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THE INFLUENCE OF A HUMAN RELATIONS LABORATORY ON THE EFFECTIVENESS OF THIRD-YEAR PSYCHIATRIC NURSES

BY

© KENNETH LLOYD CHECKLEY

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

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FACULTY OF GRADUATE STUDIES

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled THE INFLUENCE OF A HUMAN RELATIONS LABORATORY ON THE EFFECTIVENESS OF THIRD-YEAR PSYCHIATRIC NURSES, submitted by Kenneth Lloyd Checkley in partial fulfilment of the requirements of the degree of Doctor of Philosophy.

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ABSTRACT

This study was designed to determine the influence of an intensive short-term residential human relations laboratory experience on the effectiveness of third-year psychiatric nursing students' work with selected long-term hospitalized male psychiatric patients.

Twelve female members of the third-year class of psychiatric nursing students at the Alberta Hospital, Edmonton were selected for participation in the project. Two groups of six each were formed having been matched only on the criterion of nursing aptitude as measured by the Nursing Aptitude Test developed by Thelma Hunt. The experimental group participated in a short-term human relations laboratory experience while the control group were subjected to a placebo form of treatment. Prior to this treatment period and again following it each of the students completed the following instruments: The California Psychological Inventory, the Orientation Inventory and the Personal Orientation Inventory.

Following this aspect of the research project three pairs of psychiatric nursing students were selected from the experimental group and three pairs from the control group. Each pair met daily for one hour with a selected group of long-term male patients. Prior to the commencement of the group sessions on the ward and again following their conclusion, some four weeks later, each of the patients was assessed by a member of the permanent nursing staff using the following

instruments. The Hospital Adjustment Scale, The MACC Behavioral Adjustment Scale and the Psychotic Reaction Profile.

The data obtained were compared by the use of a one-way multivariate analysis and Hotelling's T^2 statistic. There were no significant differences noted at the desired level (.05). The student nurses interactions during their involvement with the patients in the group to which they were assigned were observed for ten-minute segments five times on the fifth, eleventh, seventeenth, twenty-second and twenty-seventh day of the four-week research period. These data were recorded by the use of Bales' Interaction Record and were subjected to a two-factor analysis of variance with repeated measures on factor 'B'. The analysis revealed that the experimental group responded significantly more positively, interacted more with their patients and employed fewer negative comments than did the control group.

This study did not reveal any significant changes in the personality of the students participating in the research treatment. Neither did it reveal any changes in the behavioral adjustments of the patients involved; however it did reveal significant differences in the manner in which the experimental subjects interacted with their patients as compared with the interaction of the control subjects with their patients.

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INTRODUCTION

Purpose of the Study

A movement is developing in the psychiatric community for the greater utilization of paramedical personnel in the actual treatment of the mentally ill. In particular, psychiatric nurses are becoming increasingly more involved with their patients in a therapeutic role. While it is true that many hospitals prefer that their psychiatric nurses continue with their traditional roles of being custodians and administrators of medication, some hospitals now take the view that, under proper conditions and with adequate training and supervision, the role of the psychiatric nurse can be expanded to reinforce treatment programs. In order to ensure that this changing role of the psychiatric nurse receives the support necessary for its initiation, psychiatrists must change some of their traditional views. According to Maxwell Jones (1964) this change is taking place:

> A fundamental change is occurring in the psychiatrist's concept of himself in the social field. From being the therapist in a two-person relationship, he is becoming the leader or co-leader in a therapeutic group or community meeting (p. 5).

Implicit in this movement for changing the role of the psychiatric nurse is the need to reconsider the training programs to which they are subjected. Programs aimed at

adequately preparing student nurses for their new role must emphasize therapeutic human interaction. Leon (1968) in a discussion of mental health training programs stated, "Therapeutic human relationships involve a process of dynamic interaction. We do not do things to people. We become involved in interacting with them (p. 24)."

Consequently training programs must be modified to include a greater emphasis on the dynamics of human interaction. However, Leon warned that this is not enough. Students must be taught that their training is not static but rather that it is a dynamic continuous process. Leon summarized the new approach needed for the preparation of mental health workers in this manner:

> While we are training people for therapeutic human involvements with others, we must at the same time train them for innovation -- not merely accepting the environment in which they are working as a situation that cannot be changed (p. 21).

The study undertaken by the present writer provided for the observation of selected third-year psychiatric nursing students' participation in a short-term human relations laboratory designed to help them discover and use their own resources for healthy and productive living, to find their own personal blocks to learning and change, to explore intrapersonal, interpersonal and group dynamics and to find opportunities for self expression. This exploration of the self is of extreme importance in the preparation of psychiatric nurses. Jones (1966) suggested:

> ... if staff do not spend a great deal of time examining their own inter-personal problems and how to deal with them it is doubtful if they are fully prepared to help patients in handling their problems of living (p. 1011).

Following their human relations laboratory experience the students were observed for a period of four weeks as they interacted with the members of the patient-group to which they were assigned. The purpose of this observation was an attempt to ascertain the influence of the students' participation in the human relations laboratory on the effectiveness of their work with patients on a continuing care ward at the Alberta Hospital, Edmonton.

General Statement of the Problem

This study attempted to determine the influence of an intensive short-term human relations laboratory experience on the effectiveness of third-year psychiatric nursing students' work with selected long-term hospitalized psychiatric patients.

Rationale for the Study

Research in T-group and related group process phenomena has increased steadily since its appearance on the psychological scene. This is not surprising for the founding fathers of this movement proclaimed as one of the initial purposes the necessity, "to accomplish through research a

gradual improvement in the theory and procedures of human relations training (National Training Laboratories, 1962, p. 14)." Unfortunately little research has been conducted to determine the efficacy of T-group training in modifying behavioral outcomes. Campbell and Dunnette (1968) strongly urged researchers to accept this challenge stating:

> Researchers must devote more effort to specifying the behavioral outcomes they expect to observe as a result of T-group training. The specifications should include the kinds of situations in which the behavior will or will not be exhibited (p. 99).

The study conducted by the present writer was designed to evaluate the results of human relations training upon the effectiveness of third-year psychiatric nursing students' performance in group psychotherapy with long-term hospitalized psychiatric patients. It was suggested that observable differences in the nurse-patient interaction would be noted between the experimental and control subjects favoring the former.

Programs currently being employed for the preparation of psychiatric nurses appear to be generally adequate. However students find it both difficult and trying when they are required to interact with chronic patients. Their primary concerns are feelings of inadequacy and difficulty in communicating with these withdrawn, isolated patients. In an effort to remedy this situation Collingwood (1969) suggested the use of group training to increase the communicative facility of mental health workers:

> There is a large body of evidence in the

> literature indicating that the core facilitative dimensions of empathy, respect, genuineness and concreteness are positively related to more effective interpersonal communication within many contexts such as psychotherapy, teaching, child rearing and everyday functioning (p. 461).

The basic characteristic of chronic psychiatric patients, particularly if they are psychotic, is their impoverished communication with the environment (Battegay, 1965). Kramer and Daniels (1959) suggested that the chronic psychotic patient is unable to form meaningful social relationships. They noted:

> His isolation and withdrawal may be conceived of as a defense against the anxiety engendered by human contact. If one could provide an experience in which the anxiety was diminished and the relatedness fostered, these defenses might be reduced in intensity (p. 119).

Kramer and Daniels concluded that group psychotherapy may be a useful treatment procedure with chronic hospitalized patients. Papanek (1969) supported this conclusion and stated, "Man as a social being needs one-to-one and group relations for survival and growth, and for the unfolding of his potential. Man needs socialization to become individualized (p. 397)." However, Papanek added a note of warning:

> But, we have to realize that such relationships, even if intended to be curative, can be any one of three things; destructive, stagnant or therapeutic. They can increase psychologic pathology leave it as it is, or hopefully decrease it (p. 397).

Clinicians responsible for the treatment of psychiatric patients often see it as a process of re-education. The

maladaptive behavior mechanisms which the patient has developed requires unlearning and in its place the patient must learn new effective behavior patterns (Hanson, Rothaus, O'Connell, and Wiggins, 1969). Group therapy, an effective experience-based educational innovation, is seen as a suitable treatment. The authors noted that the patient may utilize the feedback he gets and develop a sense of responsibility for himself:

> Once the participant becomes established in the laboratory, he begins to realize that his stereotype of the patient role is no longer appropriate. He is now held accountable for his behavior and must learn to make decisions, to handle problems that come up in relation to his group and to the laboratory as a whole, and to deal with crises (p. 127).

In a further comment the authors noted:

> Part of the philosophy of the laboratory is that only when the participant realizes that he is responsible for his behavior can he assume some controls over it (p. 127).

In an outcome study of group psychotherapy Yalom (1970) found that patients underwent a shift in their therapeutic goals somewhere between the third and the sixth month of therapy. Their initial goal, the relief of suffering, was replaced by new goals usually interpersonal in nature. "Thus goals changed from wanting relief from anxiety or depression to wanting to learn to communicate with others, to be more trusting and honest with others, to learn to love (p. 19)." It is true that the initial goal could very easily have been achieved in dyadic psychotherapy. However the latter goals would seem to be achieved most successfully in group psychotherapy. Perhaps it could be concluded that dyadic and group

psychotherapy complement each other and often serve supplementary functions directly related to the goals of the patients.

In summary it must be noted that the study conducted is, in reality, a two-part study. The first part involves the participation of selected students in a human relations laboratory while the second part deals with the interaction of the nursing students with selected groups of long-term hospitalized psychiatric patients. Evidence supporting the premise that participation in a human relations laboratory will result in observable behavioral changes in applied situations is scant and highly subjective. Nevertheless the writer concurs with Campbell and Dunnette (1968) who concluded: "The evidence, though limited, is reasonably convincing that T-group training does induce behavioral change in the 'back home' setting (p. 98)."

The utilization of group psychotherapy has been well studied and documented over the years (Bion, 1961; Bradford, Gibb and Benne, 1964; Corsini, 1957; Mullan and Rosenbaum, 1962; Ohlsen, 1970; Perls, 1969; Rogers, 1967; Satir, 1967; Whitaker and Lieberman, 1964; and Yalom, 1970) and, while still controversial, appears to have won a place as a legitimate treatment procedure. Unfortunately there is a paucity of empirical research supporting a study such as the one undertaken by the present writer; however the need for research attempting to evaluate behavioral outcomes of human relations laboratory experiences warrants this study.

CHAPTER II

REVIEW OF THE LITERATURE

The general plan of this chapter is a review of the literature related to the study conducted by the writer. In addition a review of selected research studies similar to the one being presented herein is also included. The first section of this review deals with some aspects of human relations laboratory training which are relevant to the first segment of the writer's study in which the experimental subjects participated in a short-term human relations laboratory. The second phase deals with the nurse as a therapist. Included in this section is a review of the interpersonal problems faced by the nurse, the usefulness of human relations laboratory training in the nurse's preparatory program and the feasibility of employing nurses in this relatively new role. The third segment deals with some aspects of group psychotherapy particularly relevant to the employment of this form of treatment with psychiatric patients. The final portion of this chapter deals with research studies which have attempted to determine the usefulness of human relations laboratory training as a change-agent in a variety of settings.

Human Relations Laboratory

Introduction. Human relations laboratory training

had its beginning as a result of a workshop held during the summer of 1946 when Kurt Lewin and some of his associates met in a conference aimed at developing effective leaders in facilitating communication. The following summer some of these same conference members met at Bethel, Maine and established the National Training Laboratories. The term laboratory, a temporary residential community shaped to the learning needs of its members, derived its usage from the fact that the essential method of learning in this procedure is one in which members are helped to diagnose and experiment with their own behavior and relationships in an environment created for this purpose. The National Training Laboratory has grown rapidly since its inception with many major universities having established research centres for group dynamics and offering graduate courses in group processes. Officially it is known as the National Training Laboratory Institute For Applied Behavioral Sciences and is associated with the National Education Association located in Washington, D.C. (Bradford, Gibb and Benne, 1964).

Miles (1962) defined human relations laboratory training as:

> ... intensive group self-study, procedures, usually taking place in a residential setting, and designed to bring about increased sensitivity and skill in relation to social-psychological phenomena occurring in interpersonal groups, and organizational situations (p. 4).

The T-Group. Although activities such as lectures dealing with the theoretical aspects of group dynamics, films,

demonstrations and nonverbal exercises are employed at the discretion of the trainer in charge of the group, the major element of human relations laboratory training is the T-group experience. Bradford, Gibb and Benne (1964) defined a T-group as follows:

> A T-Group is a relatively unstructured group in which individuals participate as learners. The data for learning are not outside these individuals or remote from their immediate experience within the T-Group. The data are the transactions among members, their own behavior in the group, as they struggle to create a productive and viable organization, a miniature society; and as they work to stimulate and support one another's learning within that society (p. 1).

Goals and meta-goals. Implicit in the functioning of most T-groups, according to Schein and Bennis (1965) are a number of seldom articulated meta-goals, that is goals which exist at a general level. Schein and Bennis (1965) mentioned five meta-goals which they considered to be the ultimate aims of all T-group training. These are for participants to achieve:

- a spirit of inquiry,
- an expanded interpersonal consciousness,
- an increased authenticity in interpersonal relations,
- an ability to act in a collaborative and independent manner with peers, superiors and subordinates, and
- an ability to resolve conflict situations through problem solving rather than through coercion, or power manipulation.

Campbell and Dunnette (1968) suggested that there are a number of more specific goals or objectives usually made explicit in a well functioning T-group. The list which they present is drawn from a variety of sources (Argyris, 1964; Buchanan, 1965; Miles, 1960; Schein and Bennis, 1965; and Tannenbaum et. al., 1961):

- increased self-insight or self-awareness concerning one's behavior and its meaning in a social context,
- increased sensitivity to the behavior of others,
- increased awareness and understanding of the types of processes that facilitate or inhibit group functioning and the interactions between different groups,
- heightened diagnostic skill in social, interpersonal and intergroup situations,
- increased action skill (at interpersonal rather than simply the technological level), and
- learning how to learn.

These goals are achieved in the T-group through a common core of processes relative to the goal or goals considered paramount by the trainer and his preferences with regard to techniques (Campbell and Dunnette, 1968). However common to most groups are the following features; a small (10 to 15 members) unstructured face-to-face group, a trainer

who does not assume a leadership role, participants discussing themselves, a focus on the "here and now", and cognitive aspects of problems ancillary to feelings and emotions.

Group pressure. A powerful force influencing the achievement of a group's goals is the pressure exerted by the group itself. Cartwright and Zander (1960) reviewed the literature on group pressure and identified three functions which they believe pressure towards uniformity serve:

(1) To help the group accomplish its goals,

(2) To help the group maintain itself as a group, and

(3) To help the members develop validity or "reality" for their opinions (p. 169).

They further point out that the pressures applied on group members are directed toward "approved" behavior and are often called group standards. However, it is noted that the group's standards are concerned with only a few of the actions and opinions held by the members.

Leadership. Throughout the history of the National Training Laboratories the concept of leadership has been a controversial issue. Haiman (1951) traced the development of democratic group leadership noting that the ideals which are now held to be true and unchanging have emerged slowly. Three types of leadership were distinguished by Ross (1957): the person who is ahead of his group because of some outstanding achievement; the person who is the head of his group having had the leadership bestowed upon him in a gesture of status;

and the person who emerges in a given situation assisting the group to determine and achieve its goals. He is a head of a group. This latter view of leadership is favored by those who seek a shared leadership situation. Gordon (1951) suggested that leadership must assure an individual freedom from dependency upon others. He noted that an individual must find sufficient freedom in his everyday life to allow for the greatest realization of his individuality.

In a discussion of group processes Kemp (1970) contrasted the styles of leadership common to the authoritarian, democratic, client-centred, T-group and encounter settings. The authoritarian leader is seen as establishing the purposes and objectives, and the methods by which they will be attained. The democratic leader is pictured as the facilitator encouraging freedom of expression, respect for the individual and endeavouring to understand the individual and the meaning of his verbal expression. The client-centered leader is characterized as a listener who conveys his interest in each member through his genuine warmth, empathy and his non-evaluative attitude. The techniques employed are clarification, reflection, synthesizing and the linking of members' ideas. Leadership in a T-group is seen as multifaceted and determined in large measure by the personal values and beliefs of the trainer. The direction taken by the trainer is relative to the organization with which he is working. The leader of an encounter group is perceived as a facilitator of the thoughts and feelings of the members. He is not a member in the usual sense. His techniques vary from per-

missiveness in the early stages to interpretation and evaluation in the later stages. The importance of the trainer in any group situation cannot be over emphasized. Garwood (1967) stressed this point and noted, "... what transpires in a sensitivity training group (T-Group) varies with its composition and most especially with the trainer (p. 471)."

Developmental Stages. It is generally agreed by observers of T-groups that distinct stages are identifiable in the development of the group over time. Rogers (1967) noted that groups tend to pass through four stages in sequential order. He has labelled these stages as milling around, resistance to personal expression or exploration, description of past feelings, or the expression of negative feelings, and the expression and exploration of personally meaningful material.

Foley and Bonney (1966) discussed the stages through which groups pass in their development. They identified the early group sessions as constituting the establishment stage. In this stage group members reveal individual characteristics through verbal and non-verbal expression and receive feedback from the other group members. Role and status relationships have been polarized by the termination of this stage. The group enters the transition stage once through the establishment stage. Here the members accept the group goals as being unique. Early in this stage they realize that the purpose of their existence as a group is to allow therapeutic experiences to take place. Unfortunately this realization

carries with it a negative connotation about discussing one's personal problems. It is at this point that the group's development is often characterized by a lack of involvement on the part of the group members for fear of violating the perceived social norm which prevents them from discussing personal problems. This incongruency is resolved by the acceptance of a new norm that insists on the discussion of personal problems.

In a rather comprehensive review of the literature Tuckman (1965) identified four stages in the sequential development of small groups. Stage one is characterized by the testing of the trainer which helps the group members identify the boundaries of both interpersonal and task behavior. Coincident with this testing is the establishment of dependency relationships with the leader, other group members or pre-existing standards. This orientation, testing and dependency constitute the forming stage. The second stage is characterized by conflict and polarization around interpersonal issues. Emotionality is noted in the attempt to carry out group tasks. Resistance caused by this behavior is evident and this may be called the storming stage. In the third stage, this resistance is overcome. This stage is characterized by a development of in-group feeling and cohesiveness, by the evolving of new standards and the adopting of new roles. In the actual task situation personal opinions are expressed. Hence, this stage is called norming. The final stage is that

in which interpersonal structure becomes the tool of task activities. In this stage roles become flexible and functional, and the group's energy is directed into the task at hand. The structural issues which plagued the group earlier have now been resolved and the structure has become supportive of task performance. This stage, therefore is labelled as performing.

Confusion of terminology. A great deal of confusion exists with regard to group procedures and much of this is due to the inappropriate use of the terminology (Kagan, 1966). Some T-groups are designed to meet individual needs whereas others are designed to meet organization demands. Unfortunately the terms T-groups, sensitivity group training, encounter group, residential laboratories, and marathon laboratories are often used interchangeably with no regard for their basic differences. Encounter groups, confrontation sessions and marathon laboratories are focused on the individual. Encounter groups according to Birnbaum (1969), encourage participants, "to explore in some depth their own feelings and motivations, as well as those of other group members. The object is to stimulate an exchange that is inhibited by a minimum of reserve and defensiveness (p. 83)." Marathon laboratories are characterized by the intensity of the experience, usually forty-eight hours with few interruptions. T-groups and sensitivity groups have been used most often to increase a member's interpersonal awareness and to correct distorted perceptions.

The problem of silence. One of the most threatening situations to arise in a group is the elongating periods of silence which tends to occur when the initial burst of enthusiasm has subsided. It is especially important that those who work with withdrawn chronic patients be assisted in their understanding and acceptance of this potentially devastating problem.

In a discussion of the silent period Hughs (1957) suggested that the criticism engendered is based on the assumptions that the total value of the group process should lie in the result, ignoring the process, and that nothing is occurring during the period of silence. Hughs pointed out that the silent period may be the most fruitful portion of the session. It is during this silence that the participant may be balancing the thoughts of the group with his thoughts, experiences and background and observations in a practical situation. Silence does not necessarily mean that an impasse has been reached. It is possible that much creative thinking occurs during this break in the discussion. The floor is open during this silent period and a free atmosphere allows anyone to talk. This freedom to be the one to begin the discussion is self-enhancing to each individual. Even though thoughts may remain unspoken they have been fashioned and clarified and this completeness of the thought process increases the chance for agreement throughout the thinking of the group members.

Jeep and Hollis (1957) also suggested that silence

is a valuable part of group dynamics. However, they noted that it is often threatening to the member of an inexperienced group. They suggested that the value of silence, in the group process, be discussed soon after the first threatening silence occurs to avoid the threat to members in the future.

The influence of Kurt Lewin. The National Training Laboratories Institute is deeply indebted to the work of Kurt Lewin, a German psychologist who emigrated to the United States in an effort to escape from the impending Nazi takeover of his native land. At this time Lewin was expanding his work in field theory and developing an increasing interest in group dynamics. Lewin's research led him to believe that well established beliefs could be changed when the individual was able to examine them personally and conclude that they were unsatisfactory. Methods aimed at changing attitudes must provide the individual with opportunities for discovering the deleterious effects upon himself and others of his traditional behavior. The individual must see himself as others do. Only when this occurs will his attitudes and subsequent behavior change (Yalom, 1970).

Theoretical background. Sheperd (1964) reviewed the theoretical foundations of human relations training. Included were the theoretical formulations of Lewin, Homans, Bales, Thibaut and Kelly, Hemphill and Cattell and Bau. A more detailed account of the work of Homans and Bales is given by Olmsted (1959). These models tend to be cognitive in nature and do not account for the feelings and attitudes of the group participants.

The clearest statement of a theoretical position wherein group-level processes were given a major emphasis without abandoning attention to the individual was presented by Whitaker and Lieberman (1964). According to the authors the psychologic group formation is triggered by any shared effects rather than by emotional relationships evolving around a central person. The crux of the therapeutic process is the group's more or less effective efforts at resolving conflicts. At any point in the group's development two opposing forces are discernable: the disturbing motive (wish) and the reactive motive (fear). The group's efforts to cope with these forces are termed the group solution. The disturbing and reactive motives constitute a shared unconscious conflict which the authors term the "group focal conflict." The group solution represents a compromise between these opposing elements and is aimed at the alleviation of the reactive fears as well as at the gratification of the disturbing wish. These solutions may be restrictive, directed merely at alleviating fears or enabling, that is satisfactorily resolving personally disturbing impulses.

The following two theories to be discussed stress a progressive phase movement of the group as an entity toward maturity and shared group affects. They stress the predominance of basic emotional themes related to the members' feelings toward the leader, other group members, and the group itself in each of the developmental phases. Bion (1959) identified three dominant themes; dependency, fight-flight and

pairing, in relation to the individual's dominant fantasied perceptions.

The Fundamental Interpersonal Relations Orientation system (FIRO) was developed by Schutz (1958). After a review of a large number of studies of interpersonal behavior he concluded that the three basic interpersonal needs are inclusion, control and affection. These three needs require resolution as the group progresses. Schutz noted that initially the group deals with the problem of inclusion: to join or not to join; to commit oneself or not. The second stage, control, entails a leadership struggle in which individual members compete to establish their place in the hierarchy culminating in resolution. The final stage is characterized by the group's dealing with the problem of affection. Distinctive features of this stage are emotional integration, pairing, and the resolution of intimacy problems.

The National Training Laboratories Institute views learning as a transaction between learner and environment in which neither learner nor environment is regarded as fixed and in which both undergo change. In the T-group the stimulus is the behavior of the other persons. The members tend to positively reinforce an individual's "correct" responses and to negatively reinforce his "incorrect" responses. The T-group develops standards against which the correctness or appropriateness of a member's response can be measured. Hence much individual learning about the criteria of appropriateness occurs in the T-group. The importance of instantaneous feed-

back concerning the effects of the leader's exploratory responses cannot be over-emphasized. A serious problem faced by T-groups is the withholding or distorting of responses by persons with whom another person has tried to interact. The T-group leader must endeavour to assist the group in identifying and managing those factors which are causing members to withhold or distort their responses so as to reduce them and allow feedback to become more instantaneous and authentic (Bradford, Gibb and Benne, 1964).

The general theoretical models presented above do not give a clear picture of the human relations laboratory learning process. These are theories of group development but they often leave the individual without any real understanding of how to induce change or to create a learning situation (Schein and Bennis, 1965). Schein and Bennis noted, "Another way of focusing the dilemma of theory is to point particularly to the lack of learning or change theory, not of all theory (p. 271)." The authors have developed a theory of learning through laboratory training. This theory will be presented in some detail in an effort to answer the questions most often asked of laboratory trainers, namely why does it work and how do people learn in a T-group?

Theoretical model developed by Schein and Bennis. Learning theory in reference to laboratory training has been difficult to develop because, "the learning outcomes involve at one and the same time a cognitive element (increased awareness), an emotional element (changed attitudes), and a

behavioral element (changed interpersonal competence) (Schein and Bennis, 1965, p. 272)." They suggested that the solution to this problem resides in the concept of a sequential cycle of interdependent learning steps. The initial step is a dilemma or the awareness of some disconfirming information which produces attitude change. This attitude change precipitates a behavioral change which in turn serves as data for other group members producing new awareness in them. The new awareness produces attitude change and more behavioral change. Hence the cyclic effect. In order to be able to learn from the laboratory, a person must change his attitudes about the learning process itself. Schein and Bennis (1965) noted:

> In effect, he must come to accept some of the meta-goals of laboratory training, particularly those which pertain to a spirit of inquiry and a willingness to be more authentic in relationships. The person will not be able to obtain new awareness of himself and others unless he learns to pay attention to and to value the here and now data which he and others generate in the laboratory (p. 273).

The importance of this step is reiterated:

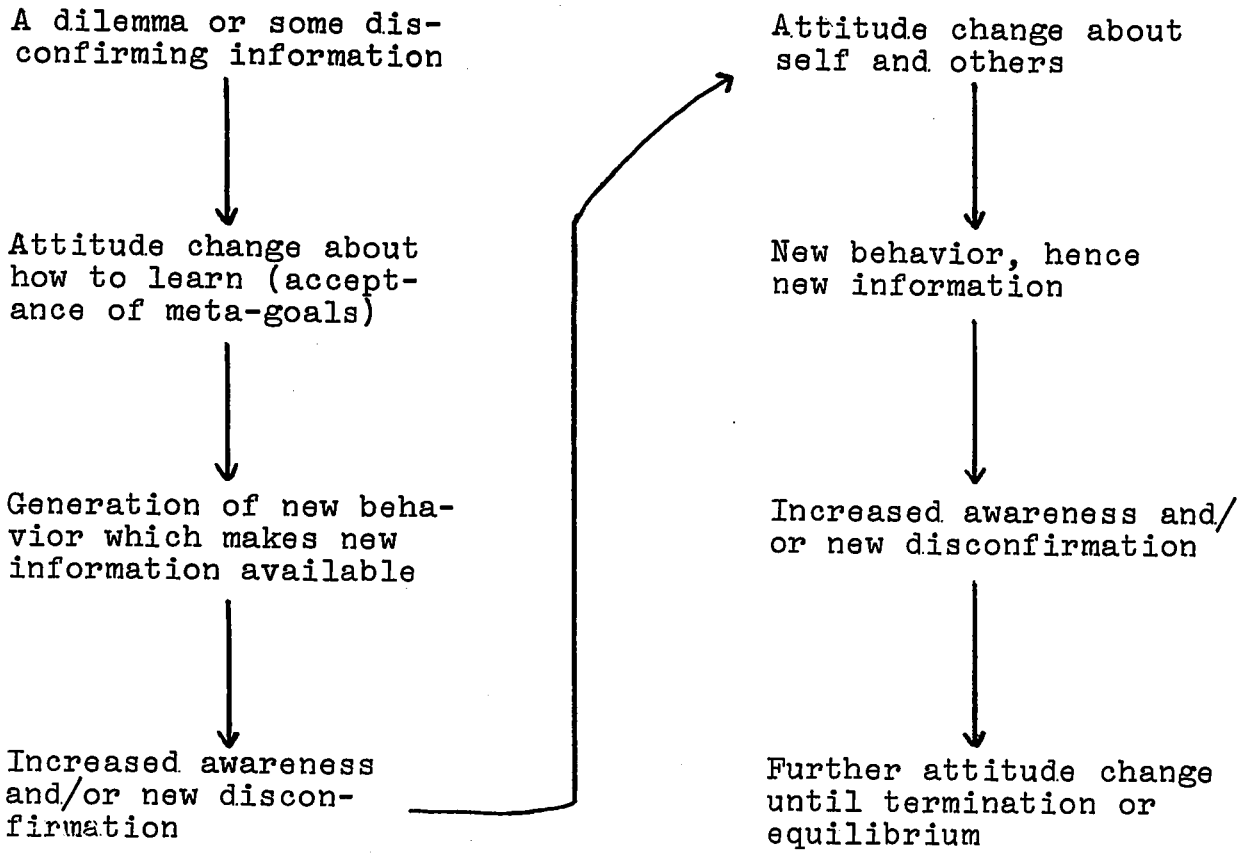
> Learning to pay attention to and value such data involves a fundamental attitude change toward the learning process itself. This first attitude change step is, therefore the single most important component in the total learning cycle (p. 273).

If this step is successfully completed group members will begin to reveal their reactions and feelings about each other and the group thus generating the data which others need to increase their awareness of what is happening.

At this point the new data (reactions and feelings) serve as an information input which may disconfirm certain other attitudes. Not attitudes towards learning but attitudes which the group member has toward himself, toward others and toward groups in general. This causes the cycle of attitude change to begin anew. Schein and Bennis (1965) noted that the basic elements of this cycle are:

> (1) that information serves both as the source of attitude change and increased awareness, depending upon the degree to which it unfreezes the person, (2) that attitude change is the fundamental prerequisite to behavior change, and (3) that only behavior change makes new information available to others. In this sense, the three levels of learning are highly interdependent and must be treated as parts of a single learning process (p. 274).

The major component of the learning process is attitude change. The attitudes referred to are those which pertain to the learning process and those which pertain to self, others and groups. These attitudes are generally quite central to the individual and, according to the authors are likely to be integrated with his self-concept and his personality. The disconfirmation that arises produces strong emotional responses and anxiety about one's basic sense of identity. Attitudes in this area are likely to be tenaciously held and resistant to change. The cyclical nature of this theory is presented in a diagram from Schein and Bennis (1965, p. 274).



The model developed by Schein and Bennis (1965) to effect attitude change corresponds closely to what Lewin identified as the stages of change: unfreezing; changing; and refreezing. Stages one and two are necessary conditions of change, whereas stage three is concerned with the stability of whatever change that may have occurred. In each of the stages certain key mechanisms are identifiable. Schein and Bennis (1965, p. 275) summarized the model as follows:

Stage 1. Unfreezing

1. Lack of confirmation, i.e. disconfirmation.
2. Induction of guilt-anxiety.
3. Creation of psychological safety

by reduction of threat or removal of barriers to change.

Stage 2. Changing
1. Scanning the interpersonal environment.

2. Identifying with a model.

Stage 3. Refreezing
1. Personal-integrating new responses into the rest of the personality and attitude system.

2. Relational-integrating new responses into ongoing significant relationships.

An important condition must be met in order that change may occur. That is, sufficient psychological safety must prevail or the individual will merely become more defensive and rigid. In a secure situation the individual will seek new information about himself which will permit him cognitively to redefine some of the beliefs he holds about himself and his relationships to others. This new information may be obtained by one of two basic mechanisms:

> 1. Scanning the available interpersonal environment for relevant cues.
> 2. Identifying with some particular other person whose beliefs seem to be more viable (Schein and Bennis, 1965, p. 276).

As the individual's frame of reference shifts he develops new beliefs about himself which lead to new attitudes and behavioral responses.

Schein and Bennis (1965) outlined clearly those forces which they believe initiate the first and most important attitude change - learning how to learn and coming to value the meta-goals of laboratory training. It is felt that

once this crucial step is completed the learning process essentially takes care of itself. In the residential laboratory the participant has, from the beginning, imposed upon him a social structure and a culture that have been largely created by the staff. It is noted that this social structure in combination with the training design creates the essential forces that make learning possible. The authors have grouped these forces into three major categories.

I. Forces that motivate learning by unfreezing the delegate. Included in this group are the following: (1) isolation from accustomed sources of support - one's associates, family and the daily routine; (2) removal of self-defining equipment such as the title and status one may have in the "back home" situation; (3) loss of certain areas of privacy, for example at a residential laboratory participants share rooms; (4) lack of confirmation or actual disconfirmation of roles which are appropriate in the "back home" situation, the participant's accustomed role is not supported but rather support is given to the participant's adoption of a learner's role; (5) breakdown of hierarchical authority and status structures in favor of a kind of peer culture and informal status based on laboratory norms; (6) a set of laboratory norms about the value of the learning process and the method of learning, the participant soon learns that he must actively participate, expose himself, be willing to seek help available, be willing to tolerate some tension and above all trust the basic laboratory method; and (7) a deliberately

created lack of structure to heighten consciousness of self and the creation of unavoidable dilemmas.

II. Forces that enhance willingness to be open and authentic by reducing threat from others. This group of forces includes the following: (1) the laboratory is seen as a temporary game; it is short, informal and isolated from the everyday world. There is no product to be manufactured and, with the exception of team training, none of the relationships formed during the laboratory are permanent or extended into the "back home" situation. The individual's basic needs are taken care of and a clear-cut routine of activities minimizes choices resulting in a culture which de-emphasises responsibilities while concentrating on learning or change; (2) The learning method is seen as protective. The threat from others is reduced by placing an emphasis on specific here and now events and acts rather than people, by an objective reaction and analysis rather than evaluation, and by the legitimacy of experimentation; (3) The psychological theory presented offers protection in declaring that feelings are ever present and normal, that every individual has both tender and tough emotions and that feelings have causes which can be understood; (4) Group members view the staff as a source of protection. The existence of a planned set of learning experiences and related theory convinces the members that all is well and that they will not allow anyone to be really hurt; and (5) Most laboratory personnel accept the responsibility of providing counseling services should the need arise.

III. Forces that enhance willingness and ability to listen to and pay attention to the reactions and feelings of others by reducing threat from within. (1) The temporary nature of the laboratory experience with its basic egalitarian atmosphere works toward providing reassurance for the members; (2) The learning method emphasizing objectivity, nonevaluation and focusing primarily on incidents and behavior rather than on how to cope with their innermost feelings; (3) The presentation of psychological theory relevant to the problems of listening and feedback tends to support the exercises and interventions which the trainer may utilize; and (4) Laboratory staff members assist members in coping with their inner threats partly by being available as powerful figures whose strength can be borrowed through identification and example.

Summary. This segment began with a brief sketch of the historical development of the group movement stressing the contribution made by Kurt Lewin. A distinction was made between the laboratory method and its major component the T-group. Several goals and meta-goals were enumerated and the influence of group pressure in achieving these goals was noted. The important concept of leadership was discussed primarily because of the role of the leader as a model for the group members to emulate. Certain developmental stages over time were presented in the belief that the final assessment of the outcomes of the research study undertaken must take into consideration the level of development achieved by the research group. The extensive confusion with regard to term-

inology was noted. Silence, the ever-present problem in groups was discussed and the evidence presented appears to indicate that there is some value in the silent period regardless of how difficult it may be for those concerned. A considerable portion of this segment was devoted to the theoretical foundations underlying the group process movement. Evidence seems to support the suggestion that many of the theories presented are primarily concerned with small group development as opposed to dealing with what actually transpires in a group to effect change. The model developed by Schein and Bennis (1965) was presented in some detail as it focuses primarily on the process of change within a group in a residential setting such as the one employed in this study.

Literature Dealing With the Nurse as a Therapist

Preparation of psychiatric nurses. The preparation of psychiatric nurses is a difficult task for it requires a delicate blending of the traditional basic nursing procedures with the interpersonal skills necessary to effect a therapeutic nurse-patient relationship. The innovation of group methods, milieu therapy and administrative psychiatry has been referred to as the third revolution in psychiatry. Many writers, including Jones (1965) feel that this recent emphasis on group centered techniques is replacing Freudian methods as the major component of psychiatric treatment procedures. The introduction of group process courses into the

preparatory programs of mental health workers is steadily increasing. Leon (1968) stated:

> ... training programs should emphasize self understanding and its role in understanding and relating to others; how institutional needs and patterns affect both therapy and training, and thus help or hinder training goals; and finally, that students must have their needs met before they can meet the needs of others (p. 70).

In a discussion of some of the principles underlying the training of mental health workers Leon suggested that there are two things which keep one from becoming involved in a therapeutic relationship with another person. These two factors are one's psychological defenses and the institutions that surround one and force him to play certain roles. He noted that what was once considered the inevitable deterioration of the schizophrenic is now felt to be largely the impact of institutionalization. Hospital workers, according to Leon, have found many ways of avoiding human encounter with their patients. Patients should be treated by those who understand their needs and they should not be required to fit themselves in with the needs of a bureaucratic institution.

Training programs must take place in the proper atmosphere to enable the trainee to feel free enough to develop his own potential in his own way and to use his personality in rewarding therapeutic relationships with his patients. Training programs must be continuously evaluated in order to ensure the maintenance of continual awareness of the process by which knowledge and the experiential insights necessary to modify the feelings and behaviors of the students are imparted.

Leon noted that people must be led gradually into this new approach. Lectures can, according to the author, be employed to emphasize the concept that understanding one's self is one of the most important aspects in working with persons who are mentally ill.

Training programs must become more concerned with the mental health worker's social competence, that is his ability to handle the world about him. Leon (1968) suggested that:

> We must train workers to impart the necessary social competence to those who need it and to deal at the same time with the anxiety aroused by the lack of the necessary skills (p. 70).

According to Jones (1966) the usefulness of sensitivity training for personnel has been shown in industry and he predicts that the medical profession will increasingly give more consideration to such research. He noted that there is a need for trained workers to be able to communicate with patients who have become masters at one of society's unwritten dictates which implores a person to deny direct expression to his feelings and calls for him to use censored communication with his fellow man. Too many psychiatric patients, perhaps because of their lack of communicative facility, can not find anyone to whom they can turn and express their feelings without being misunderstood or ridiculed. Workers must be trained to help patients learn to cope with the stresses of life outside which have caused many of them to enter the hospital. Jones (1966) noted that:

> By working through some of their problems

> in hospital they can experience a living-learning situation which can be applied when they return to the world outside (p. 1009).

Selection of candidates. The problem of selecting candidates for the positions in a mental health training program is complex and difficult. There appears to be little indication from relevant research that the problem is being adequately attacked. In the general area of nursing, Coe, Huels, Curry and Kessler (1967) noted that studies aimed at the prediction of nursing success have been neglected and that the studies undertaken in this area have failed to reveal predictive characteristics. The authors formulated a study to test the hypothesis that if a nurse's attitudes are similar to the attitudes of the charge nurse, she will be rated high in job performance. The subjects, twenty-eight psychiatric nurses and fourteen psychiatric technicians, were rated on job performance by their immediate supervisor, the charge nurse. A semantic differential attitude scale was completed by subjects and their charge nurses at two different times, thirteen months apart. The results showed that there was no consistent relationship between congruency of attitude with charge nurse and rated performance. The authors suggested that this result may have occurred because the supervisors and their subordinates generally agreed with respect to these job-oriented concepts. This may be substantiated by the fact that the nurses in this group were selected during employment interviews on the basis of their attitudes.

The implications drawn from a study by Hurst and

Fenner (1969) have direct relevance to the development of a selection mechanism. They discussed the marathon or extended session group as a potential technique for predicting performance in counselor training. It also provides the participants with feedback concerning their interpersonal strengths and weaknesses. This method provides a sampling of some of the behaviors usually associated with counseling competence. The twelve trainees agreed to meet in this pre-practicum extended-session group. The sixteen hour marathon session was held in the living room of an off-campus residential-type home. At the conclusion of the session the co-leaders and participants ranked all group members according to perceived counseling effectiveness. The trainees then participated in a practicum experience at the conclusion of which peer and practicum supervisor rankings were obtained. Statistical treatment of the data indicated the potential value of the marathon session as a predictive technique for counselor training.

Student counseling. A problem that perplexes most administrators of preparatory programs for psychiatric nursing students is the need for counseling by student nurses. An interesting study by Carnes, Cleland and Beha (1964) noted that the variety, intensity and number of personal problems among nursing students increased when they were serving their psychiatric affiliation. Among the problems noted are the following:

1) The patient-nurse relationship often gives

students difficulty particulary as it relates to the maintenance of a professional status while encouraging warm interpersonal relationships.

2) Many students have difficulty distinguishing between purely conversational and therapeutic behavior.

3) Students become engaged in a considerable amount of self-diagnosis, analysis of each other and attacking each others' defenses.

4) The varied approaches to mental illness give rise to problems of a philosophic and value nature among the students.

5) Identification with the patient is an ever present danger and invariably presents problems.

In conclusion, the authors noted that:

> The change from a tangible, physically-oriented, fact-centred, educational routine to the intangible, personality-oriented emotionally threatening psychiatric affiliation appears to stimulate a unique quantity and quality of stress for student nurses. Not only is the familiar physical care duty almost lost to them, but also they must more or less face themselves for the first time as a requirement implicit or direct in their work (p. 311).

Utilization of the psychiatric nurse. The concept of the "therapeutic community" (Jones, 1965) provides for far greater utilization of the psychiatric nurse as a change-agent directly involved in the treatment of the patients. This is a somewhat radical departure from the traditionally care and management oriented psychiatric nurse of the past. However, this approach is not to be instituted without some serious

thought. Jones (1965) in a discussion of the therapeutic team approach to the treatment of the mentally ill noted some of the problems inherent in such a program. There is the problem of confidentiality among patients. Is it prudent to share information about patients in group meetings or ward conferences? Another major problem is whether or not the doctors can accept a role which is subservient to other disciplines. The doctor's medical education has, according to Jones, encouraged the harboring of omnipotent fantasies. Do the members of the therapeutic team wish to create a democratic, equalitarian structure, or do they wish to have supervisors? If they choose the former, they must give up the luxury of complaining and of having a highly paid and high status scapegoat. It is often very threatening for well trained persons, such as psychiatrists to be criticized in meetings by members of other disciplines especially if they are less senior people.

However, Jones (1965) concluded that the therapeutic community is:

> ... a workshop in which what we are doing and why we are doing it is examined daily and an attempt is made to reconcile all the skills available with the task at hand (p. 10).

Regardless of the difficulties encountered, psychiatric nurses are becoming increasingly more involved in the treatment of their patients. This involvement generally centers around the introduction of group psychotherapy into the total psychiatric program on a ward. Psychiatric nurses

can be utilized in group therapy according to Brown (1962) provided they are properly trained and subsequently properly supervised. He noted that the greatest problem to be encountered in the creation of such a project is that of selling the value of a nurse doing group therapy to the members of the medical staff. The resources necessary to initiate such a program exist in any hospital but they must be utilized effectively thus enabling the trained nurse to become the catalyst for group therapeutic processes.

Summary. It may be stated that the greater utilization of the psychiatric nurse in psychotherapy requires some changes in the traditional preparatory program of psychiatric nurses. More emphasis must be placed upon freeing the student nurse from psychological defenses she may have which prevent her from relating easily and confidently with her patients. Increasingly human relations laboratory training is being considered as an integral part of the psychiatric nurse's training to remove the impediments noted above.

Literature Dealing with Some Aspects of Group Psychotherapy

Introduction. Group psychotherapy is practised in a wide range of settings including institutions, outpatient clinics and in private practice. The patients are of all ages with a variety of diagnoses, including psychoses, neuroses, alcoholism and psychosomatic disorders. In order to function properly the patients must realize that they are

being helped by the group and the therapist and not the therapist alone. As the members develop confidence in their group the therapist assists the patients in an examination of their attitudes as revealed by their interactions. The effectiveness of a therapeutic group depends upon three factors: evocation, support and implicit direction.

During group interaction an individual's maladaptive responses must be evoked, for only those responses which are verbalized can be changed. The evocation of this response must be accompanied by an expression of emotion. It is this emotional outburst which provides the energy needed to disrupt old behavior patterns and bring about a search for new ones. This evocation is fostered by a therapeutic group through the group standards of free, direct expression of feeling, the encouragement of the development of conflicts between equals, and the presence of a therapist who represents a guarantee that the feelings evoked will not get beyond the control of the patient.

Extreme emotional tension can hamper learning. In order to keep tension at an optimal level the therapist must provide the patients with emotional support at all times. It is essential that the patient develop trust in the therapist, believe he wants to help him and is capable of doing so. The patient's self-esteem must be built up if he is to develop the courage to face himself and rid himself of the neurotic ways of feeling and behaving which have been plaguing him. It is self-enhancing for the patient to realize that his advice may be of assistance to others in the therapy group.

The term "implicit direction" refers to the assistance given to a patient to enable him to become aware of his feeling and behavior and to help him perceive alternative patterns of behavior. The therapy group offers implicit direction to the members through feedback from fellow members and the leader, through the provision of models of different ways of behaving with which he can identify, imitate or reject and through exposing him to values and standards better than those which presently direct his behavior (Frank, 1964).

Group Psychotherapy defined. A precise definition of group psychotherapy does not appear to be available. Some writers (Gazda, 1969; Brammer and Shostrom, 1960) tend to view group psychotherapy (as they do psychotherapy) on a continuum. The lower less complex end of this continuum is designated by Gazda (1969) as group guidance with group counseling and group psychotherapy extending toward the upper more complex and involved end respectively. Gazda (1969) distinguished between these three forms of group endeavours primarily on the basis of their orientation. Group guidance is seen as a preventive service designed to prevent the development of problems, with the content being educational, vocational, personal and social information not taught in organized academic courses. Group counseling is more remedially oriented although still bearing definite preventative traits. It is aimed at those individuals according to Gazda (1969) who:

> ... have entered into a spiral of self defeating behavior but who are, never-

> theless, capable of reversing the spiral without counseling intervention. However with counseling intervention the counselee is likely to recover more quickly and with fewer emotional scars (p. 9).

Group psychotherapy, a term credited to J.L. Moreno (1936), and defined by him (1962) simply as, "group psychotherapy means to treat people in groups (p. 263)." The orientation in group psychotherapy (Gazda, 1969) is entirely remedial and is designed for those who suffer from severe emotional problems. The therapy employed is at a deeper level and focuses on the reconstruction and rehabilitation aspects not attempted on the therapeutically less complicated levels of the continuum noted above.

Goals in group psychotherapy. It is difficult to state clearly defined goals for group psychotherapy because of the variation and extent of the pathology afflicting each of the members. The therapist must keep in mind that the individuals in group psychotherapy are generally patients and that the desired goal is to bring the patient back to normal functioning. This is in direct contrast to the individuals who participate in a human relations laboratory who are generally functioning normally, allowing their trainer to concentrate on the goal of assisting them to improve their functioning above the level at which they entered the group and indirectly assisting them to improve the functioning of the groups in which they have or will have membership upon their return to the usual environment.

This sentiment was expressed by Pattison (1965)

who visualized therapeutic goals along a continuum:

> ... this continuum would commence with regressed, narcissistic, psychotic patients, for whom we would pose goals of diminished secondary psychotic defenses, i.e., hallucinations, projections, delusions, somatizations, etc. Intermediate might be patients with dysfunctional neurotic symptoms for whom the goals would be symptom alleviation, i.e., depression, alcoholism, anxiety, phobias, acting-out, etc. At the further end of the scale would be patients with primarily intrapsychic symptomalogy for whom the goals would lie in self-awareness and manifest character re-structure (p. 392).

Group psychotherapy with psychotics. Clinicians employing group psychotherapy with psychotic patients have found this a worthwhile approach. The relationship established by the therapist with schizophrenics is more important than any particular technique he may have perfected. This point is emphasized by Ogara (1959). He noted that group psychotherapy with schizophrenics should, in his view, be conducted twice weekly for periods of one and one-half hour duration. According to the author, groups should not exceed six members, be closed homogeneous, and selected on the basis of problems, not symptoms.

Battegay (1965) stated that a psychotic condition impairs one's communication with others to a varying extent, resulting in a loss of contact with the environment. The sufferer retires further and further into his psychotic world. The author suggested that group psychotherapy is a treatment worthy of consideration and asked:

> What could be more natural, then, than to fit psychotic patients into a social nexus

> such as is provided by a therapy group in order to provide them, at least within the limits of therapy, with that relationship with the external world which will bring them out of their more or less complete isolation within themselves (p. 316).

The group is not infrequently a strong enough call to reality to convince the schizophrenic that there is an outside world with other people in it. The resulting sense of security that the schizophrenic feels often allows him to regress. The alert therapist can use this regressed state to assist the patient in working through some of his unresolved conflicts. However, Battegay warned that psychotics with weak egos can not tolerate participation in the group for they feel too exposed to the group and fear the loss of their individuality.

The dangers inherent. The use of group approaches whether group psychotherapy or the related human relations laboratory training variations may be dangerous for some candidates. The next segment of this review presents some of the well documented critical comments. In a strong indictment of sensitivity training and its core the T-group, Crawshaw (1969) noted that it was considered the precipitating factor in the emotional breakdown of each of the three cases discussed in his paper. To guard against this possibility, it is suggested that the prospective participant in the T-group experience be made abundantly aware of what the choice implies when he becomes involved in learning about himself. The author stated that the therapist must accept responsibility for his clients and provide them with the protection

necessary when they undertake to learn about themselves in the presence of others. Crawshaw felt so strongly about the necessity of trainers assuming full responsibility for their clients that he urged the placing of T-group research to the test of the Nuremberg Rules which evolved following the investigation of the notorious Nazi medical experiments. Among these rules the ones which appear most relevant to human relations laboratory training are:

> The experiment should be conducted to avoid all unnecessary physical and mental suffering and injury.
>
> The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved (p. 139).

Few would argue that all persons can profit from involvement in a specific group experience. Kuehn and Grinella (1969) have identified four groups of patients whom they feel should be excluded from T-group experiences. Psychotic individuals should be excluded because they tend to regress rapidly during group experiences, become cognitively disorganized, develop anxiety which approaches panic and have difficulty reorienting themselves at the termination of the sessions. Character neurotics are too rigid, exhibit strong defenses against awareness of how others see them, tend to avoid intimate relationships and display excessive intellectualization and isolation. It is feared that hysterics will see the T-group experience as a type of religious conversion and become "true believers" without any real insight. Individuals in crisis are felt to be bad risks also for they

will often seek patienthood and are looking desperately for a new way to cope with their problems. Hence, they may see the T-group as a panacea. To ensure that such persons are excluded from T-group experiences, the authors suggested that participation be voluntary rather than mandatory as it is in many cases regardless of how subtle this may be. In addition they recommend that a selection process be employed as is the case for most demanding and complex tasks.

Jaffe and Scherl (1969) discussed two of their cases whom they believe suffered from acute transient psychosis as a result of participating in an intensive T-group experience. They hypothesized that this occurred because the group experiences produced a rapid lowering of defenses, thus permitting the psychotic reaction to develop. The T-group encourages openness, intimacy, and closeness; however, the authors fear that is has little structure for handling the anxiety that is usually evoked. Group members in their support for openness often support behavior from a member which in reality is irrational. They accept and encourage this behavior without being aware of its impact or meaning to the individual. It is accepted that the T-group is a situation deliberately designed to lower defenses, reduce threat, and, in theory, permit learning to take place. However, in actuality it may happen that defenses are lowered without compensating supportive mechanisms becoming available, greatly increasing the risk of psychopathological reactions occurring.

To correct this unfavorable situation, it is sug-

gested:

1) That participation be voluntary.

2) That participation be based on informed consent, with respect to purposes and goals.

3) That participants be screened.

4) That participants understand what types of behavior are permissible.

5) That a follow-up of all participants be available to deal with problems of group termination.

Lay group psychotherapists. An interesting study reported by Poser (1966) indicated that untrained lay therapists achieved slightly better results than psychiatrists and psychiatric social workers doing group therapy with similar patients. The patients were male chronic schizophrenics while the lay therapists were eleven young women between the ages of 18 and 25. All were undergraduate university students with no training or experience in psychology. Changes in the psychological test performance of the patients before and after five months of group therapy served as the criterion of therapeutic behavior change.

Rioch (1966) in a criticism of the above study raised the question of whether the patients were aware of the status attached to the various therapists and the institutional hierarchy. She suggested that the patients likely did make a distinction among the therapists and that this may have accounted, at least in part, for the results. She commented that:

... one possible factor in the positive

> results obtained by the nonprofessionals was that the patients cooperated more readily with people who were felt to be closer to themselves in the social hierarchy, that is, close to the bottom of the ladder (p. 292).

In a more critical comment on Poser's study Rosenbaum (1966) questioned the experimental design and noted that the term "group psychotherapy" was poorly defined. The untrained therapist, with an abundance of enthusiasm, may bring the deteriorated patient into a group experience promoting interaction. However, Rosenbaum stated that this may not be of much use for he noted that the "... approach is inspirational and, while helpful in the more surface sense, does not get to the 'guts' of any problem (p. 294)." Untrained therapists may help chronic schizophrenics in the sense that they give them support. However, it is noted that therapists who are interested in deep seated change use support as one technique only. Consequently these therapists will emphasize supportive techniques less and their patients may respond less enthusiastically which in turn may adversely affect the evaluative results.

Conclusions. Rosenbaum and Hartley (1962) surveyed the therapists present at the Sixteenth Annual Conference of the American Group Psychotherapy Association and accumulated the following information relevant to the practice of group psychotherapy. The following conclusions were drawn.

1) The optimal size of groups in psychotherapy appears to be eight, with a range of five to twelve.

2) Among the therapists, psychologists were divided evenly on whether the age range in the groups was significant.

3) A great number of therapists felt that neurotics would respond well to group psychotherapy; however, a larger number felt that most kinds of patients including neurotics, and psychotics would respond to group psychotherapy.

4) Acute psychotics and psychopaths were generally considered to be the main groups who would not respond to group psychotherapy.

5) The therapists considered that the results varied least with neurotics whether they received individual or group psychotherapy.

At the seventeenth annual training institute of the American Group Psychotherapy Association, Hartley and Rosenbaum (1963) presented the members with a questionnaire listing the criteria which group psychotherapists have used to judge the progress of their patients. The therapists were asked to judge these criteria and to choose the three they considered of greatest importance and in order of importance. The authors noted that there is little difference in the ranking of the criteria by those therapists of different professional affiliations. The top three criteria used by therapists to judge improvement in patients were:

> ... improved interpersonal functioning in and out of the therapy group; self-acceptance, self-confidence, self-reliance; and flexibility, the ability to cope with and adopt to a variety of experiences (p. 83).

Summary. The studies reviewed in this segment suggest that adequate preparation is essential for those who wish to conduct group psychotherapy programs with emotionally disturbed individuals. It is difficult to conclude what kind of preparatory training is preferable; however, the therapeutic relationship which the therapist is able to establish with the members of his group is crucial. For it is only in an atmosphere of sufficient permissiveness and acceptance that the member feels secure enough to reveal his problems. It is important that the therapist recognize those clients who would not profit from group psychotherapy. If a therapist is unable to do this he runs the risk of inadvertently allowing the group situation to work to the detriment of the client. Serious moral and ethical questions may then arise.

Literature Dealing with Related Studies

Introduction. The literature reviewed in this section reflects the two-part nature of the research project conducted by the writer. The first segment of this section deals with group psychotherapy as it relates to chronic psychotic hospitalized patients. The second segment concentrates on related research projects employing human relations laboratory training with normal non-hospitalized persons. In each of the projects reviewed the efficacy of the T-group as a change-agent was being tested.

Group psychotherapy with chronic psychotic patients.

A major difficulty in working with chronic patients is their apparent lack of interest in either themselves or their environment. They often appear indifferent or insensitive to what is going on around them. Each of the five programs reviewed below is an attempt at involving the regressed, withdrawn patient in a meaningful relationship with others.

Mack and Barnum (1966) described a group experience with hospitalized male patients that developed out of an occupational therapy activities program. This therapist had a unique relationship with these men which allowed a strong affective involvement. The meetings centered about the theme of the members' isolation and need to achieve greater closeness within the group. The aim which evolved was the overcoming of social isolation and enhancing skills in establishing satisfying human relationships.

One of the major problems in handling chronic psychotics, according to Kramer and Daniels (1959) is their inability to form meaningful social relationships. They observed that the patient's isolation and withdrawal may be conceived of as a defense against the anxiety engendered by human contact. The program described involved six male patients who were not considered good candidates for individual psychotherapy. Among the various aspects of the total program was a group psychotherapy period of one hour two times a week. The first fourteen hours of this program were characterized by the leader being actively supportive and approaching the patients individually. The second phase of this program was characterized by group cohesion and a reduction

of guardedness between patients. Silent periods increased but the patients were now better able to cope with this. The leader's function was directed at the clarification of latent content of both verbal and non-verbal material. The leaders, a male psychiatric resident and a female psychiatric aide, expressed fears of harming the patients. This was clarified in weekly supervisory sessions with a resulting decrease in anxiety on the part of the leaders and an improvement in their therapeutic effectiveness. All six patients showed improvement in their social relatedness.

A rather interesting method of successfully integrating chronically regressed adult schizophrenics into group activities is discussed by Beard, Goertzel and Pearce (1958). Their groups consisted of four or five patients. Initially they began each group with one patient and one therapist. Patients were added, one at a time, at approximately two month intervals. The therapist added members to the group only when he was successful in establishing the desired relationship with each patient. Characteristic of all the patients involved in this project was that their condition had led to relationship failure in the home, at work and with their fellow man. The authors maintain that such patients can be treated successfully and urge therapists to consider that:

> Regardless of the degree of pathology, there remains in the patient a core of essential ego strengths. These ego strengths can be utilized therapeutically through the establishment of an activity group structure, provided the activities are relevant to the strengths. Because the requirements of the activities do not surpass the patient's ego capacity he is enabled to participate effectively in a social relationship. For the

> institutionalized schizophrenic who has lost his relationships to his environment, a first step is taken ... the participation in such an activity structure tends to isolate socially the patient's symptomatology and pathology. The patient's new experience in participation with others on a basic reality level seems to promote a process of reinstitution of lost ego capacities (p. 136).

Hanson, Rothaus, O'Connell and Wiggins (1969) discussed a four-week program which they term the D-Group or Development Group. The program centered around having the patients examine their relationships with one another, experiment with new behaviors and exchange feedback. Schizophrenics in remission saw this program as relevant to their problems since they conceptualized their problems in interpersonal terms, such as feeling of isolation, suspicion, alienation and low self esteem. Group members saw themselves as helpful to others and began to develop a sense of confidence. Their relationships became characterized as interdependent rather than dependent or counter-dependent.

The development and successes of a psychiatric rehabilitation unit consisting of seventy male and female members was discussed by Annesley (1959). The program revolved around two weekly meetings of the whole community and group meetings twice weekly attended by individual patients. The emphasis was placed on social adjustment with the aim being to assist the patients in becoming self-supporting in a job outside the hospital. He noted that the majority of the long-term patients suffered from chronic schizophrenia and can be divided into the following groups: the withdrawn and

unproductive, the overreactive with "free-floating" delusions, and the paranoid with fixed delusions and good contact with the environment. Annesley suggested that these three groups should be balanced in group therapy. The duration of stay in hospital should not influence the choice of patients for rehabilitations. Annesley noted that:

> With the passage of time, the patient becomes adapted to his illness and gains a certain stability, which enables him to ignore his symptoms, but the mechanism of adaptation is obscure (p. 170).

Group therapy often gives good results with chronic paranoid schizophrenic patients because they have retained relatively good contact with their environment and interaction with other persons. Although the numbers of patients considered helped in this project is small the implications are noteworthy. Male patients seemed to have responded to this treatment better than females. Among the thirteen patients considered improved were nine chronic schizophrenics, two with chronic hypochondriasis, one with chronic depression, and one with a character neurosis.

The studies to be reviewed below deal with the effectiveness of group psychotherapy as a treatment procedure with chronic hospitalized psychotic patients. However before considering these studies it is important to note the points made by Pattison (1965) in his evaluative review of the literature dealing with group psychotherapy. He suggested that researchers be aware of the following:

1) Clinical evaluations are not reliable, and the

lack of specific replicable criteria make comparisons difficult.

2) Many types of group activities are therapeutic but not all groups are equally therapeutic for all patient populations.

3) Negative reports of group psychotherapy by psychometric tests may reflect the inappropriateness and insensitivity of the tests for group assessment.

4) Techniques of group process vary. Each will determine the therapeutic change to be expected, the type of group process, and the patient-patient, patient-therapist relationship and interactions.

5) Regardless of the criteria under consideration, therapists are faced with the questions:

> a) is the measure a reflection of a <u>therapeutic</u> change and not just change alone, and
> b) does this measure reflect a <u>unique</u> group effect (p. 389)?

Semon and Goldstein (1957) described a study which attempted to study the value of group psychotherapy for hospitalized chronic schizophrenic patients and the relative effectiveness of different methods of treatment. The study involved four experimental groups and one control group, the former consisting of eight members while the latter contained only seven members. The age range was from 20 to 30 years. The two methods of group therapy were designated Active-Participant and Active-Interpretive. The experimental groups each received 50 hours of therapy. The <u>Palo Alto Hospital Adjustment Scale</u> was used to measure the therapeutic effect-

iveness. The results indicated that chronic schizophrenic patients improved in group therapy with respect to interpersonal functioning. Difference in the relative effectiveness of the different methods of treatment was not demonstrated.

A study designed to test the efficacy of training seven male psychiatric inpatients to function in a more interpersonally facilitative manner was conducted by Pierce and Drasgow (1969). These patients were considered as not being able to meaningfully participate in, or benefit from individual or group psychotherapy. The training group met five days per week for one and one-half hours for a total of twenty hours. They were compared with twenty-eight psychiatric inpatients in four different control groups who were receiving various drugs, individual therapy, or group therapy. The results indicated that psychiatric inpatients can significantly improve their level of interpersonal functioning in twenty hours of treatment. Perhaps the most important implication for traditional therapy is that progress in improving interpersonal relations must be taught directly and systematically.

Anker and Walsh (1961) reported on a study carried out with one hundred thirty-four male schizophrenic patients on a continuing care ward. It was hypothesized that significant improvement in behavioral adjustment, as measured by The MACC Behavioral Adjustment Scale would occur as a result of group psychotherapy, a special activity program (drama group) and heterogeneous group structure. These three

independent variables and their interactions were analyzed simultaneously by a 2 x 2 x 2 factorial design, each variable being dichotomized. The most impressive result was the consistency with which the activity group showed significant change on the various categories of The MACC Behavioral Adjustment Scale excluding the affect subscale. The group psychotherapy reached significance at the .05 level for the mobility subscores but not on the other subscores. The group structure did not achieve significance on any of the measures.

Many psychiatric patients have recovered sufficiently to be able to return to their communities yet, according to Pullinger (1968) they do not leave the hospital. They have become institutionalized. In an attempt to assist these patients to return to their community an intensive program of twelve weeks was initiated. Group therapy sessions consisting of two hours each week were held with the patients. The psychologist in charge adopted a supportive role throughout the sessions. The ward nurse also conducted a one-hour group therapy session with the group predominantly of a reassurance nature. The results of the reporting period consisting of two years indicated the qualified success of the program.

Thirty-two hospitalized male chronic schizophrenics on a closed ward were studied by Spohn and Wolk (1963). The subjects, working in four-man groups, were administered eight group problem solving tasks. It was found that the

subjects improved their level of social participation on the criterion tasks socially more challenging and complex. This improvement generalized to task performances with total strangers but not to social behavior on the ward. The results do not suggest that group problem solving techniques be employed as a form of group psychotherapy; however, they do suggest that situational determinants may modify social withdrawal in chronic schizophrenics.

In a well designed study, Kraus (1959) observed two groups of eight chronic psychotic patients who had been matched by age, sex, education, diagnosis and previous treatment. The experimental group met twice weekly for three months while the control group met at the beginning and end of the project. The effects of the group psychotherapy were evaluated by:

1) The use of a time-sampling method involving two trained observers,

2) Evaluation by the ward physician and the psychiatrist independently,

3) The therapist's report, and

4) By the use of psychological group tests.

The overall conclusion drawn was that the psychotherapeutic group sessions were of value to the chronic psychotic patients involved.

Human relations laboratory training - a change-agent.

The second major portion of this segment, as noted above, deals with the utilization of human relations labora-

tory training as a change-agent with a variety of normal non-hospitalized persons.

A study to determine the effects of a three day human relations laboratory training experience on the personality of the participants was conducted by Kernan (1963). The subjects were engineering supervisors randomly selected from the staff of a large manufacturing company. The measuring instruments used in this study were: The F Scale by Christie and his associates; Fleishman's Leadership Opinion Questionnaire; the Guilford-Zimmerman Temperment Survey, and the Thematic Apperception Test. A number of hypotheses were formulated and tested by an analysis of co-variance. However, only one variable, number of words used to related Thematic Apperception Test stories decreased significantly (opposite to that hypothesized).

Geitgey (1966) worked with one hundred three students in Associate Degree Programs of Nursing Education to study the effects of sensitivity training on their performance with particular reference to: the quality of nursing care; interpersonal relations with patients, teachers and peers; grades in nursing courses; and attrition rates. Instruments were devised to measure change in these variables. Three groups were established in this study, namely the experimental group, voluntary control group, and the control group. The experimental group received sensitivity training, the voluntary control group received lectures and discussion sessions on human relations while the control group received no treatment. Statistical findings, in favor of the experi-

mental group, were significant at the .05 level of confidence for the following comparisons: patient evaluation of nursing care between the experimental group and the voluntary control group; instructor evaluations of nursing care between the experimental group and both control groups; interpersonal relations with the instructors between the experimental group and both control groups, and interpersonal relations with peers between the experimental group and both the control groups.

Selected secondary school seminar instructors were studied by Krafft (1967) to determine the type and degrees of on-the-job perceived behavioral changes which result from the laboratory method of learning. Essentially the study aimed at determining whether human relations laboratory training could aid in educating instructors to perform more effectively in small group seminars and to become more effective in their interactions with fellow educators. The author noted that the participants themselves, their peer co-teachers and the respective principals indicated a highly significant perceived behavioral change as the participants functioned in the on-the-job situation six months following the treatment program.

Lee (1967) studied the effectiveness of sensitivity training in an in-service teacher-training program comparing two basic methods of human relations training with each other and with a control group. Sensitivity training constituted one method while the other utilized lectures,

demonstrations and discussions. The subjects were fifty-one public elementary school teachers who had volunteered to participate. Twenty teachers, in two groups of ten each, received ten two-hour sessions of intensive sensitivity training. Ten teachers received ten two-hour classes in the principles of human relations. Twenty-one teachers acted as a control group receiving no treatment but taking all the measuring instruments. Teachers involved in the sensitivity training program significantly increased their scores in the direction of more permissiveness on the Minnesota Teacher Attitudes Inventory compared with the control group. They also increased in self-esteem, or self value as measured by the Q-sort, designed for this purpose, significantly more than the control groups. Of interest was the fact that the students of teachers who had participated in the sensitivity training program were absent significantly less often than students of teachers in the control groups.

A study conducted by Gold (1967) attempted to determine whether or not a human relations laboratory program contributed to the development of undergraduate college students as persons. Specifically Gold wished to determine if students would exhibit more self disclosure behavior following the experimental treatment. A modified form of the Jourard Self-Disclosure Questionnaire was used as the evaluation instrument. The experimental group consisted of one hundred ten students and the control group consisted of thirty-three students. A significant difference was found between the experimental and control groups on change in self dis-

closure on two subscales of the evaluative instrument, namely subscale 6 - self disclosure to individual of "personality" items, and subscale 12 - self disclosure to group of "personality" items. However, these significant differences were not maintained at the follow-up evaluation some three months later.

Summary. The literature reviewed in this section identified the chronic patient as difficult to involve in programs designed to counteract their characteristic isolation and withdrawal. However the programs reviewed appeared to have succeeded primarily because the therapists were aware of the debilitating features of the chronic patients and emphasized the establishment of a meaningful therapeutic relationship as a point of departure with each of their patients.

Five studies were reviewed which attempted to determine the effectiveness of group psychotherapy as a treatment procedure with psychotic patients. Each of the studies reveal some degree of success in the overall attempt to reduce the disturbing symptoms plaguing the patients.

The efficacy of the human relations laboratory training as a change-agent was tested in each of the five studies reviewed in the concluding portion of this segment. In each case normal populations were used, including engineering supervisors, nursing students, teachers and college undergraduates. Four of the five studies reviewed employed internal criteria to evaluate the effectiveness of the human relations experience.

to which their experimental groups were subjected. Three of these studies (Geitgey, 1966; Lee, 1967; and Gold, 1967) reported significant results. Two studies employed both internal and external criteria of evaluation (Geitgey, 1966 and Lee, 1967). Both reported satisfactory results for both sets of criteria. Internal criteria of evaluation were used exclusively by two researchers (Kernan, 1963 and Gold, 1967). Gold obtained some satisfactory results while Kernan's results were not significant. Only one researcher (Krafft, 1967) employed external criteria of evaluation exclusively. His results were generally favorable.

In conclusion the literature reviewed tends to suggest that chronic hospitalized patients can become involved in group psychotherapy and profit from it provided the therapist understands and accepts the debilitating features so characteristic of chronic patients and diligently works to establish a meaningful therapeutic relationship with each of the patients. The usefulness of human relations laboratory training as a change-agent was not demonstrated. However the results are sufficiently encouraging to warrant its further investigation as a mechanism for effecting perceived behavioral change in on-the-job situations.

CHAPTER III

THE RESEARCH DESIGN

The Setting

This project was conducted on ward 4C, a continuing care unit at the Alberta Hospital, Edmonton. The study extended over a four-week period commencing January 18, 1970 and concluding February 14, 1970. During this period the student nurses involved in this study spent their complete working day on the ward.

The human relations laboratory to which the experimental group was subjected was conducted in the form of a retreat at Providence House, operated by the Sisters of Charity of Providence, Edmonton. Dr. J. Guild, Chief Psychiatrist at the Royal Alexandra Hospital, Edmonton, acted as the trainer. Dr. Guild has had considerable experience as a trainer and is recognized as such by the National Training Laboratories Institute. The students began their laboratory experience on Wednesday evening, January 14, 1970 and concluded it on Sunday afternoon, January 18, 1970.

Selection of the Student Participants

Students admitted to the Alberta Hospital School of Nursing are required to submit to an intellectual assessment,

to complete the Sixteen Personality Factors Questionnaire, by R.B. Cattell, D.R. Saunders, and G. Stice, the Nursing Aptitude Test (NAT), by Thelma Hunt, and to write an essay indicating why they have chosen to enter psychiatric nursing. While consideration was given to each of these factors the main criterion of selection for admission to the research study was arbitrarily set at a score of eighty percentile or better on the Nursing Aptitude Test. The Nursing Aptitude Test consists of six sub-tests. The first test, Judgement in Nursing Situations attempts to measure the student's ability to make appropriate judgements in hypothetical situations relevant to the duties and responsibilities of a nurse on duty. Sub-test 2, Visual Memory measures the student's capacity to remember the details of a diagram which the students are allowed to study for a short time. Sub-test 3, Memory for Content measures the student's ability to remember details presented to them from the diagram noted above. Sub-test 4, Information measures the student's general knowledge of the nursing profession. Sub-test 5, Scientific Vocabulary measures the student's understanding of words relative to the medical profession. Sub-test 6, Ability to Understand the Following Instructions measures, as is implied, the student's ability to follow instructions in a typical nursing situation. Twelve students of the third-year psychiatric nursing class met this criterion of candidacy. These students were then matched in pairs on the basis of their Nursing Aptitude Test (NAT) score. The names of the matched pairs were then placed

into a hat, one pair at a time, the first name drawn by a disinterested person became a member of the experimental group. The remaining name was placed in the control group. In this manner the members of the experimental and control groups were chosen. Members of the experimental group are identified by the use of the letters A to F, inclusive, while members of the control group are identified by the letters G to M excluding the use of the letter I. (See Tables I and II.)

TABLE I

COMPARISON OF THE MEMBERS OF THE EXPERIMENTAL GROUP

Subject	Age	WAIS	NAT %ile
A	20	112	81
B	22	115	98
C	20	127	92
D	20	113	85
E	22	103	80
F	19	126	93
Σ	123	696	529
$\bar{x}$	20.50	116	88.15
sd	1.22	8.32	7.29

TABLE II

COMPARISON OF THE MEMBERS OF THE CONTROL GROUP

Subject	Age	WAIS	NAT %ile
G	22	112	83
H	19	120	95
J	20	111	94
K	20	117	85
L	19	128	81
M	21	111	95
Σ	121	699	533
$\bar{X}$	20.15	116.50	88.83
sd	.92	6.70	6.50

A comparison of Tables I and II reveals that the experimental and control groups are closely matched on each of the three variables compared. The range of the scores obtained by the experimental and control subjects on each of the three variables is approximately the same with the exception of the WAIS scores where the range for the experimental group is from 103 to 127 as compared with the control group where the range is from 111 to 128.

Selection of the Patient Participants

In choosing the patients to participate in this study major consideration was given to finding a group of long-term patients under continuing care. It was also

considered essential that the nursing staff on the chosen ward be desirious of participating in this study. Ward 4C, which houses long-term male patients, met these criteria and was consequently chosen as the site of the research project. No attempt was made to control the population of this ward or to influence the therapies prescribed for the individual patients.

The patients on ward 4C were organized into six groups of approximately ten members. Prior to the organization of the groups, the following information was obtained for each patient: age, length of his confinement, and the diagnostic impression. However no attempt was made to match the patients on these variables. Patients were then placed in one of six groups by random selection.

Three patient-groups were chosen by random selection to become the experimental patient-groups, while the remaining three patient-groups became the control patient-groups. The groups were designated by order of selection and assigned the numbers I to VI. Groups I, II, and III were designated the experimental patient-groups while groups IV, V, and VI were designated the control patient-groups. (See Tables III, IV, V, VI, VII, and VIII.)

TABLE III

DESCRIPTION OF THE MEMBERS OF EXPERIMENTAL PATIENT-GROUP I

Subject	Age	Length of this Admission	Diagnostic Impression
1	38	4 yrs. 1 mo.	Schizophrenia
2	61	1 yr. 2 mo.	Korsakoff's Syndrome
3	37	5 yrs. 0 mo.	Mental Defective
4	56	28 yrs. 3 mo.	Schizophrenia
5	67	1 yr. 1 mo.	Korsakoff's Syndrome
6	17	1 yr. 2 mo.	Schizophrenia
7	82	9 yrs. 0 mo.	Senile Psychosis
8	31	2 yrs. 8 mo.	Schizo-Affective Psychosis
9	60	23 yrs. 7 mo.	Schizophrenia
10	44	3 yrs. 8 mo.	Epilepsy, Psychosis

TABLE IV

DESCRIPTION OF THE MEMBERS OF EXPERIMENTAL PATIENT-GROUP II

Subject	Age	Length of this Admission	Diagnostic Impression
11	52	11 yrs. 0 mo.	Epilepsy, Psychotic
12	37	1 yr. 0 mo.	Organic Brain Syndrome
13	25	1 yr. 2 mo.	Schizophrenia
14	57	3 yrs. 0 mo.	Schizophrenia
15	57	1 yr. 9 mo.	Schizophrenia
16	34	12 yrs. 6 mo.	Schizophrenia
17	23	1 yr. 8 mo.	Schizophrenia
18	46	1 yr. 5 mo.	Alcoholism, Psychotic
19	76	1 yr. 10 mo.	Senile Psychosis

TABLE V

DESCRIPTION OF THE MEMBERS OF EXPERIMENTAL PATIENT-GROUP III

Subject	Age	Length of this Admission	Diagnostic Impression
20	48	1 yr. 3 mo.	Schizo-Affective Psychosis
21	43	1 yr. 2 mo.	Schizophrenia
22	23	2 yrs. 8 mo.	Mental Defective
23	73	2 yrs. 3 mo.	Organic Brain Syndrome
24	20	0 yr. 3 mo.	Psychopath, Mental Defective
25	48	1 yr. 2 mo.	Alcoholism, Psychotic
26	28	1 yr. 3 mo.	Schizophrenia
27	55	25 yrs. 9 mo.	Schizophrenia
28	43	13 yrs. 7 mo.	Epilepsy, Psychotic
29	82	1 yr. 2 mo.	Senile Psychotic
30	34	0 yr. 7 mo.	Schizophrenia

TABLE VI

DESCRIPTION OF THE MEMBERS OF CONTROL PATIENT-GROUP IV

Subject	Age	Length of this Admission	Diagnostic Impression
31	26	2 yrs. 1 mo.	Schizophrenia
32	40	2 yrs. 3 mo.	Paranoid Personality
33	71	3 yrs. 8 mo.	Organic Brain Syndrome
34	43	1 yr. 1 mo.	Schizophrenia
35	66	3 yrs. 0 mo.	Epilepsy, Psychotic
36	28	0 yr. 3 mo.	Schizophrenia
37	30	1 yr. 1 mo.	Schizophrenia
38	22	2 yrs. 4 mo.	Mental Defective
39	44	12 yrs. 2 mo.	Schizophrenia
40	70	1 yr. 7 mo.	Schizophrenia

TABLE VII

DESCRIPTION OF THE MEMBERS OF
CONTROL PATIENT-GROUP V

Subject	Age	Length of this Admission	Diagnostic Impression
41	41	1 yr. 0 mo.	Wilson's Disease
42	52	2 yrs. 3 mo.	Organic Brain Syndrome
43	62	1 yr. 10 mo.	Pre-Senile Psychosis
44	20	2 yrs. 3 mo.	Mental Defective
45	58	16 yrs. 10 mo.	Epilepsy, Psychotic
46	36	2 yrs. 1 mo.	Schizophrenia
47	19	2 yrs. 6 mo.	Mental Defective, Epilepsy
48	39	1 yr. 10 mo.	Mental Defective, Epilepsy
49	61	0 yr. 10 mo.	Schizophrenia
50	33	2 yrs. 3 mo.	Schizophrenia
51	79	2 yrs. 4 mo.	Organic Psychosis

TABLE VIII

DESCRIPTION OF THE MEMBERS OF
CONTROL PATIENT-GROUP VI

Subject	Age	Length of this Admission	Diagnostic Impression
52	55	1 yr. 10 mo.	Schizophrenia
53	22	1 yr. 9 mo.	Mental Defective, Psychotic
54	60	1 yr. 8 mo.	Organic Brain Syndrome
55	74	0 yr. 7 mo.	Organic Brain Syndrome
56	42	4 yrs. 1 mo.	Epilepsy, Psychotic
57	27	13 yrs. 1 mo.	Schizophrenia
58	19	2 yrs. 1 mo.	Mental Defective, Psychotic
59	36	9 yrs. 1 mo.	Schizophrenia
60	60	25 yrs. 1 mo.	Schizophrenia
61	43	1 yr. 2 mo.	Schizophrenia
62	50	0 yr. 7 mo.	Mental Defective, Psychotic
63	74	6 yrs. 1 mo.	Organic Brain Syndrome

Description of the Human Relations Laboratory

The experimental subjects were given an opportunity to explore intrapersonal, interpersonal and group dynamics through innovative training activities. It was anticipated that these students would experience personal growth through greater self awareness and introspection, increased sensitivity to others, freer expression, and increase their interpersonal communicative skills. In an intensive human relations laboratory setting such as this, it was hoped that the participants would gain an impression of the impact they make on the other members of the group. Perhaps most significant is the fact that they would be encouraged to compare their impact on others with their assumptions and their intentions. (See Appendix A, p. 127)

Description of the Placebo Treatment for Control Subjects

The control group was given a placebo treatment during the same period as the experimental group was subjected to a Human Relations Laboratory. In essence the placebo treatment provided an opportunity for the members of the control group to interact as a group. Due to the necessity of the girls in the control group remaining in the regular training program of the School of Nursing, the placebo treatment was primarily carried on during the students' time off from classes. Consequently the placebo treatment program was not

of the same extent as the research treatment program given to the experimental group.

The placebo treatment consisted of two "tasks" which the students were required to complete essentially on their own. At all times during the placebo treatment, personnel trained in T-group methods were present but did not play an active role nor did they initiate any kind of group approach to the "tasks" at hand. The onus remained with the students to use the resource personnel and other assistances provided them in whatever manner they chose.

These resources consisted of relevant films, discussions with skilled T-group leaders, available reading materials, and a full day of lectures provided by leaders in the psychiatric and nursing areas relevant to their "task." (See Appendices B and C pp. 129-131.)

Description of the Research Treatment on the Ward

The trainer of the human relations laboratory, in addition to being informed of the aims of the research project, was asked to assist the students in the choice of a partner to facilitate the formation of three pairs from among the six experimental subjects. Each pair was then assigned an experimental patient-group by a disinterested person.

Members of the control group were randomly placed in three pairs. Each pair was assigned a control patient-group by a disinterested person.

An integral part of the training program for student nurses of the Alberta Hospital School of Nursing is the study and involvement in group processes. During their first year of training all of the students were given a series of lectures dealing with group dynamics. In addition they participated in a T-Group experience conducted by a competent trainer. The students in the third year of their training program, are required to study and conduct groups on selected wards. This study is the observation of a specific segment of the clinical preparation of third-year psychiatric nurses.

Prior to the commencement of their involvement with groups of patients on the wards, the students were given preparation for this aspect of their training by members of the faculty of the Alberta Hospital School of Nursing. Each student in the third-year program was supplied with a copy of the Remotivation Technique by Alice M. Robinson. The faculty members discussed this particular technique with all of the students but did not insist that it be employed by the students during their experience with patient-groups on the wards.

The students were required to spend their entire work day on ward 4C to which they had been assigned for this aspect of their training. The students worked in a group setting with the patients for a one-hour period each day. It was during this period that the observation of the student nurses interacting with their patients took place. The students involved in this study spent twenty-eight days on

ward 4C. Their interaction was observed for ten-minute segments five times during this period on the fifth, eleventh, seventeenth, twenty-second and twenty-seventh day of this period.

Administration of the Instruments of Evaluation

Human relations laboratory. The following evaluative instruments were employed in this aspect of the study.

The California Psychological Inventory, developed by H. Gough, contains 480 items and yields 18 scores which may be plotted. This inventory, according to the author, is intended primarily for use with normal subjects. The scales on this test are designed to measure personality characteristics important for social interaction. These scales can be grouped into four categories namely: Class I Measures of Poise, Ascendancy and Self-Assurance including scales one to six; Class II Measures of Socialization, Maturity and Responsibility including scales seven to twelve; Class III Measures of Achievement Potential and Intellectual Efficiency including scales thirteen to fifteen; Class IV Measures of Intellectual and Interest Modes including scales sixteen to eighteen.

The Orientation Inventory developed by B. Bass consists of three sub-scales. Sub-scale I, Self-Orientation, according to the author, reflects the extent a person describes himself as expecting direct rewards to himself regardless of

the job he is doing or the effects of what he does upon others working with him. Sub-scale II Interaction-Orientation is designed to illustrate the extent of concern with maintaining happy, harmonious relationships in a superficial sort of way. Sub-scale III Task-Orientation measures the extent to which a person is concerned about completing a job, solving problems, working persistently and doing the best job possible.

The Personal Orientation Inventory developed by E. Shostrom consists of 150 two-choice items which are scored twice, first for two basic scales of personal orientation and second for the ten sub-scales which measures important elements of self-actualization including valuing, feeling, self-perception, synergistic awareness and interpersonal sensitivity. The first scale of personal orientation is the time competence scale which measures the degree to which the individual lives in the present as contrasted with the past or future. The second scale is the support scale which is designed to measure whether an individual's mode of reaction is characteristically "self" oriented or "other" oriented.

The members of the experimental group completed the above instruments prior to and following their experience in the human relations laboratory. The members of the control group completed the same evaluative instruments with the same time interval between the initial and final administrations. However they were not subjected to the human relations laboratory experience.

Research treatment on the ward. The entire patient population of ward 4C were evaluated prior to and following the four-week research treatment period. One member of the permanent nursing staff on ward 4C completed the following instruments for each patient at the times indicated above.

The Hospital Adjustment Scale developed by P. McReynolds and J. Ferguson and E. Ballachey, consisting of 90 items, was designed to provide a quantitative estimate of the hospital adjustment of psychiatric patients. This estimate is based upon the actual behavior of the patients. Four scores are obtained from this instrument including the total score, communication and interpersonal relations, care of self and social responsibility, and relation to work, activity and recreation.

The MACC Behavioral Adjustment Scale by R. Ellsworth was designed to assess the behavioral adjustment of hospitalized psychiatric patients. This scale consisting of 16 items purports to evaluate how the patient adapts himself to various ward and off-ward situations regardless of extent of the psychopathology. There are four-sub-scale scores and a total adjustment score obtainable from this instrument. The four sub-scales are mood, cooperation, communication and social contact.

The Psychotic Reaction Profile by M. Lorr et. al., is an 85 item inventory designed to measure four types of behavior disturbances. They are withdrawal, thinking disorganization, paranoid belligerence and agitated depression. Scores are

obtainable on each of these four behavior disturbances.

Observation of student interaction. A member of the Department of Psychology, Alberta Hospital, who had been trained in group processes, observed and recorded the student nurses' interaction during their involvement with the patients in the group to which they were assigned. The Bales' Interaction Record was employed for this purpose. It was developed by R. Bales and is designed to record the verbalizations of persons participating in a group experience. The participant's verbalizations are recorded in one of the twelve categories in this instrument. The twelve categories are broken down into three segments. The first segment is the Social Emotional Area: Positive. This includes categories one, two and three. The second segment is termed the Task Area-Neutral. This segment includes categories four to nine inclusive. The remaining segment is termed the Social Emotional Area: Negative. It includes categories ten, eleven and twelve.

Limitations

The patient population used in this project was limited to those patients who were housed on ward 4C of the Alberta Hospital, Edmonton. No attempt was made to determine or maintain the population of this ward. The routine of the ward was changed only to accommodate the implementation of the research project. Generalizations from the results

obtained in this project can be made to long-term male hospitalized psychiatric patients as a group; generalizations beyond this group should be made with care.

Hypotheses to be Tested

1. There are differences between the results obtained by the experimental and control groups on the California Psychological Inventory.

2. There are differences between the results obtained by the experimental and control groups on the Orientation Inventory.

3. There are differences between the results obtained by the experimental and control groups on the Personal Orientation Inventory.

4. There are differences between the results obtained by the experimental and control patient-groups on the Hospital Adjustment Scale.

5. There are differences between the results obtained by the experimental and control patient-groups on the MACC Behavioral Adjustment Scale.

6. There are differences between the results obtained by the experimental and control patient-groups on The Psychotic Reaction Profile.

7. There are differences between the results obtained by the experimental and control groups on the Bales' Interaction Record.

CHAPTER IV

PRESENTATION AND INTERPRETATION OF DATA

Statistical Design

The data obtained by the use of the instruments with the exception of the data obtained by the use of the Bales' Interaction Record, were subjected to the same statistical analysis. Three comparisons were made of the data obtained from the experimental and control groups. The data obtained by the experimental and control groups from the initial administration of the instruments at the commencement of the project were compared, as were the data obtained at the conclusion of the treatment period by the use of a one-way multivariate analysis, namely Hotelling's T^2 statistic. A similar statistical analysis was employed in a comparison of the difference scores between the initial and final administrations of the instruments for the experimental and control groups. The .05 level of significance was employed. Winer (1962) noted that:

> This test is exact if the underlying distributions are multivariate normal. Use of Hotelling's T^2 statistic requires no assumptions of homogeneity of covariance on the population variance-covariance matrix (p. 124).

Cohn (1967) and Ohlsen (1970) recommend the use of multivariate statistical methods in the area of group counselling. Cohn (1967) suggested:

> Multivariate statistical methods appear to be promising in group counseling research because of the numerous process variables interacting in counseling and because of the complexity of goals for such counseling. In other words, the researcher is typically confronted with numerous process variables and numerous related outcome variables (p. 21).

The overall T^2 test result of the multivariate analysis is given at the bottom of each table while the specific comparisons shown in the tables take into consideration the overlapping of the variables.

The student nurses' interactions during their involvement with the patients in the group to which they were assigned were observed for ten-minute segments five times on the fifth, eleventh, seventeenth, twenty-second and twenty-seventh day of the four-week research period. These data were recorded by the use of Bales' Interaction Record and were subjected to a two-factor analysis of variance with repeated measures on factor 'B'.

Testing the Hypotheses

1. There are differences between the results obtained by the experimental and control groups on the California Psychological Inventory.

The global nature of the hypothesis precluded the use of most statistical analyses other than the one employed. Unfortunately the results of the analyses of the data by the use of a one-way multivariate analysis i.e. Hotelling's T^2

statistic are not meaningful in the California Psychological Inventory due to the small number of subjects per group (N = 6) and the large number of dependent variables (18). It is felt that a clearer understanding of the changes which may have occurred on the California Psychological Inventory as a result of the experimental treatment and the placebo treatment presented during the research period can be obtained from Figures 1 and 2. These figures illustrate the initial and final scores obtained by the experimental and control groups of nurses.

The results indicate that this hypothesis cannot be accepted. Figure 1 demonstrates that both the experimental and control groups produced relatively normal profiles. In other words the initial scores leave so little ceiling for change that one could not expect to obtain significant change. The only noteworthy variation occurs on the Capacity for Status (Cs) sub-scale where the experimental group mean is considerably higher than that of the control group. Figure 2 indicates that there are no major differences in the profiles obtained by the experimental and control groups following the conclusion of the research treatment. The experimental group obtained a relatively higher mean score on the sub-scale Sociability than did the control group.

2. There are differences between the results obtained by the experimental and control groups on the Orientation Inventory.

The results of the analyses of the data obtained do

FIGURE 1

MEAN SCORES FOR THE EXPERIMENTAL AND CONTROL GROUPS ON THE INITIAL ADMINISTRATION OF THE CALIFORNIA PSYCHOLOGICAL INVENTORY

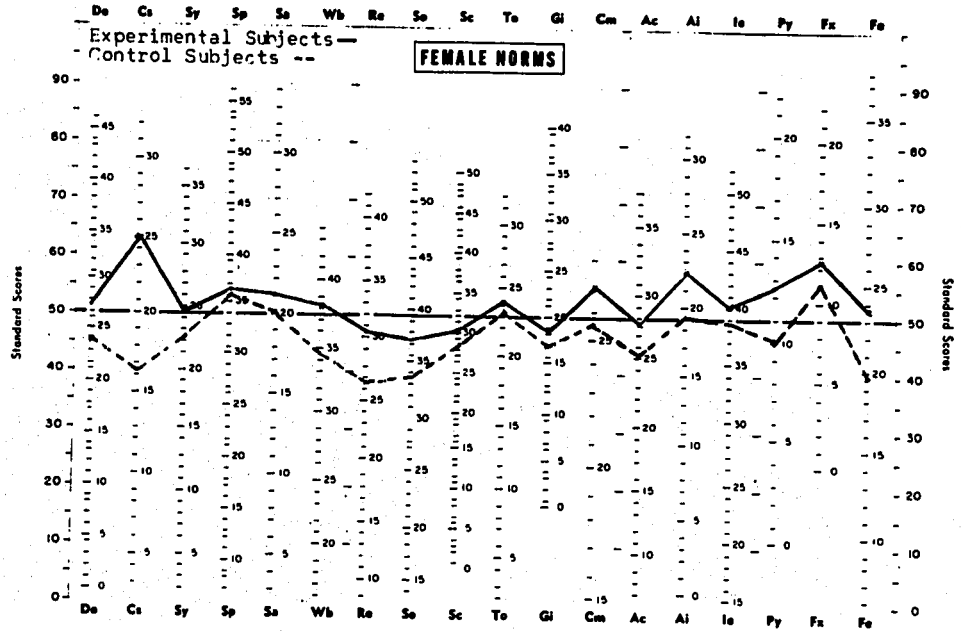
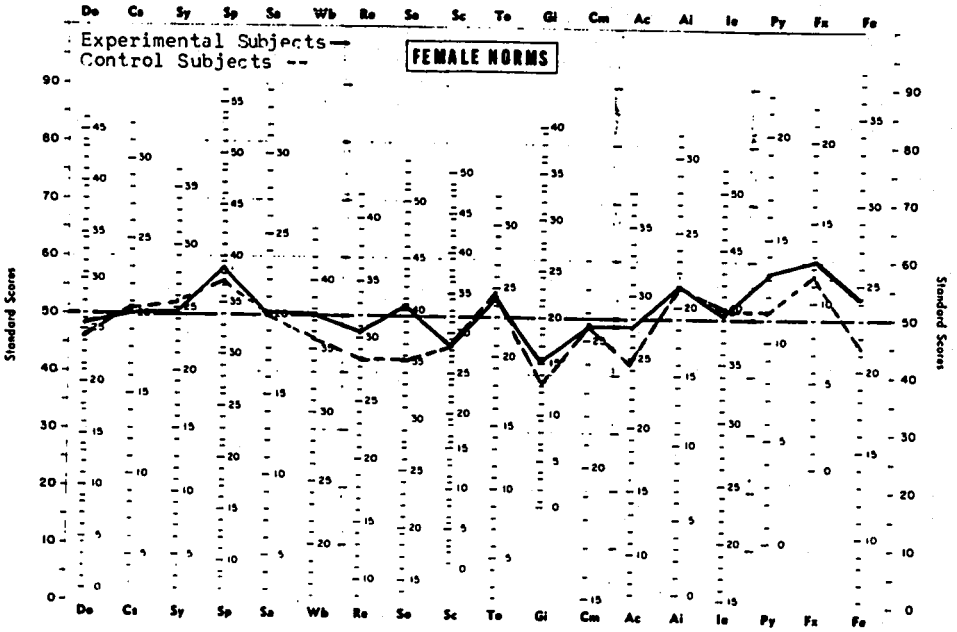


FIGURE 2

MEAN SCORES FOR THE EXPERIMENTAL AND CONTROL GROUPS ON THE FINAL ADMINISTRATION OF THE CALIFORNIA PSYCHOLOGICAL INVENTORY



not support this hypothesis; hence it must be rejected. At the .05 level of significance T^2 should equal 4.07. (See Table IX for a comparison of the initial data, Table X for a comparison of the final data and Table XI for a comparison of the difference scores between the initial and final administration.)

TABLE IX

COMPARISON OF THE RAW SCORES ON THE INITIAL ADMINISTRATION OF THE ORIENTATION INVENTORY FOR THE EXPERIMENTAL AND CONTROL GROUPS

OI Scale	Experimental Group Mean	SD	Control Group Mean	SD	T^2-Value
Self	23.8	4.2	23.2	4.1	.08
Interaction	26.5	4.1	28.7	5.1	.65
Task	30.5	3.6	31.2	4.6	.08

The overall T^2 was 5.57, the F ratio was 1.48 and P was 0.29.

TABLE X

COMPARISON OF THE RAW SCORES ON THE FINAL ADMINISTRATION OF THE ORIENTATION INVENTORY FOR THE EXPERIMENTAL AND CONTROL GROUP

OI Scale	Experimental Group Mean	SD	Control Group Mean	SD	T^2-Value
Self	23.8	3.8	21.7	4.6	.78
Interaction	30.0	7.8	29.5	5.8	.02
Task	24.5	8.9	30.5	3.5	2.34

The overall T^2 was 11.57, the F ratio was 3.08 and P was 0.09.

TABLE XI

COMPARISONS OF THE DIFFERENCES BETWEEN THE INITIAL AND FINAL ADMINISTRATIONS OF THE ORIENTATION INVENTORY FOR THE EXPERIMENTAL AND CONTROL GROUPS

OI Scale	Experimental Group Mean Diff.	SD	Control Group Mean Diff.	SD	T^2-Value
Self	- .7	1.6	1.5	4.0	.14
Interaction	-3.5	10.5	- .8	2.5	.37
Task	-5.2	7.9	- .7	4.8	.14

The overall T^2 was 2.32, the F ratio was 0.62 and P was 0.62.

3. There are differences between the results obtained by the experimental and control groups on the Personal Orientation Inventory.

Again the global nature of the hypothesis precluded the use of most statistical analyses other than the one employed. Unfortunately the results of the analyses of the data by the use of a one-way multivariate analysis i.e. Hotelling's T^2 statistic are not meaningful in the Personal Orientation Inventory due to the very small number os subjects per group (N = 6) and the large number of dependent variables (14). Changes which may be attributed to the effect of the experimental treatment and the placebo treatment presented during this research period can be seen in Figures 3 and 4 which illustrate the initial and final scores obtained by the experimental and control groups.

The results indicate that this hypothesis is rejected. However, Figure 3 does illustrate that the experimental group appeared to have been better adjusted on the Inner Directed and Self Acceptance sub-scales on the initial

FIGURE 3

MEAN SCORES FOR THE EXPERIMENTAL AND CONTROL GROUPS ON THE INITIAL ADMINISTRATION OF THE PERSONAL ORIENTATION INVENTORY

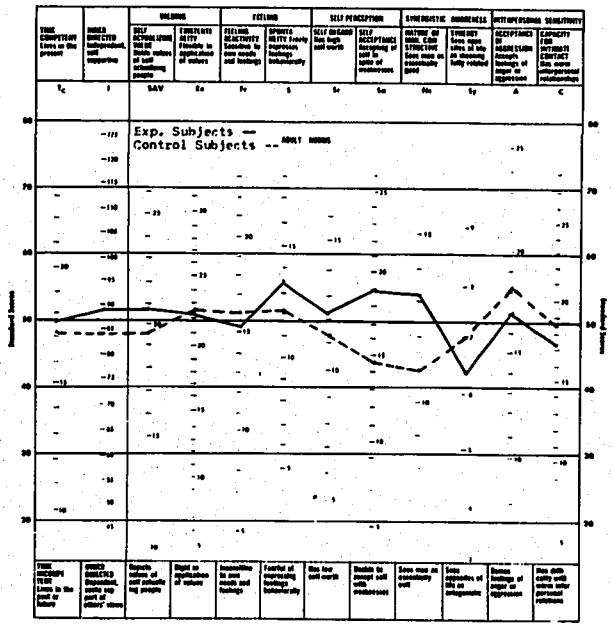
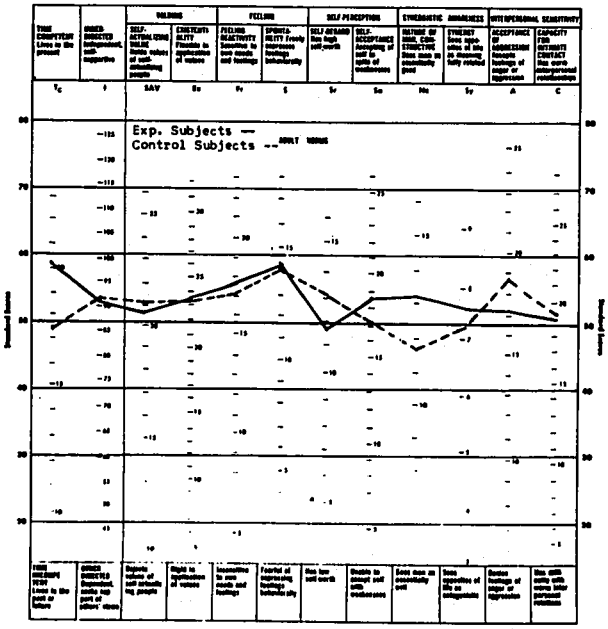


FIGURE 4

MEAN SCORES FOR THE EXPERIMENTAL AND CONTROL GROUPS ON THE FINAL ADMINISTRATION OF THE PERSONAL ORIENTATION INVENTORY



assessment. This suggests that these subjects were initially more self supportive and more able to accept themselves in spite of weaknesses. Figure 4 demonstrates that the final results obtained by the experimental and control groups are remarkably similar.

The patients involved in this study were evaluated by a senior nurse on their ward during the week immediately preceding the commencement of the research treatment and again during the week immediately following the completion of the research treatment. The following instruments were employed in this evaluation: The Hospital Adjustment Scale; The MACC Behavioral Adjustment Scale; and The Psychotic Reaction Profile. The three experimental patient-groups were combined for the statistical analysis. Three subjects, randomly chosen, were dropped from the control group to give an equal number of thirty subjects to both the experimental and control groups.

4. There are differences between the results obtained by the experimental and control patient-groups on the Hospital Adjustment Scale.

The results of the analyses of the data obtained do not support this hypothesis. To be significant at the .05 level T^2 should equal 2.59. It should be noted that on the comparison of the data obtained on the final administration of this instrument one sub-scale namely work, activity and recreation showed significance at better than the .01 level. The members of the experimental patient-groups (Table XIII)

increased their participation in the usual ward duties and recreational activities conducted on this ward during the period of the research treatment. There was no significant difference between the experimental patient-group and the control patient-group on the initial comparison (Table XII) prior to the commencement of the research treatment. Hence it may be concluded that the experimental patient-group improved their participation in the areas of ward duties and recreation as a result of their interaction with the student nurses who had participated in the human relations laboratory. However, this result does not change the overall picture and consequently the hypothesis must be rejected. (See Table XII for a comparison of the initial data, Table XIII for a comparison of the final data and Table XIV for a comparison of the difference scores between the initial and final administration.)

TABLE XII

COMPARISON OF THE RAW SCORES ON THE INITIAL ADMINISTRATION OF THE HOSPITAL ADJUSTMENT SCALE FOR THE EXPERIMENTAL AND CONTROL PATIENT-GROUPS

Sub-Scale	Experimental Mean	Experimental SD	Control Mean	Control SD	T^2-Value
Communication and interpersonal skills	62.4	28.3	62.0	31.6	.003
Care of self and social responsibility	52.4	33.9	49.3	35.6	.118
Work, activity and recreation	69.5	28.7	60.9	28.1	1.384
Total Adjustment	60.7	27.1	58.6	15.0	.085

The overall T^2 was 0.09, the F ratio was 0.02 and P was 0.99.

TABLE XIII

COMPARISON OF THE RAW SCORES ON THE FINAL ADMINISTRATION OF THE HOSPITAL ADJUSTMENT SCALE FOR THE EXPERIMENTAL AND CONTROL PATIENT-GROUPS

Sub-Scale	Experimental Mean	Experimental SD	Control Mean	Control SD	T^2-Value
Communication and interpersonal skills	72.6	28.8	73.0	26.6	.004
Care of self and social responsibility	55.8	35.3	49.2	32.4	.578
Work, activity and recreation	83.4	19.8	69.8	24.5	5.596*
Total Adjustment	71.9	25.1	66.4	25.0	.715

* $P < .01$. The overall T^2 was 0.71, the F ratio was 0.17 and P was 0.95.

TABLE XIV

COMPARISON OF THE DIFFERENCES BETWEEN THE INITIAL AND FINAL ADMINISTRATIONS OF THE HOSPITAL ADJUSTMENT SCALE FOR THE EXPERIMENTAL AND CONTROL PATIENT-GROUPS

Sub-Scale	Experimental Mean Diff.	Experimental SD	Control Mean Diff.	Control SD	T^2-Value
Communication and interpersonal skills	9.7	21.5	10.8	24.1	.029
Care of self and social responsibility	3.2	25.3	2.7	26.3	.007
Work, activity and recreation	13.7	22.0	9.4	16.7	.730
Total Adjustment	10.5	18.3	32.1	11.7	.988

The overall T^2 was 2.39, the F ratio was 0.57 and P was 0.69.

5. There are differences between the results obtained by the experimental and control patient-groups on the MACC Behavioral Adjustment Scale.

The results of the analyses of the data obtained do not support this hypothesis. To be significant at the .05 level T^2 should equal 2.59. (See Table XV for a comparison of the initial data, Table XVI for a comparison of the final data and Table XVII for a comparison of the difference scores between the initial and final administration.)

TABLE XV

COMPARISON OF THE RAW SCORES ON THE INITIAL ADMINISTRATION OF THE MACC BEHAVIORAL ADJUSTMENT SCALE FOR THE EXPERIMENTAL AND CONTROL PATIENT-GROUPS

Sub-Scale	Experimental Mean	Experimental SD	Control Mean	Control SD	T^2-Value
Mood	15.8	3.2	16.1	3.1	.166
Cooperation	14.4	3.6	13.5	3.8	.829
Communication	13.2	4.1	12.4	4.0	.589
Social Contact	11.7	4.7	10.7	4.8	.661

The overall T^2 was 0.66, the F ratio was 0.16 and P was 0.96.

TABLE XVI

COMPARISON OF THE RAW SCORES ON THE FINAL ADMINISTRATION OF THE MACC BEHAVIORAL ADJUSTMENT SCALE FOR THE EXPERIMENTAL AND CONTROL PATIENT-GROUPS

Sub-Scale	Experimental Mean	Experimental SD	Control Mean	Control SD	T^2-Value
Mood	15.4	2.9	15.4	3.3	.007
Cooperation	14.8	3.9	13.6	3.9	1.453
Communication	14.0	4.3	13.2	3.5	.586
Social Contact	13.0	4.3	11.9	5.1	.762

The overall T^2 was 0.76, the F ratio was 0.18 and P was 0.95

TABLE XVII

COMPARISONS OF THE DIFFERENCES BETWEEN THE INITIAL AND FINAL ADMINISTRATIONS OF THE MACC BEHAVIORAL ADJUSTMENT SCALE FOR THE EXPERIMENTAL AND CONTROL PATIENT-GROUPS

Sub-Scale	Experimental Mean Diff.	SD	Control Mean Diff.	SD	T^2-Value
Mood	.9	.6	.6	7.9	.025
Cooperation	2.4	1.6	1.6	8.1	.100
Communication	2.7	4.3	4.3	14.2	.198
Social Contact	3.4	4.7	4.7	14.2	.120

The overall T^2 was 6.26, the F ratio was 1.48 and P was 0.21.

6. There are differences between the results obtained by the experimental and control patient-groups on the Psychotic Reaction Profile.

The results of the analyses of the data obtained do not support this hypothesis. To be significant at the .05 level T^2 should equal 2.59. (See Table XVIII for a comparison of the initial data, Table XIX for a comparison of the final data and Table XX for a comparison of the difference scores between the initial and final administration.)

TABLE XVIII

COMPARISON OF THE RAW SCORES ON THE INITIAL ADMINISTRATION OF THE PSYCHOTIC REACTION PROFILE FOR THE EXPERIMENTAL AND CONTROL PATIENT-GROUPS

Sub-Scale	Experimental Mean	SD	Control Mean	SD	T^2-Value
Withdrawal	19.9	10.8	22.0	9.9	.572
Thinking Disorganization	5.1	4.6	4.7	3.6	.165
Paranoid Belligerence	2.7	4.1	3.1	4.8	.098
Agitated Depression	.3	.5	1.4	5.5	1.207

The overall T^2 was 1.21, the F ratio was 0.29 and P was 0.89.

TABLE XIX

COMPARISON OF THE RAW SCORES ON THE FINAL ADMINISTRATION OF THE PSYCHOTIC REACTION PROFILE FOR THE EXPERIMENTAL AND CONTROL PATIENT-GROUPS

Sub-Scale	Experimental Mean	Experimental SD	Control Mean	Control SD	T^2-Value
Withdrawal	15.1	10.2	17.5	9.6	.882
Thinking Disorganization	4.7	4.8	4.8	4.4	.007
Paranoid Belligerence	3.6	4.7	4.1	5.9	.130
Agitated Depression	.8	.7	.9	1.2	.128

The overall T^2 was 1.90, the F ratio was 0.45 and P was 0.77.

TABLE XX

COMPARISON OF THE DIFFERENCES BETWEEN THE INITIAL AND FINAL ADMINISTRATION OF THE PSYCHOTIC REACTION PROFILE FOR THE EXPERIMENTAL AND CONTROL PATIENT-GROUPS

Sub-Scale	Experimental Mean Diff.	Experimental SD	Control Mean Diff.	Control SD	T^2-Value
Withdrawal	4.6	6.5	14.5	42.3	1.592
Thinking Disorganization	.4	3.9	2.2	11.5	.637
Paranoid Belligerence	-1.0	3.4	- .6	5.9	.112
Agitated Depression	- .3	1.1	- .007	2.4	.315

The overall T^2 was 0.13, the F ratio was 0.03 and P was 0.99.

A psychologist trained in group processes and in the use of Bales' Interaction Record observed each pair of subjects as they interacted with members of their group during regularly scheduled group sessions. The observations were of ten-minute segments on the fifth, eleventh, seventeenth, twenty-second and twenty-seventh day of this four-week study.

7. There are differences between the results obtained by the experimental and control groups on the Bales' Interaction Record.

The scores on the Bales' Interaction Record were separated into the following categories: total scores, positive scores, negative scores and neutral scores. The results of the statistical analysis of these data are discussed in terms of the above categories (See Table XXV).

i) Total scores. The results of the statistical analysis of the total scores data indicates a difference between the experimental and control groups significant at the .0001 level (See Table XXI).

ii) Positive scores. The results of the statistical analysis of the positive scores data distinguished between the experimental and control groups at the .002 level of significance (See Table XXII).

iii) Negative scores. The results of the statistical analysis of the negative scores data indicates a difference between the experimental and control groups significant at the .007 level (See Table XXIII).

iv) Neutral scores. The results of the statistical analysis of the neutral scores did not differentiate the experimental group from the control group at the required level of significance (See Table XXIV).

TABLE XXI

SUMMARY OF THE ANALYSIS OF VARIANCE OF THE TOTAL SCORES ON THE BALES' INTERACTION RECORD EXPERIMENTAL GROUP VERSUS CONTROL GROUP

Source of Variation	SS	DF	MS	F	P
Between	699.60	11			
Group	540.00	1	540.00	33.84	0.0001
Error	159.60	10	15.96		
Within	1098.80	48			
Periods	48.23	4	12.06	0.56	0.69
'A * B'	191.16	4	47.79	2.22	0.08
Error	859.40	40	21.49		

TABLE XXII

SUMMARY OF THE ANALYSIS OF VARIANCE OF THE POSITIVE SCORES ON THE BALES' INTERACTION RECORD EXPERIMENTAL GROUP VERSUS CONTROL GROUP

Source of Variation	SS	DF	MS	F	P
Between	329.38	11			
Group	205.35	1	205.35	16.56	0.002
Error	124.03	10	12.40		
Within	1135.20	48			
Periods	103.67	4	25.92	1.16	0.330
'A * B'	143.73	4	35.93	1.62	0.180
Error	887.80	40	22.19		

TABLE XXIII

SUMMARY OF THE ANALYSIS OF VARIANCE OF THE NEGATIVE SCORES ON THE BALES' INTERACTION RECORD EXPERIMENTAL GROUP VERSUS CONTROL GROUP

Source Variation	SS	DF	MS	F	P
Between	151.78	11			
Group	79.35	1	79.35	10.96	0.007
Error	72.43	10	7.24		
Within	189.20	48			
Periods	11.40	4	2.85	0.66	0.620
'A * B'	6.07	4	1.52	0.35	0.840
Error	171.73	40	4.29		

TABLE XXIV

SUMMARY OF THE ANALYSIS OF VARIANCE OF THE NEUTRAL SCORES ON THE BALES' INTERACTION RECORD EXPERIMENTAL GROUP VERSUS CONTROL GROUP

Source of Variation	SS	DF	MS	F	P
Between	9377.94	11			
Group	86.44	1	86.44	0.090	0.774
Error	9291.56	10	929.16		
Within	14830.81	48			
Periods	1901.32	4	475.33	1.513	0.210
'A * B'	364.05	4	91.01	0.290	
Error	12565.50	40	314.14		

TABLE XXV

COMPARISON OF THE RESULTS OBTAINED BY THE EXPERIMENTAL AND CONTROL GROUPS ON THE BALES' INTERACTION RECORD

Category	RATING I		RATING II		RATING III		RATING IV		RATING V	
	Exp.	Con.	Exp.	Con.	Exp.	Con.	Exp.	Con.	Exp.	Con.
1. SHOWS SOLIDARITY, raises other's status, gives help, reward:	2	3	2	6	2	2	3	3	11	4
2. SHOWS TENSION RELEASE, jokes, laughs, shows satisfaction:	3	9	7	11	15	10	9	3	10	9
3. AGREES, shows passive acceptance, understands, concurs, complies:	28	17	20	10	52	11	19	8	35	1
4. GIVES SUGGESTION, direction, implying autonomy for other:	2	9	12	14	22	12	10	15	16	20
5. GIVES OPINION, evaluation, analysis, expresses feeling, wish:	19	12	10	19	14	18	34	15	37	15
6. GIVES ORIENTATION, information, repeats, clarifies, confirms	62	41	42	76	73	115	95	102	120	104
7. ASKS FOR ORIENTATION, information, repetition, confirmation:	113	102	114	113	116	120	53	110	75	110
8. ASKS FOR OPINION, evaluation, analysis, expression of feeling:	10	14	6	27	34	26	56	30	63	22
9. ASKS FOR SUGGESTION, direction, possible ways of action:	4	7	6	5	17	10	9	8	14	6
10. DISAGREES, shows passive rejection, formality, withholds help:	5	12	4	9	6	17	0	10	2	11
11. SHOWS TENSION, asks for help, withdraws "Out of Field":	0	1	0	2	1	1	0	4	0	5
12. SHOWS ANTAGONISM, deflates, other's status, defends or asserts self:	1	1	0	6	1	4	0	0	0	6

Discussion

The hypotheses tested in this study are divisible into three distinct segments. Hypotheses one, two and three were designed to determine if significant change occurred in the student nurses' test data which may be attributed to their having been subjected to the research treatment. The research treatment consisted of having the six experimental subjects participate in an intensive short-term human relations laboratory and having the six control subjects participate in a placebo treatment program during the same time period.

The result of the statistical analysis of the data obtained from the initial and final administrations of the instruments used in this segment (namely: The California Psychological Inventory, The Orientation Inventory and the Personal Orientation Inventory) did not support the hypotheses stated. It should be noted that Figures 1 and 3 indicate that the experimental and control groups initially displayed relatively similar profiles which in essence, suggests that they were equivalent groups on these variables. This result was expected and is desirable. Figures 2 and 4 reveal that the experimental and control groups again have essentially equivalent profiles. Had significant changes occurred, it would likely have been evident in a comparison of the amount of difference noted following the respective treatments given the experimental and control groups. Before concluding that change did not take place one has to consider whether the instruments

employed were sufficiently sensitive to register change following such a relatively short period of time should it have occurred. Campbell and Dunnette (1968) reported that standardized personality measures have generally yielded completely negative results. However they noted researchers have been quick to point out, "changes in such basic personality variables may be just too much to expect from such a relatively short experience, even if the T-group is a good one (p. 95)." Nevertheless the use of standardized measuring instruments is preferable to the employment of ad hoc instruments. Cohn (1967) stated:

> The rationale for including data from well-established measuring instruments is that some psychological instruments developed by investigators may be either unreliable, invalid, or measure something that instruments already available are measuring (p. 14).

It is important to note that the comparisons made were between an experimental group and a control group which had received a placebo treatment. Consequently it is not merely a matter of the difference between the traditional experimental and control group paradigm. The placebo treatment (Appendices B and C, pp. 129-131) because of the esteemed group which participated, may have given rise to a rather powerful Hawthorne effect which in turn may have been reflected in the final test data. The presentation of the placebo treatment to the control group was similar in many ways to the prior learning pattern of these students. Consequently the control subjects may have found the placebo treatment a most effective learning situation.

The difficulty of working with professional mental health workers in a group situation is emphasied by Yalom (1970) and may have some bearing on the rather equivocal results obtained in this study. Yalom suggested:

> A caveat to the group leader: groups of mental health professionals, and especially psychiatric residents who will continue to work together throughout their training, are extremely difficult groups to lead. The pace is slow, intellectualization is common, and self-disclosure and risk taking minimal. The neophyte therapist realizes that his chief professional instrument is his own person and generally is doubly threatened by requests for self-disclosre: not only his personal competence but his professional competence is at stake (p. 375).

In order to profit from a human relations laboratory experience participants must become actively involved. Certain skills are demanded of the individuals in this type of learning situation and, according to Maslow (1965), perhaps it is reasonable to expect that only a small percentage of the population can benefit. Campbell and Dunnette (1968) raised an interesting possibility with regard to the assumptions underlying a T-group and warned that they may present:

> ... a potentially troublesome paradox underlying the T-group method - their close resemblance to the major T-group objectives themselves. That is, it appears that some of the interpersonal skills most important for accomplishing the T-group's objectives are also the very skills constituting the major learning goals of the method (p. 77).

Finally it is a possibility that the results obtained in this segment of the study may well reflect what Dreyfus (1967) has termed the flight into intimacy and the equally potent fear of intimacy. Young people such as the

experimental subjects in this study often seek closeness, contact, and relatedness but fear such intimacy when the opportunity for it arises. In terms of the theoretical foundation underlying this study it is a possibility that the experimental subjects may well have become "unfrozen" (Schein and Bennis, 1965), began the process of change, found this too threatening and reverted, at least in part, back to their original rather rigid attitudinal stance.

Hypotheses four, five and six were designed to determine if any change occurred in the behavior of the patients which may be attributed to the interaction of the experimental and control groups during the research period. The instruments used in this segment of the project were: The Hospital Adjustment Scale, The MACC Behavioral Adjustment Scale, and The Psychotic Reaction Profile. The statistical analysis of the data obtained by the use of these instruments revealed no significant changes. These instruments are considered sufficiently sensitive to register behavioral changes anticipated from psychiatric inpatients. Pattison (1965) in a discussion of such instruments used in similar research noted, "The investigators were able to demonstrate consistent statistical improvement with such scales (p. 385)." However, these instruments were employed only twice in this study, during the week prior to the commencement of the study and again during the week following its conclusion. The behavior of psychiatric inpatients often fluctuates rapidly especially during the imposition of some innovation into their

daily routine. Hence it is a possibility that the data obtained does not represent a valid picture of their behavior. A social system such as a patient's peer group can resist, be indifferent to or support change in the behavior of individuals in the group (Cohn, 1967). Therefore, Cohn suggested:

> It will be important to assess whether changes in growth in a given member act as a freeing device for others to whom he is significantly related, or whether individual growth will cause a disruptive pattern in his group relationship outside of counseling (p. 19).

Nevertheless long-term psychiatric inpatients such as the ones involved in this study have traditionally responded poorly to treatment programs developed to rehabilitate them; consequently it is not unusual that the subjects in this study responded as they did.

Hypothesis seven was designed to test the student nurses' interaction with the patients in the group to which they were assigned. It appears evident that the members of the experimental group who had participated in the short-term human relations laboratory responded significantly more than did the members of the control group who had participated in the placebo program. The members of the experimental group interacted more positively with their patients than did the members of the control group. The members of the control group employed negative comments significantly more than did the members of the experimental group. There was no statistical differences in the number of neutral comments made by the experimental and control group. It would appear that the experimental subjects were able to interact in a

manner more conducive to effecting therapeutic change in their patients than were the control subjects. This is evident from the results which show the experimental subjects making significantly more statements categorized as positive, namely showing solidarity, helping the patients reduce tension and generally displaying verbally an attitude of acceptance and understanding. The control subjects' significantly greater usage of comments categorized as negative possibly reflects their overall lack of confidence in a group situation and their resulting anxieties and tension when faced with a situation for which they were not sufficiently prepared.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS AND NEEDED RESEARCH

Summary

Statement of the problem. This study was designed to determine the influence of an intensive short-term human relations laboratory experience on the effectiveness of third-year psychiatric nursing students' work with selected long-term hospitalized psychiatric patients.

Research design. Twelve female members of the third-year class of psychiatric nursing students at the Alberta Hospital, Edmonton were selected for participation in this project. Two groups of six each were formed having been matched only on the criterion of nursing aptitude as measured by the Nursing Aptitude Test developed by Thelma Hunt. The experimental group was subjected to an intensive short-term human relations laboratory while the control group was subjected to a placebo form of treatment. Prior to this treatment period and again following it each of the twelve students completed the following instruments: The California Psychological Inventory by H. Gough, the Orientation Inventory by B. Bass and the Personal Orientation Inventory by E. Shostrom.

Following this aspect of the research project three pairs of psychiatric nursing students were selected from the experimental group and three pairs from the control group.

Each pair was assigned a group of patients on ward 4C, a continuing care unit housing long-term male patients, at the Alberta Hospital, Edmonton. Each group met daily for a period of one hour. Prior to the commencement of the group sessions on the ward and again following the conclusion of the group sessions, some four weeks later, each of the patients was assessed by a member of the permanent nursing staff using the following instruments: The Hospital Adjustment Scale by P. McReynolds and J. Ferguson, The MACC Behavioral Adjustment Scale by R. Ellsworth, and The Psychotic Reaction Profile by M. Lorr. Periodically throughout the duration of the project the student nurses' interactions with the patients in the groups to which they had been assigned were observed and rated by a psychologist trained in group processes. The Bales' Interaction Record was employed for this evaluation.

The findings. Seven hypotheses were tested in this study. It was hypothesized that (hypotheses one, two and three) significant change would occur in the student nurses' test data which would be attributable to the research treatment. The results of the statistical analysis of the data obtained indicate that no significant change occurred.

It was further hypothesized that (hypotheses four, five and six) changes would occur in the behavior of the patients which would be attributable to their interaction with the experimental group during the research period. The results of statistical analysis of the data obtained do not indicate support for these hypotheses.

Hypothesis seven was designed to test the student nurses' interaction with the patients in the group to which they were assigned. Statistical analysis of the data obtained clearly demonstrates that the experimental group, which had participated in the human relations laboratory, responded significantly more positively and interacted more with their patients than did the members of the control group, who had participated in the placebo treatment program.

Conclusions

This study sought to determine if the influence of an intensive short-term human relations laboratory could be observed in the work of the student nurses during their interaction with the patients in the groups to which they had been assigned. The statistical analysis of the data obtained by the use of the Bales' Interaction Record suggests that this major question was answered in the affirmative.

Personality changes, considered measurable by the evaluative instruments employed in this study, were not evidenced. The human relations laboratory training should be seen as the initial segment of the total process of training and application. It is a possibility that the unfreezing-change-refreezing sequence of steps (Schein and Bennis, 1965), by which change is assumed to occur, began during the human relations laboratory but was not concluded there.

Perhaps the human relations laboratory tended to

initiate a process of change, characterized chiefly by an "unfreezing" (Schein and Bennis, 1965) of the students' former rigidity of behavior, which was not detected by the instruments used for this purpose. The difficulties encountered in performing adequate evaluative research are numerous, especially when the researcher attempts to produce change in persons. Miles (1965) summarized these difficulties:

> Research on any form of treatment is classically difficult, unrewarding and infrequent. When the product of a process is change in persons, the criterion problem is ordinarily a major one, whether the treatment occupies the domain of education, mental health, or social functioning. Goals are vaguely stated (partly because of ignorance and partly, it has been suggested, to protect the practitioner against charges of malpractice). Often, it is claimed that "real" change may not be assessable until long after the treatment has occurred. Even if goals are precisely and operationally defined, treatment programs themselves are usually hard to describe accurately enough for later replication. Furthermore, test-treatment interaction is quite likely; subjects are easily sensitized by pre-measure. Even more crudely, it is frequently difficult to locate anything like a meaningful control group, let alone establish its equilvalence. Finally, numbers are usually small, and the treatment population is often biased through self-selection (pp. 215-216).

The difficulties involved in evaluating a human relations training program designed to produce change in persons are compounded by the fact that the program is evaluated both in terms of its effectiveness in producing change in individuals and in producing changes in an organization (Schein and Bennis, 1965). This fact accounts, in large measure, for the limited amount of valid research in this area. Schein and Bennis (1965) stated:

> The meagerness of evidence does not reflect lack of concern on the part of practitioners of laboratory training, but the actual difficulties of gathering data which have empirical validity. Two very general problems can be identified: (1) difficulties in achieving practical change and learning goals; and (2) difficulties of gathering data in which we can have confidence as to their reliability and validity. Where human and organizational change is involved, it is difficult to determine what kinds of data we should gather that would reliably and validly reflect changes and learnings (p. 237).

The instruments employed in the present writer's study were chosen because they met two important criteria of selection: standardization, and applicability to the demands of the research study. Nevertheless it must be concluded that these instruments were likely not suitable for the demands made of them in this evaluation. This point becomes clear when one reviews the goals formulated for human relations laboratory training as noted in Chapter II.

It does appear that desirable changes in the behavior of the experimental subjects did occur as evidenced by the results obtained from the employment of the Bales' Interaction Record. This result need not be considered contradictory when compared with the lack of measurable personality change. Personality change is not necessarily a prerequisite to the kind of change recorded on the Bales' Interaction Record. The latter was specifically designed to measure the interaction of individuals in a small group setting and is therefore a more precise instrument for the evaluation of change than were the global personality tests employed.

The changes observed in the interactions of the experimental subjects were specific and apparently operative only in the on-the-job environment. The observed changes did not generalize into other areas of the participant's life and result in a measurable personality change. Kernan (1967) in a discussion of a similar situation noted:

> The program could effect changes in very specific or narrowly defined behaviors or behavioral skills, such as listening, which are not usually thought of or included when one thinks of the individual's general characteristics and way of behaving or responding, i.e. his personality. Thus the changes in the individual's behavior resulting from training may have no relationship to his more general and characteristic ways of behaving ... Thus, the behavior of the participant on the job can be seen by others as having changed without there necessarily having to be any concomitant changes in his "personality" as such (p. 138).

In a discussion of appraising outcomes of psychotherapy Ohlsen (1970) stated, "some researchers use available instruments, and thus they use as their criteria whatever these instruments measure (p. 252)." It is possible that the evaluative instruments employed were too global in nature to detect the changes that may have been effected by the research treatment. A follow-up evaluation, not included in this study, might have shown that the change which appeared to have been initiated by the research treatment in which the experimental subjects participated had become sufficiently fixed over time to be detected by the evaluative instruments. However, this appears not to be the case according to the relevant literature reporting on similar research projects (Gold, 1967).

The behavior of the patients as measured by the evaluative instruments did not change significantly; nevertheless the reports of the nursing supervisor indicate that certain patients reponded extremely well to the concern expressed by the student nurses. This was true of both members of the experimental and control patient-groups.

At the conclusion of the research period the members of both the experimental and control groups were assessed by a member of the permanent nursing staff who remained unaware of the individual student's membership in either the experimental or control group. Her comments regarding the individual students are reported here in part.

The experimental group.

A - approachable ... she certainly believed in what she was doing ... concerned with what all had to say.

B - genuine interest in the patients ... her friendliness radiates to the patients ... the patients benefited, especially one withdrawn patient.

C - participation was minimal at first ... she showed improvement throughout.

D - apprehensive and participated minimally at first ... left opportunity for open discussion and involvement of the patients.

E - as she became familiar with the patients she actively participated and promoted interaction in the group ... communicates with her patients on an equal basis.

F - she enables the patients to interact with each other ... has all the patients involved ... there is a genuine warmth between patients and staff.

The control group.

G - creates opportunity for back and forth conversation between the patients.

H - participates but lacks enthusiasm.

J - has a good group ... provides as opportunity for back and forth conversation between patients.

K - apprehensive, participation minimal at first ... patients began participating more with more relaxed participation on the part of the nurse ... an excellent job with a specific withdrawn patient.

L - kept strict control on conversation ... later relaxed her control and allowed for spontaneous remarks and general discussion among the patients.

M - tried to bring each patient into the conversation and attempted to implement interaction between patients.

A comparison of the comments made by the nursing supervisor about the experimental and control subjects reveals that certain of the experimental subjects (A, B, and F) were described as possessing more of the characteristics attributed to effective therapists. That is, these experimental subjects (A, B, and F) were described as being concerned, believing in what they were doing, possessing genuine interest, friendly, involved and exhibiting warmth. The control subjects were generally described as encouraging participation but with no mention being made of the therapeutic qualities noted above.

The results of a research project such as the one herein described often depends upon the atmosphere which exists in the setting wherein the project is conducted. It can be unequivocally stated that this research project received enthusiastic support from the attending physician and the nurses on ward 4C. Nevertheless McGee (1969) pointed out that it is necessary to prepare the individuals for their impending participation in the group. He further stated that upon commence-

ment, the group should be prepared for what is to transpire. This was not done, although, as is implied above the hospital staff and the student therapists were prepared for this innovation into the daily activity of this ward. Perhaps this lack of preparation of the patients accounts, in part, for the dirth of positive results with regard to the hypothesized behavioral changes of the patients.

The influence of the trainer in a project such as this one can not be overlooked. It is crucially important that the trainer create an atmosphere of acceptance and one conducive to new learning very early in a short-term human relations laboratory. This is particularly true in the case of student nurses who, through their prior training, have had instilled in them the traditional doctor-nurse relationship which places a certain omnipotence on the role of the doctor. This typical doctor-nurse relationship was noted by the trainer, a psychiatrist, and a concerted effort was made to break it down in order to facilitate the new learning considered desirable.

A point to be considered is that the therapists were all young females while the patients were male and predominately older men. It is possible that either the patients or the therapists would have responded differently to the same age-sex combinations.

Finally the question implicit in this study must be asked. Should human relations laboratory training become an integral part of the curriculum of a nursing education

program? The answer to this question depends upon two factors. The first factor which must be considered is whether or not participation in an intensive short-term human relations laboratory does have any worthwhile effect on the work of those who participated in it. This research study gave some evidence in the affirmative. The behavior of the patient population did not improve significantly as a result of being in contact with those students who appear to have profited from their experiences in the human relations laboratory. However, it must be recognized that a relatively minor segment of a nurse's training program is not likely to have panacea-like effects on that individual's performance. The second factor which must be considered is whether there will be any transference of the learning acquired in the short-term human relations laboratory. This depends upon many factors but it is generally conceded that learning will be transferred to the extent that the individual has a realistic understanding of what happened to him during the short-term human relations laboratory and how it relates to his past and present experiences. Eisenstadt (1967) in a discussion of the factors which influence response to human relations laboratory training suggested that the degree of readiness of the participant was most important. She concluded that the essential factors were:

> ... the participant's readiness to learn, his readiness to initiate action or experiment at home, and his perception of the degree in which the home situation contained potential for change (p. 576).

Again the importance of the trainer chosen to conduct such

an innovative program as a human relations laboratory within the general nurse's training program is evident. It is the writer's opinion that only those trainers who are well trained and competent in this specialization should be involved in this aspect of a nurse's education. Should such trainers not be available, it would seem wise not to introduce this innovation.

Recommendations and Needed Research

One of the most pressing needs in the general area of small group research is an explicit theory of learning which would specify the relation between learning experiences and learning outcomes. There is a great diversity of theory regarding the T-group change process (Bradford, Gibb and Benne, 1964). This diversity, according to Schein and Bennis (1965) may be attributed to the wide range of learning outcomes seen as possible. However this is little comfort to the researcher who remains puzzled as to the kind of outcomes he can expect from any specific T-group efforts he may employ in his research (Campbell and Dunnette, 1968).

A closely related problem is the question of transfer of learning from the training group to the participant's life outside the group. The need is especially critical in the area of rigorous outcome research. Yalom (1970) stated:

> The lack of outcome criteria and results has served to discourage research in such areas as the following: curative factors, group composition, selection of

> patients, and the relative efficacy of specialized techniques and formats (p. 380).

One of the most important prerequisites in the development of such research in the area of group psychotherapy is the establishment of goals for the individual participants. This is particularly necessary when the research project involves schizophrenic patients. Barnes (1968) suggested that the setting of goals with patients depends upon the researcher's conceptualization of the nature of the difficulty from which the patient suffers. He noted:

> If we consider schizophrenia as essentially an organic disorder that occurs in a physiologically, genetically marked person, we may develop entirely different goals than if we see schizophrenia as the product of inadequate early learning and early emotional deprivation (p. 156).

Barnes urged that the patient and perhaps those in his immediate environment be involved in the setting of goals. If this is not done the researcher is often disappointed because the patient does not achieve the goals set for him, goals of which the patient was perhaps not even aware.

The establishment of goals in group therapy, according to Ohlsen (1970) is essential to the development of sound research. He stated:

> Failure to define specific goals in <u>precise measurable or observable</u> terms for each client is one of the most serious weaknesses of the research designed to appraise outcomes of counseling. Such goals are necessary in order to define the precise criteria needed to develop and/or to select instruments and observation methods to appraise changes in clients (p. 250).

Group therapists must continue to accept as their primary goal the therapeutic treatment of their patients. Yalom (1970) concluded:

> At present, groups, self disclosure, interpersonal closeness, touching are "in." Yet the medium is <u>not</u> the message. Group therapy is not primarily a vehicle for closeness, and human contact. It is a method for effecting therapeutic change in individuals. All other goals are metaphenomena and secondary to the primary function of the group (p. 385).

More attention must be given to the creation of precise research designs if the appraisal of group psychotherapy studies is to receive the credence desirable in the scientific community. Pattison (1965) suggested that, "... appropriate research designs do not seem to have emerged (p. 383)." One of the most important aspects of a research design which is often neglected is the establishment of a baseline against which the therapeutic effectiveness of the treatment innovation being employed can be compared (Rashkis, 1959). Essentially the main concern in a research study such as the one undertaken by the present writer is how the modification of various factors in the ward situation will influence the course and outcome of the individual patient's illness. It should be noted that each ward has its own characteristic manner of influencing the course and outcome of the patient's illness. This fact must be taken into full account when a researcher attempts to establish the baseline referred to above.

A crucial aspect of a research design developed for the study of an innovative treatment program with long-term

psychiatric inpatients, is the provision for the observation of the period of personal disequilibrium, which invariably occurs, during the therapeutic process and prior to some integration (Cohn, 1967). Cohn urged: "Designs should reflect this in trying to establish the possible presence and duration of negative consequences, as well as positive consequences (p. 19)."

Traditional designs of outcome studies, according to Yalom (1970) share the common error of failing to individualize the outcomes. Yalom warned "... the conventional approach of applying one or several outcome measures to all patients and scoring each on the same "worse-improved" continuum has proven to be unsatisfactory (p. 380)." He further stated: "In summary, the standardized (nomothetic) approach to therapy outcome has severe limitations. I can think of no alternative except a laborious individualized (ideographic) approach to outcome (p. 381)."

An area of great concern to researchers is the problem of measurement. Campbell and Dunnette (1968) suggested:

> The measurement problem involves two major steps: (a) assessing what changes have occurred over the course of the training, and (b) determining how such changes are manifested in the organizational setting (p. 79).

The assessment of changes during the training process, as noted above, can most appropriately be obtained by the employment of an ideographic approach subsequent to the establishment of desired goals jointly developed by the individual participant and the researcher. The selection of the evaluative instru-

ments to be used is directly related to these goals.

In the assessment of changes which are anticipated in the "back home" situation one must consider the dichotomous nature of outcome criteria. These are the affective (attitudes, values, feelings), and the behavioral. There is an inherent assumption in this affect - behavior dichotomy that attitude change precedes and precipitates behavior change. If this assumption is correct researchers would be wise to delay measuring behavior change for some time after the conclusion of a treatment program. This presents a major problem because the measurement of attitudes has been traditionally most unsatisfactory. Hoover (1967) noted, "Reliable attitude measurement, however, has been most difficult, due to the lack of instruments sensitive enough to register subtle attitude shifts (p. 234)." Nevertheless the use of general criteria reduces the chances of obtaining significant differences and increases the possibility that important changes may be overlooked. Cohn (1967) warned: "Where only general criteria are used in the measure of change, these will be applied to many subjects for whom they have no meaning (p. 32)." Therefore, the choice of evaluative instruments in a research project is crucial. Ohlsen (1970) noted five obvious errors researchers often make in the choice of appropriate instruments. They are:

> (1) use of global criteria. (2) use for all clients of criteria appropriate for only some clients, (3) use of criteria such that growth for some clients cancelled out growth for others, (4) use of measures for which no evidence of either reliability or validity is presented, and

> (5) use of measuring devices insensitive to changes anticipated (p. 252).

Directly related to the problem of choosing appropriate evaluative instruments is the difficulty encountered in the analysis of the data obtained. The sina quo non of successful research appears to be the obtaining of significant differences. Cohn (1967) cautioned researchers not to confuse significant difference with meaningful difference. He stated:

> A prime factor in determining the magnitude that a difference needs to attain before it can properly be labelled significant is sample size. The larger the sample, the smaller the unit difference required for significance (p. 33).

The difficulty researchers encounter is that their sample size is invariably small, primarily for practical reasons, and consequently the likelihood of obtaining significant results is reduced. However, researchers should look for meaningful trends in the results obtained. This is especially important at this stage in view of the fact that the development of appropriate research designs for group work has not reached the level of sophistication considered necessary to meet the standards of rigorous research.

Data collection is another factor that should not be overlooked. An obvious shortcoming in the present writer's research project was the use of only one observer to collect the data for the Bales' Interaction Record and for the various scales employed to determine the patient's adjustment prior to and following the research treatment. Consideration should

also be given to the stage of development of the group at which the data was collected. This designation of the stage of development should be reflected in the research design (Jones and Peters, 1952).

The techniques employed by the trainer or group therapist vary considerably and will determine the therapeutic change to be expected (Pattison, 1965). Consequently the role of the trainer should be clearly stated and the research design should reflect the trainer's expectations.

The composition, size and rationale for involvement in a human relations laboratory experience must not be overlooked. Research is needed to determine the optimal size of various kinds of groups, for example the team group which must work together as a unit on their return to the community.

Research studies such as this should be replicated with the addition of three vital features. Follow-up evaluations are essential to determine how lasting the effects of such experiences are in the life and work of the participants. Another important feature to be added is the presence of a control group which would receive no research treatment at all. It is important to compare human relations training with placebo treatments of various kinds; however, in order to make an appropriate comparison a control group receiving no research treatment is necessary. Finally, studies such as the one described here should be of longer duration.

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APPENDIX A

A SYNOPSIS OF THE HUMAN RELATIONS LABORATORY

The human relations laboratory was somewhat patterned after the basic encounter groups conducted by Carl Rogers. In general the approach was non-directive; some structure and direction was evident.

Throughout the program the students worked on the improvement of their basic communicative skills with exercises such as those outlined by John L. Wallen, namely: paraphrasing -- stating in your own way what the other's remark conveys to you; behavior description -- reporting specific, observable actions of others without making accusations or generalizations about their motives, personality or character traits; and description of feelings -- specifying or identifying feelings by name, simile, figure of speech, or action urge. However the problem of initiating interpersonal interaction at sufficient depth to be of value in creating the friction necessary to cause a spontaneous interaction arose immediately and persisted. This was due, it is felt, to the small number (6 subjects and a trainer) participating in the group and the traditional attitude of nurses, characterized by submissiveness, dependence, conventiality and a need to be the doctor's hand maiden. Consequently emphasis was shifted from increasing interpersonal skills to greater personal growth.

Some time was spent on anticipating what problems the subjects would face upon conducting groups on the ward upon their return to the hospital. The small size of the

group was thought to be detrimental to the overall aim of this short-term human relations laboratory. The trainer notes that none of the subjects suffered any bad reaction as a result of their involvement in this program. On the contrary the subjects were greatly impressed both by the trainer and the program attempted with them. The trainer's influence on the girls was especially evident when they made their last farewells when many tears of joy were noted.

Notes from a conversation with the trainer, Dr. J. Guild.

APPENDIX B

RESEARCH TREATMENT

Experimental Subjects (Experimental Treatment)	Control Subjects (Placebo Treatment)
January 14, 1970 (Wednesday)	
-- 4:30 p.m. Proceeded to Providence House. Had their evening meal. Met their trainer, Dr. J. Guild, and began their first session of the Human Relations Laboratory.	-- 7:00 p.m. Control subjects viewed two films at the Alberta Hospital re: Adolescent Drug Problem. -- The control subjects were given a project or "task" to perform basically on their own. "Prepare a Plan for the Treatment of Adolescent Patients at a Psychiatric Hospital".
January 15, 1970 (Thursday)	
Human Relations Laboratory continued all day.	-- 7:00 p.m. Control subjects met at Alberta Hospital -- worked on a "task", primarily without assistance. "The evaluation of their Nursing Program for meeting the needs of youth".

January 16, 1970 (Friday) Human Relations Laboratory continued.	-- 8:30 a.m. to 4:30 p.m. Control group received special lectures as part of their training at the Royal Alexandra Hospital in Edmonton.
January 17, 1970 (Saturday) Human Relations Laboratory continued.	-- 9:00 a.m. to 3:30 p.m. Worked on the "task" assigned on Wednesday. Some resource personnel available; but not active.
January 18, 1970 (Sunday) Human Relations Laboratory concluded during the afternoon.	
January 19, 1970 (Monday) Began working on ward 4C.	-- Began working on ward 4C.
February 14, 1970 (Saturday)	Project ends

APPENDIX C

SPECIAL LECTURES

THIRD-YEAR PSYCHIATRIC STUDENTS

Schedule for Friday, January 16, 1970

Time: Begins at 9:00 a.m.

Place: 4th Floor Classroom, Royal Alex Hospital.

Program:

9:00 - 10:00	Miss A. McCormach	-Staff of Royal Alex Hospital.
10:00 - 11:00	Miss S. Makowloski	-Nursing Supervisor, Emotionally Disturbed Children's Unit, Glenrose Hospital.
11:00 - 12 noon	Dr. D. Philips	-Community Psychiatry.
12:00 - 1:30	Lunch at the Royal Alex Hospital.	
1:30 - 3:00	Dr. W. Nixon	-Family Therapy.
3:00 - 4:00	Dr. Robbie Campbell	-Hallucinogenic Drugs.
4:00 - 5:00	Miss Murphy	-University School of Nursing.
5:00 - 7:00	Evening meal at Royal Alex Hospital.	
7:00 - 9:00	Mr. Bill Stewart	-Group-Process Skills, University Extension Program.

Will you need assistance RE: Transportation?