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ABSTRACT

To determine if a relatively short training program focusing on interpersonal relationships, communication and observation skills, and knowledge and understanding of behavior would increase the empathic ability of psychiatric aides, 20 black aides of low socioeconomic background were randomly divided into an experimental and control group. The experimental group attended 12 2-hour training sessions held twice weekly for 6 weeks which focused on awareness and understanding of one's feelings and those of emotionally disturbed children and an ability to empathize with these children. Taped interviews with coached clients were obtained for each aide immediately preceding, immediately following, and 6 weeks after the training sessions, and these tapes were rated on the Carkhuff scale for levels of empathy expressed by the aides. Analysis by using a 2x3 mixed model design revealed significant differences in mean ratings between the groups, favoring positive changes in the experimental group. Though further research is recommended, the program, with minor modifications, could be used successfully as an inservice program for classroom teachers, administrators, nurses, and other groups. The training manual and Carkhuff scale for levels of empathy are appended. (SB)

Final Report

Project No. OF096
Grant No. OEG-7-71-0003(509)

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IMPROVED UTILIZATION OF NONMEDICAL MENTAL HEALTH WORKERS THROUGH INCREASED EMPATHY LEVELS OF PSYCHIATRIC AIDES.

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The purpose of this study was to determine if a relatively short training program focusing on interpersonal relationships, communication and observation skills, and knowledge and understanding of both one's own behavior and that of others, would increase the empathic ability of psychiatric aides. The program consisted of 12 two-hour meetings held twice weekly for six weeks. Both a control group and an experimental group were rated on three occasions for empathic responses with coached clients. These ratings were taken on each subject immediately prior to the treatment, immediately after the treatment, and six weeks after the treatment. Significant differences in mean ratings between the groups were found favoring positive change in the experimental group.

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St. Louis, Missouri

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U. S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

Office of Education
National Center for Educational Research and Development

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INTRODUCTION

There continues to be a severe shortage of sufficiently trained persons working in the mental health field. It has been estimated that approximately eighty percent of all nursing care for the psychiatric patients within state hospitals is given by psychiatric aides (Simpkins, 1968). Psychiatric aides are nonprofessional persons administering psychiatric and general nursing care to mentally or physically ill persons within a state hospital. The aides generally have a closer association with more of the patients than any other person. However, they have the least amount of formal education and training in the care of persons with mental disorders (Vaughn, 1962).

The availability of psychiatric aides on the wards and their physical closeness with patients creates a unique "helper" role for the psychiatric aides. Carl Rogers stated (Rogers, 1957) that the "helper" in a relationship must be empathic in order that constructive personality changes may take place in the "helpee". Psychiatric aides, with training in empathy, would be in a unique position to be therapeutic "helpers".

Empathy is the basic component in a therapeutic relationship. Empathy can be defined as the ability of one person to understand the feelings of another person, and to communicate their understanding to the other person. This involves both the experiencing of that person's feelings and the expressing to the other person that his feelings are being perceived.

The development of empathic abilities within the psychiatric aides would allow them to be more sensitive to existing feelings and better able to respond therapeutically to the patient's verbal and nonverbal communications. It would also enable them to appreciate and be aware of the feelings which cause a person to behave in a certain way, and thus able to understand patterns to human behavior which are both overt and covert.

The literature indicates that there is a positive relation between empathy and therapeutic effectiveness (Dymond, 1949; Rogers, 1957; Rogers, 1959; Truax, 1961; Buchheimer, 1963; Truax, 1966; Hogan, 1969). It also indicates that psychiatric aides should and can be trained to be empathic and therapeutic (Truax, Carkhuff and Kodman, 1953; Vaughn, 1962; Rioch, 1963; Ishiyma, 1966; Spiegel, 1967; Banks, Berenson and Carkhuff, 1967; Simpkins, 1968; Carkhuff, 1969).

In order to increase therapeutic effectiveness in the "helper" it follows that the "helpee" must increase his ability to empathize. The question as to how one goes about increasing a helpee's ability to empathize is a significant one and one that has not been adequately answered in the literature.

Carkhuff has pointed out (Carkhuff, 1969, Carkhuff, 1970) that the first step in training empathic skills is to carefully select your trainees. However, in many situations this ideal of choice is not an available option. Often, the only choice is to work with the available personnel. This is generally the situation in most state hospitals when working with psychiatric aides. It is necessary to develop these persons' empathic skills to at least a minimally acceptable level of functioning. Thus, it becomes a question of concern whether without the selection option sufficient empathic skills can be taught to a general group of para-professionals within a relatively short period of time.

This study was designed to determine whether a training program which focused primarily on interpersonal relationships, communication and observation skills, and knowledge and understanding of both one's own behavior and that of others, would increase the empathic ability of randomly selected psychiatric aides.

METHOD

Sample

The sample consisted of 20 psychiatric aides drawn from the population of aides working in the children's division of the state mental hospital in a large metropolitan area. A total of 36 aides comprised the day and evening shifts. All but one of these aides volunteered to participate in the study.

During the winter semester a pilot study (Brockhaus, 1971) was run using 10 of the aides. This reduced the available population to 25 aides. Of these, 5 aides were unavailable because of staff changes and vacations. The remaining 20 aides were used for this study.

The twenty aides were randomly divided into two groups, 10 in the experimental group and 10 in the control group. Care was taken to place the same number of aides working day and evening shifts in both groups.

The subjects were all black of low socio-economic background. Their educational level ran from grade 10 to High School graduation, with a mean of grade 11. The age range was from 35 to 45, with a mean for the control group of 40 and a mean for the experimental group of 43. Seventeen of the subjects were female, with eight females in the control group and nine in the experimental group.

Outcome Criterion

The purpose of this study was to determine if a particular program would be successful in developing in psychiatric aides the ability to be more empathic when interacting with patients. Therefore, as the outcome criterion, interviews were taped and rated by using Empathy Scales (Carkhuff, 1969) as direct measures of the empathic skills of the aides.

However, it was impossible to unobtrusively observe the aides while on the job in the psychiatric wards. The intrusion caused by the presence of observers and the lack of standardization in observations would have caused the validity of the results to be highly questionable.

Consequently the investigators decided to collect the data using trained clients and to collect interview tapes for all subjects at specified times during the project period. Interviews were held on three occasions with trained clients as a pre-test, immediate post-test, and delayed post-test to the experimental treatment. The pre-test interview was held immediately preceding the training period; the first post interview was held at the conclusion of training; and the

delayed post was held six weeks after the training.

The empathy scale used for rating the tapes describes five levels of behavior from a low of not attending to feelings (Level 1) through minimum facilitation (Level 3) to a high of accurate response to deep feelings (Level 5). For each interview a three minute sample was rated from the first half and a three minute sample was rated from the second half. The mode rating from each sample was taken as the value to represent the level at which the aide was operating during that sample of the taped interview.

Trained Clients

Three undergraduates from the University of Missouri-St. Louis were trained as clients. All three had prior experience as a client. The three were trained to function at Level 3 of Self-Exploration (Carkhuff, 1969). At this level clients volunteer a personal feeling. After each counselor response, the trained clients answered when necessary and then volunteered a personal feeling or reaction. The use of clients trained to a consistent level of self-exploration provided control over the content of the interviews. Such constant level of personally relevant material assures that differences between counselors were not caused by client differences.

Raters

Three graduate students in the counseling program at the University of Missouri-St. Louis were used as raters. Each of the three had completed training on the Empathy Scale in a beginning practicum. The three met for a total of twelve hours of training. The training criterion was an average reliability of .80 among raters using the analysis of variance technique reported by Ebel (Ebel, 1951). At the beginning of training, the three raters were moderately consistent with an individual reliability of .434 and an average reliability of .688 using 8 tapes. At the close of training the consistency among raters had increased considerably with an individual reliability estimate of .833 and an average reliability estimate of .938 using 15 tapes. The tapes used to obtain these reliability estimates were randomly drawn from the counseling practica at the University of Missouri-St. Louis.

Training began with complete familiarity with the Empathy Scale. The three learned to discriminate Level 3 responses first. Then the discrimination between non-helpful statements into Level 1 and Level 2 was accomplished. Finally Level 4 statements were learned.

The training process was made up of listening examples from recorded interviews, rating the examples, and discussion. Gradually the three raters devised more and more examples for the others to rate.

Training Program

The 10 psychiatric aides in the experimental group and one of the investigators met for 6 weeks--2 two-hour sessions per week. The program focused on: (1) an awareness and understanding of one's own feelings and those of emotionally disturbed children; and (2) an ability to empathize with these children.

The content of the sessions was based on a 43 page booklet developed by the investigator for the training program (see Appendix A). Each group member had a copy of the booklet for his own use. Course content was presented informally in the form of discussions, role playing, and training tapes.

The objectives for each session and methods of presentation are presented in Table 1. A summary of the six weeks follows.

Week 1. The group members participated freely in group discussion, and the formation of a "group feeling" began to evolve. The use of concrete examples and writing on the blackboard proved to be very helpful. Objective 16 "To gain a basic understanding of the meaning of disturbed behavior in children" was facilitated by the following assignment. Each aide was to think of a patient who she worked with and was then to list 5 characteristics of that child's behavior. Class time was then used to interpret possible meanings and reasons for this behavior. This experience seemed to bring the real ward-world into the classroom. Theories and concepts were then related to these real situations and interactions. Objective 16 was met in this manner throughout the training program.

Week 2. Role playing was used for demonstrating attitudes and feelings. A chart entitled the "Interchangeable Chart" was introduced. This was to encourage and reward the aides who used interchangeables and to help later pairing of aides for role playing situations. Each time an aide said an interchangeable during class he would receive 2 points. Each time an aide recognized that someone said an interchangeable, he would receive 1 point. The points were totaled at the end of each session and each week for two weeks. At the conclusion of the third week, the points were totaled and pairs for role playing situations were formed. Each pair consisted of one aide who had a high score and one who had a lower score. These pairs then worked together in the role playing situations in the last four sessions. The use of the chart provided a means of stimulation for the aides. The aides practiced interchangeables and were verbally rewarded by each other out of the classroom situation.

The aides were able to integrate concepts to previously learned ones and into actual ward situations. The aides seemed to become more aware of the importance of their roles with the children, and that their interactions should be purposefully therapeutic.

TABLE 1

Sequencial Listing of Objectives and Methods

	SESSIONS											
	Week 1		Week 2		Week 3		Week 4		Week 5		Week 6	
	1	2	3	4	5	6	7	8	9	10	11	12
Objectives	1 2	3 4 5 6 16	6 7 8 9 16	10 11 12 16	6 8 16	6 8	13 16	13	14 15 16	6 8	6 8 16	6 8 17
Methods	0	0	0 △ *	0 △ *	T *	T C *	0 △	0 ▨	0 T △	0 △	0 △	0 △

LEGENDS

Objectives

1. To understand the purpose of the training program
2. To understand the concept of groups as it applies to their specific group
3. To understand Sullivan's concept of human behavior as it applies to the functioning of mentally healthy and mentally disturbed children (Sullivan, 1953)
4. To understand the concept of mental health and mental illness
5. To understand Maslow's concept of the five levels of needs as it applies to mentally healthy and mentally ill children (Brown and Fowler, 1961)
6. To understand the concept of Carkhuff's levels of empathy (Carkhuff, 1969)
7. To understand the purposes of role-playing
8. To understand the concept of empathy as it relates to therapeutic functioning
9. To understand the effects one's attitudes have on interpersonal relationships
10. To understand the significance of interpersonal security as it relates to mentally healthy and mentally ill children
11. To understand some of the factors involved in the formation of a therapeutic relationship
12. To understand ten basic assumptions in regard to human behavior which have implications for psychiatric aides
13. To understand the importance of good observation and communication skills as they relate to the therapeutic effectiveness of psychiatric aides
14. To develop skill in understanding and communicating therapeutically
15. To understand the concept of anxiety as it relates to the functioning of people
16. To gain a basic understanding of the meaning of disturbed behavior in children
17. Review

Methods

△ Role Playing
O Discussion
T Training Tape
C Criterion Tape
* Interchangeable Chart
▨ Chose partners for role-playing

Week 3. The focus for this week was primarily directed towards the recognition and expression of interchangeables, and the concept of empathy. A training tape was introduced which gave examples of interchangeables and provided for class participation. The training tape also provided structure and allowed the aides to practice interchangeables as a group. This seemed to help the aides feel more confident in expressing their own interchangeables during the role playing situations. Five of the 10 aides were able to identify all interchangeables on the training tape correctly. The other five aides each missed one response. A criterion tape was also used. Four aides were able to identify all interchangeables correctly; three missed one response; and three missed two responses. The "Interchangeable Chart" was continued for this week.

Week 4. The focus for this week was primarily on communication and observation skills. The aides chose partners for role playing situations according to the total number of points each person had accumulated on the "Interchangeable Chart". At this time, the five most successful aides were able to serve as "trainers" for the five least successful aides.

Week 5. This week consisted primarily of practicing interchangeables and emphasizing the concept of empathy. The aides role played situations which happened on the ward in which they were involved. The "aide" would try to help the "patient" in the situation by letting her know that her feelings were being understood. The aides reversed roles when they found it useful. The"patient" in the situation would tell the "aide" how he felt after the "aide" expressed an understanding of her feelings. This feedback seemed to help the aides to determine their accuracy. The aides continued using interchangeables on the wards to the children and to each other. By this time, persons in the control group were also being exposed to interchangeables because they were in the same working environment as aides in the experimental group.

Week 6. The focus for the last week was the same as for the fifth week. Most of the aides seemed to be able to say interchangeables accurately and with relatively little difficulty. The group reviewed the content of the booklet during the last session.

Design

Taped interviews were obtained for each subject immediately preceding the treatment (pre-), immediately following the six week treatment (post-), and six weeks after the treatment (delayed post-). These interviews consisted of 20 minute sessions with one of three coached clients. The aides were randomly assigned to the clients so that by the end of the third interview each aide had seen each client once.

The clients were three undergraduate females attending the University of Missouri-St. Louis. They met with one of the investigators on several occasions to listen to taped interviews and role play their situations. Prior to the initial interviews they met with the three investigators and a psychiatric aide who was not included in the study. This provided the opportunity for the clients to interact with staff personnel, view the setting in which they would be working, and play their roles in a more realistic setting.

The aides were instructed that these clients were high school girls that had some personal problems with which the aides were to help them. Even though somewhat uneasy at first, the aides seemed to quickly adapt to the taped interview situation.

In total, 60 interviews were taped. "Mini-reels" were used for the taping. One interview was contained on each side of a tape.

All 60 interviews were collected before any of the tapes were rated. Using a Table of Random Numbers (Kiugh,1970) the interviews were randomly assigned numbers from 1 to 60 indicating the order in which they would be played back for rating the levels of empathic responses expressed by the aides.

Three graduate students enrolled in the counseling program at the University of Missouri- St. Louis served as raters. They were trained by one of the investigators until they reached a relatively high level of consistency in their ratings.

The tapes were played for the raters in the Language Laboratory, University of Missouri-St. Louis. This enabled the investigators to play the same tape to all three raters simultaneously so that the same parts of all the tapes were rated by the same three raters, at the same time, under the same conditions. Two three-minute segments from the first and second half of each interview were rated. Thus, ratings for six observations were taken on each interview. The means of these ratings were used as the levels of empathy for which the aides were functioning during each of the interviews.

The data were analyzed using a 2 by 3 mixed model factorial design. The randomized measure was the treatment with an experimental group and a control group. The repeated measure was the three time periods at which the interviews were collected. The .05 level of confidence was used for all statistical tests.

RESULTS

As previously indicated, the purpose of this study was to determine if a six week inservice training program meeting twice weekly for two hours and focusing on interpersonal relationships, communication and observation skills, and knowledge and understanding of both one's own behavior and that of others, would increase the empathic ability of psychiatric aides. Toward this end, pre-treatment, post-treatment, and delayed post-treatment interview tapes were collected for 10 experimental and 10 control subjects. These 60 tapes were rated on the Carkhuff scale for the levels of empathy expressed by the aides. The differences between mean ratings were tested using a 2 by 3 mixed model design.

Since the results of this study are dependent upon the reliabilities of the ratings, these results need to be presented before discussing the project results. The rater reliabilities and standard deviations are presented in Table 2. It can be noted that for the post-tapes and delayed post-tapes both the individual and average rater reliabilities were quite high, with values in the .80's and .90's, respectively. The larger average values are indicative of the confidence which can be placed in these data since average ratings were entered into the data analysis.

Further examination of Table 2 reveals that the individual reliability for the pre-tapes was only a moderately high .64. This discrepancy can probably be accounted for by the extreme homogeneity of the ratings on this series of tapes. The standard deviation was only .35 while for the other two tape sets it was .72 and .65, respectively. Nevertheless, the average rater reliability of .84 did surpass the criterion level of .80 set by the investigators.

TABLE 2

Reliabilities of Ratings

Type	Time Periods		
	Pre	Post	Delayed Post
Individual	0.642	0.870	0.835
Average	0.843	0.953	0.938
Standard Deviations	0.351	0.719	0.648

The mean ratings are presented in Table 3 and a summary of the statistical analysis is presented in Table 4. As can be noted from Table 4, all analyses were significant at the .01 level of confidence.

TABLE 3

Overall and Cell Means Mean Ratings

on Empathic Level

Group	Time Periods			
	Pre	Post	Delayed Post	Total
Control	1.333	1.517	1.467	1.439
Experimental	1.417	2.333	2.367	2.0389
Total	1.375	1.925	1.917	1.739

TABLE 4

Analysis of Variance Summary Table

Source of Variance	SS	df	MS	F
BETWEEN				
Treatment	8.817	1	8.817	41.906*
Subjects within treatment treatmen	3.787	18	0.210	
WITHIN				
Time	3.284	2	1.642	9.769*
Treatment by time	2.553	2	1.276	7.600*
Subjects by time within treatment	6.052	36	0.168	

* Significant at the .05 level of confidence

The significant treatment factor indicates that one of the treatment groups obtained higher overall ratings than the other group. Similarly, the significant F for time indicates that the level of empathy is related to the time period in which it was obtained. Examination of Table 2 reveals that overall the experimental group obtained higher ratings than the control group. Further examination of the means indicates that a systematic increase in empathic level occurred between pre- and post- ratings and that this increased level was maintained through the six week period between post- and delayed post-ratings.

However, the result of major interest was the significant interaction. Pictorially this result is illustrated in the graphs of cell means presented in Figure 1. As can be noted from the figure both groups increased in empathic level. However, the rates of increase were quite different for the two groups.

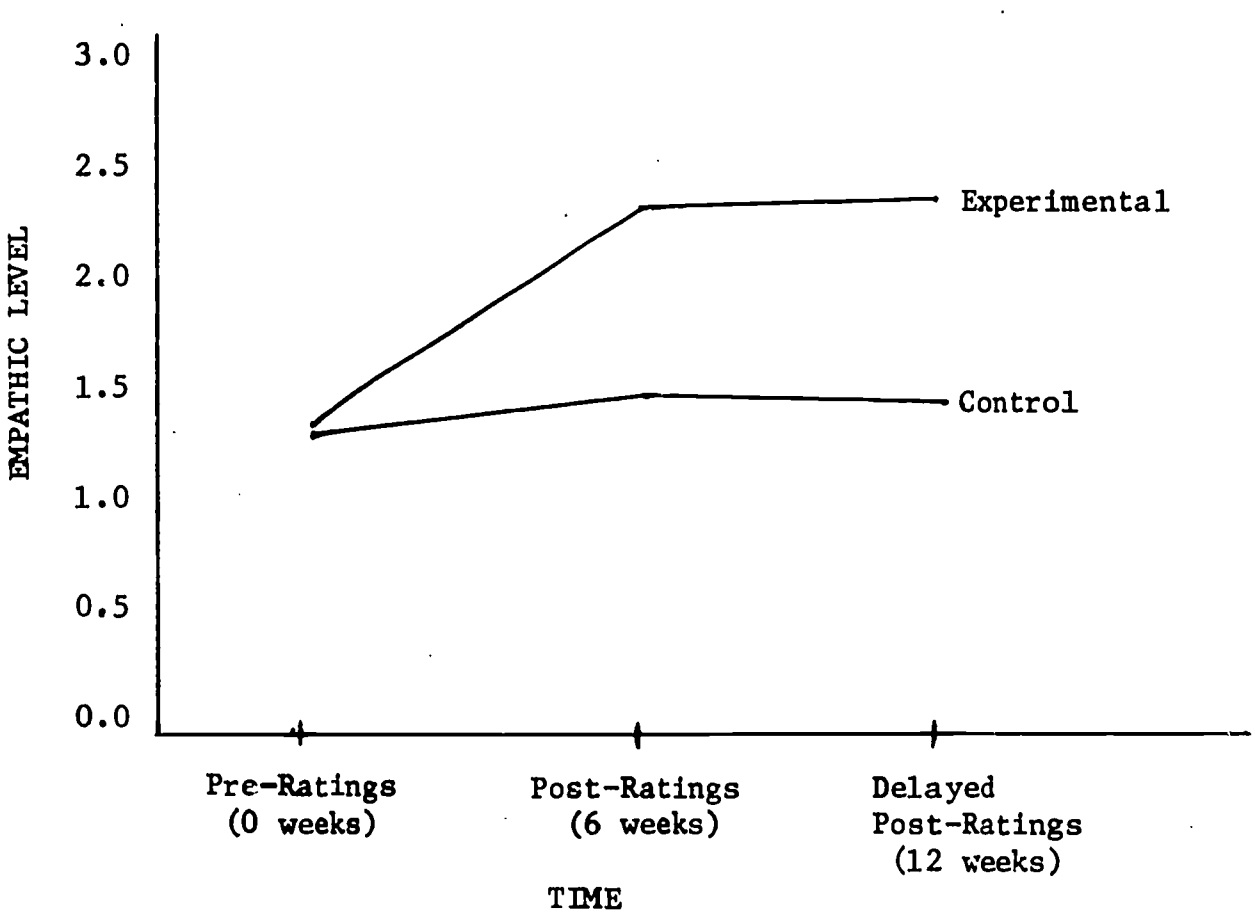

Figure 1. Mean empathic levels for experiment and control groups over the 12 week project period.

The control groups increased only very slightly over the project period. This increase might be related to any of several factors. First, it might be more than a random occurrence; second, the initial interview might serve as a learning experience for the subject; and third, the experimental and control groups interacted on the hospital wards during and after the treatment was administered.

The experimental group increased from 1.42 to 2.33 or approximately nine-tenths of a level over the six-week training period. Since the program consisted of 24 hours of instruction spread over six weeks, this represents slightly less than .04 of a unit change per hour of instruction or .15 of a unit change per week. This represented a significant change on the part of the aides who experienced the experimental program. Further examination of Figure 1 indicates that the change in the aides' empathic level was lasting, at least for six weeks after termination of the treatment.

However, even though significant changes were observed in the empathic skills of those aides in the experimental group they did not reach the minimum facilitation level of 3.0. Figure 2 represents the projection of increased levels of empathy for an expanded program based on the change rate for the six week program. It can be noted from the figure that it could be expected to take just under 11 weeks for the average aide to reach Level 3, assuming that the same rate of change could be maintained.

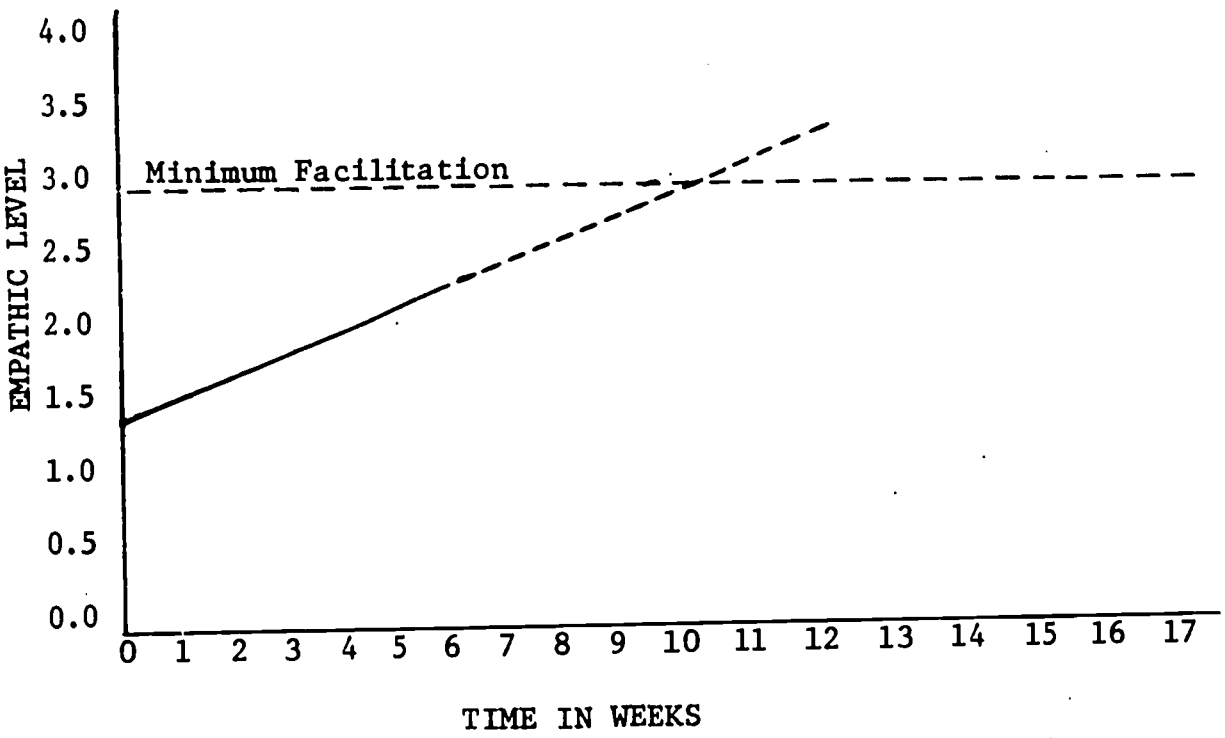

Figure 2. Projected increases in empathy for extended training periods.

Of final note, half of the experimental group were rated at Level 3 or better on at least 50 per cent of the post-treatment ratings. This result represented considerable improvement in that none of the control group reached this level and furthermore none of the experimental group obtained ratings at this level on the pre-tapes.

CONCLUSIONS

This study indicates that an inservice program meeting two two hour sessions weekly for six weeks which focuses on interpersonal relationships, communication and observation skills, and knowledge and understanding of both one's own behavior and that of others can be effective in increasing the empathic skills of psychiatric aides. Furthermore, the increases seem to be retained for at least six weeks after the termination of the program.

The results of this program were particularly encouraging since they were obtained with subjects which represented a relatively low socio-economic level and low educational background.

However, with six weeks of training the average ratings on empathy did not reach the minimum facilitating level identified by Carkhuff (Carkhuff, 1969). This indicates that even though the general success of the program was encouraging it probably needs to be revised through extending the time period or stepping up the program within the six weeks period if the minimum facilitation level, Level 3, is the criterion.

RECOMMENDATION

The results indicate that the program investigated in this study can be effectively used to train psychiatric aides through an inservice program with a resultant increase in empathic skills. However, it is recommended that further studies of this program and modifications of the program be conducted.

It seems likely that the program, with minor modification, could be used successfully as an inservice program for such other groups as classroom teachers, administrators and nurses.

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APPENDIX A

Training Program Booklet

25

SPECIAL TRAINING PROGRAM

FOR

PSYCHIATRIC AIDES

AT

ST. LOUIS STATE HOSPITAL

YOUTH CENTER

CONTENTS

INTRODUCTION

The psychiatric aide has a great deal to contribute in the treatment of mentally disturbed children. She is on the ward and with the children more than any other person on the treatment team.

It is the purpose of this training program to help the psychiatric aide develop and use her skills in the most effective way. The program will help her to develop communication skills, understand the feelings of the children who are disturbed, and help her to respond to them in therapeutic ways.

There will be twelve training sessions. We will meet twice a week for two-hours a session. The total training program will be six weeks in length. Our classes will be held in the employees building. Mrs. Joyce Brockhaus, R.N. will lead the sessions.

Participation in the training program will be limited to a small group of about ten aides. The sessions will be held during working hours. Members of the program will be relieved from the work responsibilities of their job during the two-hour sessions twice a week for six weeks. IT IS EXTREMELY IMPORTANT THAT EACH AIDE ATTEND ALL SESSIONS AND READ HAND-OUT MATERIAL AS REQUESTED.

This training program in no way influences salary, pay raises or anything else concerned with the administrative aspect of your job.

Three tests will be given. The first one you have already taken. The second one will be given at the conclusion of the training program, and the third one will be given one month later. The results of the tests will be confidential.

GROUPS

1. What is a group?

A group consists of at least two persons who have something in common.

Examples:

1. All the psychiatric aides at the Youth Center are a group because they all have similar educational backgrounds and because they are all working with children who have emotional problems.

2. All the psychiatric aides in your class when you went to aide school formed a group because you all had in common the desire to learn more....your goals were similar.

3. Persons join a Labor Union and become a group because they have similar or common problems.

2. What do group members do?

Let's talk about the groups which formed because they have similar goals or problems.

First of all the people who formed a group because they have something in common have to figure out what exactly it is that they want to do or what they want to solve or make better.

Examples:

1. Maybe some psychiatric aides formed to make a group because they all want to plan some kind of activity for the children. COMMON GOAL. Now they must decide among themselves what kind of activity would be best for the children.

2. Maybe some psychiatric aides got together and formed a group because they were unhappy with something on the ward. COMMON PROBLEM. The group members have to figure out among themselves exactly what it is on the ward that is causing them to be unhappy.

After the group members decide what their specific activity is going to be or what exactly it is that is making them unhappy on the ward, they must figure out how to plan for and accomplish their goals, or

how they are going to solve their problems.

Examples:

1. If the activity that was planned was a dance for the children, then the room, music, food, time, who would be working, and so on would have to be planned. In order for the children to benefit the most from the planned activity, the group members would themselves have to be able to work with each other in order to accomplish their goal.

2. Maybe the COMMON PROBLEM that the psychiatric aides were having on the ward that was making them unhappy was that they were not able to relate to or communicate with the patients in ways that seemed to help the patients. The "unhappy" feeling that the aides were experiencing was because they felt inadequate and frustrated. The aides could only solve this problem of ineffective communication by learning how to listen to the children more effectively, try to understand how the child is feeling at the time, and then how to effectively respond to him when he is feeling that way. The group members needed someone outside of the group to help them solve their problem. By learning these skills, the psychiatric aide will feel less frustrated and inadequate because she will understand the patient's feelings better and how to be more therapeutic herself.

SUMMARY

People who get together because they have something in common must first decide <u>what</u> it is that they have in common--be it a goal, problem, etc. Then the group members must decide what they want to do about it and <u>how</u> to go about achieving this.

3. What will this group and these group members be doing?

You will work together as a group of psychiatric aides who have something very worthwhile and necessary to contribute to the process of helping the disturbed children get better.

You will learn how to be able to express yourself in more effective ways to each other and to the children.

You will learn to be willing to compromise, and to try to

understand how the other members feel. It is perfectly alright to disagree and to have many different ideas and suggestions. As long as the disagreements serve the purpose of helping to come up with a better solution, it is fine. When disagreements serve to hurt other persons and interfere with the process of coming up with a good solution to the problem, it becomes destructive.

Group members will be sharing their ideas and feelings, and will feel free to express themselves.

We will be having lectures, discussions, using TV and tape recordings to see how good communication skills work and how ineffective poor communications are, and we will be doing role playing of situations like the ones that happen on the wards with the children. Through these we can learn how to be most effective with the children so that we can help them with their problems better and also so we don't have the inadequate or frustrated feelings like the aides in the example on the preceeding page.

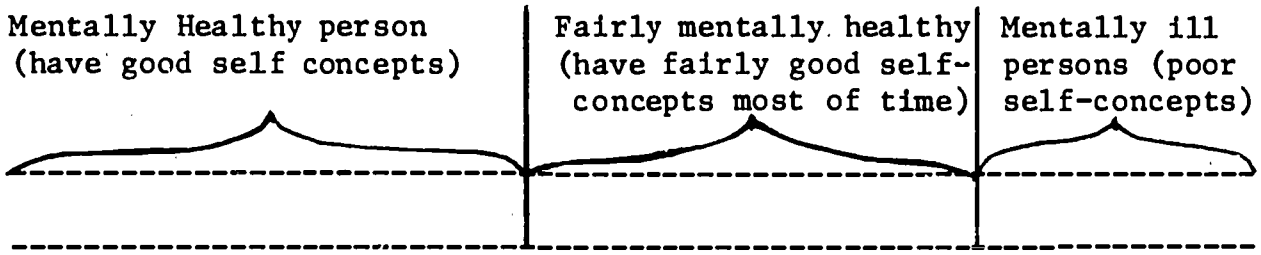
MENTAL HEALTH AND MENTAL ILLNESS

Mental health and mental illness are viewed as parts of a continuum. A person's degree of mental health or mental illness depends upon his self-concept--that is, it depends upon how the person sees himself and if he likes or dislikes himself.

There is no such thing as 100% mental illness or 100% mental health. Mentally ill persons are not ill in all areas of mental functioning.

Mentally healthy persons are able to function in life with every day problems; mentally ill persons cannot cope with problems effectively.

CONTINUUM OF MENTAL HEALTH AND MENTAL ILLNESS:



	Children from this group do fairly well as long as the home situation and their environment is stable. When it becomes unstable the children act-out and become behavior problems.	Children in this group need to have their self-concept improved --they need to learn to like themselves.
	Goal: Improve self-concept and improve home situation and interpersonal relationships so children can function well in environment and not have to act-out.	Goal: Try to move to the "Fairly mentally healthy" group so that children can learn to function in society.

HUMAN BEHAVIOR

1. What are the goals of human behavior?

    a. having needs met
    b. avoiding anxiety...having inner security

2. How are these goals achieved by healthy children?

    A mentally healthy child was born into a home situation where he was wanted and which provided him with a good self-concept. He learned to like himself because the important persons in his life showed him that they liked him. When he was very young, his parents showed their love for him by meeting all of his needs...food, clothing, warmth, safety, tenderness etc. When he became older, they showed their love for him in different ways. They still provided him with food, clothing, tenderness but in addition they allowed him some independence to grow and develop into a special person who was separate from them. He learned that his parents loved him and were good, and that the world was good. When problems faced him, he could cope with them because he had learned healthy and effective ways of coping with his anxiety, and he had faith in himself that he could manage O.K.

3. What is meant by the spiral of growth and development?

    The growth and developmental process of everyone is like a spiral. As the child grows and develops he cannot <u>always</u> be successful, achieve, and go forward. Sometimes he has to go backwards a little. After he has gained more strength, he will again be able to climb up the spiral. It is normal for everyone

to go forward and backward on the spiral to some degree in order to grow and develop.

4. Things that a healthy child has learned because of his experience:

   1. He learns that he can trust others
   2. He learns that he is a person separate from anyone else, and that he is worthwhile and important.
   3. He feels free to undertake or plan something on his own, and finds healthy ways of using some of his surplus energy.
   4. He learns to win recognition by producing things...constructive way of getting attention and learning that he is worthwhile.
   5. He learns to know who he is...mostly by the way he is treated by others and by the kind of expectations they place on him, and how he fits into the family. The consistency of others toward him is important in order for him to have a clear picture of who he is.
   6. He learns that he is able to share his feelings, warmth and love with others.
   7. As the child gets older, he realizes that he has been given a lot of love and tenderness. He is happy, and he is able to make others happy.

5. Things that a mentally disturbed child has learned because of his experiences:

   1. He learns that he cannot trust anyone because he has been disappointed and hurt by others so many times. His basic needs...food, warmth, love, tenderness have not been taken care of. He is very mistrustful. He is afraid.
   2. Because others have not treated him as though he were worthwhile or given him love and tenderness, he feels that he must be an awful person and not worthy of anything better. He has a poor self-concept. He feels ashamed of himself and doubts that he is worthwhile.
   3. Because he has not been given encouragement to become independent to grow and develop like a special person, he is afraid to try anything on his own. He feels guilty because he feels he would probably fail at anything he tries anyway.
   4. He doesn't get recognition for anything he does try...he feels very inferior...he feels worthless...his self-concept is low.
   5. Because no one really treats him like he's important or even a person, it is hard for him to even know who he is...he's just a nobody...he doesn't seem to fit into his home or in the world...he feels confused...who is he supposed to be?
   6. Because he has never been shown love, warmth, etc. he cannot give this to others...he doesn't know how...he's afraid to let anyone know how he feels...he is very isolated.

7. As he grows older, the child realized how unhappy he is, that the world has not been good to him. He doesn't belong, his needs have not been met as a young child, he doesn't feel secure, he has ineffective ways of handling his anxiety ...maybe behavior problems or maybe mentally ill. Child who has just behavior problems has had some of his needs met and has had some tenderness. Child who is mentally ill has had very few needs met.

SUMMARY

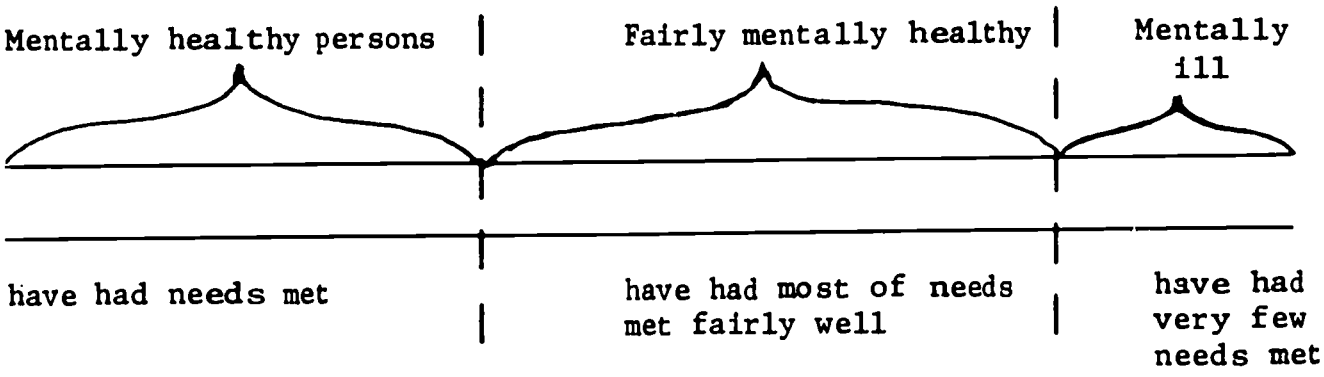
Characteristics of mentally healthy child:

1. has trust
2. has autonomy (knows he's important)
3. has initiative (will try new things)
4. has industry (likes to produce things)
5. has identity (knows who he is)
6. has itimacy (can be close with someone)
7. is happy

Characteristics of mentally disturbed child:

1. is mistrustful
2. is ashamed of himself
3. feels guilty (thinks he will fail at anything he tries)
4. feels inferior (feels inadequate)
5. is confused as to who he is
6. feels isolated
7. is unhappy

CONTINUUM OF MENTAL HEALTH AND MENTAL ILLNESS in relation to how needs are met:



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NEEDS

1. What is a need?

   According to Webster's Dictionary a need is "a condition requiring supply or relief."

2. Maslow's concept of the five levels of needs ranging from the physiologic (most basic for life) to those that represent a higher level of development (Brown and Fowler,1961, p. 19)

   1. basic physiologic aspects such as hunger and thirst
   2. needs of safety...that is, of avoiding external dangers that might bring harm
   3. need for belongingness and love...that is, to be given love, warmth and affection by another person. The love need involves both giving and receiving love.
   4. need for esteem...it includes self-respect and self-esteem as well as the respect and esteem of others
   5. need for self-realization...that of being able to utilize one's potentialities to accomplish and achieve.

   At the beginning of one's life all of our basic physiologic needs (hunger, thirst) have to be met by others because we are incapable of meeting them. If they are not met we will die.

   We have to feel like we belong and that we are loved in order for us to have a good self-concept. If we do not respect ourselves, we will never be able to achieve what our capabilities are. We will be less than what we could be.

   When our needs have been satisfied we have "feelings of self-confidence, strength and capability; whereas, if they are thwarted, or not met, we have feelings of inferiority, worthlessness and helplessness." (Brown and Fowler,1961, p. 19)

   "As the infant develops and achieves satisfaction of his basic level needs he is then freed to function on a higher level. On the other hand, if these more basic needs are not met adequately, then they claim priority, and activities of a higher level must be

temporarily postponed." (Brown and Fowler, 1961, p. 19) That is, if Maslow's need #1 is not met, need #2 cannot be met. If needs #1 and 2 haven't been adequately met, then need #3 cannot be met, and so on.

INTERPERSONAL SECURITY

Interpersonal security or inner security is one of the goals of human behavior. (refer to session on Human Behavior)

A person experiences interpersonal security when he is calm and freed from the tensions of anxiety. The need for interpersonal security might be said to be the need to be rid of anxiety.

When a person does not have interpersonal security, he is very anxious, tense or even terrified. He does not function effectively as long as he is in this state. We, as therapeutic people, have to work with this anxiety he is experiencing and help him find outlets for getting rid of it...these must be constructive of course. Methods of doing this will be discussed later.

ATTITIDES

1. What is an attitude?

   "An attitude is a feeling tone which forms the background for our reactions to certain persons, places or objects, supporting and/or limiting the response." (Brown and Fowler, 1961, p. 105)

2. Why is it significant to be aware of and understand one's own attitudes and feelings?

   "When certain patients are repulsive to us, we are apt to communicate this attitude, nonverbally and unintentionally, in caring for him. The patient usually knows what our attitude toward him is although we may not be aware of it. Attitudes cannot be observed directly but can best be noticed on the basis of the action and the feeling tone communicated. Perhaps we jerk the sheet a little suddenly when we make his bed for him or frown when we greet him. We can readily see that we will have considerable difficulty in developing a harmonious relationship with this patient." (Brown and Fowler, 1961, p. 105)

   "It is quite easy to say that 'one must correct his attitude,' but often we can change only our outward actions momentarily and our true feelings remain the same. First of all, it is necessary for us to become aware of our true feelings and to discover when and under what circumstances we feel this way. Sometimes just becoming aware will help us to change the attitude if it is not associated with strong feelings. A greater understanding of the patient and his needs may also help. At times just understanding the facts and talking them over with our supervisor or another experienced person will help us to understand the situation more clearly. It is only natural that we will be attracted toward some patients more than others but as we become aware of our attitudes we can develop more skills in establishing effective interpersonal relationships. In many instances we will find that our attitude is such that we can readily develop a harmonious relationship with patients with whom we are working." (Brown and Fowler, 1961, p. 106)

3. Destructive attitudes:

   A person with destructive attitudes causes people and situations to break up...the issue is confused. A person like this tries to "put others down" in order to make himself feel better. A person with mostly destructive attitudes has a poor self-concept. This kind of person tries to keep something good from coming from situations.

4. Constructive attitudes:

A person who has mostly constuctive attitudes integrates situations, holds interpersonal relationships together and brings people together.

1. What is an interpersonal interaction?

   "It is a mode of interaction of two or more persons." (Sullivan, 1953, p. 42)

2. What are some important facts that are concerned with interpersonal interactions or situations?

   1. "Interpersonal behavior is continually changing and not haphazardly but with apparent purpose.

   2. "The interaction brings about something different, new.

   3. "A loving person is one who, generally, when circumstances permit, integrates situations having the traits categorized as love. A hateful person is one who, when the opportunity offers, integrates situations having the traits categorized as hate or hateful.

   4. "The traits which characterize interpersonal situations in which one is integrated describe what one is. Because any person integrates interpersonal situations having many different traits, to determine whether a person may, in everyday language, be called loving or hateful, is not an easy problem. Generally speaking, personality is a function of the kinds of interpersonal situations a person integrates with others.

   5. "Interpersonal processes, like all events, do not occur with their meaning written all over them. A situation in order to be understood has to be interpreted. One must postulate goals or tendencies or impulses in a situation.

   6. "The psychiatric aide must interpret what she observes. Her interpretations will be guided by her knowledge, skill, and her past experiences." (Sullivan, 1953, pp. 92-98)

3. What are some different types of relationships?

   1. Interpersonal relationships

      "Interpersonal relationships involve the individual and his external environment or that part of the environment which is outside the living organism. The individual may interact with one or more persons or he may react to the objects in his social environment. We shall assume that an interpersonal relationship is interaction which requires that at least one of the persons involved be real. We have implied, by this

statement, that people sometimes interact with an imaginary environment. Since the individual may perceive his external environment to be different than it really is, he tends to respond to it as he sees it. For example, a patient may believe that Miss Smith, the aide, is trying to poison him when she brings his medication. Even though Miss Smith has poured the correct dosage of the prescribed medicine, the patient may still not take it. Here we can see that the patient is reacting to poison, an imaginary object in his environment. We can also see that the object was not totally imaginary. There is a medication but the patient has misinterpreted this stimulus as a poison. In this situation both the aide and the patient are real figures in the interaction.

"On the other hand, Tom may be observed to talk considerably when no one else is in his room. When the aide enters, Tom states that he is talking to his friend, Jim. Since it is known that Tom does not have a real friend named Jim, we know that he must have an imaginary friend with whom he interacts.

"Individuals also interact with other persons in the environment who are real as well as to objects which are real. Under these circumstances reality is perceived as it exists with a minimum of misinterpretation. There are several characteristic patterns which commonly predominate in aide-patient relationships and which are apt to develop in any group of people who are in proximity with one another.

> "The first of these is the domination-submission pattern and is evident when one person is habitually submissive to another who wields power over him. In this instance the submissive person has a need to be dominated and controlled by someone else.
>
> "A second common pattern is the parasitic relationship in which the patient becomes totally dependent upon the aide and any occurrence may be interpreted as a threat to his existence. This type of relationship may be fostered between the patient with very strong dependency longings and the aide with a very strong or intense need to be a mother figure.
>
> "A third kind of interpersonal relationship is the supportive type wherein the patient is able to cope with everyday experiences only after attaching himself to another person who will support him. The supportive relationship is the one most helpful in usual aide-patient situations.

2. Intrapersonal interactions

"This type of relationship refers to the individual and his internal environment or that environment within the living organism.

"CONFLICT SITUATIONS MAY ARISE BETWEEN THE INDIVIDUAL AND EITHER HIS INTERNAL OR HIS EXTERNAL ENVIRONMENT." (Brown and Fowler, 1961, pp. 108-109)

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THERAPEUTIC RELATIONSHIP

1. What is a relationship?

"It is a stage of being mutually interested. It implies the interaction of two or more persons or things in which changes continuously occur. (Brown and Fowler, 1961, p. 103)

2. What are the two main groups of motives in aide-patient relationships?

1. The positive motive
2. The negative motive

The Positive Motive

"The positive motive, which is essential for any therapeutic aide-patient relationship, is a sincere interest in the patient and a genuine desire to help him.

The Negative Motives

"The aide may be merely curious about the patient. Although a degree of curiosity is usually essential for any learning, curiosity alone is not enough in establishing the desired relationship.

"The aide may become so scientific that she may forget she is working with another human being and consider him an object of scientific interest.

"In her contact with patients the aide may also be testing the strength of her own personality. She does this by exerting pressure upon the patient to act the way she wants him to act. Then, if she succeeds in getting him to perform accordingly, she feels good because it indicates to her that her personality is stronger than that of the patient.

"Another very common negative motive is an attempt to minimize or justify the existence of one's own conflicts through working with patients. The aide may do this by manifesting an attitude of superiority in feeling that 'the patient is so much worse off than I am.'

"Another motive is promoting personal gain irrespective of the patients's welfare through using 'trick' or skills indiscriminately. For example, if the aide is caring for a very difficult patient who refuses to eat and who wants to go home, she may promise him that he may go home immediately providing he eats all of his meal. If the aide knows that going home immediately is impossible for the patient and is merely making this promise because she wants to impress others with her skill, she is using her influence indiscriminately and not for the welfare of the patient.

"In addition, the aide may be acting out her own conflicts in relationships with patients. Let us consider the case of a young aide who is still struggling to free herself from her mother who persists in dominating her life. She has received an invitation to a formal dinner dance and has her heart set on a black net gown for the occasion. While shopping for the dress, her mother insists that a dotted swiss dress will be more appropriate. Consequently, she goes to the dance in the white dotted swiss. She feels that her evening is a 'flop' because she does not make the impression that she had anticipated. She somehow feels that her mother is to blame for ruining the evening and feels rather resentful, although she does not openly express any of these feelings. The next morning, she does not feel much like going to work and finds that many little things annoy her. One of her patients is more demanding that day; after the aide cares for him, he tells the aide that he has not applied the dressing correctly and that it will probably fall off before the morning is over. The aide responds with open hostility and sarcastically tells the patient that she knows what she is doing. From then on in her contact with the patient that day she will not give an inch and will not fill even the patient's logical requests. It is easy to see in this situation that the aide is acting out her conflicts about being dominated by her mother in her relationship with this patient.

"A final negative motive which we shall consider is that of caring for the patient merely because the doctor or instructor says that she should. This does not necessarily involve the desire to follow orders nor does it imply that the aide does not do as directed by the doctor or others, but if this is the primary motive in caring for the patient, an effective relationship will be impossible.

"Usually there is one basic motive which is predominant over all the others and provides the underlying theme for the individual's actions. However, in certain situations lesser motives may become dominant at various stages of aide-patient interaction. Even though one's relationships with others are usually characterized by positive motives, anyone is apt to find that negative motives are responsible for her actions in certain situations." (Brown and Fowler, 1961, pp. 103-105)

BASIC ASSUMPTIONS IN REGARD TO BEHAVIOR WHICH HAVE IMPLICATIONS FOR PSYCHIATRIC AIDES

1. "BEHAVIOR INCLUDES THE INDIVIDUAL'S TOTAL RESPONSE TO STIMULI.

   That is, total behavior can be said to be caused from either factors occurring within the person's body or from the person's external environment. For example, such vital functions as breathing and heart action are as much a part of our behavior as what we say and what we do.

2. "THE BEHAVIOR MANIFESTED BY AN INDIVIDUAL IS GOVERNED BY HIS AVAILABLE ENERGY, WHICH IS ALWAYS WITHIN THE RANGE OF HIS MAXIMUM ENERGY POTENTIAL.

   Although the individual's maximum energy potential will remain fairly constant, the amount of energy available to him at a given time may vary considerably. In this same respect, we find that the maximum energy potential varies from individual to individual. Therefore, the aide cannot expect the same output from all individuals nor can she expect the same degree from any one individual in all instances.

3. "ALL BEHAVIOR IS PURPOSEFUL. THERE IS ALWAYS A PURPOSE INVOLVED FOR THE PERSON BEHAVING.

   Since this assumption is basic in learning to understand people, it is helpful to think in the following terms when we observe someone's obvious action. What was he trying to accomplish? Was it in terms of maintaining something, gaining something or losing something? What did it mean to him. Likewise, we find that an individual's nonobvious responses may be viewed in the same manner.

4. "ALL BEHAVIOR IS A RESPONSE TO CHANGED CONDITIONS IN THE INDIVIDUAL'S TOTAL ENVIRONMENT.

   This statement means that all behavior has a cause even though it may be difficult to discover and even more difficult to understand once it is discovered. No response is thought to occur spontaneously without some stimulus to give it reason for happening.

5. "THE RESPONSE OF AN INDIVIDUAL IN A SPECIFIC SITUATION IS THE BEST THAT HE IS CAPABLE OF MAKING AT THE GIVEN MOMENT.

   The acceptance of this assumption will make it easier for the aide to accept the patient regardless of what his response may be. He may be responding as he does because of his low energy potential, because of his past experiences in a similar situation or because

of unknown factors. Nonetheless, it is a well-known fact that everyone utilizes all of his available potentialities to cope with his experiences.

6. "WHAT AN INDIVIDUAL PERCEIVES (INTERPRETS) IS HAPPENING TO HIM IS MORE INFLUENTIAL IN DETERMINING HIS BEHAVIOR THAN WHAT IS ACTUALLY HAPPENING TO HIM.

   We act and feel not according to what things are really like but according to our images of what they are like. According to this assumption, the aide may think that she is doing something helpful for the patient while he may perceive her action as something threatening; therefore, his response may be different from that which she anticipated.

7. "THE PROVISION FOR THE SATISFACTION OF THE INDIVIDUAL'S EXISTING NEEDS WILL ALLOW FOR THE EMERGENCE OF MORE MATURE NEEDS.

   This statement implies that nursing care must be consistent with the current level of the patient's needs and, unless we can provide for his needs of the moment, we cannot expect him to make progress. In terms of this assumption we can readily see why we meet with failure when we try to make the dependent, demanding patient more independent by ignoring his requests.

8. "THERE IS INHERENT IN EVERY INDIVIDUAL A POTENTIAL FOR STRIVING FORWARD.

   It is in this assumption that we find the expression of hope that people, in general, are still capable of progressing (going forward) as well as regressing (going backwards). Furthermore, the movement must come from within the individual. There is nothing the aide can do to the patient, but she can help him to get stronger and bring together the positive forces that will help him move forward.

9. "THERE IS BOTH OBVIOUS AND NON-OBVIOUS ASPECTS OF EVERY BEHAVIORAL RESPONSE.

   Verbalizations, actions and other outward manifestations represent the obvious aspect with the simultaneously occurring thoughts, feelings and the general state of the individual representing the non-obvious aspect of the response. If we consider only the obvious manifestations of a person's behavior, we will have little real basis for understanding him because outwardly two persons can appear to be doing exactly the same thing but their motives, feelings and other subjective experiences are quite different. Therefore, we can usually be accurate in saying what a person is looking at, but we cannot be certain what he sees. Likewise, we can readily say what someone is listening to, but we can never be sure what he hears.

10. "THE INDIVIDUAL IN OUR CULTURE SATISFIES MOST OF HIS NEEDS THROUGH RELATIONSHIPS WITH OTHER INDIVIDUALS OR GROUPS OF INDIVIDUALS.

From the moment of birth, each individual requires interaction with another person or persons if he is to survive, and this pattern of interaction continues to expand and become more elaborate as the individual grows." (Brown and Fowler, 1961, pp. 23-26)

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OBSERVATION SKILLS

1. What is observation?

"Observation is an active process which requires that we be alert to all the stimuli that are impinging upon us.

"Observation is a method of collecting data in order to discover something unknown. It is also an active process and a skill which requires the use of all our sense organs." (Brown and Fowler, 1961, p. 75)

> "ANY OBSERVATION THAT A SPECIFIC INDIVIDUAL MAY MAKE WILL BE INFLUENCED NOT ONLY BY HIS PAST EXPERIENCES AND HIS TOTAL CONDITION AT THE TIME BUT ALSO BY THE SKILLS WHICH HE POSSESSES." (Brown and Fowler, 1961, p. 75)

2. What are the characteristics of good observation?

1. "It is <u>PURPOSEFUL</u>.

For example--The aide may be observing and trying to communicate with a newly admitted patient for the purpose of collecting as much detailed data as possible about the patient in order to discover what may evoke the one little spark of interest in his new environment. This type of observation is fairly general and somewhat nonstructured in that the aide is not focusing her attention on any one aspect of the patient's behavior.

On the other hand, the aide may observe the patient for very specific reasons. For example--it may be important for an aide to observe the patient's reaction to his interview with the psychiatrist or to watch his specific reactions following a therapy. In this instance, the aide is focusing her attention upon certain aspects of the patient's behavior for very definite reasons. In many instances the aide may observe the same patient for both general and specific reasons, but regardless of whether the purpose is general or specific, it should always exist.

2. "It is <u>PLANNED</u>.

That is, the aide doesn't merely 'drop in' on a situation at any time she happens to be passing by but she arranges her work so that she can spend the major part of her time with her patients. <u>It is important that the aide make some general plans for the duration and number of observations that are necessary for the effective care of her patients</u>. Some thought should also be given to the interval between

observations. This last aspect is important not only for the aide to be assured of the patient's welfare or to have something to write on the chart, but it is also essential to obtain a fairly adequate sampling of observation data throughout the patient's stay in the hospital.

3. "It is OBJECTIVE.

Objectiveness means that there is truth in what one observes. Only experience can teach us this. However, we can sometimes improve our objectiveness by comparing our observations with those of others and discussing them in conferences so as to see how our data are similar or different from the observations of others. Objectiveness in observation doesn't apply only to observing the patient and his surroundings; it also refers to objectiveness in the intentional observation of oneself." (Brown and Fowler, 1961, pp. 77-78)

3. How does the aide function as an observer?

As an observer the aide has 3 functions:

1. The spectator
2. The participant
3. The introspectionist

THE SPECTATOR

"As a spectator the aide seems to 'look on' the situation with a minimum of interaction with others. However, in this activity she may act somewhat as a 'starter' to bring about desired reactions in others without actually participating actively in the situation. Through her very presence in the hospital environment, she may act as a stabilizing influence even though she is merely looking on. It is somewhat similar to the situation in which the child feels safe playing in the back yard because he knows that his mother is in the house and will occasionally look out the window. In the hospital we have seen the aide working nights acting as a spectator when she sits in the doorway of a room because a patient feels apprehensive and has requested her support. In other situations the aide as a spectator may keep out of the range of vision of her patients so that she may learn of their interaction when they are apparently unaware of her immediate presence.

"We have said that a minimum of immediate interaction occurs between the aide and the patient in that the aide is not participating with the patient at a given moment. This idea, however, does not imply that the aide herself is not active. The primary intention of the nurse is directed toward acting as a 'starter' to 'set off' an interaction rather than to become a primary part of the interaction.

"The terms 'starter' and 'spectator' also imply a factor of distance. We don't mean that the aide is rigid or emotionally cold and, therefore, goes about without feelings of her own. Since the aide is human we realize that she, too, has feelings and will express them in the spectator role, chiefly by her attitude. The distance factor merely means that the aide isn't primarily engaged in the interaction which she has 'set off.' The aide on a psychiatric unit is often seen to do this as she creates the non-specific emotional atmosphere on the ward which is so essential as a medium for the therapeutic care of her patients.

THE PARTICIPANT

"As the participant observer the aide is actively engaged in the interaction with her patient or some other person. This can be seen when the aide is participating in activities with a specific patient or group of patients. The aide carries out such a function when she interacts with the patient during a conversation or some nursing techniques that she is performing. Unlike the aide as a spectator, the participant observer's function is one in which the aide shares more with the patient. While she is participating she is also observing.

THE INTROSPECTIONIST

"As an introspectionist the aide observes herself. That is to say, she is able to recognize and understand her own reactions to others and her own reactions to herself. When you ask yourself, 'Why does Tom irritate me?' or 'How was I therapeutic in helping Mary to become less dependent upon me?' you are playing the role of the introspectionist. The skillful aide frequently observes herself when she has elicited some behavior in a patient she didn't expect.

"We can now see that the aide may perform all 3 observational activities in a given instant. The skill that the aide develops in observation will undoubtedly depend on her ability to observe and understand herself." (Brown and Fowler, 1961, pp. 80-81)

4. What are some factors that hinder the development of skill in observation?

   1. "Defects in the sense organs or other areas of the nervous system.

   2. "The false idea that most of us have about our ability to observe. It is unusual to find a person who is either aware or will admit that he is not always alert or observant of what is going on about him. As a rule, it is difficult to develop any further skill or to acquire any greater

understanding of a subject until we become aware of the level of skill or understanding already possessed. We first have to discover our weakness if we are to become skillful, and this discovery at the most may only make us feel inadequate temporarily.

3. "We are handicapped by the state of passivity which each of us has felt at some time or other. As we go about our daily activities, we tend to get into a rut to the degree that we take everything for granted. We seldom stop to think about the why of wherefore of anything and just drift along in our ignorance, actually unaware to three fourths of what is going on about us. We need to wake up and again become an active and constructive part of our environment if we would be good observers.

4. "Limited knowledge and experience with the type of subject being observed. Accuracy in perception requires at least familiarity with the particular kind of stimuli involved if they are going to have any meaning for us.

5. "Lack of motivation to develop skills in observation. As we all know, there can be little actual learning in anything unless there is a desire to learn. After fully overcoming the previously mentioned barriers, however, the individual ususally doesn't encounter a problem in motivation but thoroughly enjoys his growing awareness and alertness to the world about him." (Brown and Fowler, 1961, pp. 78-80)

5. Why does the aide observe psychiatric patients?

"A rather close bond exists between human beings when they share their feelings and experiences with one another. Because the aide spends considerable time with her patients it is only natural that she shares certain common experiences with them. It is for this reason that the aide is often able to furnish valuable information which no other team member has the opportunity to discover. The aide, therefore, can contribute much to the total care of the patient if she communicates to others what she has observed in her relationship with the patient. To the psychiatrist her observations offer considerable information which may help with the diagnosis and the treatment plan. She is also helpful to furnishing other members of the psychiatric team with information that will enable them to carry out their roles in the care of the patient more effectively.

"An extremely important reason for the aide to observe the patient is that she may anticipate his behavior and thereby prevent the patient from injuring himself or others. Close observation helps the aide to understand the patient better and, therefore, have a better relationship with him. The aide's observations also offer many implications for planning total nursing care and

evaluating such care. In addition, the aide gains considerable insight into her own behavior by self-observation. Such an understanding will not only improve her nursing care but will also help her to achieve maturity and to assume her functions as an aide more readily." (Brown and Fowler, 1961, pp. 81-82)

6. What are some important points to remember when recording observations?

"To record means to write down, to give a true account or description of a circumstance or incident.

1. "The use of psychiatric terminology is discouraged in objective recording. The notes are written in common, everyday descriptive language since it is much more important to tell exactly what the patient did or what he said than to know only what was characteristic of his actions. The person reading the notes will then be able to interpret what has been recorded and decide for himself whether or not certain behavior trends are evident. Just as psychiatric terms have different meanings for many of us, we find that some ordinary English words may also have somewhat different concepts to each of the persons reading the notes, although sometimes not to the same degree. A more accurate communication of observation is possible, therefore, with a minimum use of psychiatric terminology and an emphasis upon descriptive terms.

2. "Personal opinion and interpretation are minimized in good recording.

3. "The information is recorded as soon as possible after the incident has been observed. The aide should arrange her work to enable her to record her observations at intervals throughout the day.

"Therefore, when we record observations of behavioral information as descriptive details of the interaction that took place and include a minimum of personal interpretation and feeling, we will be apt to communicate a true account of what actually occurred." (Brown and Fowler, 1961, pp. 82-83)

COMMUNICATION SKILLS

"It has been said that every individual has a need to communicate. Communication with self and with others helps people to relate to one another and this relationship, in turn, serves as a channel which provides for and helps further communication. Communication involves sharing with another what is primarily one's own and implies an exchange of actions. We exchange views, express our inner thoughts and feelings by both verbal and nonverbal means.

"That which is communicated may be thought of as signals which cause a certain response in the other person, and their communication may be intentional or unintentional. We can determine the success of a communicative act in relation to the reduction of tension experienced by the first one who talks. This reduction of tension is believed to be closely related to the degree of understanding which the other person gives the person who's talking first. We have all been in situations where we experienced pleasure from the release of tension following a successful communication, as contrasted with the persistent and increased tension we have experienced when our attempts to communicate have failed.

"When a person says something, his anticipations may vary from expecting that he'll either be understood or misunderstood or that his message will be distorted; consequently, with this orientation he directs his attention toward the other person's responses. ACKNOWLEDGEMENT is a response which shows that the other person accepts the content. So, in person-to-person contacts, we see people trying to secure acknowledgement of their communications. There are 4 possible forms of acknowledgement which have been identified in the process of communication.

> "The first form involves understanding and requires a warm and accepting attitude on the part of the other person, who responds in such a way that the first person who talks knows that his message has been received and really understood and as a consequence, experiences a sense of well being.
>
> "In the second form of acknowledgement, the other person responds in such a way that the first person who talks knows that his message has been received but that it has <u>not</u> been understood although the other person communicates an attitude of readiness to listen further, of wanting to understand. In this interaction, when the first person who talks gets the signal that this person wants to listen and will try to understand his communications, he experiences satisfaction almost to the same degree that he would have had his message been understood.

> "A third form of response involves mutual agreement, wherein the other person discovers and signals to the person who talks first that he is in complete acceptance with the content, that he sees it the same way. Both the one who talks first and the other person experience pleasure from reaching an agreement, although this is thought to be different from the pleasure experienced in being understood.
>
> "The fourth possible response involves mutual disagreement, wherein acknowledgement may be varied. First of all, the other person may not give any acknowledgement that the message had been received and may get up and leave. On the other hand, he may respond, and the communication progress disintegrates in the ensuing battle.

"Phases of understanding, lack of understanding, agreement and disagreement are believed to occur in the process of any healthy, potentially successful communication, but when disagreement and misunderstanding become the end goals, the process becomes destructive.

"Since everyone wants to be understood, we realize how very important our responses are to the communications of others. It will be helpful to study our non patterns of communication and become alert to the kinds of acknowledgement we give and the reaction of others to these responses.

"This achievement gives us a sound basis for learning to communicate meaningfully with people. For practical purposes, communication will be divided into the verbal and nonverbal aspects, although we seldom have one without the other." (Brown and Fowler, 1961, pp. 85-86)

1. What is verbal communication?

   > "By verbal communication, either written or oral, we mean that which involves the use of words for the purpose of conveying and clarifying one's ideas, thoughts and/or feelings to others. Unless the person or persons to whom we are trying to tell something to understand the communication, the process is incomplete." (Brown and Fowler, 1961, p. 87)

2. What is nonverbal communication?

   > "Nonverbal communication includes the attitudes, feelings, and thoughts that we convey either on purpose or otherwise through such media as our posture, gestures, facial expression, vocal tone and change in tone.
   >
   > "This type of communication is probably one of the most powerful tools available when used knowingly under the direction of the

individual. In this instance, the term powerful means the degree of influence within the process. In any situation where two or more persons interact, this nonverbal communication is inevitable. It may, therefore, be readily seen that a negative influence may result just as easily as a positive one.

"For example Miss Smith, an aide with very definite standards in regard to the indiscriminate use of drugs found that she was to care for Jim, a 17 year old boy who had been using drugs in excess, who was admitted the previous evening. Miss Smith considered herself a liberal, nonprejudiced individual and was not consciously aware of her true feelings in this respect. She assisted Jim with his routine morning care as she thought she would care for any other patient. However, after breakfast Jim asked, to her surprise, 'Why do you dislike me so? Have I offended you in any way?' Although she tried to reassure him that she liked him, his first impression prevailed.

"In this instance, the aide's disapproval of the patient's behavior was communicated to him without her being aware of it. As is illustrated here, it is very difficult to mask one's true feelings about a given idea or action, and it is practically impossible when the individual is not consciously aware of them himself. Since it is a natural tendency for people to disapprove of the behavior of others which is contrary to their own personal standards, the approval or disapproval of the actions of others is one of the easiest to communicate. The aide should constantly be alert to this fact.

"Usually we find that the proximity of the two persons involved enhances the readiness of the communication, as brought out in the example. Jim might not have become aware of the aide's feelings about him so early in his hospitalization if he had not had direct contact with her. On the other hand, it is also believed that the more intense the feeling the less direct the contact need be for the communication to take place.

"As has been implied in the inevitability of this type of communication, it is such a natural process that we often ignore it or are not even aware that it has taken place. We may find that patients don't always respond so directly as Jim did to the communication of feelings. Nevertheless, we know that they are aware of the atmosphere which is created, whether it be pleasant or unpleasant, accepting or critical.

"In interpersonal situations, feelings and gestures seem to have a mandatory function. They not only direct the other person's behavior but they also prolong and sustain certain reactions and disrupt others. That which we communicate to others on this nonverbal level is an extension of our attitudes, and it is this communication which has so much influence in evoking response in others. This feeling tone which we communicate to others and they

communicate to us is an important factor in appraising the friendliness of people. This feeling tone which is communicated may be one of friendliness and warmth, one of coldness and hostility, one of primarily increased tension, or one of 'nothingness' depending upon the amount or degree of protective covering the person wears. Have you ever had the experience of interacting with someone from whom you received no feeling tone? These experiences are puzzling because we lack the data which give meaning to what is going on. It is like a song without a musical score, which becomes something entirely different when we add the music.

"Another clue in appraising the friendliness of people is the physical distance which they maintain between themselves and others. We desire intimate contact with people with whom we are familiar and comfortable, so we bridge the distance between us and come close to these persons. On the other hand, we desire to keep people with whom we feel strange and uncomfortable at a distance, so we stay away from them and keep them as remote as possible.

"Verbal and nonverbal communication usually occur at the same time, and it is often difficult to separate them when observing an actual situation. It may be helpful now to consider some of the communication tools in more detail." (Brown and Fowler, 1961, pp. 88-90)

TECHNIQUES OF COMMUNICATION

ADVICE

"Although this technique is available and popular, it is not very effective as a therapeutic tool. Advice presupposes that one individual is not capable of directing his own activity--therefore, the two individuals are on different planes. The person giving advice selects the goals and directs the other person toward these goals. Advice, if accepted and acted upon, fosters dependence. The person who seeks advice seldom really desires it, and it may serve as a springboard for projecting the blame for failure in the future. Advice may be helpful in relieving acute anxiety, but even here it is purely supportive and the relief is only temporary. The aide, therefore, will rarely encounter a situation in which this method is indicated.

APPROACH

"Usually when we think of approach, we think of coming nearer to something or of reducing the distance between two objects, but in nursing the term often refers to the planning or thinking which is sone prior to any action which is taken.

"Let us briefly consider the two types of approach, the VERBAL and the PHYSICAL. The verbal approach is the most common and occurs whenever the aide makes contact with the patient by use of the spoken word, such as when she greets her patients or when she explains what is to be done before a plan of treatment is started. Seldom do we find an instance where the verbal approach is not indicated and, even though a patient seems to be unaware of what is going on, he will often respond if the aide takes the initiative through the verbal approach.

"One of the most important aspects of the verbal approach to patients is the nonverbal communication which inevitably accompanies it. The tone of the aide's voice, her inflection, and her general manner as she makes this contact influence the patient's response to her.

"The physical approach is any direct contact the aide makes with the patient by means of touch. It is sometimes used as an emergency measure. For example, if the aide suddenly comes upon a patient who is harming himself or others, it may be necessary to make a physical approach; but the need for such approaches can be minimized if close observation is maintained.

"Should an instance arise in which it is necessary to control the patient's activity by physical means, a verbal approach used at the same time makes the contact more effective. If the aide makes no

attempt to communicate her intentions to the patient, he is apt to misinterpret the aide's action and require firmer methods of control.

"While there are some patients who respond better to a purely verbal approach, there are other patients whose response is better if there is some physical contact with the verbal approach.

FACTORS TO CONSIDER IN DETERMINING THE PLAN OF APPROACH:

"The first factor to consider is the aide herself. The aide should examine her own attitude toward the patient and determine whether it is positive or negative. That is, is she attracted toward the patient or is her first impulse one of avoidance? A positive attitude is essential for creating an atmosphere of acceptance. While it may not be possible to have a positive attitude toward all patients, a knowledge of her attitude will help the aide in determining the plan of approach. Closely related to this attitude of acceptance is the factor of tolerance. By tolerance we do not mean that the aide should merely tolerate the patient's behavior nor should she necessarily approve it. Tolerance implies a noncritical, noncondemnatory attitude on the part of the aide regardless of the patient's behavior.

"Another factor which the aide will consider is her interest in the patient. Is she caring for the patient merely because he is assigned to her, or does she have a genuine interest in helping him to regain his health?

"The next factor to be considered is the patient. An approach based upon an understanding of the patient and his problem is most apt to bring the desired results. The aide should be able to anticipate the patient's reaction fairly accurately if she has this understanding. One important question for the aide to consider is, how is the patient apt to interpret the situation? Will the patient interpret her actions as helpful or will he feel threatened? Then, what level of approach will be necessary to communicate her intentions to the patient? Is he one who readily understands the spoken word, or will it be necessary to reinforce the spoken word with a physical approach?

"The aide then determines her purpose in approaching a particular patient, In considering the purpose we usually think in terms of both the immediate and long-term goals for the patient. Whereas the immediate goal for approaching the patient may be to help the patient to dress, a long-term goal may be to help the patient to become more independent and capable of making his own decisions. Therefore, both the immediate and long-term goals have to be considered within the framework of the over-all plan for therapy.

IMPORTANCE OF APPROACH:

"Approach has always been given an important place in psychiatric nursing probably because the first impressions gained by the patient influence his immediate and over-all adjustment to the hospital

situation. Just as the first approach made to the patient as he enters the hospital is often important in influencing his reactions throughout his hospitalization, so may the first approach to a patient on a given morning set the pace for his reactions throughout the day.

"Planning the approach usually fosters more consistency in providing therapeutic care for patients. In some situations where the staff is team orientated, the physician prescribes the approach attitude which is to direct the personnel in the care of a given patient. For example, the physician may indicate that the staff should be actively friendly toward a certain patient. On the other hand, a matter-of-fact approach may be more appropriate. These more specific directions of attitudes are very helpful in aiding the staff to be more consistent in their contacts with patients. It is, then, the function of the aide to determine her action in situations as they arise in order to follow through on the directions.

SUGGESTION

"Suggestion as a communication technique includes both encouragement and reassurance, and if used effectively, can be a powerful tool in helping the patient to change his behavior. First, the aide uses this method by being an example of an effective person. As we know, a demonstration is helpful whether we are learning new skills or refining old ones. It is sometimes helpful to encourage the patient and comment on any progress, no matter how small. For example, 'You're feeling better,' or 'You're improving.' We do this in hope that it will strengthen the patient's motivation in that direction. Suggestion is also helpful in getting patients to participate in, or to refrain from, ward routines and certain activities. For example, a patient may wish to clean out her closet at 4 P.M. The aide might say, 'Why not wait until after dinner when you'll have more time.'

"Suggestion should always be positive, the aide's selection of words is most important. For example, it would be more appropriate to say, 'How about playing checkers?' rather than, 'You wouldn't like to play checkers, would you?'

"Another important way in which an aide uses suggestion is through her nonverbal activity. This is especially true with certain patients who seek constant reassurance and who are afraid. How the aide acts and the attitudes she communicates with this type of patient will be far more effective than any verbal communication she may attempt. By these nonverbal cues, the aide can give the patient the reassurance that he is not being "laughed at" or criticized. Another way in which the aide may provide reassurance for the patient is by her neutral response when the patient says or does something that frightens or embarrasses him.

LISTENING

"Listening is another skill involved in communication and the role of the aide as a listener cannot be overemphasized. Developing skill as a listener is one of the most difficult tasks confronting an aide in psychiatry. This difficulty evolves primarily from two factors, nursing tradition and the aide herself. The aide is usually taught that the "good" aide keeps busy doing things for people. The emphasis has long been upon the use of material objects and procedures which require a manipulation of these objects. In the role of a listener, the aide is, to all appearances, very passive and very definitely lacks material objects to manipulate. The aide herself very often feels that she is not doing anything constructive and is wasting time. Therefore, she is apt to feel guilty because of her previous teachings. Therefore, prior to developing any degree of skill as a listener, the aide must become aware of her own feelings when she is placed in this role. If such situations are anxiety provoking, she must develop some means of handling her anxiety other than through manipulating material objects.

"In the role of a listener the aide also plays another role--that of the participant observer--which clearly defines how active her function really is. The aide's role as a listener may be planned or it may be incidental. Since the aide does not always know what role the patient will give to her, she should be flexible. Not only is the listening role very time consuming, but it requires great patience on the part of the aide, since we tend to feel ill at ease when periods of silence occur in our contact with others. Our first impulse is to fill in these gaps by a comment or a question, but we can fuction best by learning to wait, and as is often said, to show respect for the periods of silence. It may be that the patient is afraid to go on, or it may be that he does not know just how to express what he wants to say. If his train of thought is interrupted, the opportunity may not again arise for him to express this particular thought. As long as the patient feels pretty much at ease, it is often most helpful if the aide refrains from comments. On the other hand, if the patient is obviously becoming more tense and shows signs of embarrassment, a pertinent remark or question by the aide may enable him to continue talking.

"The role of the aide as a listener is also tied up with the use of conversation as a technique of communication.

"It is a well-established fact that the more immediate the opportunity for discussing a disturbing experience, the more effective is the relief provided through talking about it. Whether or not patients will be encouraged to talk will depend upon the directions given by the individual therapist. Only if the aide is aware of the plan of therapy and how far the patient has progressed in his therapy will she be able to function as a positive factor in cooperating with the physician and othersconcerned with the patient's welfare.

"In summary,we might say that a good listener is interested in what is being said and shows this interest through his posture and attention and other nonverbal cues rather than frequently interrupting to tell what he might have done in a similar circumstance. Since a complete absence of response may be interpreted as a lack of interest, the aide may make brief relevant remarks to indicate that she knows what has been said. As the aide becomes more sensitive to the feelings of others, she will be able to determine more readily when to remain silent and when to comment. A good listener is one who concentrates on what is being said and the feeling that is being communicated rather than on what he is going to say when the opportunity arises.

CONVERSING WITH PATIENTS

"Although conversation is usually considered a game of social contact in which there is a mutual exchange of ideas, the aide uses identical techniques and skills in working therapeutically with patients. Since there is an exchange action involved, it is implied that the aide talks 'with' rather than 'to' patients.

MEANINGFUL COMMUNICATION

"In spontaneous conversation, the aim may be varied. The aide may be attempting to get acquainted with the patient or the patient with the aide. It may offer a brief interlude of social interaction for the patient and help him to feel more a part of the situation. An opportunity for the patient to practice various skills may be provided by incidental conversation. Much can also be accomplished through relieving some of the inevitable boredom experienced in the usual hospital situation by occasionally stopping in to 'pass the time of day.' In certain instances it may be beneficial merely to divert the patient's attention from his current thoughts or problems by keeping him engaged in conversation. For example, a patient who is undergoing intensive individual psychotherapy may suddenly begin to talk of his intense dislike for his mother. The aide, knowing that this was one of his basic problems unacceptable to him previously, may wish to divert his attention and save his communication for his conference with his doctor later in the day. However, she should be reasonably sure she is only postponing the communication and not stifling it completely.

HELPFUL HINTS

"During their initial experience, some aides find it easier to converse with an individual patient, whereas others find it easier to converse with a group of patients. She can usually become more skillful if she begins where she feels most at ease and then gradually broadens her contacts to include both the group and the individual.

"In initiating conversation with both groups and individuals, the aide may find it helpful just to start talking about some commonplace topic which is not apt to provoke intense feelings, either negative or positive. A few of the topics which may be suitable in initiating such a conversation would be the weather, food, an event that is to take place in the near future, comments on something that is observable from the window, and so forth. To become a good conversationalist requires both effort and practice just as in the acquirement of any other skill.

"The main difference between diversional conversation with patients and conversation with friends is that one does not relate details of one's personal life to patients.

THERAPEUTIC CONVERSATION

"There are certain requirements in a situation if the use of this technique is going to work. First, the persons involved should be relatively close to each other. Second, an approach is necessary to start the conversation. This may be on the part of either the aide or the patient. Third, there must be a common means of exchange; that is, both persons must speak and understand the language or other symbols used. Fourth, there should be a feeling of freedom or trust on the part of both persons.

"The aide carries on spontaneous conversation with all patients, but those she converses with therapeutically are a select group. In order to function in this manner, the aide must be fairly sensitive to the feeling tones in the situation and she must be fairly sure of what she thinks is going on. In contrast to the speaking acquaintance which the aide has with all patients, her relationship with these select patients is on a different level.

"This type of relationship presupposes that the aide has an understanding of the patient and his problem and also assumes that she has a basic understanding of human behavior. All aides may not be able to use conversation as a therapeutic tool without special preparation and additional experience. When the aide does function in this manner, she usually does so in cooperation with the physician and other team members.

"Although the conversation may be started by the aide, the course of the conversation is decided by the patient. In one respect the aide serves as a sounding board for his thoughts, ideas and feelings. The aide avoids the use of direct and leading questions, and it may be helpful to use statements in the beginning which cannot be answered by "yes" or "no." The verbal activity of the aide is at a minimum with the patient doing most of the talking. The aide encourages the patient to talk by her nonverbal activity, such as nodding or various other gestures. If verbal activity becomes necessary, sometimes just a word such as "well" or "really," will enable the patient to continue. Another method of encouraging

patients to continue talking is to repeat their last thought or word expressed. Of course, one must be fairly certain of how the patient really does feel. The patient can usually be encouraged to elaborate or clarify by using such phrases as, 'Can you give me an example of that?'

"In this type of conversation the aide's attention is primarily on the feelings that are being expressed or the latent meaning of the patient's expression rather than on ther verbalized content as such." (Brown and Fowler, 1961, pp. 90-99)

ANXIETY

"A basic element of behavior is anxiety, which is a feeling state felt when a person is in some way threatened or believes himself to be in danger. This is a very unpleasurable state, or feeling. Although the actual danger may be unknown, the individual responds as though the threat came from the external environment and can only be dealt with by attacking it or running away from it. The unpleasant feeling tone is felt to be all over and is persistent and gives rise to a feeling of helplessness. In our culture, anxiety seems to be directly related to the anticipation of a loss of self worth by oneself or by others. Whenever anything happens which threatens to disturb one's usual pattern of interacting with others, one tends to experience anxiety. It is generally agreed that the experiencing of anxiety happens to everyone; therefore, the important thing is how the individual learns to cope with it." (Brown and Fowler, 1961, pp. 22-23)

EMPATHY

1. What is empathy?

   Empathy is the ability of a person to understand and appreciate what another person is feeling, and be able to communicate this understanding to him.

2. What are some characteristics of an empathic person?

   An empathic person is open to other's feelings and ideas, is flexible, warm, optimistic, spontaneous, and controlled in her emotions. She also can be described as being pleasant, friendly, cheerful, sociable, sentimental, imaginative, and tactful. (Hogan, 1969, pp. 307-316)

3. What are some characteristics of a non-empathic person?

   A non-empathic person is cruel, cold, quarrelsome, hostile, bitter, unemotional, unkind, hard-hearted, argumentative, opinionated, and carries a chip on her shoulder. (Hogan, 1969, pp. 307-316)

There is no such thing as a person who is 100% empathic or 100% non-empathic. However, it is our goal to be as empathic as is possible for us.

The degree of empathy that a person has is seen by the way he interacts with others.

4. What are some guidelines for the communication of empathy?

   "THE ULTIMATE PURPOSE OF THE EMPATHIC RESPONSE IS TO COMMUNICATE TO THE PATIENT A DEPTH OF UNDERSTANDING OF HIM AND HIS PREDICAMENT IN SUCH A MANNER THAT HE CAN EXPAND AND CLARIFY HIS OWN SELF-UNDERSTANDING AS WELL AS HIS UNDERSTANDING OF OTHERS." (Carkhuff, 1969, p. 202)

   The guidelines are as follows:

   1. "THE AIDE WILL FIND THAT SHE IS MOST EFFECTIVE IN COMMUNICATING AN EMPATHIC UNDERSTANDING WHEN SHE CONCENTRATES WITH INTENSITY UPON THE PATIENT'S EXPRESSIONS, BOTH VERBAL AND NONVERBAL.

      "The aide's intense concentration upon the patient's verbal, postural, facial, and gestural expressions enables the aide to employ all possible cues to understanding the patient's frame of reference. The key requirement for the aide is a high energy level--thus the aide is free enough to listen and to hear another person. The aide's intense concentration minimizes the possibility of premature judgements and their resulting errors.

2. "THE AIDE WILL FIND THAT INITIALLY SHE IS MOST EFFECTIVE IN COMMUNICATING EMPATHIC UNDERSTANDING WHEN SHE CONCENTRATES UPON RESPONSES THAT ARE INTERCHANGEABLE WITH THOSE OF THE PATIENT.

   "Particularly during the early stages of communication learning, it is critical that the aide insure for herself that she is attuned to the affect and meaning of the patient's expressed experiences.

3. "The aide will find that she is most effective in communicating empathic understanding when she formulates her responses in language that is most attuned to the patient.

   "Since the purpose of empathic responses is to communicate to the patient in a manner that the patient is best able to employ for his own purposes, then the aide's language must reflect her ability to assume the patient's frame of reference. This is not to say that the patient's frame of reference is a healthy one. Rather, during the initial phases of learning particularly, it is critical that a basis of communication be established in which the patient has the experience of being understood.

4. "THE AIDE WILL FIND THAT SHE IS MOST EFFECTIVE IN COMMUNICATING EMPATHIC UNDERSTANDING WHEN SHE RESPONDS IN A FEELING TONE SIMILAR TO THAT COMMUNICATED BY THE PATIENT.

   "Communication in a feeling tone similar to that of the patient provides the patient with the beginning base of empathic understanding. The patient becomes aware that the aide is tuning in on his wave length not only with an intellectual comprehension but also with a feeling of understanding. At points the aide may even express more depression or anger or elation than the patient in his restricted presentation has been able to express. In this manner the aide enables the patient to experience and express feelings he was not before able to experience and express.

5. "THE AIDE WILL FIND THAT SHE IS MOST EFFECTIVE IN COMMUNICATING EMPATHIC UNDERSTANDING WHEN SHE IS MOST RESPONSIVE.

   "This does not mean, of course, that there is no place for relative inactivity or extended periods of silence when they are appropriate. However, the more frequently the aide responds to the patient, the less likely she is to deviate from the way the patient experiences the world or the more likely she is to be aware that she is deviating a lot from the patient's problem.

6. "THE AIDE WILL FIND THAT SHE IS MOST EFFECTIVE IN COMMUNICATING EMPATHIC UNDERSTANDING WHEN SHE EMPLOYS THE PATIENT'S BEHAVIOR AS THE BEST GUIDELINE TO ASSESS THE EFFECTIVENESS OF HIS RESPONSES.

"Ultimately the aide functions to benefit the patient. If the patient is unable to make constructive use of the aide's verbalizations, no matter how brilliant the verbalizations might otherwise appear, then the helping process has not been effective. However, if the aide initially lays a good communication base and gives empathic responses, she will find that the patient is intenselyand accurately attuned to the aide's own verbal and nonverbal expressions." (Carkhuff, 1969)

ROLE PLAYING

1. What is role playing?

   Role playing is a method of act-out an experience that has happened or could have happened.

2. How will we be using role playing during this training program?

   We will be using situations which involve psychiatric aides and disturbed children. However, there will be no "real" patients involved. We will all contribute in making up the situations which will be acted-out.

   One member of the group will play the role of the "psychiatric aide" in the situation, and another group member will play the part of the "disturbed child." After the role playing situation has been acted-out by the aides, group discussion will follow. We will discuss the feelings involved between the "psychiatric aide" and the "patient," and also what observation and communication skills were used or were not used.

   We will also try to understand how the "patient" may have felt during the situation and why he felt that way. We will discuss other possible ways that the situation could have been handled by the psychiatric aide. There is no one correct solution to any role playing situation.

SUMMARY:

Through role playing situations we will attempt to practice the observation and communication techniques and skills which we have learned in earlier sessions. We will also try to "put ourselves into the patient's shoes" during our role playing situations. We will try to find ways of using our skills in the most therapeutic ways and therefore helping the children, and becoming less frustrated ourselves.

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ASSIGNMENT #1

DUE WEDNESDAY, JAN. 27, 1971

NAME:

DATE:

TO DO THIS ASSIGNMENT, REFER TO YOUR INFORMATION ON "MENTAL HEALTH AND MENTAL ILLNESS" AND ALSO ON "HUMAN BEHAVIOR."

1. Think of a child on the ward who you know. DO NOT write a name.
2. List at least 5 characteristics that you have observed of this child's behavior.

3. Where would you place this child on the mental health and mental illness continuum? Mark the place with an "X".

Mentally healthy	Fairly mentally healthy	Mentally ill

Why did you place the child here?

4. What did you think of this assignment? Include negative as well as positive remarks. Include any difficulties you had. Would you like more assignments in the future?

ASSIGNMENT #2

DUE TUESDAY, FEB. 2, 1971

NAME:

DATE:

TO DO THIS ASSIGNMENT, USE THE SAME PATIENT YOU USED IN ASSIGNMENT #1.

1. Write down some of your ideas of WHY you think this child is demonstrating this kind of behavior (as you listed in Assignment #1.)

2. Can you better understnad his behavior?_____
Why?

3. What are YOUR feelings or attitudes about working with this child?

4. What do you think this child's most obvious needs are?

5. How would you try to meet these needs in therapeutic ways?

6. What did you think of this assignment? (Answer on back of paper if you need more room).

ASSIGNMENT #3

DUE TUESDAY, FEB. 9, 1971

NAME:

DATE:

TO DO THIS ASSIGNMENT, REFER TO YOUR READING ON "BASIC ASSUMPTIONS IN REGARD TO BEHAVIOR WHICH HAVE IMPLICATIONS FOR NURSING."

You have already picked one of the ten basic assumptions.

Your assignment is to understand this assumption and explain it to the group Tuesday, Feb. 9. Give examples if this will help. You will have about 5 minutes to explain your assumption.

I am available if you need help with your assignment.

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ASSIGNMENT #4

DUE WEDNESDAY, FEB. 10, 1971

Our class Wednesday, February 10 will be on Communication Skills. All members of the group are expected to read the information handed out on "Communication Skills" before class.

Each aide will be responsible for knowing two pages of the information very well. You will pick your two pages in class Tuesday.

Your assignment is to be able to explain and give examples to the other group members about your information (on your two pages). This will help everyone understand the information better.

Since there are 10 pages on "Communication Skills," there will be two aides who will be responsible for the same two pages. You can work together or individually.

The information is divided in this way:

1. Communication Skills

2. Verbal and Nonverbal Communications

3. Techniques of Communication
   - Advice
   - Approach
     - Factors to consider in determining the plan of approach
     - Importance of approach

4. Techniques of Communication
   - Suggestion
   - Listening
   - Conversing with patients

5. Meaningful Communication
   - Helpful hints
   - Therapeutic Conversation

ASSIGNMENT #5

DUE TUESDAY, FEB. 23, 1971

We will be doing role-playing situations beginning Tuesday. These will be dealing with the patients who have <u>feelings of anxiety</u> and those having <u>feelings of distrust</u>.

To do this assignment you will be working in pairs. You will decide who you would like to work with.

Your assignment is to think of a situation that <u>really did occur</u> on the ward and that involved you (or your partner) and a patient (either one with feelings of <u>anxiety</u> or one with feelings of <u>distrust</u>). The situation should be one that you felt was a "problem"..one that you <u>did not think was therapeutic</u>. You and your partner will be given 4 index cards. They will be filled out like this:

Card #1: Describe the "problem" situation...where did it occur, what time of the day was it, who was involved in the situation itself, who else was around (personnel & kids); and generally what happened.

Card #2: Describe your feelings at the time the situation occurred and what you said to the patient during the interaction. Include non-verbal messages...your facial expression, tone of voice, posture, gestures.

Card #3: Describe what you think the patient was feeling at the time of this situation and what the patient said to you during the interaction. Include his non-verbal messages too.

Card #4: Briefly describe why this was a "problem" situation...<u>not</u> therapeutic.

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ASSIGNMENT #6

DUE TUESDAY, FEB. 23, 1971

NAME:

DATE:

LIST FIVE (5) GENERAL CHARACTERISTICS OF EACH:

I. A patient with feelings of anxiety:

1.

2.

3.

4.

5.

II. A patient with feelings of distrust:

1.

2.

3.

4.

5.

III. A patient with feelings of worthlessness:

1.

2.

3.

4.

5.

IV. A patient with feelings of elation:

1.

2.

3.

4.

5.

V. A patient with antisocial feelings (Example: Sociopathic tendencies)

1.

2.

3.

4.

5.

APPENDIX B

Levels of Accurate Empathy

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ACCURATE EMPATHY[1]

Level 1 - Ignoring client and client feelings. The counselor obviously fails to respond to client feelings when given opportunity to do so.

The counselor changes the subject, talks about himself and his own experiences, or gives lectures.

Level 2 - Responding inaccurately or partially. The counselor may almost restate the client feeling. Often counselors mention a synonymous feeling but miss the intensity of the client. Questions are rated at this level if they show an interest in the client.

Examples: "You seem to kind of, uh, almost feel mad."
"Why do you suppose you feel this way?"

Level 3 - Minimal Help. The counselor communicates an essential understanding of the client's message -- feeling and content. Without adding any material of his own, the counselor communicates essential understanding of the client.

Level 4 - Responding accurately to client feeling. The counselor communicates accurately the feelings of clients even if the client has not yet stated the feeling. The counselor facilitates client self-exploration by labeling feelings as the client begins to become aware of them.

Level 5 - Responding accurately and completely to the deepest feelings. The counselor is with the client at a time of peak feelings -- positive or negative. His voice shows the similarity of his own feelings and reactions to those expressed by the client.

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[1]Robert R. Carkhuff. Helping and Human Relations. New York: Holt, Rinehart and Winston, 1969.