

THE DYING CHILD: DIRECT OBSERVATION
OF NURSING INTERACTIONS

by

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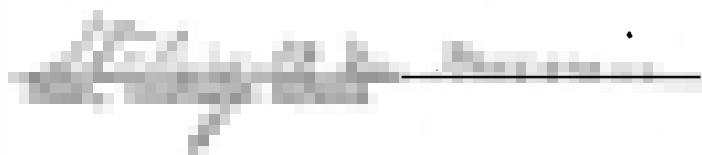
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ABSTRACT

An exploratory study was designed to investigate the verbal interactions of nurses with fatally ill children and their mothers as compared with non-fatally ill children and their mothers on an inpatient pediatric unit. The verbal behavior of registered nurses, licensed practical nurses and nurse's aides was tape recorded as they came in contact with four children with fatal illnesses and four children with non-fatal illnesses. Verbal behavior of mothers and children was also recorded. All units of verbal behavior were coded and classified using the Diers Nurse Orientation System. Percentage profiles of verbal units per category of the Nurse Orientation System were calculated.

The major findings were:

a) All nursing personnel were patient-oriented in their verbal behavior toward both groups.

b) All nursing personnel were oriented to the patients as physical persons in greater proportion than they were oriented to the patients as thinking-evaluative or feeling persons, regardless of patient group.

c) All personnel were oriented to the fatally ill children and their mothers as feeling persons in lower proportion than they were to the non-fatally ill children and their mothers.

d) All nursing personnel were oriented to the fatally ill children and their mothers as thinking-evaluative persons in greater

proportion than they were to the non-fatally ill children and their mothers.

e) All nursing personnel were oriented to themselves in greater proportion when interacting with the fatally ill children and their mothers than with the non-fatally ill children and their mothers.

f) Licensed practical nurses had a greater proportion of patient-oriented responses in the feeling dimension for both groups than did the registered nurses and aides.

g) Mothers of fatally ill children were more patient-oriented, more thinking-evaluative-oriented, and more nurse-oriented than the mothers of non-fatally ill children. They were less feeling-oriented and less other-oriented than the mothers of the non-fatally ill children.

h) Fatally ill children were less patient-oriented, less feeling-oriented, and less nurse-oriented than the non-fatally ill children. They were more thinking-evaluative-oriented and more other-oriented than the non-fatally ill children.

The findings of the study suggest that although nursing personnel were predominantly oriented toward their patients in their verbal behavior, differences were present in their patterns of interaction with fatally ill and non-fatally ill children and their mothers. In particular, the findings revealed lower proportions of patient-oriented interactions, especially in the feeling dimension, with fatally ill children and their mothers. Fatally ill children and their mothers had patterns of interaction which differed from the non-fatally ill children and their mothers. The study suggests that further investigation of the

verbal interactions of nurses, mothers, and children is warranted as a basis for developing a therapeutic nursing role with fatally ill children and their families.

CHAPTER I

INTRODUCTION

The process of dying in the United States has undergone significant changes in the course of the last century. There have been two major changes in the patterns of mortality. The leading cause of death from illness has shifted from communicable disease to the "degenerative diseases," that is, cardiovascular disease and malignant neoplasms (Lerner, 1970). In addition, people who die today are more likely to die in a hospital or other medical institution than they were earlier in the century (Lerner, 1970; Ross, 1969). In 1935, nine of the twelve leading causes of death in childhood were infectious diseases. Diseases of the heart and cancer were eighth and twelfth respectively. In 1965, three of the twelve leading causes of childhood death were infectious diseases. Cancer was the leading fatal illness in children, closely followed by congenital malformations and diseases of the heart. Included in the twelve leading causes of death in childhood were central nervous system vascular lesions, cystic fibrosis, and nephritis (Grant, 1968). The fatal illnesses of childhood tend now to be of a long-term nature requiring complex therapy and frequent hospitalizations.

The changing patterns of childhood mortality have important implications for the affected children, their families, and for health care workers. The children experience frequent hospitalizations,

separation from home and parents, and often a multitude of painful procedures in the months and years preceding death which most often occurs in the hospital. Parents live with the knowledge that eventually their children will die in spite of all efforts to save them. During the children's hospitalizations, parents must cope with the changes in the parent-child relationship and deprivation of parental function as the hospital assumes protection and management of the child (Bozeman, Orbach, & Sutherland (1955). The health care worker, particularly the nurse, is in a position to help fatally ill children and their families meet the demands of life-threatening illness. The nurse's daily responsibilities of meeting patient needs and mediating physicians' orders make her a key figure in the management of the fatally ill child (Weiner, 1970b).

An important area of nursing research is the investigation of what goes on between the nurse and the patient and what effect it has on the patient (Diers & Leonard, 1966). Nursing care includes verbal interchange with patients in addition to care of their physical needs through manual tasks. The nurse-patient interaction is dependent upon the nurse's ability to communicate effectively with the patient in relation to his needs. To do so, the nurse must be aware of her own needs and behavior as well as those of the patient (Bermosk & Mordan, 1964). The difficulties of verbal communication between nurses and dying patients and their families have been noted by many investigators (Craytor, 1969; Easson, 1968; Glaser & Strauss, 1965; Goldfogel, 1970; Hoffman, 1971; Price, 1956; Ramshorn, 1971; Ross, 1969, 1971; Smith &

Schneider, 1969). Fears of discussing death and of emotional involvement leading to the experience of loss often results in the avoidance of the patient's emotional needs (Geis, 1965; Glaser & Strauss, 1964, 1965; Quint, 1967; Wodinsky, 1964). Most studies to date have obtained their data on nurses' responses to the dying patient through interviews, questionnaires, and group meetings. Few attempts have been made to directly observe the verbal behavior of nurses with dying patients. Analyzing actual nurse-patient verbal interactions with fatally ill children and their parents may reveal patterns of interactions that may prove useful in elaborating and teaching nursing care of the seriously ill child and his family.

Statement of the Problem

The purpose of the present study was to explore nurse-parent-child verbal interactions in hospitalized children with both fatal and non-fatal illnesses.

The major research questions were:

1. What is the pattern, if any, of nursing verbal behavior with pediatric patients and their parents in general?
2. Do nursing personnel interact differently with fatally ill children and their parents than with non-fatally ill children and their parents?
3. Are there differences in patterns of interaction of registered nurses, licensed practical nurses, and nurse's aides?
4. Do fatally ill children and their parents have patterns of verbal interaction with nursing personnel that differ from those of

non-fatally ill children and their mothers?

The Diers Nurse Orientation System, a method of interaction analysis specific to nursing, was selected as the means by which verbal behavior was analyzed.

Definitions of Terms

The terms are defined for the purposes of the present study as follows:

Fatal illness: a childhood disease which is life-threatening, of at least four months' duration, and incompatible with living to adulthood.

Non-fatal illness: a childhood disease, condition, or trauma which is not life-threatening and which does not interfere with the child's expectation of living to adulthood.

Parent: the mother of the hospitalized child.

Nursing personnel: registered nurses, licensed practical nurses, and nurse's aides employed on the in-patient pediatric unit.

Patterns of verbal interaction: the percentage of verbal units per category of the Nurse Orientation System.

Review of Related Literature

The three areas of related literature that were reviewed were: fatal illness in childhood and its impact and meaning for parents, children, and health care workers, the Diers Nurse Orientation system, and the use of observation as a research method.

Reactions to fatal illness in childhood. The death of a child is one of the deepest of human tragedies. The long and debilitating illness which often precedes childhood death today is particularly difficult to witness. Instead of the growth and mastery of normal childhood there is increasing weakness and slow decline (Schowalter, 1970). Parents, professional medical personnel, and often the child himself know he will never have the opportunity to reach his adult potential (Glaser & Strauss, 1964). All involved experience deep emotional reactions to the tragedy and outrage of fatal illness in childhood.

Ross (1969) has identified five stages of adjustment to fatal illness which adult patients experience. The families of dying patients experience much the same process. The parents of fatally ill children pass through the stages of denial, anger, bargaining, depression, and acceptance in much the same way as the adult patients' families. A child is often perceived by his parents as an extension of their own physical and emotional beings (Solnit & Green, 1959). Therefore, while it has not been documented, it may be that parental experience is closer to that of the dying adult patient than to that of the family of the dying adult patient. To a parent, the death of a child may be perceived as the death of a part of himself.

The first stage of adjustment to fatal illness and impending death is denial. Denial is an early and temporary response, characterized by "shock" or numbness following the news that the illness is serious and incurable. Denial is soon followed by partial acceptance

of the diagnosis and prognosis, an acceptance which is intellectual and therefore incomplete. It is usually enough, however, to allow the patient to acknowledge the need for treatment and to pursue it (Ross, 1969). Similar responses have been observed in parents who are told that their children have fatal illnesses, (Bozeman et al, 1955; Friedman, Chodoff, Hamburg, & Mason, 1963; Kaplan, Fischman, Grobstein, & Smith, 1971; Natterson & Knudson, 1960). Parents experienced a feeling of being stunned. The news was incomprehensible. The stunned phase lasted for several days and was followed by intellectual understanding of the diagnosis and its implications. Most parents appeared able to accept the reality of the disease. Few completely denied that the illness existed or that it was serious. Intellectual acceptance usually occurred, permitting therapy to proceed (Bozeman et al., 1955; Friedman, 1967; Friedman et al., 1963).

Partial acceptance of the diagnosis and prognosis of fatal illness results in anger, the second stage of adjustment. During the state of anger the patient rebels against his fate, saying, "Why me?" He is angry at the premature termination of plans, hopes, and life itself. He lets his anger out on the people who still have the things of which he has been deprived (Ross, 1969). Parents of fatally ill children also react with anger when they have begun to accept the diagnosis. Their search for an answer to the question, "Why my child?" often leads to self-incrimination and guilt. They fear they have neglected the child, been deficient in meeting his physical needs. They fear that had they been more observant of early symptoms, the

illness would not be so devastating. Anger at the illness and its implications is partly directed inward. It is also displaced onto the environment, usually the hospital and its personnel. Anger and the frustration of helplessness in being unable to prevent the loss of the child are channeled into criticisms of the efficiency and quality of nursing care. Demands are made for services, and when rendered, they are criticized. Anger may also be directed at physicians and medical management in general in an expression of disappointment in the failure of the physicians' omnipotence (Bozeman et al., 1955; Friedman, 1967; Friedman et al., 1963; Weiner, 1970a). The stage of parental anger is a trying time for staff and families alike. Staff members often lose sight of the character of the anger and take it personally. Originally, the anger of the parents has little or nothing to do with the people at whom it is directed. But as staff react personally to it, the parents' anger is increased. Staff may respond by avoiding the family or shortening contacts with them (Ross, 1969).

The stage of bargaining tends to follow the stage of anger. The unconscious rationale appears to be that if anger does not succeed in reversing the verdict, then perhaps "acting nicely" will change the outcome. Most bargains are made with God and usually involve the request for extension of life or a few more days free from pain in exchange for some good behavior (Ross, 1969). Bargaining has not been specifically reported in the parents of fatally ill children. Bozeman et al. (1955) reported that the chief value of religion or the belief in God to mothers of children with leukemia was in the possible help it

might provide in saving the children's lives. Whether parents bargain with God for cures, extension of life, or freedom from pain for their children is not yet known.

Depression is the fourth stage of adjustment to fatal illness. It has two components. One is reactive depression, a response to changes in body image, life style, and expectations brought about by the illness. A woman may lose a breast or the financial drain of hospitalization and treatment may force the giving up of luxuries. Sadness and disappointment result. The second component of the stage of depression is anticipatory grief. The patient begins his separation from all that has been his life. He grieves in the loss of loved people, places, and all that he has known. He slowly withdraws from the world and people. It is a painful, necessary stage of adjustment, accompanied by deep depression (Ross, 1969).

Parents of fatally ill children are usually engaged in the work of anticipatory grief by the fourth month following the diagnosis of illness (Friedman et al., 1963). Anticipatory grief is not unlike that which follows the death of a loved person. Grief is a definite syndrome with psychological and somatic symptomatology (Lindemann, 1944). There is intense mental pain and suffering, with distress, deep sorrow, and painful regret (Peretz, 1970). Preoccupation with the image of the deceased accompanied by painful yearning and loneliness are present. Guilt and hostility appear. Irrational anger at the dead person for not remaining alive may provoke unacceptable feelings and guilt. The inevitable feelings of ambivalence in any relationship may be aroused,

leading to guilt regarding past quarrels, negligence, and failures. Guilt may be aroused by feelings of relief at a death following a long illness (Lindemann, 1944; Peretz, 1970). Acute grief is also characterized by irritability, impatience, and social withdrawal. Somatic symptoms such as sighing, weeping, insomnia, digestive disturbances, and anorexia are present (Lindemann, 1944).

The symptoms of anticipatory grief are similar to those of acute grief but are less dramatic and occur over time (Weiner, 1970a). During the course of the illness parents experience preoccupation with the child, irritability, guilt, hostility projected outward as previously described, insomnia, and disruption of eating habits (Bozeman et al., 1955; Weiner, 1970a). The anticipatory grieving process leads to some degree of emotional detachment from the ill child. The relationship with the child becomes less intense. Parents show greater interest in other children on the hospital unit. There is renewed interest in family affairs, old family activities, and other children in the family (Friedman, 1967). The manifestations of resolving anticipatory grief should be encouraged by professional personnel rather than aborted (Friedman, 1967; Richmond & Waisman, 1955). They are indications that the final stage of adjustment to fatal illness is at hand.

Acceptance is the fifth and final stage of adaptation to fatal illness and impending death. Anticipatory grieving is completed. The patient has detached himself from loved ones. Anger, grief, and hopelessness have been experienced, and the patient awaits death with neither happiness nor despair. Feeling is practically absent except for

a possible desire for the comfort of the presence of one loved person. He has accepted his fate and awaits it quietly (Ross, 1969). Acceptance of the loss of a child can be observed in parents who have successfully completed the stages of denial, anger, and anticipatory grief. Hope becomes more limited. Where once parents hoped for a cure for the illness, then for one more remission, hope focuses on one more good day, one more smile, the relief of suffering (Friedman, 1967; Friedman et al., 1963). Parents who have accomplished the work of anticipatory grief and have achieved some emotional separation from the child have been observed to accept the actual death calmly, with appropriate affect, and with relief that the child's suffering is over (Hamovitch, 1964; Natterson & Knudson, 1960; Weiner, 1970a).

A child's response to his own fatal illness depends on his developmental capacity to understand the meaning of death and on the emotional climate provided by those who care for him (Schowalter, 1970). The child under three years equates death with the absence of the loved person on whom he depends (Green, 1967). He does not yet appreciate the concept of death as the cessation of his personal being (Schowalter, 1970). In common with non-fatally ill hospitalized children, the most common cause of distress is separation from his mother (Bowlby, 1960; Natterson & Knudson, 1960).

The child from three to six has a growing concept of death, but he does not perceive it as permanent. He has little anxiety about his own death (Schowalter, 1970). If he does experience fear of dying, it is probably as the loss of love and attention necessary for feeling

cared for emotionally and physically (Green, 1967). The child of three to six may perceive illness as a punishment for the aggressive fantasies which appear toward parents and siblings at this age. He may bear the responsibility of punishment himself and become passive and withdrawn. Or he may project it onto parents or professional personnel, becoming angry and rebellious (Schowalter, 1970). Traumatic procedures such as injections and surgery are causes of fear and distress, and may also be perceived as punishments for his aggressive wishes (Natterson & Knudson, 1960).

The school age child gradually acquires a basis for conceptualizing death as the end of human experience (Green, 1967). By adolescence the child gains a concept of the permanency of death, and his reactions to fatal illness resemble those of the adult. Older children and adolescents often react with depression to failing strength, dependency, and with impotent anger at their unfulfilled potential (Schowalter, 1970). The maturation of the child's concept of death appears to parallel the evolution of his concept of self. His first awareness as an infant is awareness of his mother. Separation from her is his greatest fear, equated with death. As he matures, he becomes aware of his own body. Fear of harm or the destruction of his body in punishment for his "bad" wishes is his greatest fear. Finally, the child becomes aware of himself in time, that is, of life itself (Natterson & Knudson, 1960). The experience of dying has various meanings which are dependent upon the maturational level of the child.

The emotional climate created by the important adults

surrounding the fatally ill child affects the child's verbal expression of his thoughts and feelings. It was long believed that children under ten years could not comprehend death or understand what was happening to them. In 1955, Richmond and Waisman reported that the fatally ill children and adolescents they observed showed no overt concern about death. They were very passive and showed no objection to procedures. The investigators suggested that the children's behavior was due to resignation to their fate and decreased physical energy. However, Natterson and Knudson (1960) found that school age children became anxious, withdrawn, and depressed by the death of another child on the unit. Vernick and Karon (1965) found that school age children who were told their diagnosis experienced a sense of relief that their illness could be discussed with meaningful adults (parents and professional personnel). The children's relief suggested that they had already known they were seriously ill and sensed that the adults did not want them to talk about it. Recent research has shown that fatally ill children as young as six years are preoccupied with thoughts and anxieties of illness and death (Waechter, 1971). Older children may suspect the truth but evasive measures and false cheerfulness are common adult tactics for avoiding discussion. Children of all ages may feel abandoned. In addition, if their illness is too terrible to discuss as suggested by adults' evasiveness, the children will fear to mention it. They fear driving away the human contact they need (Waechter, 1971). Fatally ill children rarely talk about death because they have learned from others that it is a forbidden subject

(Schowalter, 1970).

It has been found that a core conflict exists in each worker who deals with dying children. The response of compassion leads the worker toward the child and his family with aid and comfort. The response of repulsion by the threat of death causes the worker to move away in order to protect himself from the shock of separation and loss. Those who have chosen to provide health care services have in common a desire to help sick people get well (Rothenberg, 1967). The desire may stem from needs for mastery, control, omnipotence, or the gratification of dependency. With regard to death and dying, it has been found that many health care workers feel the need to cure in order to deal with their own fears of death by means of power over illness (Weiner, 1970b). Thus the death of a patient, particularly the death of a child, poses threats to individual defense systems and greatly frustrates the primary curative goal of health care.

Several investigators have studied nurses' reactions to the dying patient. Wodinsky (1964), in a series of group meetings, explored nurses' feelings about working with adult leukemia patients. He found that many nurses felt guilty about not doing enough for the patient. They often felt almost responsible for the disease. They feared discussing death, even when the patient raised the subject. They mollified their own intense anxiety by refusing to discuss it. They found it difficult to enter the patient's room once he was in a terminal phase, and found themselves avoiding him. They also avoided the family who were frequently critical and obstructive of nursing care. The net

result was a complete avoidance of the situation resulting in guilt.

Glaser and Strauss (1965) describe the strategies by which the nurse maintains her professional composure when dealing with the dying patient and his family. Maintenance of composure is essential to enable her to do her own work and to assist other staff members. The patient's family may accuse the staff of negligence. To avoid scenes and threats to professional composure, nurses may avoid family members. The patient is given good medical care, but as death approaches the nurse progressively decreases her emotional involvement with him. She may avoid him completely, discourage conversation, and acquire a personal appearance that discourages patient-nurse interchange. Medical duties are performed efficiently while avoiding the patient as a person. When conversation occurs the nurse may listen and respond selectively, avoiding the subject of death. Patients with high social loss value make it even harder to maintain composure. A patient with social loss value is one who, because of his age, occupation, family status, personal characteristics, social class, etc., is considered a great loss to his family, occupation, and/or society at death. A child is a high social loss patient, one of the most valuable of all people in our society. His death cheats him of his opportunity for a full life. Nurses' reactions to social loss are distress, sadness, and increased efforts at providing care. If the loss is too threatening, however, the need to decrease involvement may result in avoidance strategies (Glaser & Strauss, 1964, 1965).

Wallace and Townes (1969) discuss avoidance reactions to the

terminal child. They discuss nurses who worked with many children and their families from diagnosis of leukemia to death. As a child became terminal staff interests turned toward newly diagnosed children who still had hope of response to drug therapy and away from the dying child. The investigators attributed the nurses' behavior to the full acceptance of the loss of the child with a turning to other interests, a resolution of loss and grief. Geis (1965) interviewed mothers several months after the deaths of their children. Many commented on the absence of nurses during the children's last hospitalizations in contrast with previous availability. The mothers excused the nurses on the grounds of understaffing and overwork. Geis, however, raised the question of avoidance reactions on the part of the staff. The same question might be raised for the explanation given by Wallace and Townes of avoidance during the terminal phase of illness.

Quint (1967) studied the reactions of student nurses to the dying child. Students learned from staff nurses that composure and self-control were highly valued. The students tended to follow the example. Experienced students who were assigned to fatally ill children focused their attention on the disease and its treatment to keep themselves uninvolved with the children personally. Little conversation was initiated with parents regarding the child's illness. Personal contact with the child and parents was limited, and extra assignment time with the patient was avoided. Assignment time was kept short. Conversation that did occur focused on everyday matters. Supervision was scanty, and the instructor's help was rarely sought. Nursing staff and instructors

minimized contact with the family. They rationalized that it was unfair to the family to begin a relationship and then not be there at critical moments.

Ramshorn (1971) observed patients undergoing chemotherapy for malignant disease in the life island. She found that the nurses who cared for them were concerned about the patients' conditions and the fact that many patients were depressed. However, they did not discuss these things with the patients. They felt a need to keep the patients' hopes up even if denial and distortion of reality were necessary. Patients in the life island never progressed beyond the stage of denial in their adaptation to fatal illness because the nurses would not let them. The nurses' communications to the patients reinforced denial and hindered the adaptation process.

Nurses use talk in several ways. Information is exchanged with patients for explanation and fact-gathering. Talk may be used to fill time, to amuse and divert patients. Finally, talk is a therapeutic tool to reduce anxiety and increase comfort (Craytor, 1969). The nurse who can talk meaningfully to the fatally ill child and his parents can help them meet the challenges of the stages of adjustment to fatal illness. She can help them express their anger, encourage the work of anticipatory grief, and support them when death occurs. To do so, she must come to grips with her own feelings about death, grief, and loss. In addition, she must learn that meaningful verbal communication is more than the exchange of words. It is an exchange of understood meanings (Craytor, 1969). In an effort to delineate patterns of verbal exchange

between nurses and patients and the meanings that are inherent in those patterns, Diers developed the Nurse Orientation System.

The Nurse Orientation System. The Nurse Orientation System is a method of interaction analysis in which units of verbal behavior are classified into categories. Interaction analysis is a means of describing the structure and content of verbal communication between people. Communication is reduced to quantitative form, thus providing a means of specifying and making known to others the components of verbal interaction. Interaction categories must be empirically relevant to those aspects of patient welfare which are the focus of study. When categories are thus successfully delineated, interaction analysis can reveal the elements of nursing process in the area of intervention under investigation (Diers & Leonard, 1966).

The categories of the Nurse Orientation System are based on a conceptualization of the nurse's perception of her patient. It was observed that nurses may restrict their perceptions of patient behavior, responding to patients in terms of preconceived ideas. While this unconscious maneuver may help the nurse organize the many stimuli she receives from the patient, it contributes to the distortion of her perception of the patient as he is. The limited number of patient stimuli to which the nurse responds results in misinterpretation or insensitivity to the patient's communication of his needs (Diers, 1971). Three dimensions in which the nurse can relate to a patient were identified. The nurse can relate to her patient as a physical being, that is, as a person with physical needs and bodily activities. The nurse

relating in this dimension might perceive her patient as someone having surgical pain or needing a drink of water. A second patient dimension to which the nurse can relate is the thinking-evaluative-knowing aspect. The patient is perceived as a rational person, a person who knows something, and/or a person who can evaluate his experience. The nurse relating to her patient in this dimension might ask him for information about himself which requires him to evaluate his symptoms. Finally, the nurse can relate to her patient as a person with emotions. A nurse relating to her patient in the emotional or feeling dimension might see him, for example, as a worried person, and her verbal communication would reflect this perception. Because patients are thus three-dimensional persons, the nurse's restriction of perception, and hence communication, to one or two dimensions can lead to misinterpretation of the patient's communication and failure to meet his needs (Diers, 1971).

The nurse who is relating to her patient in one or more of the three dimensions is patient-centered. Her perceptual stance or orientation is toward the patient (Diers, 1971). Her perceptual stance may shift from time to time during conversation with a patient. She may become oriented to an object and talk about a chest tube, a wheelchair, or a blanket. She may become oriented to herself in one or more of the three dimensions. She may tell the patient that she is going to lunch, indicating orientation to herself as a physical person engaged in activity. She may respond to a patient's statement by saying, "I hadn't thought of that before." She is thus oriented to herself as a

thinking-evaluative person. Or, she may say, "That makes me very happy," indicating her orientation to herself as a feeling person. The nurse's perceptual stance may shift to another person other than the patient or herself. She may talk about the patient's physicians or her husband, and each of these people are related to as physical, thinking, or emotional beings. In like manner, the patient can be oriented to the nurse, himself, or others in the three dimensions, or to an object. The categories and dimensions of the Nurse Orientation System exhaust the possibilities of perceptual stance for nurse and patient (see Appendix, p. 85). The major categories, "Object," "Patient," "Nurse," and "Other," represent all the persons and non-persons toward which attention can be directed. The dimensions, "feeling," "knowing-thinking-evaluating," and "being-doing," represent all the aspects of a person to which relating can occur. Every unit of verbal behavior in a nurse-patient interaction can be classified by category and dimension (Diers, 1971).

The classification of verbal behavior by way of the Nurse Orientation System does not provide a literal translation of the nurse-patient interaction. The concept of orientation is a reflection of meaning to the person who is speaking (Diers, 1971). The percentage of coded verbal units in each category of the Nurse Orientation System reflects the pattern of conveyed meanings in any nurse-patient interaction. For example, the nurse unit, "You're feeling pretty sad today, aren't you?" is classified as patient-oriented in the feeling dimension. The meaning of the statement as conveyed is that the nurse recognized

her patient's emotional state and responded verbally to it. In the course of any nurse-patient conversation many units of verbal behavior occur which are then classified according to their meanings to the speaker. The percentage of units per category reveals to whom or what the nurse is predominantly oriented and in which dimensions.

The Nurse Orientation System was assessed for reliability. Aspects of reliability tested were agreement between coders, agreement within one coder over time, effect of coding method (in and out of context) on agreement, and effect of coder training on agreement. Training raised both the intersubjective and intrasubjective reliability. Agreement was 50-60% with no training. Agreement between coders was not affected by the method of coding. However, on patient units the coder agreed more with herself on the out-of-context units than on the in-context units. This was attributed to having the nurse units in view while coding patient units, causing distraction. The conclusions of the study were that the categories of the Nurse Orientation System were defined sensitively enough that consistent coding could result. A brief training period raised interscorer agreement by 20% (Diers, 1971).

Several studies have been conducted using the Nurse Orientation System (Christoffers, 1967; Dumas, 1967; McBride, 1967; Schmidt, 1966; Severin, 1965; Slavinsky, 1967; Spurgeon, 1965). In general, the studies have used the Nurse Orientation System either to describe nurse-patient interactions or as a means of manipulating nursing verbal behavior to study its effects on patient welfare. Current research

with the Nurse Orientation System is focused on its use in comparing and systematically varying patterns of interaction for use in predictive studies (Diers, 1971). The present study used the Nurse Orientation System to describe nurse-patient interactions in the pediatric setting. It attempted to descriptively compare patterns of interaction of nursing personnel with two groups of children who differed in type of illness and life expectancy.

Observation as a research method. The use of the Nurse Orientation System for the analysis of verbal interactions is dependent upon verbatim recording of verbal behavior. Direct or indirect observation of the research situation is therefore necessary. Indirect observation, with the investigator removed from the research situation and behavior recorded mechanically, helps remove distortions created by the observer's presence. Indirect observation was not feasible for the present study. Direct, non-participant observation was selected. Direct observation is an appropriate research method when a problem is in an exploratory stage of research, and it is not yet possible to discern explicit relationships of variables for quantitative testing (Dean, Dean, & Eichhorn, 1969; Strauss, Bucher, Ehrlich, Sabshin, & Schatzman, 1969). It is a method well suited to behavioral description (Fox, 1966). It provides a means of forming a configuration of many units of behavior occurring at the same time (Dean et al., 1969; Zelditch, 1969). Difficult-to-quantify variables are less distorted by unstructured observation than by abortive attempts to operationalize them for quantitative analysis (Dean et al., 1969). Greater

reality in relation to the total content of the research can be obtained. Observation of a natural situation can result in greater generalizability to the larger population than is true with an experimental design (Abdellah & Levine, 1965).

Direct observation as a research method has disadvantages. Greatest perhaps is the fact that watching a research situation often changes it. Distortion occurs due to the observer's presence. However, the distortion usually does not persist. An acclimatization and orientation period at the beginning of observation when no data are collected allows the research situation to return to normal without distorting the data (Fox, 1966; Kerlinger, 1964). The introduction of bias is another disadvantage of direct observation. Observation may be distorted by the investigator's preconceptions and expectations (Dean et al., 1969; Kerlinger, 1964; McCall & Simmons, 1969; Schwartz & Schwartz, 1969). Bias is minimized through the requirements and nature of the Nurse Orientation System. The need for verbatim recording of verbal behavior requires that tape recording or other mechanical means be used. The coding system defines characteristics of each category so that units are appropriately coded with a minimum of distortion.

CHAPTER II

METHOD

The study was conducted on the 22-bed pediatric unit of a 275-bed university teaching and research hospital. Children between the ages of approximately one month and eighteen years were cared for on the unit. Reasons for admission ranged from tonsillectomy to the management of severe illness such as leukemia and cystic fibrosis. At any given time one-third to one-half of the patient population was made up of children with life-threatening illnesses. They were not expected to live to adulthood. Any of their frequent hospitalizations might terminate in death. The remaining one-half to two-thirds of the children were hospitalized for treatment of acute illness, corrective surgery, or following trauma. They were expected to recover and return to normal, active lives.

Nursing personnel on the pediatric unit were registered nurses, licensed practical nurses, and nurse's aides. Student nurses were on the unit for three days a week during the day shift. Most of the registered nurses rotated between two shifts, working the day shift for one-half of the work week and the evening or night shift for the other one-half of the week. They rotated to the shift of their preference and rarely changed from evenings to nights or nights to evenings. The practical nurses and aides tended to work one shift consistently.

Subjects

Subjects were eight hospitalized children, five mothers, and twenty-two nursing personnel. Four children with life-threatening illnesses were randomly selected over a two-week period within forty-eight hours of admission. These children, with their mothers when present, made up Group 1. Four children of similar age but with non-life-threatening illnesses were selected and observed over the same two-week period. Their mothers were also included whenever present. These children and mothers comprised Group 2. Table 1 shows the ages and diagnoses of the children, whose names are fictional, and whether or not the mother was present during at least one-half of the observations.

Four-year-old Bruce had Down's syndrome and acute leukemia. He was admitted to the hospital with viral pneumonia. His leukemia had been under control for two years, but his pneumonia was severe enough to threaten his life. He spent most of his two-week hospitalization in a croup tent with oxygen. His mother was a young, shy girl with two other children younger than Bruce. She arrived at the hospital early in the morning and stayed until late in the evening every day. She was deeply worried about Bruce and devoted to his care. She performed most of his care and acted as an interpreter of his needs to the nursing staff. He appeared content when she was present, but cried and struggled to get out of the croup tent when she left.

David was a six-year-old with acute leukemia in relapse. He had been ill for almost three years and had received most of the effective chemotherapeutic agents. He was admitted to the pediatric unit for

TABLE 1

Name, Age, Diagnosis, and Presence of Mother
for Each of Eight Subjects

	Age	Diagnosis	Presence of Mother During at Least 1/2 of Observation Periods
<u>Group 1</u>			
Bruce	4 years	Acute leukemia Down's Syndrome Pneumonia	Yes
David	6 years	Acute leukemia in relapse	Yes
Bonnie	14 years	Cystic fibrosis	Yes
Peter	14 years	Chronic renal disease	No
<u>Group 2</u>			
Jenny	2 years	Repair of cleft palate	Yes
Mark	5 years	Excision of Baker's cyst of right knee	No
Dan	13 years	Automobile-pedestrian accident: Sciatic nerve contusion	No
Ken	15 years	Ski accident: Splenectomy, Nephrectomy	Yes

the initiation of a new medication. He had no symptoms, felt well, and was active throughout his four-day hospitalization. His mother, his father, or both stayed with him at all times during his hospitalization, including overnight. David's behavior alternated between periods of withdrawal and clinging to his parents and times of activity in which he ran up and down the halls and expressed a great deal of anger toward his parents and the nursing staff. His father tended to ignore David's hostile behavior. His mother seemed anxious about it, threatening him with spankings when he tried to hit her or when he spoke angrily to a nurse. David was always quiet, shy, and inactive when his parents left for a meal.

Bonnie, age 14, had cystic fibrosis. She entered the hospital with pneumonia and in congestive heart failure. She was hospitalized for two and one-half weeks, during which time it became apparent that she would be dependent upon oxygen by mask from then on. She was a delightful child who brightened the lives of everyone who stopped to see her. She was popular with the nursing staff as well as with laboratory, physical therapy, and inhalation therapy staff members. She had periods of apparent withdrawal and irritability. She was one of two children of the broken marriage of her parents. Her older sister was well. Her mother had remarried and had several younger healthy children. Bonnie's mother spent most of each day with her. She had begun a nursing curriculum in college years before but had dropped out. She was critical of the nursing care given her child and very demanding. She was frequently angry at some aspect of the hospitalization. She

talked with nearly everyone who entered the room about Bonnie's approaching death, seemingly ignoring the child's presence. The staff of the cystic fibrosis clinic had tried for years to have her agree to psychiatric treatment. She had always refused.

Peter, age 14, had chronic renal disease. He had received a kidney transplant some months before this hospitalization. He had repeated wound and systemic infections. He was admitted with a wound infection and the possibility of transplant rejection. The opinion of most physicians and nurses was that Peter would die. He appeared very ill and cachectic. He was weak and rarely spoke more than a whispered monosyllable. His mother's visits were infrequent at the time of the study. His father was dead. Peter died a month after the study was completed.

Jenny was 22 months old when she entered the hospital for surgical repair of her cleft palate. She was the youngest of five children. Her parents were attractive, outgoing people. They led busy social lives but always arranged to spend several hours a day with Jenny during her hospitalization. Jenny was an active, gregarious child after her postoperative discomfort had dissipated. She always cried when her mother arrived and when she left. Following her periods of grieving she appeared content and cheerful. She made a rapid recovery following surgery and went home in six days.

Mark had his fifth birthday on the day he underwent surgery for excision of a Baker's cyst of his right knee. His parents were separated. His mother worked in addition to caring for Mark and his twin

brother. She visited Mark daily, but her visits were short. She appeared ill-at-ease in Mark's hospital room. Mark suffered intensely from homesickness. Each time his mother visited he begged her to take him home. She appeared confused and at a loss as to how to manage her child's distress. She told him he could go home when he could walk again, which was what the surgeon had told her. The knowledge seemed to help Mark to overcome his fear of pain and begin weight-bearing. He was discharged on the sixth postoperative day.

Dan, age 13, was hit by a car on his way home from school after basketball practice. He suffered a contusion of the sciatic nerve, leaving his left leg without sensation for three days. He had no other injuries. He was kept in bed for two days, then permitted to be up in a wheelchair. He was the middle child of seven children in his family. His mother had lost a child many years before when he was hit by a car. Dan's accident frightened her badly. She and Dan's stepfather rarely visited him during his one-week hospitalization. Dan complained of boredom while hospitalized and became a minor disciplinary problem to the nursing staff as he raced up and down the halls in his wheelchair.

Ken, age 15, had an accident on the ski slopes resulting in severe internal injuries. After a helicopter flight to the medical center, emergency surgery was performed, and his spleen and one kidney were removed. He spent the first twenty-four postoperative hours in the intensive care unit. As he appeared to be doing well he was then transferred to the pediatric unit. He had considerable discomfort during the next few days and required medication for pain every three

hours. His mother, an attractive, friendly woman, was with him most of the time. Ken had a number of worries which he expressed to her. He feared further internal bleeding, was concerned about having only one kidney, and was worried about whether he would be able to return to his normal activities. His mother reassured him and also requested that the surgeon talk with him. While Ken was able to speak of his anxieties with his mother, he almost always refused her help or the help of the nurses in physical activities. Like most young teenagers, he needed to feel independent, regardless of the pain it caused him. Ken made a rapid recovery, leaving the hospital nine days after his accident.

Nursing personnel were all staff members who had verbal contact with the children and their mothers during the observation periods. There were nine registered nurses, five practical nurses, six nurse's aides, and two student nurses. Six of the registered nurses held baccalaureate degrees, one held an associate degree, and two were diploma graduates. Experience among the registered nurses ranged from less than one year (4) to more than twenty years (2).

Equipment

A small portable cassette tape recorder was used for recording all verbal behavior. Non-verbal behavior was written in a notebook by the investigator during the observation periods.

Procedure

The method was direct observation and recording of events and

verbal interactions of mothers, children, and nursing personnel.

The investigator, the writer of this study, dressed in street clothes and a white clinic coat, sat in each child's room observing and recording for a total of five hours on five separate occasions. Two series of five observations each with two different children were completed and discarded before data gathering began. In each of the following eight series of observations, the data collected during the first observation period were discarded. The first two series and the first observation period of each subsequent series were used as acclimatization periods for staff, mothers, children, and the investigator. It was expected that data distortion due to the novel presence of the observer would be reduced by the orientation procedures.

All data were collected between the day of a child's admission and the fourth day after admission to the unit. The first observation was made no later than forty-eight hours after admission. Variations in starting time were due to the investigator's academic obligations and schedule, the availability of the mothers for obtaining consent, and the absence of the children from the unit for diagnostic procedures and treatments. It was considered necessary for the mother to be present during all observations with the two children who were not able to converse meaningfully with staff, and this altered the schedule. All observations were made on consecutive days once an observation series had begun.

Observation times were arranged so that the four data gathering hours of each series were evenly distributed between the day and evening

shifts. Observations were not made on the night shift as it was expected that children would be sleeping and few verbal interactions would occur. Two hours of observation occurred between 8:00 A.M. and 3:00 P.M. and two hours took place between 3:00 P.M. and 10:00 P.M. It was initially attempted to randomize the selection of observation hours within the two shifts. However, it was found that so many adjustments were necessary for the various schedules of children, mothers, and investigator that formal randomization was useless. Thereafter, the investigator arranged the times to be evenly distributed over both shifts and to allow for the representation of every hour between 8:00 A.M. and 10:00 P.M. at least once and not more than three times. No child was observed during the same hour on different days. Every day of the week was represented at least once.

As soon after the admission of a potential subject as possible, the investigator talked with the child and his mother about participating in the study. She introduced herself as a graduate student in child nursing studying the life of the hospitalized child. She explained that with their permission she would like to sit quietly in the child's room for several hours in the next few days and observe events occurring there. She would be tape recording conversations and sounds and would also be writing down what she saw. She would not be able to talk with them during the period of observation but would be happy to answer any questions they might have after the hour was over. The mothers were asked to sign a form giving permission to the investigator to observe, to record, and to use any material in the final

written report (see Appendix, p. 84). Every mother and child approached consented to participate.

The investigator met with the day and evening staffs before beginning observations. She told them she was studying the life of the hospitalized child. To do so, she would be observing events in various children's rooms and tape recording conversations and sounds. She emphasized that she was not there to "spy on" nursing care or to criticize in any way. She added that she hoped they would feel free to move in and out of the rooms and carry on their usual activities. She also explained that because she would be busy recording she would not be able to participate in nursing care. The last statement had a two-fold purpose. First, it set an expectation of the investigator's activity so that she would not be interrupted by requests for help. Second, it placed the responsibility for all nursing care on the regular staff. Hopefully, this conveyed the expectation that they would carry out their usual activities regardless of the investigator's presence.

Instrumentation

The verbal interactions of nursing personnel, mothers, and children were transcribed from the tapes within seventy-two hours of each observation period. The transcripts of the four observation periods of each child were placed in consecutive order. Each series of four was coded as a whole and separately from every other series.

The verbal interactions were coded from the transcripts using the Diers Nurse Orientation System (Diers, 1971). In the Diers system, a unit of verbal interaction is an utterance by one person from the time

he begins to speak to the time he stops speaking. A new unit begins when a second person begins to speak. For the purposes of coding, nurse and patient units were paired throughout the length of the transcript. All nurse units were coded first. Each unit was coded into one of the ten categories of the Nurse Orientation System. When all the nurse units in a transcript were coded, the mother and child units were coded without looking at the nurse unit category codes. Mother and child units were coded as patient units. They were differentiated by color of ink on the coding sheet, so that mother and child units could be analyzed separately (see Appendix, p. 86).

Two complete transcripts comprising eight hours of observation of two children were coded and sent to Donna Diers to check coder reliability. Miss Diers coded and returned the transcripts. Eighty-two percent agreement was achieved between the investigator and Miss Diers which the latter believed was as good agreement as was possible.

The number of units in each category of the Nurse Orientation System was counted. Percentages of units per category were calculated for nursing personnel as a whole, registered nurses, licensed practical nurses, nurse's aides, mothers, and children.

Analysis of Data

Analysis of data was descriptive. Percentage profiles of units per category of the Nurse Orientation System for nursing personnel as a whole, registered nurses, licensed practical nurses, nurse's aides, mothers, and children are presented.

CHAPTER III

FINDINGS

A total of 1,099 units of verbal behavior were coded using the Nurse Orientation System. Four hundred seventy-eight units were those of nursing personnel, mothers, and children in Group 1 interactions. Six hundred twenty-one units were those of personnel, mothers and children in Group 2 interactions. Table 2 shows the number of units coded for each level of nursing personnel, mothers and children. Each unit was coded into the appropriate category of the Nurse Orientation System. The percentage of units in each category was calculated for nursing personnel as a whole, including student nurses, registered nurses, practical nurses, and nurse's aides. Percentages per category for student nurses were not calculated as the number of units was too small to be meaningful. Percentage of units per category were also calculated for mothers when they were interacting with the nursing personnel in general, with registered nurses only, with practical nurses only, and with aides only. The same was done for the children's verbal units.

The percentage profiles of units per category of the Nurse Orientation System for all levels of nursing staff, for mothers, and for children are presented in Tables 3, 4, 5, and 6. The major orientation categories, that is, orientation toward an object, toward the patient, toward the nurse, and toward another person, are listed with the percentage of total verbal units that were found in each one. The Patient and Nurse Orientation categories have been further broken down

TABLE 2

Number of Verbal Units of Mothers, Children, and Each Level
of Nursing Personnel for Each Patient Group.

Number of Units in Group 1 Interactions	
Mothers	97
Children	128
Registered nurses	178
Practical nurses	48
Nurse's aides	24
Student nurses	<u>3</u>
Total	478
Number of Units in Group 2 Interactions	
Mothers	103
Children	176
Registered nurses	132
Practical nurses	160
Nurse's aides	38
Student nurses	<u>12</u>
Total	621

TABLE 3

Percentage of Verbal Units Per Category of All Nursing Personnel,
Mothers, and Children

		Nurse Units N = 253	Mother Units N = 97	Child Units N = 128
Group 1	Orientation			
	Object	15.8%	9.3%	22.6%
	Patient	49.7	56.7	50.6
	Feeling	2.0	5.2	4.6
	Thinking-Evaluative	9.0	10.3	10.9
	Being-Doing	38.7	41.2	35.9
	Nurse	20.6	17.5	5.3
	Feeling	2.4	1.0	0.0
	Thinking-Evaluative	2.8	0.0	1.5
	Being-Doing	15.4	16.5	3.8
	Other	9.25	7.2	11.7
		Nurse Units N = 343	Mother Units N = 103	Child Units N = 176
Group 2	Orientation			
	Object	15.0%	16.5%	9.1%
	Patient	55.5%	46.5%	59.6%
	Feeling	6.4	7.7	16.4
	Thinking-Evaluative	3.7	5.8	2.2
	Being-Doing	45.4	33.0	41.0
	Nurse	14.4	15.4	9.7
	Feeling	.8	0.0	0.0
	Thinking-Evaluative	.8	0.9	0.6
	Being-Doing	12.8	14.5	9.1
Other	4.6	11.6	2.8	

TABLE 4

Percentage of Verbal Units Per Category of Registered Nurses,
Mothers, and Children

	Nurse Units N = 178	Mother Units N = 55	Child Units N = 98
Orientation			
Object	15.7%	3.6%	22.4%
Patient	48.8	58.1	47.9
Feeling	1.12	3.6	5.1
Thinking-Evaluative	11.7	10.9	8.1
Being-Doing	36.0	43.6	34.7
Nurse	19.1	16.3	5.6
Feeling	2.8	0.0	0.0
Thinking-Evaluative	3.4	0.0	2.0
Being-Doing	12.9	16.3	3.6
Other	10.7	7.2	14.3
	Nurse Units N = 132	Mother Units N = 69	Child Units N = 32
Orientation			
Object	15.9%	20.3%	3.1%
Patient	59.8%	55.1%	71.9%
Feeling	4.5	7.2	12.5
Thinking-Evaluative	5.3	4.4	6.3
Being-Doing	50.0	43.5	53.1
Nurse	13.6	8.6	12.5
Feeling	0.0	0.0	0.0
Thinking-Evaluative	0.0	0.0	3.1
Being-Doing	13.6	8.6	9.4
Other	5.3	7.2	6.3

TABLE 5

Percentage of Verbal Units Per Category of Licensed Practical Nurses,
Mothers, and Children

		Nurse Units	Mother Units	Child Units	
Group 1	Orientation	N = 48	N = 17	N = 16	
	Object	16.7%	5.8%	12.5%	
	Patient	54.15	70.4	75.0	
	Feeling	4.17	11.7	0.0	
	Thinking-Evaluative	2.08	11.7	12.5	
	Being-Doing	47.9	47.0	62.5	
	Nurse	24.98	17.6	6.2	
	Feeling	2.08	0.0	0.0	
	Thinking-Evaluative	0.0	0.0	0.0	
	Being-Doing	22.9	17.6	6.2	
	Other	2.08	0.0	6.2	
	Group 2	Orientation	N = 160	N = 28	N = 81
		Object	15.0%	10.7%	12.3%
		Patient	51.1	28.5	75.9
Feeling		8.1	7.1	26.6	
Thinking-Evaluative		1.8	7.1	1.2	
Being-Doing		41.2	14.3	48.1	
Nurse		17.4	28.6	11.1	
Feeling		1.2	0.0	0.0	
Thinking-Evaluative		1.8	3.6	0.0	
Being-Doing		14.4	25.0	11.1	
Other		4.4	21.4	1.2	

TABLE 6

Percentage of Verbal Units Per Category of Nurse's Aides, Mothers, and Children

		Aide Units	Mother Units	Child Units	
Group 1	Orientation	N = 24	N = 24	N = 14	
	Object	16.6%	25.0%	35.7%	
	Patient	41.7	55.0	42.7	
	Feeling	0.0	5.0	7.1	
	Thinking-Evaluative	4.2	8.4	28.5	
	Being-Doing	37.5	41.6	7.1	
	Nurse	20.8	17.5	7.1	
	Feeling	0.0	5.0	0.0	
	Thinking-Evaluative	4.2	0.0	0.0	
	Being-Doing	16.6	12.5	7.1	
	Other	16.7	13.4	0.0	
	Group 2	Orientation	N = 38	N = 4	N = 25
		Object	15.7%	0.0%	8.0%
		Patient	57.8	0.0	64.0
Feeling		2.6	0.0	2.0	
Thinking-Evaluative		5.2	0.0	0.0	
Being-Doing		50.0	0.0	52.0	
Nurse		10.4	50.0	12.0	
Feeling		2.6	0.0	0.0	
Thinking-Evaluative		0.0	0.0	0.0	
Being-Doing		7.8	50.0	12.0	
Other	5.2	25.0	4.0		

into the three dimensions of feeling, thinking, and being-doing. Percentages shown for the three dimensions are percentages of total units for that group of personnel, mothers, or children. Their sum is the percentage of patient-oriented or nurse-oriented units as a whole. The feeling, thinking, and being-doing dimensions of orientation toward others have not been indicated. It was found that with very few exceptions people were oriented to others in the being-doing dimension. This was true of staff, mothers, and children. Thus the percentages shown for the Other Orientation category are composites of all three dimensions, but in actuality reflect orientation in the being-doing dimension. The percentages shown in the tables do not reflect 100% of the units. Seven percent of the units from Group 1 interactions and 12% of the units from Group 2 interactions were omitted because they could not be heard clearly on the tape or meaningfully transcribed. Their presence was noted, however, and they were coded as "unintelligible."

Table 3 summarizes the percentage profiles of all verbal units coded. The nursing personnel values include registered nurse, licensed practical nurse, student nurse, and nurse's aide units. All codable mother and child units are represented. It will be noted that the greatest percentage of verbal units falls in the Patient Orientation category for nursing personnel, mothers, and children, irrespective of group. Approximately one-half of the staff's utterances were oriented toward the children or their mothers. Mothers were oriented to themselves or their children about one-half of the time, and the children were oriented to themselves about one-half of the time. Nursing

personnel related to the mothers and children in the being-doing dimension predominantly. Mothers related to themselves or to their children in the being-doing dimension for the most part. Children were oriented to themselves as being-doing persons more than as feeling or thinking persons.

Table 3 indicates differences in the verbal behavior of the nursing staff as a whole from one group to the other. There was slightly less patient orientation (49.7% of all nursing units) in interactions with Group 1 than with Group 2 (55.5%). Personnel interacting with Group 1 mothers and children related on a feeling level 2% of the time compared with 6.4% when interacting with Group 2 patients. They related to Group 1 on a thinking level (9% of all units) more often than they did with Group 2 (3.7%). Finally, nursing personnel were oriented more to themselves when dealing with Group 1 than when working with Group 2.

Tables 4, 5, and 6 show the percentage profiles for the three levels of nursing personnel. Table 4 shows the percentages of all verbal units in each category for the registered nurses, Table 5 for the licensed practical nurses, and Table 6 for the nurse's aides. Object orientation was stable at about 15% for all levels of personnel irrespective of patient group. The registered nurses and aides were less patient-oriented in their verbal behavior with Group 1 children and mothers than with Group 2 patients. The licensed practical nurses, however, show a slightly greater percentage of patient-oriented responses to Group 1 mothers and children than to those in Group 2.

All staff had lower percentages of feeling dimension interactions with Group 1 than with Group 2. Registered nurses and licensed practical nurses related to the Group 1 children and mothers as thinking-evaluative persons more often than they did with Group 2 children and mothers. All personnel tended to refer more to themselves in interactions with Group 1 than with Group 2. Registered nurses and aides were oriented to others more often in their conversations with Group 1 mothers and children than with those of Group 2. Again, the practical nurses differed, talking more about other people with Group 2 than with Group 1.

The verbal behavior of mothers differed from one group to the other. It also differed from nursing behavior in some respects. Finally, mothers' verbal behavior appeared to differ with the three levels of nursing personnel. In general, mothers were less oriented to objects than was the staff. Group 1 mothers were less object-oriented than Group 2 mothers except when they were talking with nurse's aides.

Group 1 mothers were generally more oriented to themselves or their children in verbal behavior than were Group 2 mothers, the opposite of nursing personnel. Mothers in Group 1 related to themselves or to their children in the feeling dimension more often with practical nurses and aides than with registered nurses. In general, however, they had a lower percentage of feeling responses than the Group 2 mothers. Mothers in Group 1 made more thinking-evaluative responses than Group 2 mothers with all levels of personnel.

Group 1 mothers were slightly more nurse-oriented than Group 2

mothers as shown in Table 3. However, Group 1 mothers had a much higher percentage of nurse-oriented verbal units than Group 2 mothers when talking with registered nurses. The Group 1 mothers were less oriented to nurses than the Group 2 mothers when talking with practical nurses and aides. Finally, mothers in Group 1 were less oriented to other people than mothers in Group 2. When talking with practical nurses and aides Group 2 mothers talked about others more than Group 1 mothers. The groups appeared the same in other-orientation in conversation with registered nurses.

Group 1 children were generally less oriented to themselves than were the children of Group 2. In addition, the children of Group 1 were oriented to themselves as feeling persons as reflected in their verbal behavior less often than the children of Group 2 except in their interactions with aides. Group 1 children had higher percentages of thinking-evaluative responses with all levels of personnel than the Group 2 children.

Children in Group 1 were less oriented toward nurses than Group 2 children at all levels of personnel. Group 1 children showed a greater percentage of other-oriented responses than Group 2 children in general. Group 1 children were more other-oriented when talking with registered nurses and licensed practical nurses. Group 2 children were more other-oriented when talking with aides.

Summary of Findings

a) Nurses, mothers, and children were predominantly patient-oriented in the being-doing dimension. Percentages of units in the

being-doing dimension and the Patient Orientation category were approximately the same for nurses, mothers, and children in both groups.

b) Registered nurses and aides had lower percentages of verbal units in the Patient Orientation category for Group 1 patients than for Group 2 patients. Licensed practical nurses had nearly equal percentages with both groups in the Patient Orientation category.

c) All personnel had lower percentages of verbal units in the Patient Orientation feeling category and higher percentages in the Patient Orientation thinking-evaluative category in interactions with Group 1 than with Group 2.

d) All nursing personnel had higher percentages of verbal units in the Nurse Orientation category in conversation with Group 1 than with Group 2.

e) Group 1 mothers had higher percentages of verbal units in the Patient Orientation category than either Group 2 mothers or nursing staff. They had lower percentages of feeling dimension responses than Group 2 mothers, but higher than nursing staff. Group 1 mothers had higher percentages of patient-oriented thinking-evaluative responses than Group 2 mothers.

f) Group 1 mothers had higher percentages of verbal units in the Nurse Orientation category than Group 2 mothers. Group 1 mothers had lower percentages of other-oriented responses than Group 2 mothers.

g) Group 1 children had lower percentages of verbal units in the Patient Orientation category than Group 2 children. Group 1 children had lower percentages of feeling dimension responses and higher

percentages of thinking-evaluative responses than Group 2 children.

h) Group 1 children had lower percentages of nurse-oriented responses and higher percentages of other-oriented response than Group 2 children.

CHAPTER IV

DISCUSSION

The findings will be discussed in relation to the research situation, characteristics of the sample, and the major research questions.

The Research Situation

Direct observation of a research situation inevitably changes it. Participants know they are being watched and behavior may be consciously and/or unconsciously modified as a result. Efforts on the part of the investigator to reduce anxiety in the participants and to normalize the research situation are crucial. Nevertheless, the situation will never be as it is in the absence of an observer. Factors operating as a result of the observer's presence inevitably influence the data which are obtained. The following sections will discuss the identifiable factors that operated during the data collection period. The factors to be discussed will include those which the investigator perceived as facilitating a near-normal situation, those which gave evidence that the participants were comfortable in the observer's presence, and those which appeared to undermine the normalcy of the situation. It must be borne in mind that unidentifiable factors were undoubtedly operating as well, producing their unknown influence on the data and thus affecting its interpretability.

The investigator was well known to the nursing staff on the pediatric unit. She had worked on the unit as a staff nurse for the three

summer months preceding the study. Relationships with staff members were warm and friendly during the summer work experience. They remained so during the data collection period. The investigator's acceptance by the staff members was demonstrated by their calling her by her first name, inviting her to coffee breaks and lunch, and stopping to chat when observation was not taking place. In addition, registered nurses, practical nurses, and aides began referring new admissions to the investigator as soon as the study got under way. Almost daily staff members told the investigator of a newly admitted child who "might be interesting for your study." Staff members also approached the investigator for suggestions about how to handle troublesome situations with families being observed.

That staff members asked for advice in handling patient situations may have been an indication of defensiveness and a desire to "do the right thing" in the presence of the observer. The investigator listened to the problem, found out what was being done about it, and supported the nursing actions. The requests for help decreased as the study progressed, indicating that perhaps staff had been initially defensive, becoming less so as time passed. On the other hand, their requests for help may have been motivated by a desire to be more helpful to the families than they believed they were. When no new ideas were forthcoming from the investigator, they stopped asking her for advice.

Nursing personnel exhibited other behavior which indicated decreasing awareness of the observer's presence. During the two trial observation series there were practically no nurse-patient interactions.

It was rare that a nurse or aide entered the room while the investigator was present. Interactions increased toward the end of the acclimatization period, suggesting that staff became accustomed to the observer's presence. The absence of nurse-patient contact during the early observations may also be explained in part by a misunderstanding voiced by one registered nurse. During one trial observation period she entered a child's room, saw the investigator, and immediately left the room. Later she stopped the investigator in the hall to inquire if it was all right for her to be in the room during observation. "I couldn't remember if we were supposed to stay out or just go ahead as if you weren't there." The investigator told her to go ahead with her usual procedure regardless of the observer's presence. The investigator spoke with the other staff members individually following this episode to make certain that they were not staying out of the rooms because they thought the investigator wanted to be alone with the families. No one else seemed to have received this impression from the investigator's initial talk. Personnel showed no overt hesitation in entering the children's rooms in the observer's presence in later observation series.

Not only did staff members show no hesitation in entering the children's rooms, there is evidence to suggest that they stopped noticing the investigator. There was a decrease in verbal exchanges between the observer and nursing personnel in children's rooms. During the trial observations and the early data collection period, staff members always greeted the observer upon entering a room. Within a short period of time the verbal greeting gave way to a smile and the smile gave way to a

complete absence of acknowledgment of the observer's presence. On one occasion a practical nurse entered Bonnie's room to take her vital signs. She went about her duties, moving around the room and chatting with Bonnie and her mother. After several minutes she suddenly turned to the investigator, and in a startled voice said, "Oh! I thought there was someone sitting there but I didn't really notice! Hi!" Unlike the practical nurse most staff members were probably aware of the observer's presence all the time. However, they appeared to lose their initial hesitation and self-consciousness.

There were several factors which may have influenced the normalcy of the research situation. Staff members' awareness of the observer and of being watched may have been increased by a statement made by the head nurse when the investigator explained the study to the staff. The investigator had previously discussed the study with the head nurse and had obtained her permission to observe on the unit. She knew no more of the purpose of the study than any other participant. She attended the meeting which the investigator held with the nursing personnel to explain the study. When the investigator finished speaking, the head nurse said, "This will give us all an opportunity to look at ourselves and at our nursing care now that we have someone watching us." The investigator stressed again that she was not there to criticize nursing care but rather to observe all the events in the lives of hospitalized children. The head nurse was understandably concerned about improving nursing care on the pediatric unit. She welcomed the current study as a contribution to nursing knowledge and patient care, and she supported the

investigator's efforts fully. Nevertheless, her statement at the staff meeting may have influenced the normalcy of the research situation.

Another factor that may have had unknown effects on the data was the fact that the staff was aware of the investigator's interest in the fatally ill child. The investigator was working with several children who had leukemia. She was frequently on the pediatric unit with them when they were hospitalized. Although the investigator told the staff she was studying children with non-fatal illnesses as well, the staff focused attention on the fatally ill children in the study when talking to the investigator. It was always a fatally ill child they referred upon admission. It was always a child in danger of dying that they discussed with the investigator when there were problems of management. It may be that the staff needed to talk with someone about the many fatally ill children on the unit. They may have perceived the investigator as a specialist in the subject or as an empathic listener so that they talked more about the dying children than about the others. On the other hand, it is likely that they perceived the fatally ill child as the focus of the study. Suspecting this, their interactions with children and mothers of Group 1 may have been affected more by the observer and the study than their interactions with Group 2 mothers and children.

The two hours of observation preceding data collection with each child appeared to be an adequate acclimatization period. The investigator talked with each mother and child for a few minutes before each observation period, asking about the child's progress and verifying

that the observer's presence for an hour would be acceptable to both mother and child at that time. Most mothers and children appeared to ignore the observer after the initial conversation. Even in the first observation periods devoted to orientation, mothers and children interacted little if at all with the investigator. They knew she was a nurse yet always called for one of the staff members when they needed help. Mothers and children talked with each other, watched television, or played games. When mothers were absent children watched television or played, rarely acknowledging the observer's presence. The observer seemed to be accepted by the mothers and children as part of the hospital environment.

The Sample

Several characteristics of the sample must be considered for their possible effects on the interpretability of the data. The unique characteristics of individuals may affect the data in ways unrelated to any common characteristics of the group to which they belong when sample sizes are small. The groups comprising children, mothers, licensed practical nurses and nurse's aides were particularly small. With the exception of the nurse's aides, there were individuals in each group whose behavior was outstanding or unusual and who influenced those interacting with them.

One licensed practical nurse stood out not only from her own group but from all the nursing personnel. She was an attractive, not-quite-middle-aged woman who seemed to radiate a calm self-confidence, deep concern for her patients, and good humor. She was a highly

competent practitioner of physical nursing care and was usually assigned to the children in greatest need of skilled care. In addition, she appeared to be acutely aware of her patients' emotional needs. In the course of any extended contact with a mother or child, her large number of patient-oriented interactions included many responses to the feeling dimension of her patient or his mother. During the study she had extended contacts with two children in each group. She was, however, the only practical nurse to interact extensively with the children and mothers of Group 1.

Each of the mothers possessed individual characteristics which appeared to influence the staff members' interactions with them. Bruce's mother was a quiet young woman. She was devoted to her child and cooperated fully with his nursing care and medical regimen. She asked for help when she needed it but rarely initiated a conversation unless it directly concerned Bruce's care. Nursing verbal interactions with her tended to focus on Bruce's immediate, usually physical needs. David's mother was also quiet. She spoke little with nursing staff. Staff rarely approached her except to obtain information about David's activity or appetite. She appeared tense and anxious to the observer, often losing patience with David. Bonnie's mother had severe psychiatric problems for which she refused treatment. She exaggerated her child's symptoms to the point of being untruthful. She was demanding and critical of the nursing staff. One registered nurse characterized the general attitude of the staff toward her when she told the investigator, "I don't know how you can sit in there with that woman! I can't stand

to go in there for a minute at a time. How do you stay there for an hour?"

The two Group 2 mothers were remarkably similar to each other and very different from the Group 1 mothers. Both were attractive, gregarious, well-educated women of high socio-economic status. They were cheerful and friendly, interested in the hospital environment and in the nursing personnel as individuals. It was not unusual for staff to stop and chat with them about everything from their little brothers to their husbands. There appeared to be little tension in the interactions.

Probably the greatest individual difference in the children which affected nurse-patient interactions was the severity of illness during the hospitalization. Three of the four children in Group 1 were seriously ill at the time of admission and in danger of dying without rigorous treatment. David, however, appeared healthy. Although he had a fatal illness which was worsening, he showed no signs of it. His nursing care needs were minimal, considerably fewer than those of his basically healthy age-counterpart, Mark, in the postoperative period. David was uncharacteristic of his group in this respect. The fact may have affected the data and their interpretability.

In addition to unique characteristics of individuals, certain of the groups had peculiarities which differentiated them from others. The registered nurses were almost all young women in their twenties with less than five years of nursing experience. Of the seven registered nurses under the age of thirty, five were married and one had a child.

Most of the registered nurses had worked on the pediatric unit for less than one year. The nurse's aides were similar to the registered nurses in being young and of few years of experience. The licensed practical nurses, on the other hand, were all older women with many years of nursing experience. All were married with grown children. Most of them had worked on the unit for a number of years and had developed long-term relationships with some of the mothers and children in Group 1. The differences in work experiences and age-related life experiences of the registered nurses and practical nurses suggests that their verbal interactions with patients might be different. The possible effects of the group differences will be further explored in the discussion of the specific research findings.

The differences in the two groups of mothers have been mentioned. Group 1 mothers seemed to repel nursing contacts while Group 2 mothers welcomed them. It is probably coincidental that the two mothers in Group 2 were similar in personality, education, and socio-economic background. The Group 1 mothers also had certain characteristics in common, including lower-middle class social standing, less education, and less attractive physical appearance than the Group 2 mothers. The mothers of Bruce and David were somewhat withdrawn while Bonnie's mother had emotional and behavioral problems. It is likely that the personality characteristics of the Group 1 mothers were in part the result of having a gravely ill child. Nevertheless, the differences in the two groups of mothers were striking. They will be further examined in the discussion of the research findings.

Research Questions

The problems of the research situation and the peculiarities of the sample impose limitations on the interpretability and generalizability of the research findings. Nevertheless, the data suggest several trends in the nurse-patient interactions which are related to the research questions. The trends will be discussed in terms of those pertaining to nursing personnel, those related to mothers, and those associated with children.

Geis (1965), Glaser and Strauss (1964, 1965), Quint (1967), Wallace and Townes (1969), and Wodinsky (1964) discuss physical and emotional avoidance of the fatally ill patient on the part of nursing personnel. Numbers of verbal interactions alone provide no information about frequency or length of physical contact. Many verbal units may fill a short period of time while an hour of physical proximity may pass with but few verbal exchanges. Nevertheless, the raw numbers representing the verbal units for each level of personnel in the current study suggest that personnel were more vocal with Group 2. However, the difference may be more a reflection of staff assignment and unit management factors than any real difference of response to the two patient groups. Registered nurses were plentiful on the day shift. They gave direct patient care to children in both groups. Evening shift registered nurses, however, were always team leaders. Their patient interactions were approximately equal in each group as they gave medications and made rounds. Their number of verbal interactions reflects their equal involvement with both groups in direct patient care and as team

leaders. The nearly equal number of verbal units for nurse's aides when interacting with the two groups reflects similar equal involvement. While they were usually assigned to Group 2 patients, they occasionally were responsible for Group 1 patients. In addition, they answered call lights and ran errands for the two groups in about equal measure.

The practical nurses had nearly 100 more verbal units in interaction with Group 2 patients than with Group 1 patients. Physical avoidance may have occurred between practical nurses and Group 1 patients, but assignment factors are more likely the cause of the discrepancy. Practical nurses were assigned to Group 2 patients on both day and evening shifts. They cared for Group 1 patients only on the evening shift during the data collection period. There were brief practical nurse-patient exchanges during the day shift but no extended contact with Group 1. Thus there were fewer opportunities for practical nurse interactions with Group 1 mothers and children. The number of verbal units in their Group 1 interactions represents predominantly interactions on only one shift, whereas the number of verbal units for their Group 2 contacts reflects interactions on two shifts.

The raw data suggest that the pediatric staff members had essentially equal numbers of interactions with the two groups of children and mothers and probably did not engage in physical avoidance of Group 1 as a whole. The character of their verbal interactions as delineated by the Nurse Orientation System reveals both similarities and differences in their verbal orientation to themselves, to the

mothers, and to the children of the two groups. The characteristics of the staff's verbal behavior will be discussed with reference to the possible explanations for the differences observed among levels of personnel and between the two patient groups.

The verbal behavior of all nursing personnel was patient-oriented, with approximately one-half of their verbal units falling in the Patient Orientation category. The nurse's role is that of attending to the patient's needs. Thus it is not surprising that the greater part of a nurse's verbal behavior is oriented toward the patient in an effort to discover and meet those needs. All personnel tended to be oriented to the mothers and children predominantly as physical persons, that is in the being-doing dimension. The emphasis on the physical aspects of the patients springs from two possible sources. The children were hospitalized with physical illnesses requiring medical or surgical management. Much of their nursing care was devoted to carrying out the therapeutic regimen. Therefore, considerable effort and interest were invested in the children as physical persons which is reflected in the verbal behavior of the staff. Children and their mothers are more than physical entities, however. They have emotional needs as well, not a few of which may be direct results of illness and hospitalization. The greater emphasis on the patients as physical persons coupled with the very low percentage of verbal units oriented to the patients as feeling persons suggest that nurses were perhaps ignoring emotional needs. Diers (1971) suggests that nurses relate less to the feeling dimension of their patients than to the physical aspects

because of inability to approach patients on the feeling level and uncertainty as to how to handle them if they did. Thus a second explanation for the preponderance of being-doing interactions is that nurses feel more competent in that mode. Although they may be aware of the existence of emotional needs in their patients they are uncomfortable and unsure of their ability to be helpful in conversation at the feeling level.

The licensed practical nurses made a greater proportion of patient-oriented responses on the feeling level with both groups as compared with registered nurses and aides. The difference may be attributable to the unique characteristics of the practical nurse group, outlined above. They were older than most other staff members, had raised their families, had more years of nursing experience behind them, had worked on the pediatric unit longer, and had developed long-term relationships with some of the families of the fatally ill children. For example, one of the practical nurses had known Bonnie since her diagnosis of cystic fibrosis thirteen years before. The practical nurse group also included the nurse described above who was exceptionally aware of her patients' emotional needs. It is suggested that the practical nurses' greater life experience enabled them to meet the patients' emotional needs more frequently than the young and comparatively inexperienced registered nurses. The implication is that professional nursing education does not necessarily confer the ability to meet patients' emotional needs, but rather it is a combination of an individual's personal qualities combined with experience in the world and

with people.

All nursing personnel had lower percentages of feeling dimension verbal units in interactions with Group 1 than with Group 2. There are several possible explanations for this finding. First, the fact that the Group 1 children had fatal illnesses may have created anxiety and threats to the nurses' composure (Glaser & Strauss, 1965). Interaction on a feeling level with mothers and children of Group 1 was more difficult than with Group 2 mothers and children and was therefore avoided. Feeling level conversations with Group 2 children and mothers was easier because there was little threat of the discussion of death. In addition, the Group 2 children made more feeling level responses in orientation toward themselves than the Group 1 children, perhaps encouraging nurses to respond in the same dimension. Another possible explanation lies in the behavior of the children. Chronically and fatally ill children tend not to talk about their illness-related feelings with adults unless the opportunity is presented. Even then many will not share how they feel about their disease and prognosis (Waechter, 1971). A reciprocity may exist between nursing staff and children. The staff, unaware of how much the child knows, how much the parent wants the child to know, and probably anxious about discussing the subject may avoid feeling level confrontations with the child. The child, receiving no encouragement from the staff, also avoids the subject. Of course, there are feeling level responses which do not deal with illness, dying, and death. However, it is possible that these elements are foremost in the nurse's perception of the fatally ill child and lead to avoidance of all

emotional contacts. Finally, the lower percentage of patient-oriented feeling responses by nurses to Group 1 patients may be related more to the individual characteristics of the mothers than to the fact of the children's fatal illnesses. It was observed previously that the Group 1 mothers, by their silence, shyness, or demandingness, seemed to repel nursing staff. They at least did not appear to welcome conversation at any level in contrast to the outgoing Group 2 mothers. Perhaps nursing personnel were willing to talk with the Group 1 mothers to enable them to meet the children's medical needs, but could not tolerate prolonged conversation or emotional exploration, especially since the mothers tended to discourage conversation. The mothers' personality characteristics were undoubtedly partially the result of having a desperately ill child. It is likely that the staff perceived this, adding to a general feeling of inadequacy in dealing with emotional needs, especially where death was concerned.

The registered nurses and aides had lower percentages of verbal units in the Patient Orientation category as a whole when interacting with Group 1 patients than with Group 2 patients. The licensed practical nurses had nearly equal percentages with both groups. The difference appears to lie in the differences of feeling-orientation described above plus differences in other-orientation. The registered nurses and aides had a greater proportion of responses in the Other Orientation category in general than the practical nurses. They had a greater proportion of other-oriented responses to Group 1 than to Group 2. Talking about other people may have been easier and less anxiety-producing for

the younger staff members. All levels of nursing personnel had a greater and approximately equal proportion of nurse-oriented responses when interacting with Group 1 than with Group 2. Again, anxiety and avoidance tactics may have led nurses to the relative safety of discussing their own lives with the fatally ill children and their mothers. They talked about themselves, thus limiting opportunities to talk about the child. On the other hand, staff members may have talked about themselves and shared aspects of their lives in an effort to amuse and divert Group 1 mothers and children, thus relieving some of their anxiety (Craytor, 1969).

All nursing personnel were oriented to Group 1 mothers and children as thinking-evaluative persons in greater proportion than they were to Group 2 patients. Several explanations for the difference are plausible. It may represent a shift from the more threatening emotional dimension to the comparative safety of rationality in dealing with dying children and their mothers. On the other hand, the emotional impact of fatal illness may have had virtually nothing to do with staff behavior in this respect. Rather, it may be a result of the staff's recognition of the long-term nature of the illness and the experiences of both children and mothers with the disease and its treatment. The staff may have perceived the mothers and children as partners in care. They could be relied upon to provide accurate and valuable information about symptoms, equipment, and general problems. They were more knowledgeable about the children's illnesses and hospitalizations than the Group 2 mothers and children, who generally had little hospital

experience. The staff's reliance on the information Group 1 children and mothers could provide is illustrated in the following dialogue between a registered nurse and Bonnie. They are discussing the fact that Bonnie missed one of her postural drainage treatments the day before.

R.N.: Now, tell me again, Bonnie, what happened yesterday?

Bonnie: Well, the girl from the clinic came to get me to take me down for the postural drainage. But then the nurses said I couldn't go because I had to go upstairs for something else-- an EKG or something. So I went upstairs for that and when I got back it was too late for clinic.

R.N.: It must have been in the afternoon sometime.

Bonnie: Nope! When I got back dinner had been here for about a half-hour.

R.N.: And then you got your treatment on evenings?

Bonnie: Yup.

R.N.: Okay. So it was just that time in the afternoon that you missed. Bonnie, if you can see that something is happening and you've missed one, say something to someone, okay? In case we don't catch it you can remind us.

The behavior and personality characteristics of the Group 1 mothers have been discussed. The common behavioral manifestations of parents anticipating the death of a child may help to explain the trends outlined in their verbal behavior. All of the Group 1 children had been ill for years. The mothers knew they would eventually die. The long courses of the children's illnesses allowed the mothers time for preparatory mourning (Friedman, 1967; Friedman et al., 1963; Natterson & Knudson, 1960; Richmond & Waisman, 1955). Several of the five manifestations of grief described by Lindemann (1944) are particularly

helpful in understanding the interaction patterns of the Group 1 mothers. Preoccupation with the image and memory of the deceased is one. Preoccupation with the living child is one phase of the anticipatory grieving process. As adaptation progresses there is a gradual relinquishment of the child with increasing interest in others (Friedman, 1967; Friedman et al., 1963; Natterson & Knudson, 1960; Richmond & Waisman, 1955). A second behavioral manifestation of grief described by Lindemann is irritability, impatience, and social withdrawal. In addition, parents of fatally ill children are often hostile and angry toward hospital staff. They may criticize the quality and efficiency of nursing care in their frustration and helplessness over being unable to prevent the loss of their children (Weiner, 1970a).

Group 1 mothers had higher percentages of verbal units in the Patient Orientation category than Group 2 mothers. The figures may represent the greater preoccupation with their children and with themselves characteristic of preparatory grief. In interactions with nursing personnel they showed more concern and insistence that their children's needs be met. Most of their patient-oriented responses were in the physical dimension, probably reflecting their concern for the children's medical management and their hope for one more recovery. They had fewer feeling level interactions with staff than the Group 2 mothers. Their lower percentage of units in the feeling dimension may reflect a combination of factors. The social withdrawal characteristic of grief may have prevented them from engaging in interchange with nurses except when necessary for the children's welfare. The nurses

may have responded to the withdrawal by withdrawing themselves from emotional contact so that feeling level interactions were blocked. Perhaps it was a reluctance on the part of the nurses to discuss emotional elements that inhibited mothers from talking. Probably there was a combination and interaction of the various factors to produce a minimum of feeling dimension exchanges.

Characteristics of the grieving process may account for the differences observed between Group 1 and Group 2 mothers with regard to orientation toward nurses and others. The Group 1 mothers were more nurse-oriented in their verbal interactions. They may have wanted to direct attention away from themselves and their anxieties. However, such an explanation is inconsistent with their greater proportion of patient-oriented units and lower proportion of other-oriented units. It is suggested that their greater nurse orientation represents their concern with the quality of nursing care. They saw the staff as "doers" for their children. Their nurse-oriented responses were frequently commands, requests, and criticisms. For example, Bonnie received intravenous medication every few hours which caused some irritation and pain at the catheter site. She complained to a registered nurse who reduced the flow. Bonnie told her it was better. Her mother, however, either did not accept the child's judgment or was dissatisfied. A few minutes later a nurse's aide entered. Bonnie's mother said: "Do you think you could get the R.N. to listen to you? I think that is infiltrating and Bonnie says it just burns." The mother was oriented in part to the aide and expressed her criticism

through her. The remark reflects the irritability and impatience characteristic of anticipatory grief. It also reveals a distrust in the nursing staff's competence and an anger at their perceived inability to make her daughter comfortable. The lower percentage of other-oriented units may represent the withdrawal of interest from other people on the part of the Group 1 mothers. They all appeared to be in the stage of grief when preoccupation with their own children and with themselves was paramount.

The greater proportion of patient-oriented, thinking-evaluative responses made by Group 1 mothers probably reflects their greater knowledge of their children's illness and their management. It also coincides with the nurses' reliance on them to provide pertinent medical information.

The verbal behavior of the Group 2 mothers was directed outward and away from their children and themselves more than the verbal behavior of the Group 1 mothers. The personality characteristics previously noted were partly responsible for the difference. Nevertheless, there were differences in the stresses under which they operated during the children's hospitalizations. Group 1 mothers were coping with the long-term and immediate threat of death. Group 2 mothers, while concerned about the success of their children's surgery and their recovery, were reasonably sure the children would not die. They realistically expected their children to return home in a few days and resume their pre-hospital existence. Thus they could afford to direct their attentions away from their children occasionally and show interest in

others and the environment. Their nurse-oriented responses were fewer than those of the Group 1 mothers in relation to their total verbal units. However, they were less often requests and commands related to the children's needs. Mothers made requests, of course. But most of the nurse-oriented interactions revealed an interest in the staff members as individuals. The following conversation illustrates this type of interaction:

Mother: You're a golfer? A skier?

L.P.N.: Neither.

Mother: You've been on vacation? You're tan.

L.P.N.: Yes, as a matter of fact. I was down at the Indian reservation.

Mother: Really? I'll bet that was interesting. Is it a hobby or...

L.P.N.: No, I just wanted to see what kind of medical facilities they had down there. It was very interesting.

Mother: I'll bet.

The verbal behavior of Group 1 mothers appeared to reflect their positions as mothers of dying children. The verbal behavior of Group 2 mothers suggested a less stressful experience, permitting them to look outward.

A child's response to his own fatal illness depends on his maturational level and the emotional environment created by the important adults in his life (Green, 1967; Showalter, 1970). The child under three years of age has no concept of death as the end of self (Showalter, 1970). Separation from his mother is the cause of his

greatest distress and fear (Bowlby, 1960; Green, 1967; Schowalter, 1970). Separation and death may be the same thing to the child under three (Green, 1967). The behavior associated with separation anxiety (Bowlby, 1960) is similar to the stages through which a dying adult patient passes (Ross, 1969). The first stage of separation anxiety is protest, in which the child searches for the mother, cries, kicks, throws himself about, and cannot be comforted. In the stage of despair the child is still preoccupied with the lost mother, but becomes inactive and withdrawn. He may cry monotonously or intermittently and gives the appearance of deep grieving. The stage of detachment is characterized by a return of some activity but without normal attachment behavior. He remains remote and apathetic and shows no response to his mother when she is present (Bowlby, 1960). The young child's experience of separation anxiety is similar to the fatally ill adult's experience of anger, depression, and acceptance (detachment) described by Ross (1969). The young child, separated from his mother, experiences a kind of death. Bruce, whose mental age was about two years, and Jenny experienced the protest stage of separation anxiety when their mothers left them. Bruce did not know that he was fatally ill. Jenny did not know that she would recover and go home. Both suffered the threat of loss when their mothers were absent.

The child from three to six has little anxiety about death because he does not perceive it as permanent. However, he may equate illness and hospitalization with punishment for aggressive fantasies about which he feels guilty (Schowalter, 1970). David's behavior

suggests a projection of his feelings of guilt at being ill and hospitalized. He often spoke angrily to his parents and to nursing staff. "I'm going to take a needle and stick it in your liver!" he shouted at an aide. He frequently struck out at his parents, staff, and the investigator, hitting as hard as he dared. He was quiet and withdrawn between outbursts.

The school age child and adolescent gains a concept of the permanency of death. His reactions approximate those of the adult. Most fatally ill children of this age probably know they are dying, although they rarely speak of it. Their failure to talk about illness and death may be the result of avoidance of the subjects by parents and professionals (Schowalter, 1970; Vernick & Karon, 1965). Neither Peter nor Bonnie spoke of their illnesses during observation periods. Peter was severely debilitated and rarely spoke more than single word responses to questions. Bonnie was most often cheerful, but she had periods of apparent depression, withdrawal, and irritability.

The research findings suggest that the fatally ill children had different patterns of verbal behavior than the Group 2 children. The difference may reflect the dynamics underlying their respective emotional lives. Group 1 children had lower percentages of verbal units in the Patient Orientation category as a whole and in the feeling dimension. Perhaps they had learned that overt concern for themselves was not welcomed by adults. Their feelings were to be kept to themselves. Group 2 children were less inhibited. They could be overtly self-centered while they were ill. They could express their feelings

about being temporarily incapacitated or homesick or frightened. Group 1 children provided information (high proportion of thinking-evaluative units) and talked about other people and objects. There was little or no encouragement to discuss their anxieties and fears by either parents or staff.

The Nurse Orientation System

The Nurse Orientation System permits the classification of many units of verbal behavior into meaningful categories. In a complex and little-explored area such as the interactions of nurses with dying patients and their families the Nurse Orientation System lends order and meaning to complex interactions. In addition, its exhaustive categories provide insight into the predominant modes of orientation of nurses and patients to themselves, each other, and their environment. Discovering nurses' most frequent modes of orientation toward patients can lead to the development of the combinations of nurse behavior that are most beneficial to the patient. Diers suggested that patient-oriented nursing involves orientation to the patient as a feeling, thinking, and being-doing person in equal measure. The nursing care most beneficial to the patient is that in which the nurse's verbal behavior recognizes the patient as a three-dimensional person. If so, it should be possible for the nurse to manipulate her orientation toward the three patient dimensions (Diers, 1971). The Nurse Orientation System would thus be a valuable tool in aiding the development and teaching of nurse-patient interactions to the benefit of the patient,

whether dying or not.

Orientation would therefore appear to be an important concept in the nursing care of the fatally ill and their families. However, because it does not deal with the actual content of verbal interactions, it is limited in its use in describing nurses' behavior in the face of patient death. For example, it cannot reveal when and how often a nurse discusses or avoids the subject of death. The nurse may interact on a feeling level with her patients as some did in the current study. However, it cannot be assumed that such interactions dealt with the subject under investigation, that is, death and the nurse's willingness or ability to discuss the patient's anxieties. In the present study, not one feeling-oriented interaction of nurses with children and mothers dealt with the child's impending death. The percentage profiles of the Nurse Orientation System cannot reveal that fact. Nor can they reveal the presence or absence of nursing efforts to aid the family in the grieving process, a nursing function considered important by some investigators (Knutson, 1970). While the Nurse Orientation System can provide useful information regarding nurse-patient interactions, it is limited in its use for investigation of situations where a knowledge of content is important for interpreting findings.

Difficulties were encountered in adapting the Nurse Orientation System for pediatric use. It was developed for the analysis of interactions involving one nurse and one adult patient. Pediatric interactions frequently involve a patient and a parent to whom the nurse relates. In addition, the patient's age may prevent him from

communicating his needs. The nurse must rely on the child's mother for information and assistance in nursing care. The result is complex interpersonal situations which the Nurse Orientation System is incapable of quantifying in its present form. For example, the mother may act as a patient in one interaction and as a nurse in the next. She may ask the nurse for a cup of juice for her child, then proceed to give it to him. Another problem arises because the nurse is often oriented to the child in her verbal behavior but may actually be talking to the mother about the child or his needs. The mother may be oriented to the nurse as herself or as the mother of a child. The mother may also be oriented to her child exclusively. The child may be oriented to the mother or to the nurse.

Because of these problems, mothers were considered as patients for the purposes of the present study on the rationale that nursing personnel probably related to them as part of the patient situation. Nurses probably felt themselves to be in the helper role toward both mothers and children. While mothers often function as nurses for their children, it has been the investigator's experience that mothers on the pediatric unit are considered to be patients. Combining mothers and children into the patient category resulted in the loss of the dynamic distinctions and subtleties of interaction described above.

Another methodological problem of the Nurse Orientation System, particularly as used in the present pediatric study, is the difficulty of appropriate statistical analysis of the data. Because the sampling units are not independent of each other, the data usually do not permit

statistical treatment (Diers, 1972). Group differences can be presented only descriptively. Statistical significance cannot be known. However, efforts are being made to develop appropriate methods of statistical treatment of the data obtained through interaction analysis. In the meantime, descriptive treatment may reveal trends and directions which stimulate future research.

CHAPTER VI

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

An exploratory study was designed to investigate the verbal interactions of nurses with fatally ill children and their mothers as compared with non-fatally ill children and their mothers on an in-patient pediatric unit. The verbal behavior of registered nurses, licensed practical nurses, and nurse's aides was tape recorded as they came in contact with four children with fatal illnesses and four children with non-fatal illnesses. Verbal behavior of mothers and children was similarly recorded. All units of verbal behavior were coded and classified using the Diers Nurse Orientation System. Percentage profiles of verbal units per category of the Nurse Orientation System were calculated.

The major findings were:

- a) All nursing personnel were patient-oriented in their verbal behavior toward both groups.
- b) All nursing personnel were oriented to the patients as physical persons in greater proportion than they were oriented to the patients as thinking-evaluative or feeling persons, regardless of patient group.
- c) All personnel were oriented to the fatally ill children and their mothers as feeling persons in lower proportion than they were to the non-fatally ill children and their mothers.
- d) All nursing personnel were oriented to the fatally ill

children and their mothers as thinking-evaluative persons in greater proportion than they were to the non-fatally ill children and their mothers.

e) All nursing personnel were oriented to themselves in greater proportion when interacting with the fatally ill children and their mothers than with the non-fatally ill children and their mothers.

f) Licensed practical nurses had a greater proportion of patient-oriented responses in the feeling dimension for both groups than did the registered nurses or aides.

g) Mothers of fatally ill children were more patient-oriented, more thinking-evaluative-oriented, and more nurse-oriented than the mothers of non-fatally ill children. They were less feeling-oriented and less other-oriented than the mothers of the non-fatally ill children.

h) Fatally ill children were less patient-oriented, less feeling-oriented, and less nurse-oriented than the non-fatally ill children. They were more thinking-evaluative-oriented, and more other-oriented than the non-fatally ill children.

Conclusions

The findings suggest that the verbal behavior of nursing personnel as analyzed through their patterns of orientation may be different when interacting with fatally ill children and their mothers than when interacting with non-fatally ill children and their mothers. The findings also suggest that fatally ill children and their mothers have

verbal patterns of interaction with nursing personnel which differ from those of the non-fatally ill children and their mothers. While it cannot be concluded that nurses actively avoided the dying children and their mothers either physically or verbally, the findings suggest support for the observations in the literature that nurse-patient communication is affected in the face of the patient's fatal illness and death.

Recommendations

Malignant and congenital illnesses are leading causes of death in children. Rarely are the illnesses rapidly fatal. In the months and years of illness and therapy children are frequently hospitalized. Nursing personnel have close daily contacts with the children and their families. Long-term relationships frequently develop. It is the opinion of several investigators that nurses have a responsibility to use their nursing role and relationships to aid children and families coping with fatal illness and the grieving process (Strauss & Glaser, 1970; Knutson, 1970; Quint, 1967). Verbal communication is an integral part of the helping process. The development of effective nursing intervention is thus an important aspect of the development of the science of nursing. It is important to determine those forms and patterns of verbal interaction which are most helpful to patients.

To this end, the continued study of existing nursing interactions with fatally ill children and their families is warranted. A more complete knowledge of what current nurse-patient interactions constitute and what their effects on children and families are will provide a basis upon which to build concepts of effective nursing care.

The use of the Nurse Orientation System, suitably adapted to pediatric use, may yield valuable information concerning patterns of interaction. The use of a content analysis system is recommended in addition to reveal subject matter and specified verbal content of nurse-patient conversations.

The Nurse Orientation System appears flexible enough to allow for expansion and adaptation for pediatric use. The addition of a "Parent" category to the "Nurse," "Patient," "Other," and "Object" categories might solve part of the problem. A system of coding might be devised to clarify distinctions such as "nurse oriented to child via mother" which would not distort the intent of the system itself. The Nurse Orientation System could be a valuable asset to the study and teaching of nurse-mother-child interactions when appropriate revisions are made.

The differences of verbal behavior observed among the nursing personnel suggest that age and experience rather than education were responsible for greater patient orientation. The hypothesis has important implications for nursing practice. If age and experience are responsible for empathic interaction with patients, then efforts must be made to develop means of teaching patient orientation, especially in the emotional dimension. Patient welfare might be enhanced if the compassion and empathy that come from life experience could be taught to young adults in schools of nursing. Whether or not this can be done is a matter for further investigation. It is recommended that the possible relationships among age, experience, and empathic nursing interaction

be explored. It is also suggested that nursing curricula be examined and experimental methods of teaching patient orientation be implemented.

Another area of investigation suggested by the current study is the definition of nursing functions and roles on a pediatric unit where fatally ill children are common. Registered nurses appeared to have the most contact with these children and their mothers during the study. Practical nurses appeared to be assigned to them only on the evening shift when registered nurses were less plentiful. Nurse's aides were sometimes assigned to fatally ill children as well. The observations raise several questions. Are there formal or informal policies of patient assignment? Are patient assignments made on the basis of nursing education and training? Or are they dictated by nursing skills regardless of education? If the latter, upon what kinds of skills are assignments based? Are they based on skill in providing physical nursing care or skill in interpersonal relations? To what extent is patient need considered in making assignments of one nurse or another? Are particular individuals on a pediatric unit considered to be "experts" by their peers in given aspects of care, for example, in the care of dying children? The investigation of such questions is an area of nursing research which may clarify aspects of current nursing function and lead to more knowledgeable, planned patient care.

It is recommended that the current study be replicated, using larger samples of children, parents, and nursing personnel and several in-patient facilities. Larger, more carefully controlled samples and several institutions would reduce many of the biases of the present

study. It is also suggested that children be selected who are recognized by staff and parents to be in the terminal phase of illness. A selection of this nature would minimize the confounding effects of degree of illness and reactions to an acute crisis in which the hoped-for outcome is recovery, for a time at least.

The study of nurses' verbal behavior and its relation to the physical and emotional welfare of patients is in its infancy. Much remains to be explored and explained. Nurses can be of significant help to the family of a dying child and to the child himself. Further investigation is needed before the most effective nursing behavior and nursing role can be defined.

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APPENDIX

PARENTAL CONSENT FORM

I hereby agree to participate with my child in a research study conducted by Susan Ross, R.N. Our participation will consist of:

- 1) Permitting Miss Ross to observe and tape record events occurring in my child's room during the period of his hospitalization. All written observations and tape recordings will be used by Miss Ross and her advisory committee of the University of Utah exclusively. They will be destroyed upon completion of the written report of the study.
- 2) Permitting the use of descriptions of events and/or portions of the recorded transcript in the final written report of the research project. I understand that our names will not be divulged and all identifying information will be obscured.

(Name and relationship to child)

NURSE ORIENTATION SYSTEM

Category number	Category
0	OBJECT ORIENTATION
	PATIENT ORIENTATION
1	Feeling
2	Knowing-thinking-evaluating
3	Being-doing
	NURSE ORIENTATION
4	Feeling
5	Knowing-thinking-evaluating
6	Being-doing
	OTHER ORIENTATION
7	Feeling
8	Knowing-thinking-evaluating
9	Being-doing

Note: Reproduced from Diers (1966).

NURSE ORIENTATION SYSTEM
CODING FORM

Pt. Code _____

Study Code _____

Group _____

Unit pair	N	P	Unit Pair	N	P	Unit Pair	N	P
1			25			51		
2			26			52		
3			27			53		
4			28			54		
5			29			55		
6			30			56		
7			31			57		
8			32			58		
9			33			59		
10			34			60		
11			35			61		
12			36			62		
13			37			63		
14			38			64		
15			39			65		
16			40			66		
17			41			67		
18			42			68		
19			43			69		
20			44			70		
21			45			71		
22			46			72		
23			47			73		
24			48			74		
25			49			75		

Note: Reproduced from Diers (1966).

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