%	8.3%
Help for husband	21.4%	0%
Support	21.4%	0%
Therapy	25.0%	11.1%
Assessment	17.9%	16.7%
Social services involvement	14.3%	8.3%
Doctor/psychiatrist	10.7%	11.1%
Nurse intervention	7.1%	0%
ECT (electroconvulsive therapy)	7.1%	5.6%
Various nursing approaches	3.6%	5.6%
Help for woman	3.6%	13.9%
Counselling	3.6%	27.8%
Urgent or intensive intervention	17.9%	11.1%
Treatment	14.3%	22.2%

Appendix H

Percentages of Nurses' Recommendations to "What would you suggest?", Vignette 7 (man with daily drinking and abusive behaviours).

Category	Nurse	
	Psychiatric/mental health	Surgical
Outpatient	0%	8.8%
Social services	0%	2.7%
Counselling (individual)	20.7%	52.9%
Counselling (family)	20.7%	8.8%
Detoxification/treatment	75.9%	5.9%
Alcoholics Anonymous	27.6%	29.4%
Wife leaving husband	13.8%	0%
Therapy	44.8%	29.4%
Psych-, psycho-, psychiatric intrerventions	31.0%	14.7%
Support	27.6%	11.8%
Medications	0%	2.9%
Concern for wife	27.6%	22.9%
Help for wife	31.0%	35.3%
Help for family	20.7%	1.8%
Psychiatrist	6.9%	8.8%
Nursing intervention	3.4%	0%
Assessment	3.4%	0%
Job change	3.4%	2.9%
Legal recourse	3.4%	5.9%
Help for the man	0%	2.9%
Financial assistance	0%	2.9%
Nursing approaches	0%	2.9%
Comments that this type of behaviour is common here	0%	14.3%
Compliance dependent on insight; treatment *only if...*	44.8%	11.8%

Appendix I

Percentages of Nurses' Recommendations to "What would you suggest?", Vignette 8 (woman with withdrawn and hallucinatory behaviours).

Category	Nurse	
	Psychiatric/mental health	Surgical
Medications	44.8%	23.5%
Hospitalization	44.8%	20.6%
Assessment	51.7%	17.6%
Therapy	34.5%	23.5%
Help for the family	34.5%	11.8%
Help for the client	0%	11.8%
"Psych" interventions	27.6%	55.9%
Counselling	10.3%	35.3%
Doctor/psychiatrist	20.7%	11.8%
Support	20.7%	0%
Treatment	20.7%	11.8%
Help for client by family	17.2%	5.9%
Teaching	13.8%	0%
Social services	0%	3.1%
Outpatient	10.3%	0%
Certification (Mental Health Act)	3.4%	0%
NOT using certification	3.4%	0%
Nurse as helper	0%	2.9%
Optimism regarding outcome	3.4%	0%
Comments about the urgency of the situation	6.9%	2.9%

Appendix J

Percentages of Nurses' Recommendations to "What would you suggest?", Vignette 9 (unemployed man with moody and physically complaintive behaviours).

Category	Nurse	
	Psychiatric/mental health	Surgical
Intervention only if man wishes help	10.3%	0%
Therapy	55.2%	18.2%
Medications	44.8%	9.1%
"Psych" interventions	41.4%	36.4%
Physical assessment	20.7%	18.2%
Assessment (type unspecified)	13.8%	0%
Doctor/psychiatrist	20.7%	9.1%
Career/job change/encouragement	24.1%	15.2%
Outpatient	10.3%	9.1%
Suicide potential assessment	0%	3.0%
Counselling	6.9%	48.5%
Kick ("in ass", out of home)	0%	6.1%
Treatment	13.8%	15.2%
Help for the family	6.9%	9.1%
Hospitalization	6.9%	0%
Psychologist	6.9%	0%
Social worker/services	3.4%	0%
Holiday	3.4%	0%
Support	3.4%	3.0%
Nurse as helper	3.4%	0%
Motivation for the man	0%	15.2%

Appendix K

Percentages of Nurses' Responses to "What would you suggest?", Vignette 10 (man who sees and communicates with his deceased mother).

Category	Nurses	
	Psychiatric/mental health	Surgical
Intervention *only if...*	35.7%	3.1%
Therapy	3.3%	10.7%
Assessment	25.9%	14.3%
Medications	22.2%	10.7%
Counselling	18.5%	50.0%
Doctor/psychiatrist	14.8%	14.3%
Support	1.1%	3.6%
Outpatient	11.1%	3.6%
Nurse as helper	7.4%	0%
Treatment/care	3.7%	10.7%
Clergy	3.7%	3.6%
"Psych" intervention	14.8%	60.7%
Help	0%	7.1%
Psychologist	0%	3.6%
Meeting people as therapy	0%	3.6%
Hospitalization	0%	3.6%
Seance	0%	3.6%

Appendix L

Table L-1
Age Data for Responding Nurses

Age	Nurse	
	Psychiatric/mental health	Surgical
Mean	37.07	36.31
Range	22 to 57	23 to 64

Table L-2
Post-Secondary Education for Responding Nurses

Years of education	Nurse	
	Psychiatric/mental health	Surgical
Mean	5.02	4.35
Range	2 to 12	2 to 12

Table L-3
Nursing Experience for Responding Nurses

Years of nursing experience	Nurse	
	Psychiatric/mental health	Surgical
Mean	11.33	10.08
Range	1 to 35	3 to 31

Table L-4
Responding Nurses' Time in Present Area of Specialty

Years in present area	Nurse	
	Psychiatric/mental health	Surgical
Mean	7.56	8.42
Range	1 to 25	3 to 31

Table L-5
Educational Levels for Responding Nurses

Highest educational level	Nurse	
	Psychiatric/mental health	Surgical
Baccalaureate (nursing)	8 (26.7%)	9 (23.1%)
Baccalaureate (other)	4 (13.3%)	3 (7.7%)
Master's	4 (13.3%)	1 (2.6%)
Specialty diploma	4 (13.3%)	0

Appendix M

Letter of Permission from Dr. J Flaskerud

UNIVERSITY OF CALIFORNIA, LOS ANGELES UCLA

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO SANTA BARBARA • SANTA CRUZ

SCHOOL OF NURSING
10833 LE CONTE AVENUE
LOS ANGELES, CALIFORNIA 90024-1702

April 17, 1991

Bill Leddy, MN candidate
14304 - 114 St.
Edmonton, Alberta T5X 3Z8
Canada

Dear Mr. Leddy:

You have my permission to use the tool on perceptions of problematic behavior as you have proposed modifying it and with the proposed populations. I have done no additional research in this area. However, Cynthia Capers at the University of Pennsylvania has done a dissertation using the tool with black women and may have published it. It is possible that she has used vignettes more extensively or knows other people who have.

My research lately has been in the area of AIDS. I have not used vignettes in this research. However, Kelly and colleagues have done several studies using vignettes in studying reactions to AIDS among nurses, physicians and other health care workers. I have enclosed references to their work. Perhaps their work will be of help to you in your research with health professionals. Also, you might want to get in touch with them for guidance on the use of vignettes in research.

Good luck in your work.

Sincerely,

Jacquelyn H. Flaskerud, RN, PhD
Professor

JHF:cer

Appendix N

Coding by External Reviewer
Psychiatric/Mental health Nurses: Vignette 1
Coding is in bold italics.

Number

007

1. Many televangist (TV religious leaders) claim to heal people too. Has become (perhaps) overly- religious; especially c having 5 children-- there is nothing I really think about her behavior unless I was more informed about how much time on religious activities & how she neglects her younger ones. ***noncommital***
3. I would need more information first before a decision could be made. ***more info***
5. More information is needed to decide if intervention is needed. Her older children feel she neglects her children- but no examples are given re: time on religious activities examples of neglect (up arrow) as above.
7. Although there is an indication for concern, the above information could be describing a female Jimmy Swaggart (he does the very SAME things). You need to further detail "neglect" of children (it's hearsay right now) & time spent on religious activities & is she harming herself or (unreadable).

031

1. I think this lady may be psychotic or delusional ***psychotic***
5. That her older children take her to a doctor ***seek medical help***
7. If it wasn't for the fact that she believes she has special powers I might think she just belonged to a religion that expressed itself this way ie some Baptists etc.

038

1. I think the women has gone from appropriate religious devotion to religious delusions and grandiosity. There is also the concern of her neglect of her younger (&? older) children. ***delusional, grandiosity***
5. Further exploration of the reasons for her increase intensity of religious ideation & delusions. ***explain more***
7. nil

049

1. I think she is developing religiose delusions, possibly with visual hallucinations. ***delusions***
5. I would suggest she see a therapist for reality testing & commence antipsychotics ***medical asst/meds***
7. Try to keep as outpt because of family responsibilities. May need help via home care?

058

1. She is delusional. Is not dealing c the loss of her hsb.
delusional
5. -psychiatrist
-emotional support from a friend ***psych/support***
7. I think this woman needs help but I don't know how receptive she would be to help. How neglected are the children? Actually I think someone needs to intervene here

081

1. It is strange, bordering on mental illness. Not of great concern except that she may be neglecting her children.
bordering mental ill
5. Her religiosity is fulfilling a need for her. I would discuss better ways of caring for her children. Meds would also be considered. ***meds***
7. nil

089

1. Inappropriate, schizophrenic, religiosity, delusional.
schiz, delusional
5. Visits to a psychiatrist or walk-in clinic for thorough assessment, long-term follow-up preferably, as an out-pt in a supportive environment. Family interventions-Antipsychotic medications. ***psych/support/meds***
7. nil

Coding by External Reviewer
Psychiatric/Mental health Nurses: Vignette 2
Coding is in bold italics.

Number

010

1. Dangerous ***dangerous***
5. Try to get him to come to Emergency for assessment, if that fails, call police or see a Judge about Involuntary Examination. Wife should stay in safe place.
emerg/assess. Involuntary exam
6 Confident in my skills & resources as a nurse, not confident that the help would be successful. Depends on insight & results of examination.
7. Wife has option of pressing assault charges if above measures fail to result in this man's apprehension, as cooperation seems unlikely.

1. A pattern of violent behaviour is always cause for serious concern. ***violen***
5. -hospitalization, needs to be in protective environment and psychiatric assessment.
institute/psych assess
7. nil

052

1. Paranoid, likely hallucinating. A definite danger to society. ***paranoid/dangerous***
5. Hospitalization- likely requires certification. Pharmacotherapy- antipsychotics, sedation. Reality orientation. ***institute/meds***
7. nil

087

1. Potentially a danger to others- needs psych assessment & treatment. May need certification.
dangerous
5. Wife should seek assistance to get husband to emerg- either someone he trusts or police assistance if he refuses to seek help. ***emerg***
7. nil

066

1. I would say he is definitely paranoid and his behavior is uncalled for. ***paranoid***
5. He is very paranoid so he will have to be approached by someone who he knows and perhaps trusts a little at least. And than he could use psychotherapy first and then maybe hospitalization and medication.
psychotherapy/institute/meds
7. He might need to hospitalized and medicated first before psychotherapy although there is probably a reason why he became so paranoid so that should definitely be dealt with at some time.

150

1. Dangerous ***dangerous***
5. Hospitalization & treatment ***institute/treat***
7. nil

170

1. Paranoid psychosis c delusions of persecution.
paranoid
5. Hospitalization and psychotropic therapy -under certificates if the pt refuses therapy ***institute/treat***
7. nil

121

1. Thought disorder, high risk for violence- history of aggressive acts, suspiciousness, verbal threats of physical assault, misperceived messages from others- Ineffective family coping- ***violent, thought disorder***

5. Needs hospitalization for structured program & stabilization on meds as well as protection. Safety high priority himself, his wife & others. NB to develop trust/rapport- be calm honest help him feel safe & secure. This fellow needs hospitalization- as a formal pt if necessary. The wife needs to be included in care plans, given support & education re husband's illness.
institute/meds

7. Honest, respectful attitude is important in caring for him, note too much intimacy, warmth empathy may be seen as intrusive or as an attempt to control him. Readily acknowledge any errors made (ie I remember calling a pt by the wrong name) tactful polite but not overly elaborate apology best approach. East slighted, quick to react therefore needs to be observed closely for any changes that might lead to violence & defuse. PRN meds used when necessary. Note food/fluid intake- rest make sure physical needs are met & reassure ++ adequate staff around the clock & he will be safe.

Coding by External Reviewer
Psychiatric/Mental health Nurses: Vignette 3
Coding is in bold italics.

Number

007

1. Unhealthy behavior for two children to be raised under. This woman indicated she is unable to maturely conduct herself successfully in society. ***immature***

5. Children be removed from this home and have the woman seek counselling & job skills program.
remove children/counsel/career train

7. nil

033

1. Decompensating, labile, possible anorexic. Legal problems. (acting out) Unfit mother? Personality disorder?
decompensating/ ?anorexic

5. Psychiatric Rx outside hospital to keep family together. Possible placement for children until pt settles
psych/remove children

7. nil

044

1. Probably would benefit from psych. care.
psych care
5. Multi help- Social worker. Family Tx. Close follow-up.
social worker
7. The streets are full of people like this. Anything we can do seems a drop in a leaky bucket. I feel great frustration- her children & onward will be in a horrible cycle c society supporting them.

053

1. inappropriate- appears to something of a personality disorder c dependency traits.
personality disorder/dependency
5. -social services to interview her case -refer to a support group. ***social services/support group***
7. nil

058

1. severely emotionally disturbed.
emotionally disturbed
5. nil
7. I have difficulty c the meaning of question #6 because I would feel quite confident about trying to help her but I feel I would probably be moderately successful because people in need often don't want help.

081

1. Is having difficulty caring for self & children. Probably hasn't learned the skills.
?immature
5. Job training, parenting skills, working on ^ her self esteem. ***job t[illegible]n/parenting***
7. Obviously she must want the ass[illegible]ce.

101

1. Abnormal coping skills ? depressed, anxiety ? abusive childhood. ***decreased coping, depressed***
5. Referral for psychiatric assessment, ?group therapy ?Rx for depression ***psych assess***
7. nil

170

1. repeated disfunctional (sic) behavior patters (sic) - some borderline personality features (soliciting & criminal activity, unstable relationships, etc.)
dysfunctional
5. long term psychotherapy, increased social support and social worker involvement for the sake of the children. Parenting skills if client is amenable and some job training.
psych/social worker/parenting/job train
7. When I write "very confident" I refer to my ability to offer & plan appropriate therapy not to any assurance that the client will accept it at this time.

Coding by External Reviewer
Psychiatric/Mental health Nurses: Vignette 4
Coding is in bold italics.

Number

015

1. Psychotic- paranoid. more chronic than acute Fairly harmless but ^ agitation a concern.
paranoid/harmless delusional
5. He ought to be treated because these delusions might increase in intensity & because it may give him relief. Hospitalization (briefly)- Try to get compliance on long-term medication programme. ***hosp/meds***
7. There's not a good prognosis due chronicity (sic) and providing his delusions don't get more threatening to him he could manage s Rx.

038

1. His hearing messages through electrical waves is abnormal & he perhaps is harrassing (sic) the government personell (sic). This is also inappropriate.
abnormal/harrassment harmless
5. So far he is not a danger to anyone or himself, however he is responding to these messages & @ some point may respond to a command hallucination that could harm someone or himself.
7. nil

046

1. It is abnormal.. He is delusional.
abnormal/delusional
5. A visit to the psychiatrist. ***psych***
7. His symptoms could be reduced c psychiatric intervension (sic).

053

1. inappropriate- appears schizophrenic
schizo
5. admit probably not certifiable initiate psychotrophic (sic) medication post-discharge refer to support group (schizophrenic) ***institution/meds***
7. nil

056

1. Unusual, needs observation- at present not a danger.
unusual/harmless
5. Psych assessment if willing ***psych assess***
7. nil

060

1. As a psychiatric nurse, the behavior is irrational.
irrational/lonely/decreased self esteem
5. nil
7. I think his irrational behavior could be due to loneliness and low self-esteem. What about schizophrenia? Well, I still have to learn more about this "disease".

087

1. Annoying but not a danger to others or self. Needs psych assessment & treatment, but is treatable only if he agrees. ***annoying/harmless/mentally ill/delusional***
5. If any extended family around ie/ sibs, parents they could encourage him to see his G.P. for referral for psych assessment or family take him to psych clinic such as WIC @ UAH ***psych assess***
7. This man may go untreated for an extended period of time, esp. if he has no extended family. May eventually end up in emerg brought in by police for harassing others. May live isolated life with community aware he is "odd." Is probably mentally ill & needs chemotherapy to treat delusions & aud. hallucinations.

Coding by External Reviewer
Psychiatric/Mental health Nurses: Vignette 5
Coding is in bold italics.

Number
018

1. Shes (sic) psychotic ***psychotic***
5. maybe group therapy to keep her in touch c reality. Short term hospitalization to begin on antipsychotics
group therapy/hosp/meds
7. I believe she needs to be in hospital ASAP as the episodes last up to a week and she may suffer physically

037

1. May be other symptoms too. How concerned is she about this? How does it impair her lifestyle?
?
5. Explore further what these episodes mean to her and what help she wants. Assess.
?
7. What does she feel about these episodes? Does she want help to stop this?

046

1. It is abnormal- delusionary (sic). She has psychotic features. ***delusionary/psychotic***
5. A visit to her doctor. ***dr.***
7. This problem is not acute but more appropriate behavior should be strived for.

054

1. -auditory & visual hallucinations -socially withdrawn

hallucinating/withdrawn
5. psychiatrist> antipsychotic meds
psych/meds
7. nil

059

1. Schizophrenic c auditory & visual hallucinations.
schizo/hallucinating
5. Speak c her husband & assess patient's willingness to seek professional help.
7. nil

087

1. This lady probably has a mental illness & should have a psych assessment during one of these episodes.
mentally ill
5. A significant person in her life (ie) husband, parent) should encourage her to seek out help during one of these episodes. ***psych***
assess/OP/meds/counsel
7. This lady can probably treated (sic) on an outpt. basis, but will probably need chemotherapy c supportive counselling.

170

1. The fluctuating, episodic nature of her condition would make me suspect organicity/toxicity as much as psychosis.
psychotic
5. Diagnostic assessment ***assess***
7. nil

Coding by External Reviewer
Psychiatric/Mental health Nurses: Vignette 6
Coding is in bold italics.

Number

015

1. Very ill, psychotically depressed, catatonic features
depressed/catatonic
5. ECT Hospitalization, meds. Family help by way of social services, family (relatives)
ECT/hosp/meds/social service
7. Good prognosis I think if Rx is complied c

043

1. -could be dangerous to herself -behavior consistent c someone who is depressed with a thought disorder
depressed/suicidal
5. Again pt might benefit from her thought disorder & her depression. Might require assistance for ADL- ensure adequate nutrition balance ***family support***
7. -encourage supportive therapy for husband

054

1. -depressed> withdrawn, does not attend to ADL - suicidal ideations catatonic features at times
depressed/suicidal/catatonic
5. -psychiatrist -antidepressents (sic) support from nurse/drs ***psych/meds***
7. -Depending how severely debilitated this woman is, perhaps she would benefit from hospitalization -what is the husband's role? >is he supportive?

065

1. Major depression. Suicidal ideation. paranoid.
depressed/suicidal/paranoid
5. counselling- poss. hospitalization- poss certification if thoughts of killing self strong. medication (antidepressants) help in home (caring for family) while getting well.
counsel/hosp/meds/child care
7. nil

087

1. This woman is seriously ill & is at risk to herself & her children. ***seriously ill***
5. I would encourage her husband to take her to emergency for a psych assessment & possible admission. Have husband arrange alternative child care until wife is significantly better. ***psych assess/child care***
7. These children are at risk ie) neglect Woman is probably unable to help herself & would need assistance in obtaining treatment. May need certification, if she resists treatment.

Coding by External Reviewer
Psychiatric/Mental health Nurses: Vignette 7
Coding is in bold italics.

Number

018

1. ineffectual coping skills low self esteem ***decreased coping/decreased self esteem***
5. marriage counselling group therapy- ongoing for support ***counsel/group therapy***
7. nil

037

1. Pattern of alcoholism. His wife needs nursing intervention & Al anon. ***alcoholic***
5. Ideally, he would be seeking help and find AA treatment program. Wife & children need counselling & Al anon. ***family support/AA/Al Anon***
7. If he refuses help, and if she stays with him, she may be at high risk of violent assault.

046

1. The violence is unacceptable. ***violent***
5. Councelling (sic) ***counsel/family counsel***
7. Family councelling (sic) may be appropriate.

054

1. -aggressive -underlying depression ***alcoholic/?depressed***
5. -counselling- perhaps wife can go c him. support gp. > AA, AADAC ***counsel/AA/AADAC***
7. nil

059

1. alcohol abuse ***alcoholic***
5. AADAC Contact mental health worker or clinic and preferably get counselling in a long term drug facility ***AADAC/counsel***
7. nil

087

1. This man has life problems & possibly a mental illness, but first his alcoholism would need treatment.

alcoholism/?depress

5. Encourage man to have a psych assessment to determine if there is an underlying mental illness ie) depression which is contributing to his problems c alcohol & anger control.

psych assess/alcohol Rx

7. Even if this man is depressed, his dependence on alcohol would need treatment before psych treatment would be effective.

160

1. Dependent, frustrated person.

dependent/frustrated

5. Outpatient- family treatment. The man may not attend- but wife & children may need some options & help.

family support

7. nil

170

1. alcoholic c borderline personality traits ***alcoholic***

5. substance abuse counciling (sic) & confrontation about his behavior. -supportive therapy for his wife & family. Encourage his wife to proceed c legal action either now or defin[illegible] next time he assaults her.

counsel/family support

7. prognosis depends on his willingness to accept treatment and abstain from alcohol.

Coding by External Reviewer
Psychiatric/Mental health Nurses: Vignette 8
Coding is in bold italics.

Number

015

1. Schizophrenic- classic initial symptomatology

schizo

5. Hospitalization, meds, long term supportive gp Teaching to family, support.

hosp/meds/family counsel

7. Pretty disruptive illness resulting in major changes in expectations life goals.

033

1. Possibly schizophrenic (looking at age & premorbid personality) withdrawn. Paranoia? ***schizo/paranoid***
5. out pt Rx as lives c parents who can be responsible for her ***OP treatment***
7. nil

043

1. -Pt appears to exhibit signs of schizophrenia -Pt may be in high danger of hurting self. ***schizo/siucidal***
5. Pt should start on medication & receive therapy. Pt should be monitored closely. ***meds/therapy/family support***
7. Parents should be encourage (sic) to attend a support group.

049

1. School refusal-- onset of psychosis (hallucinations, depersonalization) ***psychosis***
5. Admission to an adult psychiatric unit & antipsychotics, insight-oriented group therapy. ***psych unit/meds/group therapy***
7. Should not be admitted involuntarily if @ all avoidable.

059

1. Suffering from mental illness- possibly schizophrenia. ***schizo***
5. appointment in outpatient department (psychiatric) or patient's doctor who will hopefully contact psychiatry. Have family involved in securing this treatment for patient. ***OP psych/family involve***
7. nil

087

1. This girl probably has a serious mental illness which requires psych assessment & treatment. ***serious mental illness***
5. Parents should either take daughter to emergency or take her to her G.P. for an urgent referral for a psych assessment > possible hospitalization. ***psych asses/Rx/family support***
7. Family will probably need support to deal with psych diagnosis. Girl may need certification if she refuses help as she may pose a threat to herself or others, depending on the content of the hallucinations.

121

1. ? Simple Schizophrenia. Impaired social interaction, sad mood, mistrust thought disordered-- body image disturbance-- Sensory-perceptual alteration ie hallucinations.

schizo

5. Assessment needed- Disorganized disturbed thought process- initially make decisions for her re grooming, activities, meals set up simple routine to prevent overwhelming her. Explain all procedures simple concise manner (**decrease**) anxiety.

assess/meds/family support

7. Family would require teaching & support. If diagnosed as schiz, the family may use denial, be very angry- grieve. The patient once improving needs help & teaching re medication compliance. Point out self Help-Support Groups.

Coding by External Reviewer
Psychiatric/Mental health Nurses: Vignette 9
Coding is in bold italics.

Number
007

1. I need more info' Perhaps he is moody b/c the pain in the back & legs- this would make me moody. Trouble c nerves? You need to expand on this! What is the medical history?

3. What matter? -the moodiness? -the back pain? -the nerves? -what? ***more info needed***

?chronic pain

5. That you give me more specific background info (especialiy medical) to indicate if there is a physical problem or is this man cdrawing?

7. The basis of my decisions on what kind of assistance this man would need completely depends on whether or not there is a genuine medical concern with this man's back, legs & what's cooking c his nerves?

010

1. Un[illegible]

5. Psy[illegible]py c mental health professional. Hypn[illegible]

Psychotherapy

7. nil

031

1. Probably depressed- expressed in physical symptoms- Perhaps avoiding difficult situations.
depressed/ low esteem
5. Should go to hospital for thorough evaluation, trial of antidepressants and follow up c therapy.
assess/meds/help re: employment
7. Needs help c re-employment when/if feeling better. Self-esteem probably low.

046

1. He may be depressed. ***depressed***
5. A visit to his doctor with specific request for help for depression. ***psychologist***
7. An appointment c the psychologist may be a good starting point.

056

1. Seclusive, probably depressed
depressed
5. See a GP- referred to psych. for support & antidepressants ***psych/meds***
7. nil

089

1. Feels unproduct[illegible] useless at a time of his life when he should be feeling the rewards of years of hard work, long relationships and children beginning to be more independent. Mild depression, anxiety and somatization result from failure to meet the standards of this age)Maslows- Eriksons)
depress
5. Referral to nurse counsellor or non-fee psychologist. Exploration of job retraining potential. Family therapy. He should have course (?sic?) have the physical symptoms checked out to make sure there is no organic basis.
psychologist/job retrain
7. Many men in this age of recession have similar pictures- we need to help them feel useful- volunteer work is also a possible area for exploration.

170

1. Depression. Loss of energy, motivation and zest, somatic complaints. Nerve medicine?=anxiolytics?
depress
5. antidepressant therapy under the supervision of a psychiatrist not a GP.
psychiatrist/meds
7. nil

Coding by External Reviewer
Psychiatric/Mental health Nurses: Vignette 10
Coding is in bold italics.

Number

015

1. could have a depression stemming from unresolved grief reaction ***depress/grief***
5. wait until the behavior worsens or interferes c other aspects of his life ***no intervention yet***
7. nil

018

1. sounds like he hasn't dealt c his mom's death ***unresolved grief***
5. group & individual therapy ***therapy***
7. nil

038

1. It is inappropriate. Needs some reality orientating. ***abnormal***
5. Seen by Dr on an outpatient basis. He is still able to function, but this may change. He will also require medication. ***OP/Dr/meds***
7. nil

044

1. Grief reaction- unresolved. ***unresolved grief***
5. Possibly psych care. Supportive. ***psych***
7. nil

059

1. abnormal. delusional. ***abnormal./delusions***
5. Speak c this gentleman and try to have him enlarge upon his experience. Point out that this is unusual behavior and that he should contact an outpatient clinic and get help for this behavior. ***OP therapy***
7. nil

087

1. May or may not have a mental illness. May have a delayed grief reaction-- should have psych assessment. ***delayed grief reaction***
5. Psych assessment should be completed- may need chemotherapy. Should also attend bereavement group. ***psych assess meds/bereavement group***
7. nil

089

1. It's questionable if this person needs any help whatsoever. Older aunts, uncles and older parents have related these kinds of phenomena in my family and other families. I don't think they are any crazier than the next perso[illegible] "sightings" seem to be a source of comf[illegible]eaved.

[illegible] *grief*

5. n[illegible] [illegible]ded no facet of his personality or behav[illegible]ated the presence of an organic or psychological illness. ***no intervention yet***

Coding by External Reviewer
Surgical Nurses: Vignette 1
Coding is in bold italics.

Number

703.

1. She is mentally ill. ***mentally ill.***
5. psychiatric care. Social services to see- esp re care of children ***psych***
7. nil

717

1. Schizophrenic ***schiz***
5. One to one therapy. Medication ***therapy/meds***
7. nil

723

1. she has delusions of grandeur and should be assessed to see if she is at risk to herself or others ie. her children. ***delusions***
5. an evaluation)see1) and psychiatric counselling if necessary. ***psych***
7. need more information to really answer these questions.

730

1. It seems as though she may have lost touch c reality. ***lost touch c reality***
5. Have her assessed by a psychiatrist. ***psych***
7. nil.

776

1. psychotic behavior ***psychotic***
5. consult with psychiatric Dr. or psychologist. Also refer to good chaplain SERVICE? ***psych/chaplain***
7. I wish to this pt refer to real good pastor for recommend to right religious way instead of this psychotic religious way

789

1. not normal. >>not coping or dealing with her new responsibilities or priorities with her family since her husband left. ***not normal***
5. councilling (sic) : psychologist: her & the family ***counsel/psych/family***
7. nil

796

1. Irrational. She needs some type of help. ***irrational***
5. Counselling- how has she coped on her own c five children t take care of ***counselling***
7. I don't think that her beliefs are of concern, but if she is neglecting her children, then that is of concern.

800

1. unusual ***unusual***
5. counselling ***counselling***
7. nil

806

1. inappropriate ***inappropriate***
5. psychiatric consultation & follow-up. Hospital ***psych consult***
7. nil

815

1. She's crazy ***crazy***
5. Psychiatric help ***psych***
7. The degree of help depends on how much she neglects (& the type of neglect) in regards to her younger children

Coding by External Reviewer
Surgical Nurses: Vignette 2
Coding is in bold italics.

Number

717

1. Paranoid schizophrenic. Personality disorder Behavioural ***paranoid/schiz***
5. Medication> antipsycohotic (sic) therpy (sic). ***meds/therapy***
7. nil

724

1. Paranoid. ***Paranoid***
5. Institutionsalizatio, possible medication to sedate and diagnose his dilusions (sic). ***institution/meds***
7. nil

743

1. His behavior is not rational or appropriate and he is in need of psychiatric help. He is a threat to the life of his family and others. ***not rational/threat***
5. Institutionsalizing c psychiatric intervention ie medication, counselling. ***institute/meds/counsel***
7. nil

771

1. Frighting (sic)- his behavior is putting others at risk.

frightening/threat

5. -counselling- -? screening for schizophrenia- perhaps medication is appropriate. His wife would also benefit from supportive counselling.

counsel/meds

784

1. neurotic, psychotic ***n[illegible]c, psychotic***
5. psychotherapy ***p[illegible]otherapy***
7. nil

794

1. unstable ***unstable***
5. psychiatric consult ***psych consult***
7. same

800

1. Psychotic ***psychotic***
5. Psychiatrist ***psych***
7. nil

806

1. dangerous ***dangerous***
5. psychiatric care (hospital) ***institution***
7. nil

815

1. He's extremely paranoid. ***paranoid/threat***
5. Hospitalization. ***institution***
7. Obviously this man is a threat to others & needs to be placed under supervision during Rx.

Coding by External Reviewer
Surgical Nurses: Vignette 3
Coding is in bold italics.

Number

713

1. coping behavoir (sic) ***coping***
5. some type of education (vocational) & child care assistance ***ed/child care assist***
7. I feel she needs help because of the involvement of children.

722

1. Immature; again this story is very sketchy what is her concern when she is in jail eg why is she hysterical in jail & how does she support her children?

Immature

5. Counselling. Remove her children until she can properly care for them. Psychiatric assessment.

counsel/psych assess/support

7. not sure what she needs other than emotional support. Does she have any support group eg family to turn to. Sounds like a very sad situation- like she is all alone in the world, a no one to turn to, no direction or career; emotionally immature.

725

1. Very insecure, lacks the ability to be a responsible parent to her children.

insecure/irresponsible

5. Counselling c a family therapist as well as c a psychiatrist.

counsel/therapist/psych

7. nil

743

1. Unstable behavior with an immature personality. She is likely looking for someone to look after her & relieve her of the burden of looking after herself and her children.

Immature

5. The children should not be left in her care. She needs counselling, financial help and specific direction in obtaining work she can handle. ***remove child/counsel/financial***

7. nil

765

1. She is not confident enough to overcome the situation. She is acting to seek more attention or probably more help or sympathy. ***not confident/attention seeking***

5. Needs Emotional and Financial help

emotional/financial help

7. nil

778

1. She 's stressed out and doesn't have very good coping skills.

stressed

5. counselling -soc services to help c support (financial etc)

counsel/financial help

7. nil

799

1. An immature person, who is seeking security & is overwhelmed with responsibilities she now has.
immature/insecure/overwhelmed
5. 1.Foster homes for children. 2.Guidance/career training for lady. 3.Foster person, perhaps live in, to provide a security, unconditional love base.
foster care/guidance-- career train
7. nil

803

1. It is immature ***Immature***
5. Give patient assistance c looking after her children. Have patient undergo training for an occupation.
child care assist/career train
7. nil

815

1. She has a very poor self-esteem. ***poor self-esteem***
5. counselling. ***counsel***
7. nil

822

1. I think her behaviour is a result of her situation. *?*
5. Group therapy. Something to ^ self esteem.Financial help. Career information.
therapy/financial help/career info
7. nil

Coding by External Reviewer
Surgical Nurses: Vignette 4
Coding is in bold italics.

Number

712

1. - he has a psychiatric disorder ***psych***
5. -psycho-therapy- medication to get his thoughts under his control ***psych therapy/meds***
7. - it is difficult to help someone with a disorder like hearing voices because it is difficult to understand the experience I think more information needs to be made available on why this occurs & how it feels- written by a pt. who has lived this experience.

713

1. Inappropriate, bizarre ***inappropriate, bizarre***
5. Help only if he indicated he will be a danger to others or himself. ***no intervention yet***
7. nil

722

1. Paranoid, hallucinations, delusions of persecution.
paranoid/delusions/lonely
5. Psychiatric hospital for treatment ***psych hosp***
7. -Could be stemming from lonliness (sic), depression, guilt feelings

723

1. He needs psychiatric help! ***psych/harmless***
5. He probably needs a lot of help to rid himself of these delusions but it seems he isn't harming anyone or himself (at least yet) so it's not too alarming yet.
no intervention yet
7. nil

730

1. His behavior is abnormal. ***abnormal***
5. That he be assessed by a psychiatrist. ***psych asses***
7. nil

743

1. He is delusional, but likely harmless. He probably annoys people, but poses no real threat.

delusional/harmless/annoying
5. Nothing at this point as he seems harmless. If he recognizes a problem c himself, he would likely seek help.
no intervention yet
7. nil

800

1. abnormal ***abnormal***
5. counselling ***counsel***
7. nil

806

1. "crazy" ***crazy***
5. psychiatric care > hospital ***psych care/hosp***
7. nil

822

1. Paranoid disorder ***paranoid***
5. Therapy ***therapy***
7. I'd like to know if his behaviour is interfering with his day-day activities. Does he have a job?

Coding by External Reviewer
Surgical Nurses: Vignette 5
Coding is in italics in right margin.

Nurse

722

1. Schizophrenia (sic), hallucinations *schiz/hallucinating*
5. Psychiatric hospital for treatment *psych hosp*
7. This is a chronic problem, but she seems to be able to deal with her life & carry on.

723

1. She has hallucinations *hallucinating*
5. psychiatric evaluation and treatment *psych asses/therapy*
7. Need more info. re: is she hurting herself or others? Can she?

724

1. Unusual ? the nature. *unusual*
5. Possible counseling and medical work- up to determine the nature of these episodses (sic). *counsel*
7. I have answered that I have no confidence to help these people in all these sitns because I am not trained in the area of psychiatry and have no interest in it.

725

1. This woman hallucinates. *hallucinates*
5. One to one sessions c a qualified psychiatrist. *psych*
7. nil

770

1. Strange *strange*
5. Medication- assessment of how much her life is affected. *meds*
7. If she can carry on her normal activities & the voices don't bother her too much-she should be OK s too much help.

784

1. depressed, psychotic *depressed/psychotic*
5. medication psychotic therapy *meds/psych therapy*
7. nil

796

1. Definitely abnormal *abnormal*
5. Psychiatric assessment & counselling (sic) *psych asses/counsel*
7. nil

803

1. Psychotic. Auditory hallucinating.
psychotic/hallucinating
5. Treat as an outpatient.. Point out reality and reassure.
treatment (OP)
7. nil

820

1. Disturbed ***disturbed***
5. Psych assessment ***psych asses***
7. nil

822

1. She needs help because her behaviour is interfering with her regular activities.
needs help
5. Therapy ***therapy***
7. nil

Coding by External Reviewer
Surgical Nurses: Vignette 6
Coding is in bold italics.

Number

703.

1. depressed, delusional, poss. suicidal
depress/delusion/suicidal
5. inpt psychiatric care -social service involment (sic) for children ***psych unit/social services***
7. nil

713

1. Depressed ***depress***
5. Therapy for depression drugs or councelling (sic)
meds/counsel

770

1. Big problem. Needs help ASAP
5. Admission to psych unit & treatment. Family involvement & plans to take care of children.
psych unit/child care
7. nil

776

1.I can't remember much of psychiatric terminology but definitely (sic)
?abnormal
5. admitt (sic) psychiatric unit ***psych unit/***
7. nil

796

1. Definitely has a problem.
5. Get help for her children also Psychiatric assessment & treatment ***psych assess/treat/child care***
7. my initial concern would be for the children's needs

798

1. major depression> lead to decreased ability to care for herself or others. She feels worthless & suicidal. ***depress/worthless/suicidal***
5. Hospitalization & constant observation to prevent injury to herself & to find reasons for severe depression. ***hosp***
7. nil

808

1. She needs help.
5. Psych Dr. Intensive councelling (sic). ***psych/counsel/meds/child care/family support***
7. This person can be helped c drugs & councelling (sic). This person needs a lot of love & care shown. - The children need help & a good explaination (sic) of their mother's behavior. -Family need support also.

810

1. Also needs to be seen by a psychiatrist. ***?abnormal***
5. ??(A psychiatrist) ***psych***
7. nil

820

1. Disturbed. ***disturbed***
5. Psych assessment ***psych assess.***
7. nil

822

1. Dangerous for herself & her children. +++ depressed ***depressed/dangerous***
5. Admitting her into hospital for intensive help. ***hosp***
7. nil

Coding by External Reviewer
Surgical Nurses: Vignette 7
Coding is in bold italics.

Number

712

1. he has an alcohol problem, related to his perception of a dead end life (perhaps) ***alcoholic***
5. support group to help him after recovery if it occurs, detox & counselling to help understand his behavior ***counsel/support group***
7. -this type of problem is greatly discussed in nursing & society. Many resources are available thereby providing information & increasing confidence in helping people in this situation

713

1. aggressive & abusive ***alcoholic/dangerous***
5. Alcoholic's Anonymous -Therapy to control anger ***AA/therapy***
7. nil

755

1. He sounds like an alcoholic ***alcoholic***
5. Joint counselling for husband & wife. Both to go to Alcoholics Anonymous. ***counsel/AA***
7. nil

765

1. a nervous alcholic (sic) man ***alcoholic***
5. Needs to see AADAC & needs lot of councilling (sic) ***AADAC/counsel***
7. Perso (sic) has a nervous personality disorder.

800

1. abnormal. ***abnormal***
5. counselling. ***counsel***
7. nil

801

1. Alcoholic. Dangerous. ***alcoholic/dangerous***
5. Referral to AA. Psychiatric help. Financial support for family. ***AA/psych/family financial support***
7. This seems very common in our society.

808

1. Not acceptable. Needs help. ***dangerous***
5. call police -Pt see Psych Dr -intensive counselling c male -provide safety for female -provide counselling for female
psych/counsel/
7. I feel his behavior will intensify & put the wife's life in danger.`

815

1. I think it's disgusting ***alcoholic***
5. He needs to be put in a detox centre c counselling
detox counsel/family support
7. His wife & children should also undergo counselling.

822

1. Inappropriate. Dangerous. Needs help so he does not hurt wife ***alcoholic/dangerous***
5. Therapy -AA > wife to be involved. ***A A***
7. He needs help because he is a threat to others and possibly himself

Coding by External Reviewer
Surgical Nurses: Vignette 8
Coding is in bold italics.

Number

713

1. Inappropriate ***schizo***
5. Therapy -possibly schizophrenic -look into past-possibly abused as a child? ***therapy***
7. nil

726

1. She seems to be out of touch c reality
schizo
5. She should go into therapy to get in touch with her true self before she becomes completely schizophrenic.

therapy
7. nil

748

1. Abnormal. Abused? Assaulted? Difficulty @ school? Poor self esteem. ***low esteem***
5. Intense psychiatric help ***psych therapy***
7. nil

771

1. ?sign of mental illness- ?schizophrenia
schizo
5. -counselling -?medication ***counsel/meds***
7. nil

785

1. schizophrenia ***schizo***
5. see a guidance counsellor & fr there a dr.
guidance counsel/dr.
7. nil

789

1. becoming a recluse, parinoid (sic), hysterical
paranoid
5. psych consult. & meds ***psych consultmeds***
7. nil

800

1. abnormal ***abnormal***
5. councilling (sic) ***counsel***
7. nil

806

1. "crazy" ***crazy***
5. psychiatric help- hospital ***psych hosp***
7. nil

808

1. not normal needs help ***abnormal***
5. See- psych Dr. -counselling for parents
psych dr./counsel>parents/meds
7. I feel the pt would be controlled c drugs.

822

1. She certainly needs help. I'd like to know what happened to change her behaviour...?event
abnormal
5. Therapy, family counselling ***therapy/family counsel***
7. nil

Coding by External Reviewer
Surgical Nurses: Vignette 9
Coding is in bold italics.

Number

703.

1. -depressed; ?mid life crisis -lazy -immature
depress/midlife crisis/lazy
5. outpt psych care ***OP psych***
7. nil

724

1. Depression, decreased confidence and self esteem
depress/low esteem
5. Psychotherapy, counselling, group support, re-evaluation of short & long-term goals, career change
psychotherapy/counsel/career change
7. nil

730

1. He possibly does have real pain & he sounds depressed.
depress/pain
5. It sounds like he should see a psychiatrist & find a way to feel better about himself. ***psych***
7. nil

765

1. This person is terribly depressed.
depressed
5. Find out the cause of his depression & try to make him happier with a better job ***job train/meds.***
7. Gradual introduction to a non stressful job. Make his home and work place happier. May need some antidepressent (sic) medication.

778

1. Depressed, anxiety ***depressed***
5. ?counselling ?meds ***counsel/meds***
7. nil

789

1. giving up. Doesn't like pressures of life anymore, > male menopause ***giving up/male menopause***
5. Kick in the ass!
7. nil

799

1. person who is removing himself from responsibility & main stream- dependent on medication-- "psychosomatic-"? c depression
depressed/psychosomatic
5. Person needs to be willing to seek other help agencies. Reevaluation of complaint, & subsequent treatment. Group setting? for personal skills evaluation & teaching. Give wife a vacation.
assess/group therapy/broaden interests/family support
7. Needs to enlarge interest areas_ too self-orientated-- and wife to withdraw from doing everything-- needs to develop independence again.

800

1. abnormal ***abnormal***
5. councilling (sic) ***counsel***
7. nil

810

1. a lazy bum ***lazy***
5. wife should kick him out
discourage wife from supporting
7. nil

822

1. Depressed- psychosomatic symptoms.
depressed/psychosomatic
5. Therapy. Something to ^ self esteem. Career counselling. ***therapy/career counsel***
7. nil

Coding by External Reviewer
Surgical Nurses: Vignette 10
Coding is in bold italics.

Number

712

1. I think it is a grief-provoked behavior -it is normal
normal/grief
5. -working c him to help him through his grief process& to discover if talking c his mother helps him.
help c grief
7. nil

722

1. hallucinating ***depress/hallucinate***
5. psychiatric assessment & treatment
psych assess/Rx
7. probably depressed, never adjusted to the loss of his mother.

770

1. OK ***normal/grief***
5. Have a "pretend" seance & let him think that his mother is retiring to another sphere& won't be seeing him again.
pretend seance
7. Did he go through grieving process-

784

1. psychotic ***psychotic***
5. meds psychotherapy
psychotherapy/meds
7. nil

785

1. introvert ***introvert***
5. meet people> see counsellor ***counsel***
7. nil

792

1. Depressed. Auditory & visual hallucinations.
depress/hallucinategrief
5. Psychiatric counselling. Group therapy to help him deal c grief of his mother's passing.
psych counsel/group therapy
7. He should be treated. It may not cause great concern but it's affecting his life. Maybe he is still grieving or maybe he really does have a psychiatric problem.

?aire too long comment

798

1. normal ***normal/grief***
5. He is grieving for his mother- wants to feel close to her & in some way communicate & share his feelings of loss. 7. nil

800

1. abnormal ***abnormal***
5. psychiatrist ***psych***
7. nil

808

1. Needs help. ***?abnormal***
5. Needs help although he is not a danger to the public. He may be a danger to the public if his mom suggests or tells him to do something ie) kill, harm etc. ***psych***
7. I would make a referral to see a Psych Dr. This was time consuming. I hope these people get help & get diagnosed.

822

1. Sad. Has not gotten over his mother's death. ***?normal/grief***
5. Bereavement counselling. ***bereavement counsel***
7. nil