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A rules-based study of nurse-geriatric patient communication

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A RULES-BASED STUDY OF

NURSE-GERIATRIC PATIENT COMMUNICATION

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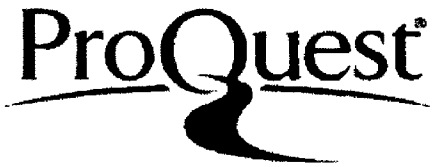

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A Rules-Based Study of Nurse-Geriatric Patient Communication

Director: Dr. Wesley N. Shellen

The purpose of this study was to determine whether education, length of experience, and role in the nursing home affect perceptions of communication rules pertaining to sexuality and the aged. The rules were derived from an extensive review of the nurse-patient communication literature. Scenarios based on the rules were presented, with adjective scales used to rate the behavior of a care-giver in each scenario. Through Analyses of Variance, differences in the responses of bachelors-degree nurses, associates-degree nurses, nurse aides, and geriatric patients to four types of scenarios were measured. The four types of scenarios pertained to sexual activity of geriatric patients, touch/affection behaviors of patients and staff, issues of sex role in the nursing home, and other issues.

Statistically significant differences in the perception of communication rules were found. Care-givers in the scenarios were rated higher by geriatric patients than by any of the staff. This was true even pertaining to scenarios depicting rule violations by care-givers. The patients' higher ratings may reflect a sense of powerlessness. Associates-degree nurses consistently differed in rules perception from nurse aides and bachelors-degree nurses. The perceptions of rules by bachelors-degree nurses and nurse aides were in greater conformance with textbook rules and were more sensitive to various types of scenarios than were the perceptions of rules by associates-degree nurses. Experience was not found to be a significant variable affecting the perception of rules by care-givers.

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> Whether we realize it or not, every patient goes through a process of socialization in which he learns the norms of the different professional groups and determines how his own norms fit with the professional ones (Leininger, 1970, p. 157).

Chapter 1

INTRODUCTION

GOAL

The goal of this study was to determine whether education, length of experience, and role in the nursing home affect perceptions of communication rules pertaining to sexuality and the aged. Subjects in the health care setting were tested using a series of scenarios. The subjects rated a care-giver in each scenario using twelve adjective scales. Analysis of variance was used as the statistical technique for analyzing the differences in response to the scenarios by the subjects using the following variables: education, experience, and role in the health care setting. The differences in response by the subjects to four types of scenarios were analyzed: those related to explicit sexual behavior, those related to touch/affection behavior, those related to sex role

behavior, and those dealing with other types of behavior.

OPERATIONAL DEFINITION OF TERMS

Two terms integral to this study require clarification. The first is: Rule. In arguing for a research methodology suitable for the study of man, Romano Harre (1974) specified that such a methodology must take into account man's unique ability to choose his course of action. Communication rules contribute to a sense of order and meaning out of which man can chart his own course. Rule must be understood, then, to be a tool in the everyday life of all of us. Rules are not necessarily explicit, often not institutional and do not connote authoritarianism or mechanism. Rules are one means by which we organize and make sense of our world and our communication with others (Cushman and Whiting, 1972).

The second term requiring clarification is: Sexuality. In addition to the expression of physical passion, sexuality should include efforts to maintain a gender identity through dress, grooming and social customs. Sexuality will also include behaviors which express sensuality and affection. Sexuality in the study of the elderly takes on a broader meaning than might be

the case for the study of younger generations. Burnside argues that in geriatric settings, residents seek to be close to one another for the sensual pleasures of warmth and security of balance (Burnside, 1976). Touch will be included as a sexual behavior under these conditions.

RELEVANCE OF THE PROJECT

The rules examined in this study were derived from nursing textbooks and were chosen to represent "strategic" (Spradley, 1980, p.18) areas of nurse-geriatric patient communication. In the present study, indications from the nursing literature were used to determine what is most in need of empirical examination. The geriatric setting in general is a fertile field for communication study because of the long-term residency and the common sense of loneliness and abandonment felt by patients. Further, demographics point to the need for special attention to geriatric care.

Reinhardt (1979) presents statistics on the rising proportions of the population which will require geriatric care.

> Four percent of the population in 1900 was over 65 years of age, almost 11% was in 1976, and by the year 2030 a projected 17% to 20% will be in that age group. In fact, those

> people over 85 years of age are the fastest growing age group in the country (p. ix).

This increasingly large segment of our population is affected by communication rules pertaining to sexual conduct, including touch behaviors and concepts of sex role. Barnett (1972) found that the least frequently touched group in the health care setting was the elderly, 66 to 100 years old. Hollinger (1980) further pointed out how significant the deprivation of touch experiences might be for geriatric patients. The elderly undergo serious changes in body image and diminishment of distance receptors such as sight and hearing. Their sense of worth and their sexual/haptic needs do not necessarily diminish. In fact, Hollinger found some evidence that touch sensitivity in the elderly may increase due to thinning and transparency of epidermal layers.

Geriatric patients, then, are typically deprived of sensory input and affirmation of the worth of their bodies by diminished touch, a sensory channel which tends to remain in good working order and which could do much to enhance personal body esteem.

USES FOR THE PROJECT

My project addresses two problems in the health care field. Murphy (1971) called for nursing practice based on scientifically derived information, not "tradition, imitation and intuition." An empirical method was employed in this study for gathering information about what subjects in the health care setting, both patients and care-givers alike, think of certain behaviors.

It is hoped that the specific findings in this project using the rules approach will address a second problem: patient dissatisfaction with nurse-patient communication. Peitchinis (1976) quoted a dissatisfaction rate of 60-70 percent. This dissatisfaction is not merely cosmetic; it has health consequences. Peitchinis cited studies by Moody, Baron and Monk (1970), Hutton (1963), Volpe and Kastenbaum (1967) and Buchanan, Brooks and Greenwood (1972) which document modification and even reversal of the effects of the aging process by improvements in staff and patient communication behaviors. This study provides quantified information about differences in rule perception by the various paricipants in nurse-patient interaction in geriatric settings.

A final use for this study pertains to the polemical issue of two-year versus four-year training of registered nurses. In conversations with educators in the nursing programs at Montana State University and Miles Community College, it was found that one of the salient arguments against two-year programs pertains to the nurse's communication skills. This study contributes evidence for determining whether significant differences in communication attitudes exist in the geriatric setting.

Chapter 2

PREVIOUS RESEARCH

The literature relevant to this study has been divided into two broad areas: nurse-patient literature and communication-rules literature.

Nurse-Patient Literature

Sociologists, social psychologists and social interactionists have examined the effect of roles, power, status and exchange theory in health care institutions. A relatively early study (Kogan, 1961) examined social role as a variable in hospital interactions. Distinct and consistent roles were discovered for both the patient and the nurse. These roles were perceived by both nurse and patient. The important point in Kogan's work was the hypothesis that role perception might influence interactions. Crane (1975) established how role perception might affect health care practice. Health care professionals varied their attitude and treatment (eg. special care of patients) based on the professional's view of the patient's potential social role. Role and associated

rules for communication behavior are closely bound together. Cushman (1977) confirmed the link between roles and standardized usage or rules.

Brower (1981) added further evidence of how the nurse's self-perception of social role affects performance. Specifically, nursing home staff who viewed themselves as lower-status professionals carried that stigma to their interactions with residents. The result was a fostering and perpetuating of dependence by the resident who was viewed as "the burden of care for unchallenging patients" (Brower, 1981). The constitutive rules in such a situation may require that geriatric patients fulfill the role of useless burden.

Worsley (1980) found that the nurse's understanding of roles leads to attributions by nurses of stereotypes for patients. Worsley not only measured attributions by nurses, but further determined some interactional consequences of such attributions. After a longer period of care for a patient, the patient is viewed as more demanding, less competent and possibly dirtier. This stereotype holds significance in particular for the geriatric patient. One must ask to what extent are the nurse's attributions negotiated with the patient to establish coordinated meanings for behavior which is unbecoming to the patient.

A second area of nurse-patient literature contributing background for this study is the research on touch. Sexuality, as defined in this research project, largely relates to the patient's need to touch and to be considered touchable. Perhaps rules research will uncover both communication rules for specific behaviors and rules for determining what is "judicious" (Barnett, 1972) and appropriate touch behavior in the nursing home.

Barnett (1972) referred to the power and the fundamental nature of touch in sensual and symbolic realms of patient experience, maintaining that touch may be the first channel for symbolic interaction in the developing human. Weiss (1979) surveyed knowledge on touch and human development, physiologic aspects of touch, and focused on touch as therapy. Weiss attempted to establish a complete categorization of symbols of touch, in hopes that nurses could be more aware of the nature of their touching while monitoring response to it.

Weiss (1979) recognized the variety of contexts, relationships, developmental ranges, socio-economic variables, and influences of gender on the meaning of touch. This recognition points out the complexity of studying communication which may not have a codified

meaning shared by the other interactants. Efforts to control variables in the scenarios for the present study benefit from Weiss's categorization of variables which influence the meaning of touch behaviors.

An early study of touch was conducted by Aguilera (1967). Nurse-initiated touching proved to be an effective means of establishing verbal interactions and cooperative therapeutic relations with patients. Touching was positively correlated with frequency of talk. Aguilera's study does not use a language of touch to enable us to clarify what sort of touch is involved -- a pat on the back, a stroke in a sensitive area, etc. A study by DeAugustinis, Isani, and Kumler (1964) which indicated that touch may be misinterpreted by client or nurse as much as 50 percent of the time leads to a qualification of Aguilera's findings: certain touch behaviors will enhance verbal interaction. Those touch behaviors conforming to rules of appropriateness in the minds of nurse and patient need to be uncovered.

Weiss's codification of touch behaviors would have increased the validity of Langland's work with touch and elderly confused clients (1982). Langland controlled a number of variables such as sex of interactants and location of touch, but he did not

control intensity and action. In spite of the reservation, Langland's findings seem to confirm a priori hypotheses: light touch on the forearm caused significant increases in nonverbal responses of attentiveness, relevant verbal responses, and appropriate action responses. This confirms the importance of touch in conveying relational aspects of communication.

In a study which moved further toward operationalizing therapeutic touch, Watson (1975) concentrated on expressive, unnecessary touch rather than instrumental touch. Watson had found that 68 percent of nurse touching of patients was instrumental. The significant relational touching is more salient to the study of nurse-patient interaction. Nurses were found not to be affectively neutral. "Increasing distance of body regions from genital zones, same sex between persons, high social status of the initiator, and relative absence of physical impairment" were conducive to touching. Watson did not clearly describe methodology of the study. Several scenarios in this study were developed to explore further the variables of status of initiator and distinction between instrumental and expressive touch.

DeWever (1977) found that not all touching is perceived favorably by the recipient, regardless of efforts to be appropriate. White female nursing home residents would most likely perceive discomfort if an older male nurse affectively touched or held the resident's hand. If a male or female nurse placed an arm around the female resident's shoulder, discomfort would be felt. Females more than males were likely to perceive discomfort.

The question of 'who may touch whom in what way and when' has great potential for rules-based research. Questions of sanction and generality of opposite sex prescriptions on touch are important. Both Schwartz (1974) and Reinhardt (1979) provided strong support for the idea that nursing home staff represent social mores concerning patient-patient touch.

> Although our society's mores and norms are clearly changing in this respect, nonetheless we recognize the unmistakable tendency to view physical intimacy, when exhibited by the old, not merely as irrelevant but even inappropriate.... (Schwartz, 1974, pp. 23-24).

The present study provides a pilot methodology for basing such suppositions upon empirical fact.

The research on touch implies that theories can codify the 'meaning' of touch and that researchers can examine the myriad variables to refine meanings. However, the understanding obtained from the present literature

might better serve as a basis for defining a methodology by which the individual nurse can achieve behavioral flexibility. Rather than attempt to codify and document, researchers might operationalize the discovery of consensually appropriate touch through an understanding of rules dynamics.

Implications for the quality of care given to the geriatric patient are numerous in the literature on touch. Impaired male patients in a setting staffed predominantly by females might be isolated from affective touch. Orderlies might need training and encouragement to affectively touch male patients. The area of nurse-patient touch holds good potential for establishing behavioral rules. Particularly helpful would be rules (called meta-rules by some theorists) governing the appropriateness of touch and how to determine appropriateness.

Another area of nurse-patient literature which makes a contribution to the present study is the research on interpersonal skills in health care settings. Brockway (1976) studied two styles of nursing reassurance for counselees prior to abortion. One style was a textbook model of reassurance, the other a brusque information-gathering style. Contrary to what one might intuit, a vocal stress evaluator (PSE) and the

Middlesex Questionnaire found no significant difference in the efficacy of the two styles for reduction of stress in the counselee. Brockway's findings indicate the need to conduct the present correlational study using nurse education as an independent variable. In this way, academically promulgated knowledge can be further tested. The present study will test the relationship between educational level and perception of communication rules.

Shoemaker (1977) studied sensitivity of nurses to nonverbal communication of patients. Using the PONS and several measures for self-monitoring of expressive behaviors, it was discovered that length of time in nursing was significantly related to less sensitivity to nonverbal behavior. This finding indicates the need to test the relationship between length of time in nursing and perception of communication rules. Assumptions and value-laden concerns with 'the value of experience' must be tested in practice. The present study will present a methodology for such testing through rules exploration.

A fourth area of nurse-patient literature, interactional analysis, contributed to my concept of a methodology for empirically validating rules for communicative behavior. Methven and Shlotfeldt (1962)

devised 30 hypothetical situations which cause stress to nurses. Nurses were then given choices of how to respond. The choices and situations in the measure provide a scale of listening and empathy for the respondents. This method, unlike the scenario technique to be employed in this study, does not consider all of the protagonists in a health-care setting. Neither the patient nor the textbook author are included. Both of these overlooked participants, the one fully present, the other present by influence, are integral parts of the setting.

Diers and Leonard (1966) published an article including a literature review of nurse-patient interaction, a call for patient-centered health care, an assertion that interaction be viewed as part of the cure, and an assertion of the value of social science research in enhancing care. They posited that interactional treatment must be specific, measureable, and teachable (describable), and that interactional coding schemes should be specific to nursing. Their coding scheme (Nurse Orientation System) analyzed what the person is attending to: feeling, knowing, being, doing, thinking, and evaluating. In 1972 Diers *et al* replicated work done in 1966 using the scheme. The effects of nurse interaction on diminishment of pain were examined using the coding scheme. Interactants

who were found through coding to view the patient as a feeling and doing person were more effective.

Criticisms of the nurse-patient interactional inventories and coding-schemes center on the question of whether they capture the nature of communication phenomena between persons or measure communicative traits of persons. None of the schemes actually codify interactions. A scenario-based questionnaire might address more directly the rules for interaction -- the communicative interaction itself. This is more properly the domain of communication research.

Nussbaum et al (1982) presented important information in two areas of nurse-patient interaction. Content of conversation was documented and correlated with patient well-being. Communicator Style of staff was analyzed and compared among staff positions and between on-duty and off-duty interaction. Nurses and nurse aides were more open, dramatic, dominant, relaxed, friendly, and attentive with nursing home residents than with others. Staff who report a high affinity with residents correlated with a more friendly and relaxed style and more often discussed old times, religion, and problems of old age. Nussbaum posited that personal problems of staff might be appropriate and helpful topics of conversation with patients by shifting the focus for a

time from the patient's problems. One scenario addresses this possibility.

The most widely applicable point made was an admonition against training and prescribing behavior for staff before one knows what is already being done by the staff. This admonition applies to textbooks which imply or state communication rules without a method of empirically validating the existence of the rules. The future will call for training which provides an understanding of the communication process, a knowledge of tendencies of communicators and expectations of interactants. The nurse will further benefit if some systematic method of coordinating management of meaning is tested and taught.

RULES LITERATURE

The theoretical base for experimental rules research is derived in large part from the work of Romano Harre (1974). Harre argued that the "old psychological paradigm" by which social scientific experimentation is conducted proves inadequate. The inadequacy is fundamental, not merely a methodological maladjustment. The old paradigm fails to take into account that man

often is intentional and that explanation of man's behavior must include the telic possibility, ie. man does because man chooses to do. Harre explains that methods which work for thing-like subjects will not work for the study of man and his social meanings.

Harre called for an 'ethogenic' (1974, p. 153) method for the study of man's social phenomenon. This method embraced the challenge to unravel the effect of the meaning of relationships, settings and actions. Harre suggested the

> use of scenarios to simulate the imaginative rehearsal of episodes and to bring out intuitions of social propriety in the justificatory accounts that one can ask from the participators under each imagined choice of path (p. 159).

The scenario method, which Harre calls an exploration rather than an experiment, attempts to uncover the plan-making, self-monitoring and goal directed patterns of the actor, ie. the rule conscious behavior of the actor.

The scenario method gains further credence as an experimental tool through the theoretic position of Frentz and Farrel (1976). Like Harre, they based their theory upon the conviction that the human actor is capable of choice and responsibility. Further, they argued that study of human behavior must be particularistic and situation-specific and finally,

that episodic meaning must be ascertained. Their major contribution to the experimental method of rules research is their clarification of the importance of the context to the shared meaning of communication acts. One cannot attempt "to explain symbolic acts independent of the episodes in which they occur" (p. 340). This is called the episodic force of the act. This concept chastens the researcher to (1) take carefully into account the context or episode under consideration and (2) take into account the judgement of the participants.

Donohue et al (1980) have grouped rules categories into two major perspectives, the homogeneous and the heterogeneous. The first describes how people make talk, the second explains how people use talk. This project will contribute to the heterogeneous perspective, contributing to the verification of rules by: (1) isolating task requirements (2) measuring the extent of individual rule knowledge (3) measuring the breadth (generality) of the rule and (4) measuring the amount of force (necessity) of the rule.

Because the rules tradition tends to be thought of as radically removed from the positivist tradition of scientific inquiry, the phrase 'rule experiment' may be viewed as oxymoronic. A comparison of the rules

perspective with the positivist perspective might prove enlightening. This is not done as an attempt to answer to positivist standards. Harre has cogently elucidated how the rules perspective can more effectively study the unique, telic behavior of man. Rather, a comparison will point out the ways in which the rules researcher may attain the objectives and rigor shared by positivist researchers.

Generality and necessity loom as major concerns in the positivist tradition. This researcher argues that both objectives are achievable using the rules approach to experimentation. Miller (1978) has questioned the generality of rules in more personal relationships, since the more personal relationship would by typified by more idiosyncratic rules -- rules unique to the relationship. It may be that the relational rules conform to meta-rules. In any case, ample and essential interactions in the health care setting, particularly in long-term care, may lend themselves to standards of generality by virtue of their less interpersonal, more ritualized nature (Walker, 1967).

The more provocative question pertains to necessity. In a perspective asserting human potential for planning and choosing behaviors, how can theoretic statements specify relationships which obtain because of the

operation of some definable force rather than occur capriciously (Cushman and Pearce, 1977)? On the one hand, the perspective asserts the possibility of caprice, on the other it claims to ascertain necessity by overruling caprice. The rules perspective achieves necessity, not by nomic force, but by normative or practical force (von Wright, 1971).

A second major concern of the positivist tradition is the need to explain, predict and control. If one is not doing all three, one is often not considered to be a scientist. Rule researchers vary in their concern with these objectives. A strong case may be made that it is premature in a newly founded discipline to be concerned with anything other than description (Harre, 1974). However, rules research may be designed to accomplish each of the three positivist objectives. Cushman and Whiting (1972) assert point blank that "the communication rules form general and specific patterns which provide the basis for the explanation, prediction and control of communication behavior."

Shimanoff (1980) made a case for rules versions of each.

> The point here is that why an actor wants to create a certain situation may be beyond the power of rules to explain, but why s/he behaves in certain ways given his/her desires can be explained in terms of rules. So explanation is not involved in the infinite

> regress of why questions, a regress which is futile given the ultimate arrival at choice and intentionality adhered to by rules proponents. One can predict behavior by using the rule as a "warrant for the prediction (claim) that a behavior will occur...." (Shimanoff, 1980, p. 232).

Cushman (1977) conceded that rules "theory would be strong on explanation and control and weak, relative to a laws perspective, on prediction" (p. 45). However, when one again considers the telic nature of man, it is the most realistic and accurate means of prediction available for more complex social behaviors (Toulmin, 1974).

Shimanoff asserted that control of human behavior, though not an absolute requirement in the scientific tradition, is attainable in the rules perspective. One can make rules explicit to the rule-ignorant or one can modify an identified rule. Cushman stated that

> The rules perspective differs from the laws and systems perspectives in that it extends the legitimate range of scientific invention from causal to practical regularities... (1977, p. 37).

In this researcher's opinion, the rules perspective emancipates research from a reductionist understanding of the limited mechanistic behaviors in man's repertoire. We further escape the tautology of imputing drives as the cause of behavior which is defined in terms of the drive.

A qualitative thrust also exists in the theory of rules experimentation. Harre (1974) called for "justificatory accounts" (p. 159). Frentz and Farrel call for participant observation techniques to enhance understanding of the judgements made during the "rehearsal of episodes" (Frentz and Farrel, 1976, p. 348). The most specific guidelines for qualitative research using the rules perspective come from Pearce (1977). Pearce uses the term 'naturalistic' to describe any study which includes the actor's meanings and combines telic and causal explanation. He makes an important argument for qualitative methods. "Not only must the theory be parsimonious and powerful, it must demonstrate that persons use such rules" (p. 54). Qualitative methods are further supported, not merely as preliminary and exploratory procedures but as an integral method to a theory which views man as intentional and purposive. Pearce called for both naturalistic and objectivistic methods to understand more completely the subject of study. In response to this position, qualitative aspects of the present research project will <u>not</u> serve as preliminary techniques. Comments of respondents will be an integral part of the analysis of rules context and criticizability.

Having provided a conceptual framework and a justification for rules experimentation, a review of rules experiments follows.

Although experiments using the rules approach are limited, some precedent and direction can be obtained by reviewing the particular studies which have been completed. Two studies, Knapp et al (1973) and Krivonos and Knapp (1975) serve in several respects as exemplary rules experiments, even though the researchers apparently did not intend the projects as rules experiments: in neither study were rules explicitly stated, but in both cases, the researchers attempted to uncover regularities in leave-taking and greeting behaviors of subjects. The researchers declared that the regularities are subject to normative force.

The exemplary elements of the two projects pertain to methodology: both are experiments which do not use pen and paper as the mode of data gathering. Coding of behavior by trained observers is used as the primary method. The coding scheme is based on qualitative procedures, enabling the project to claim sensitivity which Miller (1970, p. 103) calls for. The final exemplary feature of the two

studies is the degree to which variables were controlled and accounted for in the study.

Knapp et al (1973) and Krivonos and Knapp (1975) failed to meet two important elements proposed in rules theory. Harre (1974) and Frentz and Farrel (1976) emphasized the importance of context or episodic conditions in determining the meaning which subjects will attribute to behaviors. Secondly, Shimanoff (1980) stressed throughout her book that the identification of a rule must include proof of its prescriptive power. Both of the experiments assert that prescriptive power exists, but neither study attempts to identify any normative force. Finally, in documenting the various regularities in behaviors, neither study weights the importance of the various behaviors. This would involve isolating a behavior and treating it as a variable.

O'Brien (1978) contributed to the repertoire of rule methodology a significant milestone by conducting a field study of an organization. O'Brien found systematic and empirical evidence for variability in the application of rules for men and women. The significant contribution by O'Brien was her use of a complex methodology: a

combination of field and laboratory research methods, the study of variables in their naturalistic context and the creation of intruments in the field rather than imposing constructs upon the subjects.

Pearce and Conklin (1979) presented theoretical material on the hierarchical nature of meanings and rules in a communication situation. They proceeded by applying the theory in a study of indirect responses. From the study, the importance of contextual variables is asserted as a factor in creating meaning at one level of the hierarchy which affects all lower levels of the hierarchy.

> The data consistently support the proposition that higher meanings are prepotent over lower ones. An utterance or sequence of utterances which follows one set of rules is incoherent if it violates a higher set of rules (p.86).

One study of the relationship between rules and psychological variables has been conducted. Shimanoff (1980, p. 262) posits the value of this sort of study while apparently overlooking the contribution of Rogers and Jones (1975). In their study, the personality variable of high/low dominance was measured and then subjects participated in a cooperative task. Although Rogers and Jones failed to attend to the relationship level (Watzlawick et al, 1967) and tended to

concentrate upon input-output considerations rather than viewing the task situation as a process, the study does indicate the viability of studying the interplay of psychological traits and rule performance.

Rushing (1976) contributed a strong case for the value of naturalistic or field research which she argues is better suited to rules research than laboratory experimentation. Nonverbal tactics and customs are uncovered which help define the meaning of a situation and concomitant meaning of behaviors in the situation. Although Rushing did not use the scenario technique, her observations about variables which impinge upon episodic meaning should be considered in developing scenarios. She defined social occasion, purpose, topic of conversation, roles, and rapport as definitional elements of encounter situations.

Shellen and Bach (1983) and Weathers (1979) utilized the scenario method for uncovering a subject's perceptions of rules. Particularly helpful is the groundwork of these researchers in establishing control of variables in the scenarios and the development of methods for determining subject responses to the scenarios. Shellen and Bach provided a useful concept in determining the normative force or criticizability of behaviors. The sanction of a behavior as

inappropriate, eg. dominant behavior in a disagreement is perceived as inappropriate and traditionally would be viewed as sanctioned. However, subjects in the study also rated the behavior positively in terms of effectiveness. Sanctions must be viewed as multi-dimensional. Shellen and Bach described criticizability, by analogy with linguistic behavior, as being grammatical.

> Just as grammaticality functions as the standard of judgement for evaluating linguistic behavior, rules theorists in communication argue that standards exist for the criticizability of behaviors governed and prescribed by communication rules (p. 15).

Weathers (1979) provided a model closest to the intentions of the present study. Scenarios were designed involving student-teacher interchanges concerning a disputed test item. The message was varied from assertive to non-assertive and the various audiences who rated the scenario behaviors served as the second independent variable. Both objective questionnaire responses and open-ended narrative responses were solicited from the raters. The study served to uncover rules concerning assertiveness and served as a correlational study of student and teacher perceptions of the rules and situations.

From the nurse-patient literature on roles, affection, touch and sexuality in geriatric settings and from the

brief tradition of rules theory and experimentation, the following research questions arise.

RESEARCH QUESTIONS

Several questions were explored in this project. (1) What effect do role in the health care setting and type of scenario have on how subjects rate care-givers in hypothetical situations? This question is asked both for ratings of effectiveness and ratings of appropriateness of behavior. This dimensionality of sanction is potentially of great value in refining empirically based generalizations about various role-members in nursing homes and about care-givers with varying degrees of experience. Therefore, implied in each research question is the further question: will various participants in the nursing home setting differ in their judgements of the scenarios along the lines of the two dimensions (appropriateness and effectiveness)?

Analyses of variance were conducted for responses of nurse aides, associates-degree nurses, bachelors-degree nurses and nursing home residents using four types of scenarios (sexual activity, touch/affection, sex role,

and other). To increase reliability, three scenarios were used for each type.

(2) What effect does the respondent's length of education have on how the respondent rates the effectiveness and appropriateness of care-givers in hypothetical situations? Education for care-givers is an important issue. According to four Miles Community College nursing faculty, claims are being made in the profession that associates-degree nurses lack the sensitivity of bachelors-degree nurses and that nurse aides are further removed from the sort of sophistication needed to provide optimally appropriate and effective care. In fact, the nursing profession faces changes in registration which will distinguish Registered Nurses with bachelors degrees from those with associates degrees.

(3) What effect does length of experience as a care-giver have on how the respondent rates the effectiveness and appropriateness of care-givers in hypothetical situations? Researchers have found that greater experience leads to jaded behavior, eg. non-verbal sensitivity decreased with experience (Shoemaker, 1977). If this is so, care-givers with greater experience might tend to value effective behavior over appropriate behavior.

Chapter 3

METHODS

The derivation of scenarios, the development of adjectival scales, the selection of subjects, and the procedures for administration of the research instruments are presented in this chapter.

Derivation of Scenarios

The scenarios developed for this study were derived from textbooks in nurse communication and geriatric nursing practice. In an effort to avoid a recurrent criticism of rules research, ie. that phenomena described in rules research are trivial (Bochner, 1978, p. 188), potential rules were derived according to three criteria: (1) the importance of an issue in nursing care or pedagogy that tended not to involve nurses in highly interpersonal interactions. This meets the need for strategic importance (Spradley, 1980) of the rule to be derived and assures that the rule will not be idiosyncratic and lack generalizability (Miller, 1978). (2) evidence of

prescriptions of behavior in the textbooks. (3) evidence of descriptions of regularities in the textbooks which could be tested to determine whether prescriptive force applies.

Many more regularities were found than explicit prescriptions. Authors tended to qualify statements using modal verbs which fall short of outright prescription, eg. the nurse may warn the patient of the consequences or the nurse can expect the patient.... Sanctions for behaviors were seldom described in the textbooks. One of the tasks of this project will be to devise means of identifying the prescriptive (criticizable) element of a regularity.

Before further description of the process of rule derivation and related development of scenarios is undertaken, three further generalizations about the textbook material are in order. (1) It seems irrelevant whether the author intended to be presenting rules for behavior. This study is not a reflection on the perspicacity of the authors selected, nor is it a survey of the authors' readiness or ability to use rules terminology and rules structure. The study is a test of a methodology which might henceforth be used by authors in nursing. (2) Whether the rules were accurately derived rules according to the judgement of

the authors is a moot question. The study is not intended as an interpretation of the texts, but as the testing of a methodology and the correlational analysis of the participants in the geriatric health care setting. The paramount question is whether the rule exists in the rest home with sanctions and whether it is perceived similarly by the various classes of subjects. (3) Seventeen textbooks were reviewed in this study. Those chosen as sources of rules or potential rules were current, often-cited works in the field. They were not chosen as exemplars of good or bad work, but as representative of the present thinking in the field of nursing, based on this researcher's judgement of current periodical citations and based on conversations with nurse-educators at Montana State University and Miles Community College.

As the textbooks were surveyed, prescriptions of behavior and descriptions of regularities of behavior were noted. Those passages which, in light of the review of the nurse-patient literature were deemed important, received a qualitative judgement as to whether the passage met Shimanoff's criteria for identification of a rule (1980): (1) followable (2) criticizable (3) contextual. If a passage met these tests, it was identified as a rule. If a passage met numbers one and three, it was identified as a potential

rule. Those behaviors which were not ostensibly criticizable were selected to test the efficacy of the methodology in determining criticizability. (See Appendix A for a detailed description of the derivation of each rule and the scenario for examining it.)

Pearce (1977, p.54) stated that a rules application must not only "be parsimonious and powerful, it must demonstrate that persons use such rules." The present methodology is intended to demonstrate such usage or non-usage of rules stated or implied in textbooks. The creation of scenarios based upon the textbook passage was developed as a test. The precedent for this method appears in the literature review. Specifically, Cushman calls for a test for rule usage in two ways.

> If role-taking is the central mechanism for the learning of context and procedural rules at each systems level, then it ought to be possible to measure an individual's mastery of a standardized usage [rule] either by asking the individual what he is expected to do or by reports of individuals who observe his use of the standardized usage" (Cushman, 1977, p. 39).

The scenario method fulfills the second alternative.

In this study, the ethnomethodological technique of making the knowledge problematic was employed. Each scenario was written so that the rule was violated or adhered to in a discreet and neutral way. No blatant

violations of rules which would obviously be subject to criticism were devised. This makes the rule problematic for the subject and focuses normative attention upon the rule, leading to a measurement of the sanction and specificity (Cushman, 1977) of the rule.

Measurement of the Sanction

Adjective scales were used to test attitudes toward each hypothetical rule. (See Appendix C for a copy of the scenarios and adjective scales.) This study does not report actual behaviors of care-givers. The question of whether the subject's attitude toward the rule corresponds in any way with behavior pertaining to the rule would serve as the basis for a follow-up study.

The master list of adjectives was derived from previous scenario experiments (Pearce and Conklin, 1979), (Norton, 1978), (Berquist, 1980), (Shellen and Bach, 1983). Several of the prior scenario experiments used qualitative procedures for gathering adjectives. Because the master list will be refined by respondents in the health care setting during the pilot test of the instrument, and because the adjectives in the master

list are intuitively satisfying as being relevant to the scenarios, no qualitative generation of adjectives was undertaken.

From Pearce and Conklin (1979) the following words were considered: usualness, humor, appropriateness, friendliness and respect. From Norton (1978) several potential scales were extrapolated based upon the communicator style construct: attentive, contentious, friendly and dominant. From Berquist (1980) a long list of potential scales were considered: imaginative, natural, relevant, sincere, non-threatening, unique, confident, informative, concerned, pleasant, tactful, knowledgeable, other-directed, aggressive, original, appropriate, understandable, genuine, friendly, at ease, interesting, honest, believable, witty, refined, meaningful, considerate and bold. The present researcher added several adjectives to the pool: responsible, caring, realistic and good.

From Shellen and Bach (1983), the present researcher adapted the concept of dimensionality of sanction. The sanction or criticizability of the regulative rule is embedded in the adjective scales along two dimensions: appropriateness and effectiveness. It is conceivable that a staff member's behavior might be considered appropriate without being considered

effective. For example, listening to a patient discuss a problem for an hour while delivering medication might be appropriate, but the other patients might be neglected. This could be construed as appropriate but not effective behavior.

The scales were arranged in two orders to reduce pattern effects.

Importance of Context

Ellis (1980, p. 104) stated: "Interactants use strategies-within-contexts to accomplish certain processes." This succinctly states the inter-relatedness of context, behavior and meaning which Delia (1980) and Rubin (1977, 1979) have theorized and researched. Of particular importance are the findings of Rubin that ambiguity of context directly affects communicative behavior. Knapp stated the peril of ignoring context in communicative circumstances. "...none but the most foolhardy would guarantee success of any message or opener without knowledge of the context in which it was used" (Knapp, 1978, p. 110).

Baxter (1980) provided a most complete admonition to consider contextual variables in conducting research.

> The relevance of our research to the real world can never be enhanced until communicologists become cognizant of the situation. Our research is situation-bound in the perceptions of our respondents or research subjects but, we often do not know: (1) what the situation is because we have not focused on it (2) how the research situation mirrors the situations of life because we don't study them" (1980, p. 30).

Situational variables were controlled in the following ways. A major element in health-care settings is the degree to which the situation meets ideal conditions. Often, overwork, time pressure and lack of salary incentive impinge upon the ideal. However, textbooks tend to assume that those impingements have somehow been eliminated and that refinements in nursing practice are affordable in terms of time and energy. The scenarios in this study will make clear the status of these constitutive rules: the care-giver is neither pressed for time nor overworked. Otherwise, perceptions of the scenarios may be colored by defensiveness or an inclination to view the issue as moot in the face of other pressures in the situation. Additionally, several other constitutive rules and aspects of the practical syllogism (von Wright, 1971, and Cushman and Pearce, 1977) are involved. The assumed constitutive rules include: (1) no prior

interaction has alienated the care-giver from the patient, ie. the situation is amicable; (2) based on the assumption of the textbooks, the care-giver has normal intelligence and competence, but need not be outstanding; (3) related to the practical syllogism, the care-giver intends to do what is best for the patient, however that may be construed by the individual.

Additional variables were controlled in the scenarios as appropriate. All care-giving in the scenarios was done by a staff member not specified as to status. This will reduce bias of respondents to specific educational backgrounds and positions in nursing home staff hierarchies. The number of communicators, number of sensory channels available and the degree of physical proximity (Miller, 1978) were controlled when appropriate. Related to physical proximity, non-verbal behaviors, particularly touch, were attended to using the categories devised by Weiss (1979): duration, location, action, intensity, frequency and sensation. Based on much of the touch research in nursing literature, the sex of interactants was controlled. Rushing (1976) cites the social occasion, purpose, rapport and roles of interactants as significant variables in the situation. From the health care literature, several related variables can be deduced:

whether the institution is long-term or not, length of patient-nurse relationship, the patient's capacity to understand, the patient's condition and the patient's educational background, and the nurse's experience in practice. Each of these variables was considered in developing the context of the scenario.

Pilot Test of the Instrument

Harre (1974) and Mixon (1971) stated that the scenario and accounts (in the ethnomethodological sense) should be reflexive, allowing for mutual revision. To refine the scenario, this reflexive process was employed. Ten social science graduate students at the University of Montana, and five nurses and five patients at nursing homes other than those used in the study completed the Qualitative Factor Identification Instrument. (See Appendix B.) The pilot respondents were asked to indicate which adjectives on the master list fell into the dimensions of appropriateness or effectiveness. The five adjectives for each dimension which were most often selected by the respondents as a group comprised the adjectival scale in the final questionnaire. In addition, effective and appropriate were included as adjectives in the scale.

Once the adjectives best defining the dimensions of appropriateness and effectiveness had been determined, a pilot version of the final questionnaire was tested using three nursing faculty from Miles Community College. The questionnaire was modified until the faculty members and this researcher agreed that each scenario reflected a rule derived from a specific textbook passage. We further agreed in placing three scenarios in each of four categories: sexual activity, touch/affection, sex role, and other.

Administration of the Final Instrument

Because some respondents were physically incapable of completing the questionnaire, both oral and written versions were available. Oral versions of the questionnaire were highly scripted to maintain consistency with the written administration. To maintain control of interviewer bias, comments were solicited in the oral administration by using only the structured set of questions available to respondents using the written administration. All administrations of the questionnaire were done by the researcher.

Residents of the nursing homes were given the opportunity to use a forced choice Q sort technique for

responding to the adjective scales. The resident was given a stack of cards. Each card had one of the adjectives printed on it. The resident was requested to place the cards in three piles: one for cards that describe the staff member's behavior in the scenario, one for cards that do not, and one for cards about which the resident had no opinion.

The entire questionnaire involved the completion by the subject of one hundred forty-four (144) adjective scales as well as forty-eight questions soliciting narrative response. The researcher found that the nursing home residents were unable to complete such a task. The residents were then asked to complete only the scales for appropriateness and effectiveness, which were the definitional terms for the two dimensions of sanction as had been determined by the qualitative pilot study.

Selection of Subjects

To measure the range and homogeneity of the communication rules (Cushman, 1977), a selection from four populations was made: (1) registered nurses with bachelors degrees; (2) registered nurses with associates degrees; (3) nurse aides; (4) residents in

nursing homes. Twenty subjects were tested from each population.

Subjects were selected using a convenience sample. Those patients who were able to follow the instructions and complete the questionnaire were included. The staff at Miles City, Montana's Custer County Rest Home, The Friendship Villa, Holy Rosary Hospital, Veteran's Administration Hospital and the Public Health Office comprised groups 2, 3, and 4. Only twenty-two bachelors-degree nurses work in the entire community. This limited number, as well as the relatively limited number of competent nursing home residents led me to use a convenience sample.

The following criteria were used in selecting subjects. All subjects were lucid, ie. capable of carrying on a conversation about current events in their lives. All subjects spoke and understood English fluently.

The distribution of subjects by sex, age and role in the health care field is shown in Table I.

Table I: Demographic Data on Subjects

Role	Sex		Age				
	Male	Fem	0-20	20-40	41-60	61-80	81-100
Nurse Aide	2	18	0	16	3	1	0
A.A. Nurse	1	19	0	11	8	1	0
B.S. Nurse	1	19	0	13	5	2	0
Resident	10	10	0	0	4	5	11

Chapter 4

RESULTS

Factor Analysis

In order to determine whether dimensions exist in the way subjects sanctioned the care givers in the scenarios, a series of factor analyses were conducted. These analyses were run on the responses of all the subjects except the residents. The residents had not completed all of the adjective scales, due to the taxing nature of the questionnaire.

The adjective scales under consideration were subjected to three factor analyses: principal components with orthogonal rotation, principal components with oblique rotation and principal components with one factor. A variable was considered as loading on a factor according to two criteria: (1) a value of .50 or greater; (2) a difference in loadings by the variable between factors greater than .30.

All three of the principal components factor analyses (orthogonal rotation, oblique rotation, and one factor) provided the same results. All of the significant loadings were on the first factor. In each run, the same five variables loaded significantly. Table II presents the orthogonal rotation.

Table II: Varimax Rotated Factor Matrix

Variables	Factor 1	Factor 2
Unconcerned	-0.01369	0.33575
Efficient	0.52097	0.34586
Dishonest	0.29402	0.45133
Responsible	0.72205*	0.20089
Effective	0.69763*	0.16145
Respectful	0.82065*	0.02819
Considerate	0.86374*	0.00707
Disorganized	0.07896	0.45247
Informative	0.53437*	0.19767
Appropriate	0.85280*	-.08548
Unfriendly	-0.01716	0.37566
Comprehendible	0.53397*	0.01182

* indicates scales representative of the factor

The variables which loaded significantly were all adjectives with a positive valence. Because the

factor analysis reflects this artifact, the dimensionality of the adjective scale was not supported. Based on this result, the plan to combine adjective scales into the two dimensions of effectiveness and appropriateness was abandoned. The remaining analyses of data were conducted using only the Effectiveness and Appropriateness scales as dependent measures.

Analyses of Variance

Research Question #1

The first research question was: What effect do role in the health care setting and type of scenario have on how subjects rate care-givers in hypothetical situations? A two-way analysis of variance with Effective as the dependent variable, a two-way analysis of variance with Appropriate as the dependent variable, and a series of sixteen oneway analyses of variance with Sheffe/ Contrasts were used to examine the first research question. The two-way analyses employed a 4 x 4 design (four levels of Role in the health care setting x four levels of Scenario Type). The oneway analyses of variance were conducted to determine the sources of significant variance in the two-way analyses.

In the first two-way analysis of variance there was a significant difference in the rating of care-givers for effectiveness among the four Roles in the health care setting ($F_{3,76}=2.86$; $p<.05$). There was a significant difference in the rating of the care-giver for effectiveness among the four Scenario Types ($F_{3,228}=14.68$; $p<.05$). There was a significant interaction effect in the rating of the care-giver for effectiveness among the four Roles and the four Scenario Types ($F_{9,228}=3.9$; $p<.05$). The results are summarized in Tables III and IV, The Table of Means and The Analysis of Variance.

Table III: The Table of Means (Effectiveness)

	Sexual Activity	Touch/Affec	Sex Role	Other
associate	5.75	5.35	5.15	5.25
bachelor	5.65	5.05	3.80	5.85
Nurse Aide	5.75	5.35	4.60	5.70
Resident	5.30	6.50	5.25	6.00

Table IV: The Analysis of Variance (Effectiveness)

Source	SS	df	ms	F	p
Role	18.56	3	6.19	2.86	0.041
Error	164.33	76	2.16	--	--
Scenario	52.11	3	17.37	14.68	0.000
Role x Scenario	41.61	9	4.62	3.91	0.000
Error	269.78	228	1.18	--	--

The level of significance was set at .05.

In the second two-way analysis of variance, there was a significant difference in the rating of care-givers for appropriateness among the four Roles in the health care setting ($F_{3,76}=8.34$; $p<.05$). There was a significant difference in the rating of the care-giver for appropriateness among the four Scenario Types ($F_{3,228}=14.53$; $p<.05$). There was a significant interaction effect in the rating of the care-giver for appropriateness among the four Roles and the four Scenario Types ($F_{9,228}=2.96$; $p<.05$). The results

are summarized in Tables V and VI, The Table of Means and The Analysis of Variance.

Table V: The Table of Means (Appropriateness)

	Sexual Activity	Touch/Affec	Sex Role	Other
associate	5.35	5.00	4.75	4.80
bachelor	5.10	5.10	3.75	5.40
Nurse Aide	5.10	4.80	3.95	5.75
Resident	5.20	6.30	5.15	6.20

Table VI: The Analysis of Variance (Appropriateness)

Source	SS	df	ms	F	p
Role	39.96	3	13.32	8.34	0.000
Error	121.43	76	1.60	--	--
Scenario	58.31	3	19.44	14.53	0.000
Role x Scenario	35.61	9	3.96	2.96	0.003
Error	305.08	228	1.34	--	--

The level of significance was set at .05.

Effectiveness was the dependent variable for the first four oneway analyses of variance using Role as the independent variable. Again, each of the four runs used data from only one of the four Scenario Types respectively. Among the four roles, there was no significant difference in the rating of the care-giver for effectiveness in scenarios pertaining to sexual activity ($F_{3,76}$=.63; NS).

Among the four roles, there was a significant difference

in the rating of the care-giver for effectiveness in scenarios pertaining to touch/affection ($F_{3,76}=7.70$; $p<.05$). Sheffe/contrasts revealed that all three care-givers differed significantly from the care-receivers who approved more highly of the effectiveness of the care-giver in the touch/affection scenarios.

Among the four roles, there was a significant difference in the rating of the care-giver for effectiveness in scenarios pertaining to sex role ($F_{3,76}=5.23$; $p<.05$). Sheffe/contrasts revealed that bachelors-degree care-givers differed significantly from associates-degree care-givers and from residents. bachelors-degree care-givers rated the care-giver lower in effectiveness than the associates-degree care-givers and the residents.

Among the four roles, there was no significant difference in the rating of the care-giver for effectiveness in scenarios pertaining to other issues ($F_{3,76}=1.39$; NS).

Appropriate was the dependent variable for the last four oneway analyses of variance using Role as the independent variable. Again, each of the four runs used data from only one of the four Scenario Types respectively. Among the four roles, there was no significant difference in the rating of the care-giver

for appropriateness in scenarios pertaining to sexual activity ($F_{3,76}$=.23; NS).

Among the four roles, there was a significant difference in the rating of the care-giver for appropriateness in scenarios pertaining to touch/affection ($F_{3,76}$=9.06; $p<.05$). Sheffe/contrasts revealed that nurse aides differed significantly from the residents who approved more highly of the appropriateness of the care-giver in the touch/affection scenarios.

Among the four roles, there was a significant difference in the rating of the care-giver for appropriateness in scenarios pertaining to sex role ($F_{3,76}$=5.23; $p<.05$). Sheffe/contrasts revealed that nurse aides and bachelors-degree nurses differed significantly from the residents who approved more highly of the appropriateness of the care-giver in the sex role scenarios.

Among the four roles, there was a significant difference in the rating of the care-giver for appropriateness in scenarios pertaining to other issues ($F_{3,76}$=4.11; $p<.05$). Sheffe/contrasts revealed that associates-degree nurses differed significantly from the residents who approved more highly of the appropriateness of the care-giver in the other issues scenarios.

Eight runs were made using Scenario as the independent variable. The dependent variable for the first four runs was Effective. Each run used data from only one of the four Role groups respectively. Among the four scenarios, there was no significant difference in the rating of the care-giver for effectiveness by associates-degree nurses ($F_{3,57}=1.70$; NS).

Among the four scenarios, there was a significant difference in the rating of the care-giver for effectiveness by bachelors-degree nurses ($F_{3,57}=29.79$; $p<.05$). Sheffe/ contrasts revealed that the bachelors-degree nurses' rating of care-givers in the sex role scenarios was significantly lower than the other three scenarios. In addition, bachelors-degree nurses rated touch/affection and other issues scenarios significantly different from each other.

Among the four scenarios, there was a significant difference in the rating of the care-giver for effectiveness by nurse aides ($F_{3,57}=6.16$; $p<.05$). Sheffe/ contrasts revealed that the nurse aides' rating of care-givers in the sex role scenarios differed significantly from the sexual activity and other issues scenario types. Behaviors in sex role scenarios were rated lower.

Among the four scenarios, there was a significant difference in the rating of the care-giver for effectiveness by residents ($F_{3,57}=2.95$; $p<.05$). Sheffe/ contrasts revealed no significant differences among the scenarios.

The dependent variable for the last four runs was Appropriate. Each run used data from only one of the four Role groups respectively. Among the four scenarios, there was no significant difference in the rating of the care-giver for appropriateness by associates-degree nurses ($F_{3,57}=2.06$; NS).

Among the four scenarios, there was a significant difference in the rating of the care-giver for appropriateness by bachelors-degree nurses ($F_{3,57}=20.38$; $p<.05$). Sheffe/contrasts revealed that the bachelors-degree nurses' rating of care-givers in the sex role scenarios was significantly lower than the other three scenarios.

Among the four scenarios, there was a significant difference in the rating of the care-giver for appropriateness by nurse aides ($F_{3,57}=8.43$; $p<.05$). Sheffe/ contrasts revealed that the nurse aides' rating of care-givers in the sex role scenarios differed significantly from the sexual activity and other issues

scenario types. Behaviors in sex role scenarios were rated lower.

Among the four scenarios, there was a significant difference in the rating of the care-giver for appropriateness by residents ($F_{3,57}=2.79$; $p<.05$). Sheffe' contrasts revealed no significant differences among the scenarios.

Summary of Results for Research Question #1

In the two-way analysis for both effectiveness and appropriateness, significant variances were discovered pertaining to the variables Role and Scenario, as well as the interaction of the two. The following significant differences were found in the oneway analyses:

The bachelors-degree nurses and the nurse aides rated the care givers in the sex role scenarios lower than the other respondents did. This was true in both ratings of effectiveness and appropriateness.

The bachelors-degree nurses and the nurse aides differed significantly from the residents in ratings of the sex-role scenarios.

All three types of care givers differed from the residents in ratings of touch/affection scenarios.

In only one instance did a significant difference occur between the ratings for effectiveness and

appropriateness. associates-degree nurses rated the appropriateness of the care givers in the "other" Scenario Type significantly lower than did the residents. These two groups of respondents did not differ significantly in rating the effectiveness of care givers in the same scenarios.

Research Question #2

The second research question was: What effect does the respondent's length of education have on how the respondent rates the effectiveness and appropriateness of care-givers in hypothetical situations? Oneway analyses of variance using the independent variable Education (no degree, associates-degree, and bachelors-degree) were run with two dependent variables (effective and appropriate). Each run used data from only one of the four Scenario Types respectively.

There was no significant difference among the three education levels in the rating of the care-giver for effectiveness in scenarios pertaining to sexual activity ($F_{2,57}$=.235; NS).

There was no significant difference among the three education levels in the rating of the care-giver for effectiveness in scenarios pertaining to touch affection ($F_{2,57}$=.142; NS).

There was no significant difference among the three education levels in the rating of the care-giver for effectiveness in scenarios pertaining to sex role ($F_{2,57}$=2.684; NS).

There was a significant difference among the three education levels in the rating of the care-giver for effectiveness in scenarios pertaining to other issues ($F_{2,57}$=3.675; NS). Sheffe' contrasts revealed that care-givers with no degree differed significantly from care-givers with the associates degree.

There was no significant difference among the three education levels in the rating of the care-giver for appropriateness in scenarios pertaining to sexual activity ($F_{2,57}$=.665; NS).

There was no significant difference among the three education levels in the rating of the care-giver for appropriateness in scenarios pertaining to touch affection ($F_{2,57}$=1.508; NS).

There was a significant difference among the three education levels in the rating of the care-giver for appropriateness in scenarios pertaining to sex role ($F_{2,57}$=3.805; $p<.05$). Sheffe' contrasts revealed that care-givers with the associates degree differed

significantly from both the care-givers with no degree and those with the bachelors degree.

There was a significant difference among the three education levels in the rating of the care-giver for appropriateness in scenarios pertaining to other issues ($F_{2,57}=4.710$; $p<.05$). Sheffe' contrasts revealed that care-givers with the associates-degree differed significantly from both the care-givers with no degree and those with the bachelors-degree.

Summary of Results for Research Question #2

The care givers with no degree and those with the bachelors degree responded similarly. The no-degree and bachelors-degree respondents differed significantly from the associates-degree respondents on both the sex role and the other issues scenarios. In addition, the no-degree respondents differed significantly from the the associates-degree respondents on the other issues scenarios.

In only one instance did a significant difference occur between the ratings for effectiveness and appropriateness. associates-degree nurses rated the appropriateness of the care givers in the sex role

Scenario Type significantly lower than did the no-degree and bachelors-degree respondents. These two groups of respondents did not differ significantly in rating the effectiveness of care givers in the same scenario.

Research Question #3

The third research question was: What effect does length of experience as a care-giver have on how the respondent rates the effectiveness and appropriateness of care-givers in hypothetical situations? Oneway analyses of variance using the independent variable Experience (1 through 3 years, 4 through 7 years, 8 through 11 years, and over 12 years) were run with two dependent variables (effective and appropriate). Each run used data from only one of the four Scenario Types respectively.

There was no significant difference among the four experience levels in the rating of the care-giver for effectiveness in scenarios pertaining to sexual activity ($F_{3,56}=1.935$; NS).

There was no significant difference among the four experience levels in the rating of the care-giver for effectiveness in scenarios pertaining to touch affection ($F_{3,56}=2.272$; NS).

There was no significant difference among the four experience levels in the rating of the care-giver for effectiveness in scenarios pertaining to sex role ($F_{3,56}$=2.151; NS).

There was no significant difference among the four experience levels in the rating of the care-giver for effectiveness in scenarios pertaining to other issues ($F_{3,56}$=.953; NS).

There was no significant difference among the four experience levels in the rating of the care-giver for appropriateness in scenarios pertaining to sexual activity ($F_{3,56}$=2.538; NS).

There was no significant difference among the four experience levels in the rating of the care-giver for appropriateness in scenarios pertaining to touch affection ($F_{3,56}$=2.597; NS).

There was no significant difference among the four experience levels in the rating of the care-giver for appropriateness in scenarios pertaining to sex role ($F_{3,56}$=2.023; NS).

There was no significant difference among the four experience levels in the rating of the care-giver for

appropriateness in scenarios pertaining to other issues ($F_{3,56}$=.896; NS).

Summary of Results for Research Question #3

To summarize the results of analyses pertaining to the third research question, no significant differences were discovered involving the variable: Experience.

Chapter 5

DISCUSSION

In order to determine whether dimensions exist in the way subjects sanctioned the care givers in the scenarios, a series of factor analyses were conducted. These analyses were run on the responses of all the subjects except the residents. The residents had not completed all of the adjective scales, due to the taxing nature of the questionnaire.

Dimensionality of sanction in the geriatric health care setting was not found in the factor analyses of the adjective scales. To further test the question of dimensionality, duplicate runs of all analyses of variance were made using both effective and appropriate as dependent variables.

In only two of the thirty-four runs was any difference between ratings of effectiveness and appropriateness discovered. Apparently, nursing home staff do not distinguish between what is appropriate or ideal and what is the most effective means of getting one's work done. Possibly there is no difference between the most efficient and the most appropriate behavior, or the responses may

reflect the fact that the study measures attitudes, not behaviors. One might find a greater difference between appropriateness and effectiveness if one were rating actual performance.

The discussion of the results of the analyses of variance which follows will only distinguish between ratings of effectiveness and appropriateness in those two runs where a difference occurred. Future research might seek dimensionality in a different pool of adjectives. However, it is more likely that such a well defined situation as staff-patient communication in a geriatric setting affords only one dimension of sanction: appropriateness of behavior.

Research Question #1

The first research question was: What effect do role in the health care setting and type of scenario have on how subjects rate care-givers in hypothetical situations? A two-way analysis of variance with Effective as the dependent variable, a two-way analysis of variance with Appropriate as the dependent variable, and a series of sixteen oneway analyses of variance with Sheffe/ Contrasts were used to examine the first research question. The two-way analyses employed a 4 x 4 design (four levels of Role in the health care setting x four levels of Scenario Type). The oneway analyses of variance were

were conducted to determine the sources of significant variance in the two-way analyses.

Baxter (1980), Frentz and Farrel (1976), Delia (1980), Knapp (1978), and Rubin (1977 and 1979) argued for careful consideration of the situation in conducting communication research. The two-way analyses of variance bear out this argument. Situation was varied in the study by the use of different Scenario Types. Scenario Type (sexual activity, touch/affection, sex role, and other issues) was a statistically significant main effect. It was likewise significant in interaction with Role.

In sorting through the numerous statistically significant results looking for patterns, it became apparent that Scenario Type represented not just differences in the type of situation. The Scenario Types also represented groups of rule violations and rule conformities. Touch/affection and sex role were each comprised of three scenarios which violated communication rules based on textbook quotations. (See Appendix A.) Two out of the three scenarios dealing with sexual activity violate a communication rule based on a textbook quotation. Two out of the three scenarios dealing with other issues conform to a communication rule based on a textbook quotation.

Several trends were discovered. Residents rate nearly all of the care-givers in the scenarios higher than the other respondents did. Their comments indicated appreciation of the care they receive. They described their status as that of a dependent who should praise and thank the care-giver for any service rendered. They tended to comments implying that the care-givers knew best. This confirms the sociological studies summarized by Kogan (1961) which indicated the pervasive effects of power and status upon attributions and attitudes in geriatric health care settings. A graphic example of this effect of power and status is the grouping of all three care-givers as significantly different from the residents in their rating of the touch/affection scenarios. All three groups rated the rule-violating behavior in the scenario lower than did the resident group.

It was found that associate-degree nurses did not distinguish significantly between the various situations. The other three groups did: residents rated behaviors pertaining to sexual activity and sex role scenarios lower than the other two Scenario Types. Both aides and bachelors-degree nurses rated the touch/affection and sex role Scenario Types significantly lower. These two types were purely comprised of rule violations. The results seem to indicate greater sensitivity by aides and

bachelors-degree nurses than associates-degree nurses to differences in both the issue of the scenario and whether it involves violation of the ideal as depicted by the textbook author.

One of the more significant trends was the tendency of nurse aides and bachelors-degree nurses to group in the Sheffe/ contrasts in opposition to the associates-degree nurses. Both bachelors-degree nurses and aides rated the sex role scenarios lower than the residents and associates-degree nurses did. The sex role scenarios were all violations of textbook rules. Perhaps the aides and bachelors-degree nurses are more idealistic, adhering more to the textbook view. Perhaps the associates-degree nurses are more oriented to the wishes of the residents who revealed in their comments that sex role was no longer relevant to them. A typical quote will illustrate this: "In here, that [sex role] doesn't matter any more."

The dichotomy of aides/bachelors versus associates/residents is not clear-cut. associates differed significantly from residents in the rating of other issues. Residents rated the predominantly rule-conforming behaviors higher than the associates-degree nurses. So, although there is a tendency to a dichotomy between the pairs of groups,

there is a stronger tendency to responses by associates-degree nurses which contradict the textbook prescriptions. This contradiction may coincidentally be shared by residents because of an artifact. Residents defer to the staff by giving high ratings to care-givers. Most of the care-givers in the scenarios violate rules. Hence, the residents share with the associates-degree nurses, by coincience, a contradiction of the textbook rules.

This researcher is not in a position to decide whether it is preferable for care-givers to hold attitudes adhering to the ideal of the textbook or the reality of the society of the rest home. Brockway (1976), in fact, gave evidence that academically promulgated behavior does not necessarily lead to the highest patient satisfaction. However, the nursing profession is grappling with the certification of nurses with discrepant degrees (including associate and bachelor). My findings do support the argument that significant differences in communication attitudes exist. The evidence could justify the creation of two levels of Registered Nurse certification. The attitudes of the two groups differ significantly, with the bachelors-degree nurse being more sensitive to the situation and more aligned with the textbook prescription than the associates-degree nurse.

One of the two instances when the dependent measure accounted for a significant difference in variance happens to be the instance when residents and associates-degree nurses differed significantly on the Sheffe' contrasts. In rating effectiveness of care-givers pertaining to other issues, associates-degree nurses did not differ significantly from residents. In rating appropriateness, associates-degree nurses did differ significantly. Hence, associates-degree nurses found rule-conforming behavior more effective than appropriate. Further research might find that the associates-degree nurse has reasonable cause for the tendency to contradict the textbook prescription based on some distinction between what is appropriate and what will work. The more limited exposure to communication theory and liberal arts training of the associates-degree nurse may be viewed as an inadequacy or strength, depending upon one's point of view.

Research Question #2

The second research question was: What effect does the respondent's length of education have on how the respondent rates the effectiveness and appropriateness of care-givers in hypothetical situations? Oneway analyses of variance using the independent variable Education (no degree, associates-degree, and bachelors-degree) were run with two dependent variables (effective and appropriate). Each run used data from only one of the four Scenario Types respectively.

The analyses of variance for Education are similar to those for Role. The only difference being the exclusion of residents as a level of the independent variable. This exclusion is illustrative. Fewer significant differences occurred. This supports the supposition that a dichotomy between aides/bachelors and associates/residents may exist. associates tended to rate rule violations higher and rule conformities lower. Residents shared the tendency to rate rule violations higher, doing so to a greater degree than the associates. Without the extreme of the residents, fewer significant differences arise.

This researcher found that the no-degree group (nurse aides) differed from associates-degree nurses by rating the predominantly rule-conforming behaviors lower

than the associates-degree nurses. This contradiction by nurse aides of the textbook prescriptions sets them apart to some extent from the bachelors-degree nurses who did not contradict textbook rules at statistically significant levels in any of the runs.

The second instance when the dependent measure accounted for a significant difference in variance occurred in the rating of the sex role scenarios. bachelors-degree nurses and no-degree aides did not differ significantly in their rating of the effectiveness of the care-giver. They did differ significantly in their rating of the appropriateness of the behavior. This indicates that not only can associates distinguish between what works and what might be most appropriate, but so can aides and bachelors-degree nurses. This weakens the argument that associates-degree nurses might be more realistic than either aides or bachelors-degree nurses.

The final significant difference in this series of analyses repeated the grouping of aides and bachelors-degree nurses in opposition to associates-degree nurses. Again, the no-degree subjects and the bachelors-degree subjects rated rule-conforming behaviors in the other issues Scenario Type higher than did associates-degree nurses.

Research Question #3

The third research question was: What effect does length of experience as a care-giver have on how the respondent rates the effectiveness and appropriateness of care-givers in hypothetical situations? Oneway analyses of variance using the independent variable Experience (1 through 3 years, 4 through 7 years, 8 through 11 years, and over 12 years) were run with two dependent variables (Effective and Appropriate). Each run used data from only one of the four Scenario Types respectively.

Apparently, experience in health care work does not significantly affect the effectiveness and appropriateness ratings of care-givers in the scenarios. It could be that education may confound the effects of experience. Or perhaps the era when one trained interacts with experience. A follow-up study should be done using several two-way analyses of variance to determine whether interaction effects occur among era of training, education, and experience in health care prior to education. Such a study might also examine whether associates-degree nurses have greater experience in health care, thereby possibly explaining the affinity of their responses with the responses of the residents. As it stands, this study does not support the literature which indicates experience leads to less sensitive and jaded communicators (Shoemaker, 1977).

Methodological Implications

Several points should be expressed concerning the methods employed in the present research project. The reliability of the study would have been enhanced by the inclusion of subjects from a wider geographical distribution. All of the subjects were employed in Miles City, Montana. Selection bias was perhaps greater due to the difficulty of obtaining sufficient numbers of subjects.

Furthermore, the sample probably was quite insular. The researcher has lived in the area for six years. It is his impression that most of the subjects are a product of the regional culture and that most of them were trained at Miles Community College and/or Montana State University. Hence, the generalizability of the results is called into question. Do the significant differences occur as an artifact of the programs in which the care givers trained, or are the differences based on the nature of the training for bachelors-degree and associates-degree nurses everywhere?

However, this researcher suspects that the differences in response are not artifacts of the nursing programs at Montana State University and Miles Community College. It is suspected that the associates-degree nurse has a lower sense of committment to the profession than

the bachelors-degree nurse. The associates-degree respondents seemed to provide fewer narrative comments and the rate of completion of the questionnaire was lower. This may indicate the lower committment to the profession which is further reflected in the tendency by associates-degree nurses to less sensitive responses which also tend to contradict the textbook rule.

Another challenge to the reliability of the study is posed by the possibility of a socially desirable response set in the responses of nurse aides and bachelors-degree respondents. The nurse aides, from a sense of duty, the bachelors-degree nurses from a sense of the importance of research, may have been more concerned with providing the "right" answer. This could lead to the conclusion that associates-degree nurses, having more power than nurse aides but less awareness of research than the more extensively educated bachelors-degree nurses, would feel less obligation to provide the "right"answers.

Reliability is further challenged by the possibility that differences may have occured due to inherent differences between the oral and written administration of the instrument. Although care was taken by the researcher to provide a standard, non-committal delivery of the oral version, one cannot rule out the possibility of an

artifact. For example, one respondent commented on a written version of the instrument that the tone of voice of the care giver in the scenario was not described. This was an uncontrolled variable in the written version. It would be subject to even greater variability in the oral administrations. An independent rating of the delivery by a trained set of observers would have enhanced reliability.

Three additional enhancements of reliability would be advisable for future research using this design. Inter-item reliability among the scenarios within a Scenario Type could be computed. Test re-test and replication would also broaden generalizability and heighten reliability of the findings.

The validity of results would have been enhanced by providing uniformity within the group of scenarios comprising a Scenario Type. All scenarios of a given type should have been either rule violations or conformances. This was true for only two of the four types.

Implications for Future Research

Several implications for future research arise from the present study. Three implications pertain to geriatric health care in general and two pertain to rules-based research in this field.

In the scenario portraying a care giver who shares a personal problem with the resident, some interesting results occur. When the respondents were asked whether they approved of the sharing of personal problems, 12 were neutral, 23 were favorable, and 45 were opposed. However, 13 of 20 residents were favorable. This indicates a discrepancy between the care givers and the residents, with the residents preferring more involvement with the lives of staff. The topics of conversation and related levels of satisfaction deserve further study.

Two areas of geriatric communication might provide fruitful results: a skills test of care givers might be developed and tested. A survey of patient satisfaction might be developed to determine whether residents prefer the care of certain types of care givers, with the types based on education, experience or special in-service communication training.

The rules-based research conducted in the present study

measured the attitudes of respondents. A corrollary study of the respondents' behavior would be useful in several regards. A study of behavior through participant observation could provide information on differences between attitude and behavior. Furthermore, it could provide information on the sanction for a rule and the means of indicating the sanction.

Further study in geriatric health care might also examine how differences in attitudes toward communication rules affect staff-staff communication. The methodology set forth in my study enables measurement of such attitudes. This enables the researcher to move beyond demographic differences among care-givers to differences in rule awareness and interpretation.

Finally, a rules-based training program might be developed. This program could then be tested using the instrument developed in the present study to determine the effectiveness of the training in instilling care givers with the skills for coordinating the management of meaning with geriatric patients. This coordination would not only involve identification of rules and their sanctions, but the ability to create appropriate, unique responses to situations embedded with rules.

APPENDIX A

DERIVATION OF THE SCENARIOS AND RULES

I will provide the following information in this appendix: (1) A copy of each scenario; (2) a quote or paraphrase of the textbook passage upon which the scenario is based; (3) formulation of a communication rule based on the textbook passage; (4) indication of whether the care-giver in the scenario conforms to or violates the rule; (5) indication of the type of scenario as deemed by three Miles Community College faculty and me.

Scenario #1

(1) Two ladies who live in a nursing home are walking down the hallway holding hands. A staff member tells them to stop holding hands. How would you describe the staff member's behavior?

(2) "It is not unusual for nursing home staff to discourage displays of affection, especially if the individuals are of the same sex (Burnside, 1973, p. 459)." "Sexual overtures may be strongly discouraged by personnel, as, for instance, when a director of nurses requested two elderly ladies not hold hands when they walked down the hall (Burnside, 1976, p. 459)."

(3) Burnside condemned the behavior which was cited as not unusual. Therefore, the rule would be: A staff member must not (should not) discourage touch/affection among same sex residents of nursing homes.

(4) Caregiver violates the rule.

(5) Touch/Affection

Scenario #2

(1) A couple in the nursing home have been seeing a lot of each other during the past year. They are considering marriage. When they ask the opinion of the staff member, the staff member says they should not get married. They should wait until they know each other better. How would you describe the staff member's behavior?

(2) Two authors provide sources for this scenario. Leininger (1970, p. 162) provided an over-arching norm: "Another implicit cultural norm found in a hospital is that patients should acquiesce to the authority, directives, and help of professional staff, and particularly of the physician. Burnside (1973, p. 461) criticized the interference of care-givers in the decision to marry which was made by residents in a nursing home. Burnside quoted the care-giver as recommending the couple wait to get to know each other better.

(3) A care-giver must not (should not) interfere with relational decisions made by residents.

(4) Care-giver violates the rule.

(5) Sex Role.

Scenario #3

(1) A male resident in the nursing home who formerly owned a ranch, has trouble dressing himself. However, he does not simply want to put on plain clothes like so many other residents wear. He wants to wear his western clothes because they are more manly. The staff member doesn't feel that she should have to help him with snap-button shirts and tight cowboy boots. She tells him that there is no reason why he can't dress like the other patients. How would you describe the staff member's behavior?

(2) Schwartz (1974, p. 23-24) condemned any practices of staff which reduce the patient's sex role identity. Among others, Schwartz condemned "dressing residents in asexual clothing."

(3) The staff member must not (should not) block the resident's efforts to maintain a sex role identity.

(4) The Care-giver violates the rule.

(5) Sex Role

Scenario #4

(1) A man and a woman who live in the nursing home have been flirting with each other lately. The man blows her a kiss and winks as she walks by him. A staff member sees this and tells the man to "act his own age." How would you describe the staff member's behavior-

(2) Schwartz (1974, p. 23) condemns the practice of staff in admonishing residents to "act your age."

(3) The staff member must not (should not) admonish the residents to act their age.

(4) The care-giver violates the rule.

(5) Touch/Affection

Scenario #5

(1) Two staff members are on break. The one tells about how two of the patients have been seeing a lot of each other and flirting with each other. The staff members says that she suspects there is some hanky-panky going on between the two residents. How would you describe the staff member's behavior?

(2) Burnside (1973, p. 462) calls for "respecting the aged, whatever their views on sexuality may be." Eliopoulos (1979, p. 319) proscribes "joking about two aged person's interest in and flirtation with each other."

(3) The staff member must (should) respect the aged person's right to develop intimate relationships. This respect must (should) include refraining from gossip about the aged person's intimate relationships.

(4) The care-giver violates the rule.

(5) Sexual Activity.

Scenario #6

(1) A staff member makes a mistake in caring for one of her patients. It is not a life threatening mistake, but could be the cause of discomfort for the resident. She goes to the resident and tells him or her about the mistake. How would you describe the staff member's behavior?

(2) "A nurse should tell a patient honestly if she has done something wrong in caring for him" (Peitchinis, 1976, p. 19).

(3) The textbook states the rule explicitly.

(4) The care-giver conforms to the rule.

(5) Other.

Scenario #7

(1) A married couple move into the nursing home. They feel that the arrangement of their room is meant to tell them something. The room has single beds instead of a double bed as they are accustomed to having. They ask a staff member if this means that they aren't supposed to sleep together any longer. She tells them that they shouldn't have need of a double bed now. How would you describe the staff member's behavior?

(2) Burnside (1973, p. 476) presented the situation of the married couple wanting a double bed. She stated that most institutions have no double beds, implying a rule against their use. She recommended wiring the single beds together, thereby implying her own rule. Eliopoulos (1979) argues that there should be a private time and a private place for intimacy.

(3) The care-giver must (should) respect the resident's desire to sleep with a spouse in a double bed.

(4) The care-giver violates the rule.

(5) Sexual activity.

Scenario #8

(1) A male staff member in his late thirties is walking down the hall with a female nursing home resident. She says something funny and he laughs. As he tells her how sharp-witted he thinks she is, he wraps his arm around her shoulders and gives her a brief squeeze. How would you describe the staff member's behavior?

(2) Barnett (1972) and Weiss (1979) suggested that geriatric patients need to be touched more than they are by staff. Weiss recommended brief hugs. However, Weiss warned that orderlies may be judged as inappropriate when they touch elderly female patients. This scenario is particularly interesting as an example of using rules research to empirically validate or invalidate suppositions.

(3) A male care-giver must not (should not) use affectionate touch behaviors when interacting with female residents.

(4) The care-giver violates the rule.

(5) Touch/Affection

Scenario #9

(1) A female resident of a nursing home asks to speak in private with one of the staff members. The resident confides that she feels pain in her groin area when she makes love with her partner in the nursing home. The staff member provides her with medical information about this problem for older women. The staff member also provides the resident with a sterile lubricant. Technically, the staff member has broken no rules of the nursing home. How would you describe the staff member's behavior?

(2) "The nurse can explain about vaginitis, the importance of lubrication during intercourse, and dyspareunia" (Burnside, 1973, p. 457).

(3) The rule would be a re-statement of the quote in (2). The only change would be the replacement of the modal verb "can" with must (should). This would address the timidity of textbook authors to use prescriptive verbs, even when context clearly indicates the author is prescribing.

(4) The care-giver conforms to the rule.

(5) Sexual activity.

Scenario #10

(1) A staff member is visiting with a resident of a nursing home. They are alone in the day room. The staff member discusses a personal problem. How would you describe the staff member?

(2) Peitchinis (1976, p. 20) suggests that a care-giver discuss his or her own problems and concerns with the patient. Nussbaum (1982) studied topics of conversation. Satisfaction of geriatric patients was increased by discussion of topics other than the resident's health, including personal affairs of the care-giver.

(3) The care-giver must (should) discuss his or her personal affairs with the resident.

(4) The care-giver conforms to the rule.

(5) Other.

Scenario #11

(1) A resident tells a staff member that the world's morals are getting worse all the time. The resident thinks that part of the problem is that men and women dress so much alike. He thinks that women should act more feminine, especially toward men. The staff member says that is unfair to women, because they need more freedom than they had in old fashioned days. How would you describe the staff member's behavior?

(2) An overarching rule in the literature seems to be : rise above your personal views and grant the rights of patients to have their own view and concomitant behavior. Burnside (1973, p. 462) calls for "Respecting the aged, whatever their views on sexuality may be." Leininger warns of the danger of role related power of the care-giver. "Another implicit cultural norm found in a hospital is that patients should acquiesce to the authority, directives, and help of professional staff..." (Leininger, 1970, p. 162).

(3) The care-giver must not (should not) impinge upon the opinions of the resident.

(4) The care-giver violates the rule.

(5) Sex Role.

Scenario #12

(1) A staff member is distributing evening snacks to residents in their rooms. She enters a male resident's room without knocking. How would you describe the staff member's behavior?

(2) Eliopoulos (1979) argues that there should be a private time and a private place for intimacy.

(3) The care-giver must (should) knock before entering a resident's room.

(4) The care-giver violates the rule.

(5) Other.

APPENDIX B

QUALITATIVE FACTOR IDENTIFICATION

INSTRUCTIONS: I am conducting research on the perceptions of various members of a health care setting toward certain behaviors. One of my methods for discovering those perceptions will be an adjective scale factored into two dimensions. I am asking you to consider the attached list of adjectives and to place each of them in one of three categories -- appropriate/inappropriate, effective/ineffective, or other. Because some adjectives might describe both the appropriate and effective domains, you will need to decide which dimension is most salient for the adjective.

Please indicate your opinion by marking each adjective using the following key.

A = Appropriate/Inappropriate

E = Effective/Ineffective

O = Other

Several examples follow.

..O.. LANGUOROUS

..A.. SNIPPY

..O.. AGGRESSIVE

Your help is greatly appreciated.

THANK YOU

GLEN T. CAMERON

KEY

A = APPROPRIATE?INAPPROPRIATE

E = EFFECTIVE?INEFFECTIVE

O = OTHER

....	USUAL	....	RESPECTFUL
....	CONTENTIOUS	....	DOMINANT
....	EFFICIENT	....	SINCERE
....	RELEVANT	....	INFORMATIVE
....	CONCERNED	....	PLEASANT
....	TACTFUL	....	KNOWLEDGEABLE
....	AGGRESSIVE	....	COMPREHENDIBLE
....	GENUINE	....	FRIENDLY
....	AT EASE	....	INTERESTING
....	HONEST	....	CONSIDERATE
....	REFINED	....	FRIENDLY
....	SENSITIVE	....	HONEST
....	RESPONSIBLE	....	CARING
....	REALISTIC	....	EFFECTIVE
....	ASSERTIVE	....	GENTLE
....	BRASH	....	STRONG WILLED
....	ORGANIZED	....	FIRM

APPENDIX C

SAMPLE QUESTIONNAIRE

INSTRUCTIONS

This questionnaire has been devised to gather information about what is viewed as appropriate and effective behavior for staff in nursing homes. In this booklet, you will find ten short scenarios dealing with interesting situations that occur in nursing homes. As you imagine the scenarios, you can assume that the staff member is satisfied with the work conditions in the rest home. He or she is not overworked, or underpaid, and he or she wants to do the best possible job.

After you have imagined the scene, respond to the set of scales listed below the scenario. You will see a word used to describe the staff member's behavior in the imaginary scene. You can choose to agree or disagree with the description, or choose not applicable. For example:

FIRM AGREE DISAGREE NOT APPLICABLE

You would choose to circle one of the three words, depending upon whether you agreed, disagreed or felt the adjective was not applicable in describing the staff member's behavior.

INFORMATION ABOUT YOU

Age:.....

Sex:.....

Role: (check one of the following)

Registered Nurse with bachelors degree .....

Registered Nurse with associates degree .....

Registered Nurse with three year diploma .....

Nurse Aide .....

Resident in a nursing home .....

Have you ever worked in a nursing home? .....

Are you currently working in a nursing home? .....

If you are a staff member in a rest home, how many years of experience do you have in health care work? .....

During what years did you train for nursing? .....

Scenario #1

Two ladies who live in a nursing home are walking down the hallway holding hands. A staff member tells them to stop holding hands. How would you describe the staff member's behavior?

UNCONCERNED	AGREE	DISAGREE	NOT APPLICABLE
EFFICIENT	AGREE	DISAGREE	NOT APPLICABLE
DISHONEST	AGREE	DISAGREE	NOT APPLICABLE
RESPONSIBLE	AGREE	DISAGREE	NOT APPLICABLE
EFFECTIVE	AGREE	DISAGREE	NOT APPLICABLE
RESPECTFUL	AGREE	DISAGREE	NOT APPLICABLE
CONSIDERATE	AGREE	DISAGREE	NOT APPLICABLE
DISORGANIZED	AGREE	DISAGREE	NOT APPLICABLE
INFORMATIVE	AGREE	DISAGREE	NOT APPLICABLE
APPROPRIATE	AGREE	DISAGREE	NOT APPLICABLE
UNFRIENDLY	AGREE	DISAGREE	NOT APPLICABLE
COMPREHENDIBLE	AGREE	DISAGREE	NOT APPLICABLE

COMMENTS:

What do you feel is the most important issue in the scenario?

Have you experienced anything like this situation? If so, what happened?

Do you think the staff member should be praised or criticized in this situation? What are your reasons for praising or criticizing?

Scenario #2

A couple in the nursing home have been seeing a lot of each other during the past year. They are considering marriage. When they ask the opinion of the staff member, the staff member says they should not get married. They should wait until they know each other better. How would you describe the staff member's behavior?

INFORMATIVE	AGREE	DISAGREE	NOT APPLICABLE
EFFICIENT	AGREE	DISAGREE	NOT APPLICABLE
DISHONEST	AGREE	DISAGREE	NOT APPLICABLE
APPROPRIATE	AGREE	DISAGREE	NOT APPLICABLE
RESPECTFUL	AGREE	DISAGREE	NOT APPLICABLE
CONSIDERATE	AGREE	DISAGREE	NOT APPLICABLE
COMPREHENDIBLE	AGREE	DISAGREE	NOT APPLICABLE
DISORGANIZED	AGREE	DISAGREE	NOT APPLICABLE
EFFECTIVE	AGREE	DISAGREE	NOT APPLICABLE
UNFRIENDLY	AGREE	DISAGREE	NOT APPLICABLE
RESPONSIBLE	AGREE	DISAGREE	NOT APPLICABLE
UNCONCERNED	AGREE	DISAGREE	NOT APPLICABLE

COMMENTS:

What do you feel is the most important issue in the scenario?

Have you experienced anything like this situation? If so, what happened?

Do you think the staff member should be praised or criticized in this situation? What are your reasons for praising or criticizing?

Scenario #3

A male resident in the nursing home who formerly owned a ranch, has trouble dressing himself. However, he does not simply want to put on plain clothes like so many other residents wear. He wants to wear his western clothes because they are more manly. The staff member doesn't feel that she should have to help him with snap-button shirts and tight cowboy boots. She tells him that there is no reason why he can't dress like the other patients. How would you describe the staff member's behavior?

INFORMATIVE	AGREE	DISAGREE	NOT APPLICABLE
EFFICIENT	AGREE	DISAGREE	NOT APPLICABLE
DISHONEST	AGREE	DISAGREE	NOT APPLICABLE
APPROPRIATE	AGREE	DISAGREE	NOT APPLICABLE
RESPECTFUL	AGREE	DISAGREE	NOT APPLICABLE
CONSIDERATE	AGREE	DISAGREE	NOT APPLICABLE
COMPREHENDIBLE	AGREE	DISAGREE	NOT APPLICABLE
DISORGANIZED	AGREE	DISAGREE	NOT APPLICABLE
EFFECTIVE	AGREE	DISAGREE	NOT APPLICABLE
UNFRIENDLY	AGREE	DISAGREE	NOT APPLICABLE
RESPONSIBLE	AGREE	DISAGREE	NOT APPLICABLE
UNCONCERNED	AGREE	DISAGREE	NOT APPLICABLE

COMMENTS:

What do you feel is the most important issue in the scenario?

Have you experienced anything like this situation? If so, what happened?

Do you think the staff member should be praised or criticized in this situation? What are your reasons for praising or criticizing?

Scenario #4

A man and a woman who live in the nursing home have been flirting with each other lately. The man blows her a kiss and winks as she walks by him. A staff member sees this and tells the man to "act his own age." How would you describe the staff member's behavior-

UNCONCERNED	AGREE	DISAGREE	NOT APPLICABLE
EFFICIENT	AGREE	DISAGREE	NOT APPLICABLE
DISHONEST	AGREE	DISAGREE	NOT APPLICABLE
RESPONSIBLE	AGREE	DISAGREE	NOT APPLICABLE
EFFECTIVE	AGREE	DISAGREE	NOT APPLICABLE
RESPECTFUL	AGREE	DISAGREE	NOT APPLICABLE
CONSIDERATE	AGREE	DISAGREE	NOT APPLICABLE
DISORGANIZED	AGREE	DISAGREE	NOT APPLICABLE
INFORMATIVE	AGREE	DISAGREE	NOT APPLICABLE
APPROPRIATE	AGREE	DISAGREE	NOT APPLICABLE
UNFRIENDLY	AGREE	DISAGREE	NOT APPLICABLE
COMPREHENDIBLE	AGREE	DISAGREE	NOT APPLICABLE

COMMENTS:

What do you feel is the most important issue in the scenario?

Have you experienced anything like this situation? If so, what happened?

Do you think the staff member should be praised or criticized in this situation? What are your reasons for praising or criticizing?

Scenario #5

Two staff members are on break. The one tells about how two of the patients have been seeing a lot of each other and flirting with each other. The staff members says that she suspects there is some hanky-panky going on between the two residents. How would you describe the staff member's behavior?

INFORMATIVE	AGREE	DISAGREE	NOT APPLICABLE
EFFICIENT	AGREE	DISAGREE	NOT APPLICABLE
DISHONEST	AGREE	DISAGREE	NOT APPLICABLE
APPROPRIATE	AGREE	DISAGREE	NOT APPLICABLE
RESPECTFUL	AGREE	DISAGREE	NOT APPLICABLE
CONSIDERATE	AGREE	DISAGREE	NOT APPLICABLE
COMPREHENDIBLE	AGREE	DISAGREE	NOT APPLICABLE
DISORGANIZED	AGREE	DISAGREE	NOT APPLICABLE
EFFECTIVE	AGREE	DISAGREE	NOT APPLICABLE
UNFRIENDLY	AGREE	DISAGREE	NOT APPLICABLE
RESPONSIBLE	AGREE	DISAGREE	NOT APPLICABLE
UNCONCERNED	AGREE	DISAGREE	NOT APPLICABLE

COMMENTS:

What do you feel is the most important issue in the scenario?

Have you experienced anything like this situation? If so, what happened?

Do you think the staff member should be praised or criticized in this situation? What are your reasons for praising or criticizing?

Scenario #6

A staff member makes a mistake in caring for one of her patients. It is not a life threatening mistake, but could be the cause of discomfort for the resident. She goes to the resident and tells him or her about the mistake. How would you describe the staff member's behavior?

UNCONCERNED	AGREE	DISAGREE	NOT APPLICABLE
EFFICIENT	AGREE	DISAGREE	NOT APPLICABLE
DISHONEST	AGREE	DISAGREE	NOT APPLICABLE
RESPONSIBLE	AGREE	DISAGREE	NOT APPLICABLE
EFFECTIVE	AGREE	DISAGREE	NOT APPLICABLE
RESPECTFUL	AGREE	DISAGREE	NOT APPLICABLE
CONSIDERATE	AGREE	DISAGREE	NOT APPLICABLE
DISORGANIZED	AGREE	DISAGREE	NOT APPLICABLE
INFORMATIVE	AGREE	DISAGREE	NOT APPLICABLE
APPROPRIATE	AGREE	DISAGREE	NOT APPLICABLE
UNFRIENDLY	AGREE	DISAGREE	NOT APPLICABLE
COMPREHENDIBLE	AGREE	DISAGREE	NOT APPLICABLE

COMMENTS:

What do you feel is the most important issue in the scenario?

Have you experienced anything like this situation? If so, what happened?

Do you think the staff member should be praised or criticized in this situation? What are your reasons for praising or criticizing?

Scenario #7

A married couple move into the nursing home. They feel that the arrangement of their room is meant to tell them something. The room has single beds instead of a double bed as they are accustomed to having. They ask a staff member if this means that they aren't supposed to sleep together any longer. She tells them that they shouldn't have need of a double bed now. How would you describe the staff member's behavior?

UNCONCERNED	AGREE	DISAGREE	NOT APPLICABLE
EFFICIENT	AGREE	DISAGREE	NOT APPLICABLE
DISHONEST	AGREE	DISAGREE	NOT APPLICABLE
RESPONSIBLE	AGREE	DISAGREE	NOT APPLICABLE
EFFECTIVE	AGREE	DISAGREE	NOT APPLICABLE
RESPECTFUL	AGREE	DISAGREE	NOT APPLICABLE
CONSIDERATE	AGREE	DISAGREE	NOT APPLICABLE
DISORGANIZED	AGREE	DISAGREE	NOT APPLICABLE
INFORMATIVE	AGREE	DISAGREE	NOT APPLICABLE
APPROPRIATE	AGREE	DISAGREE	NOT APPLICABLE
UNFRIENDLY	AGREE	DISAGREE	NOT APPLICABLE
COMPREHENDIBLE	AGREE	DISAGREE	NOT APPLICABLE

COMMENTS:

What do you feel is the most important issue in the scenario?

Have you experienced anything like this situation? If so, what happened?

Do you think the staff member should be praised or criticized in this situation? What are your reasons for praising or criticizing?

Scenario #8

A male staff member in his late thirties is walking down the hall with a female nursing home resident. She says something funny and he laughs. As he tells her how sharp-witted he thinks she is, he wraps his arm around her shoulders and gives her a brief squeeze. How would you describe the staff member's behavior?

INFORMATIVE	AGREE	DISAGREE	NOT APPLICABLE
EFFICIENT	AGREE	DISAGREE	NOT APPLICABLE
DISHONEST	AGREE	DISAGREE	NOT APPLICABLE
APPROPRIATE	AGREE	DISAGREE	NOT APPLICABLE
RESPECTFUL	AGREE	DISAGREE	NOT APPLICABLE
CONSIDERATE	AGREE	DISAGREE	NOT APPLICABLE
COMPREHENDIBLE	AGREE	DISAGREE	NOT APPLICABLE
DISORGANIZED	AGREE	DISAGREE	NOT APPLICABLE
EFFECTIVE	AGREE	DISAGREE	NOT APPLICABLE
UNFRIENDLY	AGREE	DISAGREE	NOT APPLICABLE
RESPONSIBLE	AGREE	DISAGREE	NOT APPLICABLE
UNCONCERNED	AGREE	DISAGREE	NOT APPLICABLE

COMMENTS:

What do you feel is the most important issue in the scenario?

Have you experienced anything like this situation? If so, what happened?

Do you think the staff member should be praised or criticized in this situation? What are your reasons for praising or criticizing?

Scenario #9

A female resident of a nursing home asks to speak in private with one of the staff members. The resident confides that she feels pain in her groin area when she makes love with her partner in the nursing home. The staff member provides her with medical information about this problem for older women. The staff member also provides the resident with a sterile lubricant. Technically, the staff member has broken no rules of the nursing home. How would you describe the staff member's behavior?

INFORMATIVE	AGREE	DISAGREE	NOT APPLICABLE
EFFICIENT	AGREE	DISAGREE	NOT APPLICABLE
DISHONEST	AGREE	DISAGREE	NOT APPLICABLE
APPROPRIATE	AGREE	DISAGREE	NOT APPLICABLE
RESPECTFUL	AGREE	DISAGREE	NOT APPLICABLE
CONSIDERATE	AGREE	DISAGREE	NOT APPLICABLE
COMPREHENDIBLE	AGREE	DISAGREE	NOT APPLICABLE
DISORGANIZED	AGREE	DISAGREE	NOT APPLICABLE
EFFECTIVE	AGREE	DISAGREE	NOT APPLICABLE
UNFRIENDLY	AGREE	DISAGREE	NOT APPLICABLE
RESPONSIBLE	AGREE	DISAGREE	NOT APPLICABLE
UNCONCERNED	AGREE	DISAGREE	NOT APPLICABLE

COMMENTS:

What do you feel is the most important issue in the scenario?

Have you experienced anything like this situation? If so, what happened?

Do you think the staff member should be praised or criticized in this situation? What are your reasons for praising or criticizing?

Scenario #10

A staff member is visiting with a resident of a nursing home. They are alone in the day room. The staff member discusses a personal problem. How would you describe the staff member?

UNCONCERNED	AGREE	DISAGREE	NOT APPLICABLE
EFFICIENT	AGREE	DISAGREE	NOT APPLICABLE
DISHONEST	AGREE	DISAGREE	NOT APPLICABLE
RESPONSIBLE	AGREE	DISAGREE	NOT APPLICABLE
EFFECTIVE	AGREE	DISAGREE	NOT APPLICABLE
RESPECTFUL	AGREE	DISAGREE	NOT APPLICABLE
CONSIDERATE	AGREE	DISAGREE	NOT APPLICABLE
DISORGANIZED	AGREE	DISAGREE	NOT APPLICABLE
INFORMATIVE	AGREE	DISAGREE	NOT APPLICABLE
APPROPRIATE	AGREE	DISAGREE	NOT APPLICABLE
UNFRIENDLY	AGREE	DISAGREE	NOT APPLICABLE
COMPREHENDIBLE	AGREE	DISAGREE	NOT APPLICABLE

COMMENTS:

What do you feel is the most important issue in the scenario?

Have you experienced anything like this situation? If so, what happened?

Do you think the staff member should be praised or criticized in this situation? What are your reasons for praising or criticizing?

Scenario #11

A resident tells a staff member that the world's morals are getting worse all the time. The resident thinks that part of the problem is that men and women dress so much alike. He thinks that women should act more feminine, especially toward men. The staff member says that is unfair to women, because they need more freedom than they had in old fashioned days. How would you describe the staff member's behavior?

INFORMATIVE	AGREE	DISAGREE	NOT APPLICABLE
EFFICIENT	AGREE	DISAGREE	NOT APPLICABLE
DISHONEST	AGREE	DISAGREE	NOT APPLICABLE
APPROPRIATE	AGREE	DISAGREE	NOT APPLICABLE
RESPECTFUL	AGREE	DISAGREE	NOT APPLICABLE
CONSIDERATE	AGREE	DISAGREE	NOT APPLICABLE
COMPREHENDIBLE	AGREE	DISAGREE	NOT APPLICABLE
DISORGANIZED	AGREE	DISAGREE	NOT APPLICABLE
EFFECTIVE	AGREE	DISAGREE	NOT APPLICABLE
UNFRIENDLY	AGREE	DISAGREE	NOT APPLICABLE
RESPONSIBLE	AGREE	DISAGREE	NOT APPLICABLE
UNCONCERNED	AGREE	DISAGREE	NOT APPLICABLE

COMMENTS:

What do you feel is the most important issue in the scenario?

Have you experienced anything like this situation? If so, what happened?

Do you think the staff member should be praised or criticized in this situation? What are your reasons for praising or criticizing?

Scenario #12

A staff member is distributing evening snacks to residents in their rooms. She enters a male resident's room without knocking. How would you describe the staff member's behavior?

UNCONCERNED	AGREE	DISAGREE	NOT APPLICABLE
EFFICIENT	AGREE	DISAGREE	NOT APPLICABLE
DISHONEST	AGREE	DISAGREE	NOT APPLICABLE
RESPONSIBLE	AGREE	DISAGREE	NOT APPLICABLE
EFFECTIVE	AGREE	DISAGREE	NOT APPLICABLE
RESPECTFUL	AGREE	DISAGREE	NOT APPLICABLE
CONSIDERATE	AGREE	DISAGREE	NOT APPLICABLE
DISORGANIZED	AGREE	DISAGREE	NOT APPLICABLE
INFORMATIVE	AGREE	DISAGREE	NOT APPLICABLE
APPROPRIATE	AGREE	DISAGREE	NOT APPLICABLE
UNFRIENDLY	AGREE	DISAGREE	NOT APPLICABLE
COMPREHENDIBLE	AGREE	DISAGREE	NOT APPLICABLE

COMMENTS:

What do you feel is the most important issue in the scenario?

Have you experienced anything like this situation? If so, what happened?

Do you think the staff member should be praised or criticized in this situation? What are your reasons for praising or criticizing?

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RAW DATA

KEY:

Columns	Variable	Code
1-2	Sex	(Unknown=1;Male=2;Female=3)
3-4	Role	(Unknown=1;Associate=2; Bachelor=3;Aide=4;Resident=5)
5-6	Veteran	(Unknown=1;Yes=2;No=3)
7-8	Current	(Unknown=1;Yes=2;No=3)
9-10	Experience	(Actual number of yrs.)
11-12	Vintage	(Actual yr. of graduation)
13-14	Scenario	(Number of the Scenario)
15	Unconcerned	(Agree=1;Disagree=2; Not Applicable=3)
16	Efficient	(Agree=1;Disagree=2; Not Applicable=3)
17	Dishonest	(Agree=1;Disagree=2; Not Applicable=3)
18	Responsible	(Agree=1;Disagree=2; Not Applicable=3)
19	Effective	(Agree=1;Disagree=2; Not Applicable=3)
20	Respectful	(Agree=1;Disagree=2; Not Applicable=3)
21	Considerate	(Agree=1;Disagree=2; Not Applicable=3)
22	Disorganized	(Agree=1;Disagree=2; Not Applicable=3)
23	Informative	(Agree=1;Disagree=2; Not Applicable=3)
24	Appropriate	(Agree=1;Disagree=2; Not Applicable=3)
25	Unfriendly	(Agree=1;Disagree=2; Not Applicable=3)
26	Comprehendible	(Agree=1;Disagree=2 Not Applicable=3)
27	Relevance	(None=1;Yes=2;No=3)
28	Sanction	(None=1;Praise=2; Criticism=3)

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