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A STUDY OF THE EFFECT OF A SERIES OF NURSING INTERVIEWS IN
PROMOTING CONSTRUCTIVE BEHAVIORAL CHANGE IN A GROUP
OF AGGRESSIVE FEMALE PSYCHIATRIC PATIENTS

by

LUCY DIANE JOHNSON BOLICK

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Approved:

Mrs. Laura Wadby, A.V. Ph.D.
Head, Major Department

Mrs. Margaret Barkley
Chairman, Examining Committee

Henry L. Parsons
Graduate Dean

MONTANA STATE UNIVERSITY
Bozeman, Montana

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ABSTRACT

The purpose of the study was (1) to determine if a series of nursing interviews which aids the patient to talk through aggressive episodes is an effective method for nurses to use to promote a positive change in the aggressive behavior of the psychiatric patient, and (2) to determine the way the staff respond to various aggressive behaviors displayed by aggressive female psychiatric patients.

The study was conducted at the state mental hospital in Montana. The population was made up of adolescent and adult female patients living on a locked extended care ward. Two groups of five patients met the criteria for participation in the study. Patients in the experimental group were interviewed by the investigator for thirty minutes twice a week for five weeks. The control group did not have any contact with the investigator during the five week period.

The primary hypothesis for the study was: The frequency of aggressive behaviors displayed by a selected group of female psychiatric patients will be significantly reduced following a five week series of nursing interviews which aid the patient to talk through aggressive behavioral episodes with the investigator. A second hypothesis tested was: Staff responses to the aggressive behavior of psychiatric patients will be controlling or punishing and will not allow the patient to talk through aggressive behavioral episodes.

The primary hypothesis was rejected on statistical evaluation of the data collected on a behavioral frequency checklist. Non-statistical evaluation of data obtained from the interviews and behavioral frequency checklist suggest that one patient in the experimental group made considerable progress in reducing aggressive behavioral episodes. The fact that the patient was nonpsychotic and had been hospitalized a short period of time, while the other patients in the experimental group were psychotic and had been hospitalized for much longer periods of time, suggests a need for further study.

Data collected, using an open response questionnaire, indicates that the staff responses to aggressive behavior displayed by patients in the sample frequently was inconsistent and often reinforced defensive aggressive patient behavior due to the staff's frequent use of disciplinary or controlling action as a response to the patient's aggressive behavior. Thus, the second hypothesis was accepted.

The study findings provoked recommendations for further study involving both the aggressive psychiatric patient and the nursing profession.

CHAPTER I

INTRODUCTION

Aggression is a common human trait. Within normal limits aggression is a requisite for successful social adaptation. To live in society, however, one must learn to channel aggression into constructive activity. Some, particularly when they are emotionally or physically ill, vent their feelings in ways which may be destructive to them and to those around them.¹

A psychiatric nurse often finds herself the recipient of a patient's anger and hostility expressed in aggressive behavior although she may not be the origin of such emotions. When one is confronted with anger and hostility the natural tendency is to defend oneself, to react protectively or by counter attack to the threat to oneself or ones self-image. However, a defensive response by the nurse to aggressive patient behavior will do nothing to promote a positive change in the patient's behavior. Manfreda has stated:

It is important for the nurse to develop an awareness of her own feelings and reactions toward aggressive behavior and their influence upon the individual patient's behavior... responses which cause the patient to feel fearful, rejected, punished, or unduly controlled may reinforce defensive aggressive behavior.²

¹Beatrice R. Brooks, "Aggression," American Journal of Nursing, December 1967, p. 2519.

²Marguerite L. Manfreda, Psychiatric Nursing (Philadelphia: F. A. Davis Co., 1964), p. 93.

Peplau has described the purpose of nursing as aiding the patient to grasp the meaning of his health problem and to learn from his current experience with it. The nurse has the opportunity to utilize the nursing situation to stimulate the patterning of behavior due to stress in the direction of new learning and favorable change in the patient.³

When working with an aggressive patient the nurse should question whether her approach to the patient reinforces deviant behavior. The nurse should provide an opportunity for the patient to learn new ways of dealing with interpersonal relationships.

Nursing literature provides many suggestions as to how the nurse can promote learning for the patient who acts out hostile or angry feelings in aggressive behavior. However, no research was found conducted to test the effectiveness of these nursing approaches in promoting constructive behavioral change in the aggressive hospitalized psychiatric patient. Nor, was research found conducted to determine the type of responses exhibited by the staff when various aggressive behaviors are displayed by patients on a psychiatric ward.

³Hildegard E. Peplau, Interpersonal Relations in Nursing (New York: G. P. Putnam's Sons, 1952), p. 343.

Statement of the Problem

The problem dealt with in this study was as follows: (1) Will a series of nursing interviews which aids the patient to talk through aggressive behavioral episodes promote constructive behavioral change in aggressive female patients living on an extended care psychiatric ward, and (2) Do staff responses to aggressive behavior displayed by the psychiatric patient tend to reinforce aggressive behavior?

Purpose of the Study

The purposes of the study were: (1) to determine if a series of nursing interviews which aid the patient to talk through aggressive episodes is an effective method for nurses to use to promote a positive change in the aggressive behavior of the psychiatric patient, and (2) to determine the way the staff responds to various aggressive behaviors displayed by aggressive female patients living on an extended care psychiatric ward.

Statement of the Hypothesis

The primary hypothesis used in this study was: The frequency of aggressive behaviors displayed by a selected group of female psychiatric patients living on an extended care ward will be significantly reduced following a five week series of nursing interviews which aid the patient to talk through aggressive behavioral episodes with the investigator. A second hypothesis for the study was: Staff responses to

aggressive behavior of psychiatric patients will be controlling or punishing and will not allow the patient to talk through aggressive behavioral episodes.

Limitation of the Study

The sample available at the time the study was conducted was limited and therefore any statistical treatment of the data obtained during the study was of limited value as no generalization could be made.

The variables of age, diagnosis, level of intelligence, medications, number of admissions and length of hospitalization could not be controlled due to the limited sample size.

The weekly interviews did not allow the investigator to talk to the patient about every aggressive episode displayed by the patient. In addition, the interview method did not provide the patient with an opportunity to talk through aggressive episodes immediately after the aggression was displayed.

The behavioral examples of aggression included on the open response questionnaire and the frequency checklist were not tested for validity or reliability prior to their use in the study.

Assumptions of the Study

The study was based on the following assumptions: (1) defensive, judgmental, or authoritarian responses by the nurse to the patient's

anger or hostility reinforces aggressive behavior, and (2) the sources of anger and hostility often are not recognized by the patient.

Definition of Terms

Hostility. An emotional reaction to a personal threat or frustration wherein either verbal or motor aggressive action offers relief.⁴

Frustration. Any interference with, blocking of, or barrier to a need, drive, or desired goal.

Threat. A situation which disrupts personal security and results in anxiety.

Anger. An emotional reaction to a personal threat or frustration wherein overpowering thoughts or actions are used to obtain relief.

Anxiety. "A vague and unspecific apprehension which occurs as a reaction to threats to personal security."⁵

Ego Defense (Mental) Mechanism. "A psychological technique performed by the ego but carried out below the subject's threshold of awareness, designed to ward off anxiety."⁶

⁴Judith Ann Moore, "Encountering Hostility During Psychotherapy Sessions," Perspectives in Psychiatric Care, Vol. VI, No. 2, 1968, p. 60.

⁵Rollo May, The Meaning of Anxiety (New York: Ronald Press Co., 1950), p. 51.

⁶Charles K. Hofling and Madeleine Leininger, Basic Psychiatric Concepts in Nursing (Philadelphia: J. B. Lippincott Company, 1960), p. 507.

Denial. A mental mechanism used to evade or escape the unpleasant or disagreeable realities of living by ignoring or refusing to acknowledge their existence.

Talking through aggressive behavioral episodes. The patient is encouraged in the nursing interview to describe what preceded the aggressive episode, what his expectations were, what happened instead, his reactions including his thoughts, feelings and actions. In addition, the patient is encouraged to discuss alternative actions which he can take in similar situations in the future which will not be harmful to himself or others.

Reaction formation. A mental mechanism whereby a character trait is developed to an extreme degree to control the presence of its opposite.

Rationalization. A mental mechanism which explains or justifies an individual's ideas, actions and feelings in a plausible light.

Displacement. A mental mechanism whereby an emotion felt in a previous situation where its expression would not be socially acceptable is transferred into another situation.

Projection. A mental mechanism where feelings which are associated with emotionally painful experiences or undesirable characteristics possessed by the projecting individual are thrown off or onto someone or something else in the environment.

Nursing Interview. The verbal communication which occurs within the interaction between nurse and patient and which is directed toward the maintenance, promotion or restoration of health.⁷

Aggression. "Any verbal or non-verbal, actual or attempted forceful abuse of the self, another person or thing."⁸

Constructive Behavioral Change in the Aggressive Patient. Behaviors which are considered to evidence constructive behavioral change in the aggressive patient include: (1) A reduction in the frequency of aggressive behavior exhibited by the patient on the ward, (2) ability to verbalize aggressive feelings and/or behaviors and surrounding events to the investigator, (3) verbalization of awareness of the effects of aggressive behavior on oneself and others, and (4) Verbalization of intent or actual attempts to handle aggressive feelings in ways which are not harmful to the patient or others, including altering environmental situations which have resulted in aggressive behavior in the past.

⁷Loretta S. Bermosk and Mary J. Mordan, Interviewing in Nursing (New York: The Macmillan Co., 1964), p. 4.

⁸Janice Clack, "Nursing Intervention into the Aggressive Behavior of Patients," Burd, S. and Marshall, M. (eds.) In: Some Clinical Approaches to Psychiatric Nursing (New York: The Macmillan Co., 1963), Chapter 33, p. 199.

CHAPTER II

REVIEW OF LITERATURE

A survey of professional nurses in western New York State conducted in 1967 by the Department of Continuing Education of the School of Nursing at the State University of New York at Buffalo disclosed that psychiatric nurse practitioners recognize their own need to know more about intervening in dysfunctional behavior. Of the specific behaviors defined as problems in this survey, an overwhelming majority of responses indicated that the behavior of hostile patients was considered the most difficult to deal with effectively.

According to Kneisl and Kelly, patients who present the greatest problems to psychiatric nurses are those who are physically assaultive, sarcastically ingratiating or verbally aggressive or derogatory. The dynamic of hostility, or anger, as a response to anxiety is the commonality in all of these aggressive behaviors.⁹

Efforts have been made in recent nursing literature to provide the nurse with a theoretical framework for nursing intervention into hostile or angry aggressive patient behavior. Included in this theoretical framework are the concepts of anger and hostility as they relate to aggressive patient behavior and suggestions as to how the

⁹Carol R. Kneisl and Holly S. Kelly, "Hostility In The Nurse-Patient Interaction," Perspectives in Psychiatric Care, Vol. VII, No. 4, 1969, p. 150.

nurse, using the concepts of anger and hostility as a guide, can help the patient learn from aggressive behavioral episodes.

Anger is an emotional state which may reinforce and heighten aggressive behavior. When a patient experiences anger, a number of physiological alterations take place which serve to prepare the organism to take aggressive action of some kind. Hays defines the concept of anger operationally using four steps: (1) there is an experience of a frustration, reduced self-respect, or unmet expectations; (2) an unpleasant, uncanny, powerless feeling occurs which is called anxiety; (3) the anxiety is changed immediately and usually without recognition into feelings or actions of power directed against the blocking object, a substitute or the self; and (4) relief is felt.¹⁰ Anger serves a very useful purpose if it can be felt and expressed freely, because it usually promotes a pleasant, powerful feeling, which is quite the opposite of the feeling of anxiety for which it is substituted. But it also veils the original threat which gave rise to the anxiety.

A frequent response to the feeling of anger is that of oral or physical aggression, which may be more or less directed at the object causing discomfort or anxiety. For example, aggression may be directed against a nurse who somehow reminds the patient of someone else with

¹⁰ Dorothea R. Hays, "Anger: A Clinical Problem," Burd, S. and Marshall, M. (eds.) In: Some Clinical Approaches to Psychiatric Nursing (New York: The Macmillan Co., 1963), Chapter 19, p. 115.

whom he has a reason to be angry, or, a patient who feels angry and does not want to direct aggression against any person may slam the door. When anger is expressed in oral or physical aggression the expression is through controlling maneuvers, attack or injury. The expression may be verbal as in sarcasm, non-verbal as when glaring or physical such as hitting. The purpose of such aggressive behavior is to drive the anger-provoking object away. If this is accomplished, the person will feel relief provided he does not feel guilty or ashamed of his outward expression. If the object is not driven away, or his anxiety is otherwise reinforced such as through feelings of guilt or shame, then the person does not feel relief and may again express his anger in oral or physical aggression or in other ways. He may resort to escape, avoiding his own feelings with such behaviors as withdrawal or by use of defense mechanisms such as denial, displacement, projection, rationalization or reaction formation.¹¹ Sometimes an outward expression of aggression is felt to be too dangerous or inappropriate and anger is expressed inwardly toward the self through such behaviors as somatizing, depression or suicide.¹²

¹¹Mary D. Thomas, Joan M. Baker and others, "Anger: A Tool For Development of Self-Awareness," American Journal of Nursing, December, 1970, p. 2587.

¹²*Ibid.*, p. 2586.

Ideally, the person may use the experience of anger for constructive development in achieving greater self-knowledge through the processes of learning and problem solving.

Nursing literature provides several suggestions as to how the nurse can help the patient use the experience of anger for increased self-awareness. Hays suggests three operations which will help the patient cope with the experience of anger in a meaningful way. These operations include: (1) helping the patient to accept himself as feeling angry; (2) helping the patient to find out why he feels angry; and (3) assisting the patient in using the energy inherent in anger in a constructive way. This energy should be used, if possible, to deal with the problem at hand, to learn about or dissolve the difficulty, or, if this is not possible, to work on some other constructive project.¹³ Thomas, Baker and Estes view certain patient behaviors as an indication of a patient's readiness to learn to use anger for constructive development. If he is able to notice his feeling of anger and to describe it to another person, he should be assisted through the subsequent steps of the learning process. These steps include: (1) fully describe the situation in which the feeling occurs; (2) discuss various ways the situation may be solved; (3) decide upon a solution; (4) use the possible solution and evaluate its effectiveness the next

¹³Hays, *op. cit.*, p. 110.

time a similar situation occurs; and (5) continue the process until the patient finds a satisfying solution.¹⁴

Not all patients are able to utilize the learning process in channeling anger into self-awareness. Sometimes a patient's anger outweighs his ability to reason, and, for certain patients the learning process is too painful and threatening. Thomas, Baker and Estes suggest that when a patient is unable to utilize the learning process, the nurse should encourage the patient to verbally "blowup" or to focus his attention on a physical activity which is not harmful to himself or others.¹⁵

Hostility is a feeling component of many aggressive acts. Like anger, hostility is a substitute for the feeling of anxiety and serves to heighten the aggressive drive. Hostility is a feeling and attitude which builds up slowly and can endure. Man has the distinct capacity to maintain stimuli associated with former experience and visualize it in relation to later experiences in living. Reflecting inwardly upon rejection, humiliation, and disappointments for long periods may increase one's reservoir of hostility which may be expressed through later experience. Hostility may be a well-ingrained personality characteristic in some persons.¹⁶

¹⁴Thomas, Baker and others, *op. cit.*, p. 2590.

¹⁵Thomas, Baker and Estes, *op. cit.*, p. 2590.

¹⁶Manfreda, *op. cit.*, p. 92.

According to Buss, when an individual is confronted with a succession of frustrating situations stemming from the same source, anger gradually blends into hostility. Hostility causes increased drive toward destruction, damage or hurt to the object viewed as the source of frustration.¹⁷ Moore has defined hostility operationally as follows: (1) a person experiences a threat or frustration; (2) anxiety is experienced; (3) tension is relieved by verbal or motor aggressive action that is directed toward some kind of destruction of the object, self, others or an inanimate one, which is interpreted as the source of frustration or threat.¹⁸ When hostility is expressed in aggressive behavior it may take the form of sarcastic, abusive or rude remarks. The person may be argumentative, demanding, verbally or physically attacking or threatening. Rejection and fault finding are other behaviors resulting from a hostile attitude. Hostile aggression can be expressed passively as well as actively. Passive aggression may be expressed by such behaviors as procrastination, stubbornness, obstructionism and intentional inefficiency. Passive aggression reflects hostility which the individual feels he cannot express openly and is the expression of the person's resentment at failing to find gratification in a relationship with an individual or

¹⁷A. H. Buss, The Psychology of Aggression, (New York: John Wiley & Sons, 1961), p. 17.

¹⁸Moore, *op. cit.*, p. 60.

an institution upon which he is overly-dependent.¹⁹ It is not always possible to detect who is really the focus of the patient's hostility, for the tendency to displace this feeling on those less threatening and less able to retaliate is a common one.²⁰

When inhibiting influences prevent the expression of hostile feelings, the person calls various ego defense mechanisms into operation to cope with the hostility such as projection, displacement, reaction formation and denial.²¹

According to Kiening, in order to deal with a patient who is acting out his hostility in aggressive behavior one must first understand the dynamic bases of hostility and the behavioral processes which hostility activates. When behavior seems to indicate the presence of hostility, the nurse should validate her assumptions with the patient and assist the patient in the description and clarification of what he is experiencing and the possible reasons behind these feelings. It is essential that the nurse be aware of her own feelings and to bring them under conscious control. Her response must reflect acceptance and understanding. She needs to keep in mind that usually the patient's

¹⁹American Psychiatric Association, The Diagnostic and Statistical Manual of Mental Health, (Washington, D. C., 1968), p. 43.

²⁰Sister Mary Martha Kiening, "Hostility," Burd, S. and Marshall, M. (eds.) In: Some Clinical Approaches to Psychiatric Nursing (New York: The Macmillan Co., 1963), Chapter 10, p. 194.

²¹Moore, *op. cit.*, p. 60.

aggressive behavior is not so much against her personally as it is a reaction to a frustrating situation as the patient sees it.²² Peplau emphasizes that the nurse must provide an atmosphere in which the patient can express his feelings without fear of judgment or retaliation. Permitting the patient to express aggression directly toward the nurse who listens therapeutically may aid the patient in becoming aware of his feelings and goals. Consistent, non-punitiveness and a non-judgmental attitude toward the patient's aggression may make it possible for the patient to reflect upon and doubt the validity of his present behavior, as well as the need for it in relating to a mature nurse who accepts him as he is.²³

Clack suggests that in order to make aggression a basis for learning something new for the patient, the nurse should direct the patient to explore what went on or what led up to the aggression. She should encourage the patient to observe and describe what his expectations were, what happened instead of the anticipated fulfillment and to describe his reaction, his thoughts, feelings, and his actions.²⁴ Clack hypothesizes that when one nurse copes with each aggressive episode of a patient's, for a period of time, and directs that patient to talk-through the antecedents of his aggression, even on a superficial

²²Kiening, *op. cit.*, p. 201.

²³Peplau, *op. cit.*, p. 96.

²⁴Clack, *op. cit.*, p. 200.

level, the patient will soon begin to steer his own efforts toward more understanding and resolution of his aggression.²⁵

Manfreda also indicated that it is helpful to encourage the aggressive patient to discuss his behavior, thoughts and feelings. Events which precipitate the emergence of the individual's aggression may be revealed, often providing clues to the underlying motivation for the aggression.²⁶

Summary

The nursing literature indicates the following: (1) it is important for the nurse to understand the concepts of anger and hostility and recognize the behavioral expressions of these emotional states; (2) the nurse must be able to use her own feelings of anger or hostility for increased self-awareness and remain non-judgmental and accepting when a patient expresses aggressive behavior; (3) in order to make angry or hostile aggression a learning experience for the patient, the nurse should encourage the patient to explore what led up to the aggression, what his expectations were, what happened instead, what his reactions were, including feelings, thoughts, and actions. Thus, events which precipitate the emergence of an individual's aggression may be revealed, often providing clues to the underlying

²⁵*Ibid.*, p. 204.

²⁶Manfreda, *op. cit.*, p. 94.

motivation for the aggression; (4) once the patient is aware of his feelings and their source, he can learn more constructive ways to cope with his feelings in the future; and (5) if a patient is not ready to learn from his aggression, he should be directed to an activity where his aggression can be released without harm to himself or others.

CHAPTER III

THE RESEARCH DESIGN

An experimental design using the method of difference, was utilized to test the primary hypothesis in the study. The factor of difference or the independent variable in the study was the interview series designed to aid patients to talk through aggressive behavioral episodes with the investigator. The dependent variable to be measured was the amount of reduction in aggressive behavior noted in those patients receiving the interview series as compared with a parallel group who did not receive the interview series. The survey method was also utilized in the study to determine the staff responses to various aggressive behaviors exhibited by patients in the sample.

Sample Selection

The sample for this study was obtained from a ward population living on an extended care, locked psychiatric ward located at the state mental hospital in Montana. At the time this study was conducted the population on the ward consisted of twenty-one chronic psychotic and nonpsychotic adolescent and adult females. Sample selection was limited to one ward so that each sample subject was under the care of the same physician, came into contact with the same ward personnel and ward routines, and shared the same ward setting. An extended care locked ward for chronically psychotic and nonpsychotic females was

selected because of the high frequency of aggressive behavior often characteristic of patients on this ward.

For admission to the study the patients had to meet the following criteria: (1) the patient was not receiving individual or group psychotherapy during the time the study was conducted, (2) the patient was expected to remain hospitalized on the present ward during the time the study was conducted, and (3) during a two week period preceding initiation of the study the patient was frequently observed exhibiting aggressive behavior on the ward.

To determine the frequency of aggressive behavior exhibited by patients on the ward, the investigator developed a behavioral checklist comprised of nine examples of aggressive behavior. A copy of the behavioral checklist is provided in Appendix A. Examples included on the questionnaire were taken from an article in the American Journal of Nursing.²⁷ Two full-time ward attendants working on the ward in the two week period immediately preceding initiation of the study were selected by the investigator from both the day and the evening shift to act as observers. No full-time ward personnel were available during this two week period on the night shift. Each observer was asked to rate each patient on the ward as to the number of times the patient

²⁷Programmed Instruction, Educational Design Inc., "Understanding Hostility" American Journal of Nursing, October 1967, p. 2134.

exhibited nine aggressive behaviors included on the behavioral checklist during the two week period immediately preceding the initiation of the study. The patient was considered to have a high frequency of aggressive behavior when he was observed by at least one pair of observers, that is, two observers on the same shift, to exhibit a minimum of two different aggressive behaviors at least twice or a minimum of four different aggressive behaviors at least once in the two week period.

Ten patients on the ward met the criteria for admission into the study. Five of the ten sample subjects were selected at random for the experimental group. The remaining five subjects were assigned to the control group. Because of the limited sample size the variables of diagnosis, intelligence quotient, age, medication, length of hospitalization and number of admissions could not be controlled. A comparison based on available information of the control and experimental subjects as to age, medication, diagnosis, intelligence quotient, if provided in the chart, number of admission and length of hospitalization is provided in Appendix B and C.

Functions of the Control Group

The control group carried on their daily activities and ward interaction without any contact with the investigator. To avoid contact with the control group, the investigator did not go on the ward during the time the study was conducted. Interviews with patients in

the experimental group and communication with the ward personnel were conducted in an office isolated from the ward by a locked door.

Functions of the Experimental Group

In addition to their usual activities and interactions on the ward, each patient in the experimental group was interviewed by the investigator for thirty minutes twice a week for five weeks. Interviews were scheduled at a time which did not interfere with the patient's participation in scheduled ward activities or work assignments. The ward personnel were given a written schedule indicating the date and time for each patient's interview. When the investigator arrived at the office where the interviews were conducted, she pressed a buzzer which signaled the ward staff that it was time for the patient to be sent to the office. Ward staff were asked to come back to the office and inform the investigator if the patient was unable to keep his appointment.

Content of the counseling interviews was not shared with the ward personnel. The investigator's communication with the staff was limited to answering questions concerning the staff's participation in the study, clarifying instructions, and praising the staff for their cooperation.

Description of the Nursing Interview Series

The five week interview series was designed to promote constructive behavioral change in patients who frequently act out hostility or anger in aggressive behavior. The interviews were structured to assist the patient to talk through aggressive behavioral episodes and to learn constructive ways to handle aggressive feelings and to alter situations which have caused aggressive behavior. A theoretical framework for the structure used in the nursing interview series is provided in Appendix D.

During each interview the patient sat in a chair facing the interviewer who was seated behind a desk to facilitate note taking. The door to the office was closed during each interview to assure privacy. Smoking was permitted if the interview was scheduled at the ward's routine smoking time. The ward personnel were instructed to send the allotted cigarettes with the patient. The investigator did not want the interview to interfere with a scheduled pleasurable activity.

The investigator attempted to reinforce the patient's coming to the interview by making the interview an ego supporting experience. The investigator greeted the patient at the door by name, expressing appreciation for his coming and asked him to be seated. The investigator allowed the patient to express negative feelings without approving or disapproving but, instead, trying to understand. The

investigator praised the patient for any efforts to describe his actions and feelings during the interview. In addition, the investigator attempted to gain the patient's trust by keeping information discussed in the interviews confidential and by being continually interested in the patient and his comments.

In the first interview a staff member accompanied each patient to the office where the interviews were conducted and remained until the patient was introduced to the investigator. During the first interview, the investigator obtained the patient's permission to conduct the interviews and to take notes during each interview. The patient was told how long the interview series would last, how often the interviews would be held, and the length and date of each interview. The purpose of the interview series was also explained to the patient. The investigator told the patient that she wanted the patient to discuss his life on the ward, his goals for the future and any problems he might have getting along with others on the ward. The investigator explained that she had no authority to change the ward routines nor could she control the behavior of the staff or the patients. The patient was informed that what was discussed in the interviews was confidential and would not be discussed with the ward staff or other patients. However, the investigator informed the patient that should it become necessary to communicate any information discussed in the interviews to someone the patient would be told in

advance exactly what would be communicated to whom and for what reason.

In the second interview the investigator focused on gathering data about the patient's present life situation. The investigator assisted the patient in describing his life on the ward, asking him what he did during the day, what he did with others, his interests, his job and his goals for the future.

In the third and subsequent interviews, the investigator focused on encouraging and assisting the patient to describe specific aggressive episodes from his present experiences on the ward. When encouraging a patient to describe aggressive behavioral episodes, the investigator avoided using the words angry or hostile. Instead, the patient was asked if he found himself getting annoyed, perturbed or irritated at someone or something that happened on the ward recently. Each aggressive episode that the patient presented was discussed in as much depth as the individual patient could tolerate, according to the decision of the investigator. The investigator first encouraged the patient to describe events surrounding the aggressive behavioral episode in detail including what preceded the episode, what the patient was doing and what others were doing, what the patient's expectations were, what happened instead of the anticipated fulfillment, and the patient's reactions including his thoughts, feelings and actions. Next, the investigator focused on the consequences of the patient's

aggressive actions. The patient was asked to tell the investigator what happened after the aggression was expressed. Then the investigator discussed how the patient could prevent such consequences in similar situations in the future. Discussion centered on methods of handling aggressive feelings without hurting oneself or others and ways to remedy the situation causing the aggression. The investigator discussed ways to avoid difficulties in relationships with others on the ward, ways to earn respect and privileges from others and how to become involved in worthwhile activities on and off the ward.

The last five minutes of each interview was used to discuss goals for the next interview and to summarize progress to date from both the patient's and investigator's point of view.

Two weeks prior to termination of the interview series, the patient was reminded of the termination date. In the remaining interviews, the investigator encouraged the patient to express feelings and concerns about termination. In addition, short term goals for the future were discussed as well as ways the patient could accomplish these goals after the interview series ended.

Tools and Techniques for Collection of Data

In order to determine the staff's response to aggressive patient behaviors, the investigator devised an open response questionnaire comprised of nine examples of aggressive behavior. Each staff member was asked to complete an open response questionnaire for each patient in

the study. For each aggressive behavior listed on the questionnaire, the ward personnel were asked to write down what they would say and do to the patient when he was observed exhibiting the behaviors. A copy of the open response questionnaire is provided in Appendix E.

To gain evidence of the patient's progress toward the use of aggression as a learning experience, the investigator analyzed the notes taken during each interview for the following behaviors: (1) the patient verbalizes aggressive feelings and behaviors and events surrounding the feelings or behavior to the investigator, (2) the patient verbalizes awareness of the effects of his aggressive behavior on himself and others, and (3) the patient verbalizes the intent or actual attempts to handle aggressive feelings in ways which will not hurt himself or others or to alter environmental situations which directly or indirectly have resulted in aggressive action.

The investigator devised a behavioral checklist which would provide a daily count of nine aggressive behaviors exhibited by patients in the sample. This behavioral frequency checklist is provided in Appendix F. Each eight hour shift of ward personnel was given a checklist for each patient in the study and asked to keep a daily count as to the number of times the nine aggressive behaviors were displayed by the patient over the five week period the study was in progress.

CHAPTER IV

ANALYSIS OF DATA

Results of the staff responses to the open response questionnaire and the content analysis of interviews are reported first as these results illustrate several reasons for the lack of positive results obtained in relation to the primary hypothesis tested in the study.

Analysis of Staff Responses to Open Response Questionnaire

To determine the type of responses of the staff to the nine aggressive behaviors included on the open response questionnaire, the staff responses were placed into different categories according to the type of response. The determination of the consistency of staff response to the various examples of aggressive behavior was made by tabulating the total number of staff responses falling into each response category for each behavioral example on the questionnaire. Separate tallies were kept for staff responses to patients in the control and experimental groups.

Results of Analysis of Staff Response to Open Response Questionnaire

The number of questionnaires returned for each subject in the study varied from six to nine in number. The staff's responses to the nine aggressive behaviors on the questionnaire fell into the following categories: (1) ignore the behavior, (2) talk to the patient to

reassure, (3) scold, threaten or demand the behavior stop, (4) restrict privileges, and (5) restrain the patient in some manner.

For each aggressive behavior on the questionnaire, the number of staff responses in the five response categories is reported as the percentage of the total number of staff responses returned for that behavioral example. Table 1 shows the percentage of staff responses in each response category for both the control and experimental group. The high percentage peaks in staff responses for each behavioral example fall in the same response categories for both the control and the experimental group. This indicates that the staff were responding to the nine aggressive behaviors exhibited by patients in the control group in a similar manner as those in the experimental group. Table 1 shows that in six of the nine behaviors on the questionnaire, a large percent of the staff responses fell in two or three different response categories. 80% to 100% of the staff responses to the control and experimental group fell in the response categories, ignore the behavior and scold, threaten or demand the behavior stop for the following behavioral examples: (1) example five (threatens to divulge information which could embarrass another patient or staff member), (2) example six (causes conflict by telling a patient or staff member that others are talking or laughing about him or planning to hurt him), and (3) example eight (demands that others comply with his wishes). 96% of the staff responses to patients in the control group and 97% of the staff

Table 1. Percentage of staff responses in five response categories for nine aggressive behavioral examples on Open Response Questionnaire (reported separately for control and experimental groups).

Staff Response Categories	Ignore the Behavior	Experimental Control	Scold, Threaten or Demand					Restrict Privileges	Restrict in Some Manner	Experimental Control
			Talk to the Patient to Reassure	Experimental Control	Experimental Control	Experimental Control	Experimental Control			
Aggressive Behavior	Experimental Control	Experimental Control	Experimental Control	Experimental Control	Experimental Control	Experimental Control	Experimental Control	Experimental Control	Experimental Control	Experimental Control
1. Verbally abusive to others	33	15	0	5	34	48	9	11	24	21
2. Physically aggressive in some way toward environment	8	16	0	0	8	16	8	4	76	64
3. Physically aggressive in some way toward others	8	10	0	3	12	10	0	0	80	77
4. Interferes with the duties or activities of others by physical action or harassment	0	9	0	0	100	79	0	0	0	12
5. Threatens to divulge information which will embarrass or otherwise put another patient or staff member in a bad light	57	67	0	5	43	28	0	0	0	0

Table 1. Continued

Staff Response Categories	Ignore the Behavior	Talk to the Patient to Reassure	Scold, Threat- en or Demand		Restrict Privileges	Restrain in Some Manner				
			the Behavior to Stop	Experi- mental Control						
Aggressive Behavior	Experi- mental Control	Experi- mental Control	Experi- mental Control	Experi- mental Control	Experi- mental Control	Experi- mental Control				
6. Causes con- flict by telling a patient or staff member that others on the ward are talking about that person, laughing at him or planning to hurt him	34	35	17	13	46	48	0	0	3	4
7. Complains about the un- kind intentions or actions of others toward him	44	45	52	4	3	0	0	0	0	0
8. Demands that others comply with his wishes	50	25	0	3	50	64	0	4	0	4
9. Resists or re- fuses to perform ward duties, follow ward rules or suggestions made by others	27	32	0	0	33	30	33	38	7	0

responses to patients in the experimental group fall in the response categories, ignore the behavior and talk to the patient to reassure for behavioral example number seven (complains about the unkind intentions or actions of other patients or staff toward him). A high percent of staff responses to patients in the control and experimental group were divided among three response categories for behavioral example one (verbally abusive to others) and behavioral example nine (resists or refuses to perform ward duties or follow rules or suggestions made by others). 84% of the staff responses to patients in the control group and 91% of the staff responses to patients in the experimental group fell in the following response categories for behavioral example one: (1) ignore the behavior, (2) scold, threaten or demand the behavior stop, and (3) restrain the patient. For behavioral example nine, 100% of the staff responses to patients in the control group and 93% of the staff responses to patients in the experimental group fell in the response categories, ignore the behavior, scold, threaten or demand the behavior stop and restrict privileges.

The staff showed a higher degree of consistency in the type of response returned for the remaining three behavioral examples included on the questionnaire. The majority of staff responses returned for behavioral example two (physically aggressive toward the environment), behavioral example three (physically aggressive toward others) and behavioral example four (interferes with the duties or activities of

others by physical action or harrassment) fall in one response category. For behavioral examples two and three, 64% to 80% of the staff responses to patients in the control and experimental group fell in the scold, threaten or demand the behavior stop response category. For behavioral example four, 79% of the staff responses to patients in the control group and 100% of the staff responses to patients in the experimental group fell in the restrain the patient response category.

Summary and Discussion

Staff responses to the open response questionnaire support the hypothesis that the staff respond to the aggressive behavior of psychiatric patients with controlling or punishing actions and do not allow the patient to talk through aggressive behavioral episodes.

A high percent of staff response to eight of the nine behaviors included on the open response questionnaire fell in the ignore, scold, restrict and restrain response categories. A high percent of staff response in the talk to the patient response category was found only for behavioral example number seven (complains about the unkind intentions or actions of others).

Staff responses to aggressive behaviors included on the questionnaire were frequently inconsistent. A high percent of the staff responses for six of the aggressive behaviors fell in two or three different response categories. Thus, the staff responses to the nine

aggressive behavioral examples included on the questionnaire indicates that (1) the staff's response to aggressive behavior of the patient is frequently inconsistent, and (2) the staff frequently use some form of disciplinary or controlling action as a response to the patient's aggressive behavior rather than talking to the patient about his aggression.

Both staff inconsistency in response to aggressive patient behavior and the staff's frequent use of responses which cause the patient to feel fearful, rejected, punished, or unduly controlled may reinforce defensive aggressive patient behavior.²⁸

Analysis of Interview Content

The investigator analyzed notes kept during each interview to gain evidence of the patient's progress toward the use of aggression as a learning experience. The presence or increase in the following behaviors was considered evidence of such progress: (1) the patient verbalized aggressive feelings and behaviors and events surrounding the feelings and behavior to the investigator, (2) the patient verbalized awareness of the effects of his aggressive behavior on himself and others, and (3) the patient verbalized the intent or actual attempts to handle aggressive feelings in ways which would not hurt himself or others including altering environmental situations which

²⁸Manfreda, *op. cit.*, p. 94-97.

directly or indirectly resulted in aggressive behavior. Results of the content analysis of the interviews are reported for each patient in the experimental group using the letter code used when reporting patient data earlier in the study (see Appendix A). The behaviors of each subject are described in general terms without actual verbal content in order to help preserve the anonymity of the patient. Due to the length of the content analysis of interviews, the results for individual patients in the experimental group are provided in Appendix G.

Summary and Discussion

All the patients in the experimental group made some progress in the ability to identify feelings of anger or hostility and to describe the events that resulted in such feelings and how the feelings were expressed in aggressive behavior. The description of events surrounding aggressive episodes described by the patients gave the investigator many clues as to frequent sources of frustration for the patient on the ward such as restriction to the ward and lack of equipment on the ward for physical activities. Such clues could serve to guide the nurse in reducing frustrating situations for the patient on the ward.

Patients A, C, and E did not show progress beyond an ability to describe aggressive episodes and the feelings and events surrounding each aggressive episode. They viewed their aggressive behavior as a

defense against the aggressive patient behavior and staff disciplinary action directed toward them. These patients felt their aggression was justified. The patients verbalizations during the interviews provided evidence that the disciplinary actions of the staff to aggressive patient behavior may act as an added source of frustration for the patient and result in more aggressive behavior. Patient C, who showed the least progress in the interview series, was almost continually on activity restrictions due to her aggressive behavioral outbursts. She expressed a great deal of resentment about these restrictions and expressed her resentment in further aggressive behavior. This led to still further restriction and thus, a cyclic aggression-counter-aggression-aggression pattern was established between the patient and the staff. The patient's running away from the hospital resulted in more disciplinary actions. As a result the patient withdrew, showing no further interest in her environment or in the interviews.

Patient D and to some extent Patient B were able to admit to the investigator that their aggressive behavior hurt them and they expressed a desire to find ways to cope with frustrating situations on the ward in ways which would not get them into trouble with the staff. Patient D and Patient B showed evidence of attempting to express anger in ways which would not harm themselves or others and to alter situations which were frustrating or anger provoking for them.

Patient D showed the most evidence of using feelings of anger and hostility for a learning experience. Unlike other patients in the experimental group, Patient D had been hospitalized for less than a year and had a non-psychotic diagnosis. It is possible that a five-week interview series is not of sufficient length to alter aggressive behavior patterns in psychotic patients who have been hospitalized for long periods of time and in whom aggressive behavior patterns are well established.

Analysis of the Frequency of Nine Aggressive Behaviors in the Control and Experimental Group

Using an unreplicated nested model analysis of variance statistical test,²⁹ the investigator tested for the significant differences in the number of times nine aggressive behaviors were observed being displayed by patients in the control and experimental group over a five week period. Table 2 shows that all the F values were insignificant at the .05 level. Therefore, the hypothesis was rejected.

Discussion

It is of some interest that although the group analysis yielded insignificant results, visual inspection of the data provided in Table 3 suggests that patient D did improve in reducing the number of aggressive

²⁹Quinn McNemar, Psychological Statistics (New York: John Wiley and Sons, 1969), p. 379-381.

Table 2. Unreplicated nest model analysis of variance for the frequency of aggressive behaviors in experimental (N₂₅) and control (N₂₅).

Source	Sum of Squares	df	Variance Estimate	F*
Individuals	1734.88	8	216.86	
Groups (Experimental versus Control)	200.00	1	200.00	*
Weeks	234.08	4	58.52	*
Groups x Weeks	93.60	4	23.40	*
Remainder	1139.92	32	35.62	
Total	3402.48	49		

* F values were not significant at the .05 level. Dependent variable = total score (across three shifts and across nine measures).

Table 3. Total number of aggressive behaviors exhibited each week by patients in the experimental group. N=5

Patient	Week 1	Week 2	Week 3	Week 4	Week 5
A	11	16	10	13	12
B	8	4	5	10	14
C	22	20	15	15	33
D	36	28	6	11	7
E	2	4	2	4	5

episodes observed by the staff over a five week period.

Analysis of interview content for evidence of learning to use aggression as a learning experience also suggested that Patient D showed

the most progress compared with other patients in the experimental group. Patient D, unlike the other patients in the experimental group, was diagnosed as being nonpsychotic and had been hospitalized for a relatively short period of time. This suggests that it would be valuable to study the nursing interview series utilized in this study in relation to the variables of diagnosis and length of hospitalization.

Table 4 shows the number of aggressive episodes exhibited by patients in the control group each week the study was in progress.

Table 4. Total number of aggressive behaviors exhibited each week by patients in the control group. N=5.

Patient	Week 1	Week 2	Week 3	Week 4	Week 5
F	24	13	10	16	15
G	2	0	0	0	3
H	7	3	4	4	2
I	10	13	13	5	4
J	17	6	6	23	13

Visual inspection of the number of aggressive episodes exhibited by patients in the control group indicates that there was considerable fluctuation from week to week. Such fluctuation could be the result of changes in the ward environment or the result of individual patterns of aggressive behavioral outbursts. Such fluctuation was also present in the weekly number of aggressive behaviors exhibited by patients in

the experimental group with the exception of Patient D (see Figure 3).

The investigator suggests several factors may have contributed to the lack of significant difference in the frequency of aggressive behaviors displayed by the experimental and control groups.

1. The design of the study did not provide the investigator with an opportunity to talk through every aggressive episode exhibited by the patient immediately after the aggression occurred. The aggressive behavioral episodes discussed with the patient were limited to those the patient brought up for discussion in the interview. In addition, the behavioral episodes discussed in the interview often occurred several days prior to the interview.

2. The staff's response to aggressive behavior on the open response questionnaire indicates that the staff reinforce aggressive patient behavior and do not give the patient an opportunity to talk through aggressive behavioral episodes. Thus, patients in the experimental group spent a great deal of time in an environment which reinforced aggressive behavior and a very short period of time in interviews talking through aggressive behavioral episodes with the investigator. It is the investigator's opinion that the staff's responses to aggressive behavior were more influential on the patient's aggressive behavior than that of the investigator due to the staff's opportunity to respond to each aggressive episode immediately after it occurred. Unfortunately, the staff's response tended to reinforce aggressive

behavior rather than providing a patient with the opportunity to learn from his aggression.

The investigator sees a need for further study to determine if a significant reduction in patient aggressive behavior will occur when the staff consistently provide the aggressive patient with an opportunity to talk through each aggressive behavioral episode immediately after it occurs.

Summary

The unreplicated nested model analysis of variance indicated that there was no significant difference in the number of aggressive behaviors exhibited by the experimental group and the control group. Thus the hypothesis was rejected that the number of aggressive behaviors observed in the experimental group would be significantly reduced following a nursing interview series which aids the patient to talk through aggressive behavioral episodes.

One patient in the experimental group did show considerable improvement in reducing aggressive behavior exhibited on the ward. The investigator suggests a need for further study to determine the effects of the nursing interview series used in this study on nonpsychotic patients hospitalized for short periods of time. The patient who showed considerable improvement was the only patient in the experimental group who was nonpsychotic and hospitalized for a relatively short period of time.

The investigator listed two factors which may have contributed to the lack of significance in difference of frequency of aggressive behavior in the control and experimental group.

1. The interview series did not provide the investigator with the opportunity to discuss every aggressive behavioral episode that occurred immediately after the aggression occurred.

2. Staff had the opportunity to respond to each aggressive episode immediately after it occurred. According to the results of open response questionnaire, the staff responded in ways which reinforced aggressive patient behavior.

The investigator suggests a need for further study to determine the effect of a staff response which allows the patient to talk through aggressive behavioral episodes immediately after they occur on reducing aggressive patient behavior.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The purpose of the study was (1) to determine if a series of nursing interviews which aids the patient to talk through aggressive behavioral episodes is an effective nursing method to promote a positive change in the aggressive behavior of the psychiatric patient, and (2) to determine the way the staff respond to various aggressive behaviors displayed by female patients living on an extended care psychiatric ward.

The primary hypothesis tested in the study was: the frequency of aggressive behavior displayed by a selected group of female patients living on an extended care psychiatric ward will be significantly reduced following a five week series of nursing interviews which aid the patient to talk through aggressive behavioral episodes. The second hypothesis tested was: staff responses to the aggressive behavior of psychiatric patients will be controlling or punishing and will not allow the patient to talk through aggressive behavioral episodes.

An experimental design using the method of difference was utilized in the study to test the primary hypothesis. The factor of difference was the interview series. The dependent variable to be measured was the amount of reduction in aggressive behavior noted in those patients receiving the interview series as compared with a

parallel group who did not receive the interview series. The sample for the study was obtained from an extended care psychiatric ward. Ten patients met the criteria for participation in the study. Five patients were randomly assigned to the experimental group and the remaining five subjects were placed in the control group. Because of the limited sample size the variables of age, diagnosis, length of present hospitalization, number of admissions, intelligence quotient, and medications could not be controlled.

The control group carried on daily activities and ward interaction without any contact with the investigator during the five weeks the study was in progress. In addition to daily activity and interaction on the ward, each patient in the experimental group was interviewed by the investigator for thirty minutes twice a week for five weeks. The interviews were structured to assist the patient to talk through aggressive behavioral episodes in order to learn constructive ways to handle aggressive feelings and to alter situations which have resulted in aggressive behavior in the past.

A behavioral checklist devised by the investigator was used to obtain the daily frequency of nine aggressive behaviors exhibited by patients in the sample over a five week period. An unreplicated nested model analysis of variance was used to test for significant differences in the number of aggressive behaviors displayed by patients in the experimental group in the five week period as compared

with the number of aggressive behaviors displayed by patients in the control group. In addition, notes taken by the investigator during each interview were analyzed for evidence of each patient's progress in using aggressive behavioral episodes as a learning experience.

An open response questionnaire devised by the investigator was used to determine the staff's responses to nine aggressive behaviors exhibited by patients in the sample.

Conclusions

Because of the small sample size utilized in the study, the investigator is limited in her ability to generalize the study findings to other situations. Therefore, the findings shall have to be considered specific only to this particular investigation.

1. The primary hypothesis was rejected as there was no significant differences in the number of aggressive behaviors displayed by patients in the experimental and control group in the five week period the study was conducted. Although the group analysis yielded insignificant results, a visual inspection of the data suggests that one patient improved considerably in reducing the number of aggressive episodes displayed over the five week period. This patient, unlike the other patients in the experimental group, was nonpsychotic and had been hospitalized for less than one year. It is possible that the nonpsychotic patient who has been hospitalized for a short period of time may benefit more from a short term interview series than the

psychotic patient who has been hospitalized for many years and in whom aggressive behavior patterns are well established.

2. There were several factors which may have contributed to the lack of significant difference in the frequency of aggressive behavior displayed by patients in the experimental and control group. Two thirty minute interviews a week did not allow the investigator sufficient time to talk through every aggressive episode exhibited by the patient on the ward; nor could discussion of aggressive behavioral episodes follow immediately after the behavior occurred. The staff, however, had the opportunity to respond to each aggressive behavior displayed by the patient immediately after the behavior was observed. Unfortunately, the staff frequently reinforced the patient's aggressive behavior by the use of disciplinary or controlling actions. Considering the short period of time spent by the investigator talking through aggressive behavioral episodes with the patient in relation to the amount of time the staff spent in contact with the patient, it is not unlikely that the staff responses which often reinforced aggressive patient behaviors had more influence on the patient's behavior than did the response used by the investigator.

3. Verbalization of patients during the interviews gave the investigator considerable evidence that an aggression-counteraggression-aggression pattern frequently develops between the aggressive patient and the staff when the staff continue to use disciplinary and controlling

actions as a response to aggressive patient behavior.

4. Analysis of the staff responses on the open response questionnaire indicate that the staff frequently respond to aggressive patient behavior with disciplinary or controlling actions rather than by talking to the patient about his aggression; thereby, reinforcing defensive aggressive patient behavior. Thus, the second hypothesis was accepted.

5. The staff frequently do not respond to aggressive patient behavior in a consistent manner. For six of the nine aggressive behaviors included on the questionnaire, a high percent of staff response fell in two and sometimes three different response categories. Inconsistency in the type of staff response to aggressive patient behavior will do nothing to alter the patient's present aggressive behavior pattern and may even increase aggressive patient behavior.

Recommendations

The findings in this study provide a basis for recommendations of two types: (1) suggestions for further study, and (2) recommendations for the health professions.

1. It would be valuable to conduct a study in which the entire staff respond to each aggressive behavior displayed by the patient immediately after the behavior occurs assisting the patient to talk through the aggressive episode to determine if such a method would result in a significant reduction in the aggressive behavior displayed

by the patient on the ward. Such a study would provide data in relation to the effectiveness of a consistent staff approach as a method of reducing aggressive behavior in psychiatric patients.

2. The interview series should be given to a much larger sample population in which the variables of diagnosis, age, length of hospitalization, intelligence quotient, and medications received can be adequately controlled. It would be valuable to determine the effects of the interview series on a large sample of nonpsychotic patients who have been hospitalized for less than one year so that statistical inferences can be made.

3. A study should be conducted to determine if a behavioral conditioning approach by the ward staff would bring about a significant reduction in aggressive patient behaviors.

4. Present staff responses to aggressive patient behavior indicates the need for in-service education which assists the staff in developing a consistent response to patient aggression which helps the patient learn to cope with his aggressive feelings more constructively. The present staff responses to aggressive patient behavior tend to reinforce aggressive patient behavior and, therefore, help to keep the patient hospitalized on an extended care ward.

APPENDIX A

BEHAVIORAL FREQUENCY QUESTIONNAIRE

APPENDIX A

BEHAVIORAL FREQUENCY QUESTIONNAIRE

Introduction

The purpose of this questionnaire is to rate each patient on the ward as to how frequently he displays certain aggressive behaviors. The following letter code will be used to indicate how many times a behavior was observed by the rater:

- A. Not observed
- B. Observed only once
- C. Observed more than once but less than five times
- D. Observed more than four times but less than ten times
- E. Observed more than nine times

In the space to the left of each behavior listed below, place the code letter which indicates how many times you observed the behavior displayed by the patient over the preceding two week period (January 18, 1971 through January 30, 1971). Write the patient's name in the space provided. Return completed questionnaire to the head nurse's office no later than 7:00 p.m. Tuesday, February 2, 1971.

Name of Patient _____

- _____ 1. Verbally abusive to others ie., swearing, obscene language, name calling, derogatory remarks, sarcastic remarks.
- _____ 2. Complains about the unkind intentions or actions of others toward him.
- _____ 3. Demands that others on the ward comply with his wishes ie., being bossy with other patients, demanding attention from others, etc.

- _____ 4. Resists or refuses, verbally or nonverbally, to perform ward duties, follow ward rules, or to follow suggestions made by others.
- _____ 5. Threatens to divulge information which will embarrass or otherwise put a staff member or another patient in a bad light with others.
-
- _____ 6. Causes conflict by telling a patient or staff member that others on the ward are talking about that person, laughing at him, and/or planning to hurt him.
-
- _____ 7. Interferes with the duties or activities of others by his physical actions or by harrassing.
-
- _____ 8. Physically aggressive in someway toward the environment ie., slamming doors, throwing objects, kicking furniture, breaking windows, etc.
-
- _____ 9. Physically aggressive in someway toward others ie., shoving, kicking, bumping, or throwing something at someone, etc.

APPENDIX B

IDENTIFYING DATA FOR PATIENTS IN THE EXPERIMENTAL GROUP

APPENDIX B

IDENTIFYING DATA FOR PATIENTS IN THE EXPERIMENTAL GROUP

Patient	Age	Diagnosis	Number of Admissions and Length of Present Hospitalization	I.Q., if Available	Medi- cations*
A	46	Hebephrenic Schizophrenia	1st admission 20 years		
B	46	Schizophrenia, chronic undif- ferentiated	1st admission 9 years		
C	16	Mental retard- ation with Psychosis	3rd admission 1 year Transfer from state institu- tion for the retarded	Moderate mental retarda- tion	
D	18	Aggressive reaction of adolescence	2nd admission Less than 1 year		
E	58	Organic Brain Syndrome with Psychosis	1st admission 12 years		

*Each patient in the experimental group was receiving three or more different medications during the time the study was conducted.

APPENDIX C

IDENTIFYING DATA FOR PATIENTS IN THE CONTROL GROUP

APPENDIX C

IDENTIFYING DATA FOR PATIENTS IN THE CONTROL GROUP

Patient	Age	Diagnosis	Number of Admissions and Length of Present Hospitalization	I.Q., if Available	Medi- cations*
F	25	Hysterical Inadequate personality	2nd admission Less than 1 year		
G	66	Paranoid Schizophrenia	1st admission 29 years		
H	56	Paranoid Schizophrenia	1st admission 10 years		
I	43	Schizophrenia Chronic undif- ferentiated	1st admission 19 years		
J	26	Explosive personality	1st admission 7 years		Moderate mental retarda- tion

*Each patient in the control group was receiving three or more different medications during the time the study was conducted.

APPENDIX D

THEORETICAL FRAMEWORK FOR INTERVIEW

APPENDIX D

THEORETICAL FRAMEWORK FOR INTERVIEW

1. Rationale for Interviewing

- a. One of the aims of psychotherapy is to restore to the patient a control over his emotions. Before this can be accomplished, he must be able to make the proper symbolic connections with his emotions. Therapeutic interviewing helps to accomplish this and enables him to scrutinize, identify and elaborate on his feelings and their sources.³⁰
- b. Encouragement of verbalizations is a prime task during interviewing. This is done by attentively listening to the patient.³¹
- c. Psychologically, listening may help the patient by making him feel important enough for someone to listen to him or it may relieve some of his inner tension when he talks out some of his thoughts.³²
- d. By showing the patient how to avoid difficulties in his relationships with people, it may relieve him of much anxiety, tension and hostility.³³

2. Selection of Themes for the Interview

- a. To avoid stirring up inner conflict the interview is kept on everyday situational problems.³⁴

³⁰Lewis R. Wolberg, The Technique of Psychotherapy (New York: Grune and Stratton, 1954), p. 158.

³¹Wolberg, *op. cit.*, p. 162.

³²Hofling and Leininger, *op. cit.*, p. 43.

³³Wolberg, *op. cit.*, p. 40.

³⁴Wolberg, *op. cit.*, p. 169.

- b. Existing environmental difficulties constitute a bulk of an individual's preoccupations. Most likely he will be prompted to talk about inadequacies in his environment that provoke inharmonious strivings, inspire conflict, or create disturbances in interpersonal relations.³⁵
- c. Only a relatively limited number of things can be mentally absorbed and integrated at the same time. Taking up one subject at a time and exploring as many facets of it as possible, will result in the most effective use of the interview.³⁶

3. The Climate of the Interview

- a. To promote an effective climate, the nurse plans for sufficient time to allow exploration of the patient's feelings and expression of feelings and time enough for terminating the interview with a review of progress made and a plan for the next interview.³⁷
- b. The setting should be as quiet and free from interruptions as possible. Moving to a private room may ensure the undivided attention of patient and nurse.³⁸
- c. Confidentiality and privacy promote the patient's exposing problems, inadequacies and misfortunes when the nurse shows she can be trusted by not divulging information to others except when this is clearly stated to the patient and the reason as well as to whom the information and what information will be shared.³⁹
- d. Professional attitudes of warmth, acceptance, objectivity, and compassion are essential for effective interviewing.⁴⁰

³⁵Wolberg, *op. cit.*, p. 167.

³⁶Wolberg, *op. cit.*, p. 173.

³⁷Bermosk and Mordan, *op. cit.*, p.-57.

³⁸*Ibid.*

³⁹*Ibid.*

⁴⁰Bermosk and Mordan, *op. cit.*, p. 62.

4. Opening the Interview

- a. It is highly desirable that the patient be put at ease and that the purpose of the interview be understood as clearly as possible.⁴¹
- b. As the patient enters the therapist's office, the latter may greet him with a smile, introduce himself, gesture to the chair, invite the patient to be seated, and briefly introduce the general purpose of the interview.⁴²
- c. Such words as anxious, angry and afraid may evoke a response of denial. It is well to use other words which describe the behavior but which carry a lesser emotional impact.⁴³

5. Terminating the Interview

- a. Setting up an exact time for each visit with the patient is constructive in establishing a climate of trust, acceptance and consistency.⁴⁴
- b. When the interview is one in a series toward a long-term goal, the nurse terminates the interview by reviewing with the patient the progress made toward the goal and the topic for the next interview.⁴⁵

⁴¹Wolberg, *op. cit.*, p. 160.

⁴²Wolberg, *op. cit.*, p. 160.

⁴³Bermosk and Mordan, *op. cit.*, p. 115.

⁴⁴Bermosk and Mordan, *op. cit.*, p. 141.

⁴⁵Bermosk and Mordan, *op. cit.*, p. 144.

APPENDIX E

OPEN RESPONSE QUESTIONNAIRE

APPENDIX E

OPEN RESPONSE QUESTIONNAIRE

Instructions

The purpose of this questionnaire is to obtain examples of current methods used on the ward to control aggressive behavior exhibited by those patients participating in the study. It is not the intent of the investigator to evaluate these methods in any way. To help assure that each respondent remains anonymous, do not put your name or shift on the questionnaire. Each ward employee who has worked on the ward since February 8, 1971 at least 5 or more shifts, is asked to complete this questionnaire for each patient in the study. Completed questionnaires should be returned to the manila envelope in the head nurse's office no later than March 3, 1971 at 7:00 p.m.

This questionnaire is comprised of nine examples of aggressive behavior. Drawing on the observations you have made of each of the patient's behaviors on or since February 8, 1971, provide the information requested in the blank space to the right of each example.

For those behaviors you have observed the patient display on or since February 8, 1971, describe what action was taken including (1) what was said to the patient, (2) what was done to the patient, such as restraints, and (3) if no action was taken then state, "no action taken".

For remaining behaviors which you have not observed exhibited by the patient on or since February 8, 1971, describe what you would most probably do when this behavior is exhibited by the patient. Include what you would say to the patient and what you would do to the patient. If you feel no action is required then state, "no action required". This description should indicate what you would probably do in the practical working situation as it is now, not what you would like to do if you had more time, for example.

OPEN RESPONSE QUESTIONNAIRE

Name of Patient _____

AGGRESSIVE BEHAVIORS

1. Verbally abusive to others ie.,
swearing, obscene language,
name calling or derogatory
or sarcastic remarks.

2. Physically aggressive in some
way toward environment ie.,
slamming doors, throwing
objects, kicking furniture,
breaking windows, etc.

3. Physically aggressive in some
way toward others ie.,
shoving, kicking, bumping
or throwing something
at someone.

4. Interferes with the duties
or activities of others by
his physical actions or by
harrassing.

5. Threatens to divulge information
which will embarrass or otherwise
put a staff member or another
patient in a bad light with others

6. Causes conflict by telling a patient
or staff member that others on the
ward are talking about that person,
laughing at him, and/or planning
to hurt him.

OPEN RESPONSE QUESTIONNAIRE, Page 2

7. Complains about the unkind intentions or actions of others toward him.

8. Demands that others on the ward comply with his wishes ie., being bossy with other patients, demanding attention from others, etc.

9. Resists or refuses, verbally or nonverbally, to perform ward duties, follow ward rules, or to follow suggestions made by others.

APPENDIX F

BEHAVIORAL FREQUENCY CHECKLIST

APPENDIX F

BEHAVIORAL FREQUENCY CHECKLIST

Instructions for Use of Behavioral Frequency Checklist

The purpose of this behavioral frequency checklist is to determine how frequently certain aggressive behaviors are displayed by specific patients on each shift over a five week period starting at 3:00 p.m., February 8, 1971 and ending at 3:00 p.m., March 12, 1971. A behavioral frequency checklist has been provided for each patient in the study and for each shift. There is a folder for each shift located in the head nurse's office. A behavioral frequency checklist is to be completed daily by each shift for each patient in the study. All ward personnel on each shift should be familiarized with the procedure for completing these checklists.

Each time a member of the ward staff observes one of the patients in the study displaying a behavior on the ward which is described in the behavioral frequency checklist, the staff member should record this behavior on the patient's checklist by putting an X in the square which indicates the date of the observation and the specific behavior observed. When two or more ward personnel are present during a certain display of aggressive behavior, only one X should be entered on the patient's checklist. However, if the same type of aggressive behavior is displayed by the same patient more than once during the same shift, then more than one X would be entered in that square.

The checklists should not be removed from the head nurse's office for any reason. Please do not discuss the checklists or the study outside the office.

Ward personnel should handle aggressive behavior displayed by patients in the study in their usual manner. Observations of the patients in the study should be made in a casual manner.

Name of Patient

1. Verbally abusive to others ie., swearing, obscene language, name calling, derogatory remarks, or sarcastic remarks.

2. Physically aggressive in some way toward environment ie., slamming doors, throwing objects, kicking furniture, breaching windows, etc.

3. Physically aggressive in some way toward others ie., shoving, kicking, bumping, or throwing something at someone.

4. Interferes with the duties or activities of others by his physical actions or by harrassing.

5. Threatens to divulge information which will embarrass or otherwise put a staff member or another patient in a bad light with others.

6. Causes conflict by telling a patient or staff member that others on the ward are talking about that person, laughing at him, and/or planning to hurt him.

[illegible]

BEHAVIORAL FREQUENCY CHECKLIST (Continued)

Shift

Name of Patient

Aggressive Behaviors

7. Complains about the unkind intentions or actions or others toward him.
8. Demands that others on the ward comply with his wishes ie., being bossy with other patients, demanding attention from others, etc.
9. Resists or refuses, verbally or non-verbally, to perform ward duties, follow ward rules, or to follow suggestions made by others.

8. Demands that others on the ward comply with his wishes ie., being bossy with other patients, demanding attention from others, etc.

9. Resists or refuses, verbally or non-verbally, to perform ward duties, follow ward rules, or to follow suggestions made by others.

DATE _____

APPENDIX G

CONTENT ANALYSIS OF INTERVIEWS

APPENDIX G

CONTENT ANALYSIS OF INTERVIEWS

I. Verbalization of Aggressive Feelings and Behavioral Events

Patient A

Initial responses of the patient to questions about her experiences with anger were limited to nonspecific statements. For example, she admitted that she often got angry and that she hated everyone and let them know it. By the fourth week in the interview series she was describing specific behavioral events leading to her anger and to some extent what she did when she got angry. She was able to tell the investigator that she was not able to trust people on the ward and that she knew others were talking and laughing about her. She admitted that she never asked the patients if they were talking about her. She also described her response of "telling them off" and that it did the job because these persons stopped talking or laughing. Her descriptions of aggressive behavioral episodes indicate that she was receiving negative reinforcement for her aggression because her behavior stopped the behavior in others she felt was directed toward her.

Patient B

When the investigator focused the interviews on anger, the patient talked freely about her experiences with anger. However, her descriptions of behavioral events surrounding aggressive episodes and

her reasons for her anger were often hard to understand. The patient frequently jumped from one topic or thought to another and frequently used symbolic language. By the end of the interview series with considerable concentration and continual refocusing by the investigator, the patient was able to describe more clearly a few aggressive episodes including the behavioral events surrounding the aggression. For example, she reported feeling angry when she observed a patient going through her coat pockets and she described the specific aggressive behavior that occurred and the consequences of her aggression.

Patient C

Initially when asked to describe what she did when she got angry the patient shrugged or smiled. In the following interview the subject described the disciplinary actions of others toward her when she got angry but could not describe what led up to her aggressive behavior, or exactly what she did when she was angry. In the fourth and fifth interview the patient volunteered the description of a specific time she got angry, including what led up to her anger and what she did when she was angry and the disciplinary actions of the staff that followed. In remaining interviews the patient was guarded and at times mute.

Patient D

The patient's first descriptions of aggressive episodes were general statements about how other patients on the ward always

irritated her and the ways she "let them have it". In subsequent interviews the subject began to describe specific behavioral events surrounding her frequent aggressive behavioral outbursts. For example, she described her resentment of the staff physician for not transferring her to an open ward but sending a "less deserving person" instead. She described specific aggressive behavior she expressed toward the patient who was transferred. She expressed her feelings of frustration in not being able to talk to the staff physician in private. The investigator allowed the patient to ventilate her resentful feelings toward the staff physician without being judgmental. An appointment was arranged by the investigator for the subject to discuss her feelings with the staff physician in a private conference. In subsequent interviews, the patient continued to discuss specific aggressive episodes, describing what her expectations were preceding the aggression, what happened instead, how she felt and acted and the consequences of her actions.

Patient E

When the investigator focused on aggressive behavioral episodes, the subject was able to describe times on the ward when she felt angry or resentful of other patients. She described specific behaviors of other patients that upset her. For example, she complained that some of the younger patients frequently picked on her and teased her. She described how she felt when this happened and what she did to get the

other patients to stop these behaviors. She admitted she would verbally scold the patient and demand the patient stop teasing her. She then complained to the staff about the patient asking the staff to make the patient stop the behavior. She admitted this frequently did not stop the behavior of the other patient.

II. Verbalization of the Effects of Own Aggressive Behavior on Oneself and Others

Patient A

The patient did not verbalize any awareness that her aggressive behavior was a cause for the ward restrictions and aggressive behavior she was receiving from others. She continued to verbalize dislike for the restrictions the staff had placed on her privileges and the aggressive actions of other patients toward her which she felt justified her use of aggression toward the staff and patients in return.

Patient B

In the last two weeks of the interview series, the subject began to discuss the effect of her aggressive behavior in terms of the disciplinary actions that resulted and in a few instances she verbalized an awareness that her aggressive behavior might have caused aggressive behavior in other patients.

Patient C

The subject did not verbalize any awareness of her behavior being the cause of the "mean" actions of others on the ward toward her.

The investigator had just begun to focus on how the patient could make others like her when progress in the interviews stopped. The subject ran away from the hospital, was brought back to the ward and disciplined. In subsequent interviews the patient was guarded and at times mute.

Patient D

In the first few interviews the patient indicated that she enjoyed being aggressive because of the secondary gains it provided. For example, she stated that it was worth it regardless of the disciplinary actions of the staff and that she was going to continue to act this way. In the last two weeks of the interview series, the patient was verbalizing an awareness of the harm she was doing to herself by being aggressive because it kept her on a locked ward and prevented her from being assigned to a job on the hospital grounds.

Patient E

The subject did not verbalize any awareness of how her frequent complaining about the intentions and actions of other patients might cause an increase in the aggressive behavior expressed toward her by patients on the ward.

III. Verbalization of Intent or Attempts to Handle Angry or Hostile Feelings Constructively or Alter Environmental Situations which Result in Aggressive Behavior

Patient A

When the investigator attempted to focus on how the patient could handle angry feelings constructively, the patient responded with a shrug, nervous laughter or mutism. This was interpreted by the investigator as an indication of the patient's lack of readiness to learn to handle anger constructively. In addition, the investigator attempted to focus on what the subject could do to remove the restrictions placed on her activities by the staff. The investigator suggested that the patient ask the staff why the restrictions were imposed and what she could do to earn the privileges she desired. The investigator did not get any feedback that the patient tried this suggestion.

Patient B

The subject verbalized intent to alter her aggressive behavioral response to certain situations on the ward which made her angry. For example, she did not act aggressively toward a patient when she observed that patient going through her coat pockets. Instead, she verbally explained to the patient that the coat was hers and that the other patient was not to go through her pockets. She told the patient she would report her to the staff if it happened again. When reporting this incident to the investigator, the patient expressed pleasure that her behavior stopped

the patient from going through her pockets but did not get her into trouble with the staff.

The subject complained of having little to do on the ward and desired to make more friends. At the end of the interview series, the patient reported an attempt to increase her contact with other patients by asking them to play a game of chinese checkers. Unfortunately, her attempt was not successful as the patients refused to play. The investigator praised the patient for her attempts to reduce situations on the ward which were frustrating to her.

Patient C

Before the patient ran away from the hospital, the investigator was attempting to focus on how the subject could express her anger in physical activities instead of aggressive behavior toward other patients and thus avoid disciplinary restriction to the ward which she resented. The patient expressed a desire to go shopping and attend off the ward recreational activities. The investigator attempted to focus on how the subject could earn these privileges by finding out what the staff expected her to do. The patient did not verbalize any intent to carry out the investigator's suggestion.

Patient D

The investigator focused on ways the patient could handle feelings of anger and resentment without getting into trouble using the patient's desire for a job and a transfer to an open ward as incentive. In the

third week of the interview series, the patient reported playing pool and volley ball when she felt angry and taking her anger out on the ball. In the fourth week of the interview series, the patient was assigned to the job off the ward she had wanted since the interviews began. After her job assignment, the patient reported attempts to handle patients on the ward who irritated her without being aggressive. For example, the patient handed a kleenex to another patient whose frequent drooling and runny nose irritated the patient. The investigator praised the patient for her success in coping with an anger provoking situation in a constructive manner.

Patient E

The investigator focused on ways the patient could bring about a change in the behavior of other patients on the ward by altering her own behavior. The investigator discussed the fact that the patient's angry response to the patients who kept teasing her only increased their teasing. The investigator suggested that the patient try ignoring the younger patients when they teased her and observe what happened. The patient wanted the investigator to change the behavior of those who teased her and did not express any intent to follow the investigator's suggestion. The patient frequently complained about a lack of something to do. During the last week of the interview series, the investigator focused on the patient finding a worthwhile activity off the ward. The patient expressed the intent of going to occupational therapy by herself

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in the afternoons and starting an embroidery project.

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