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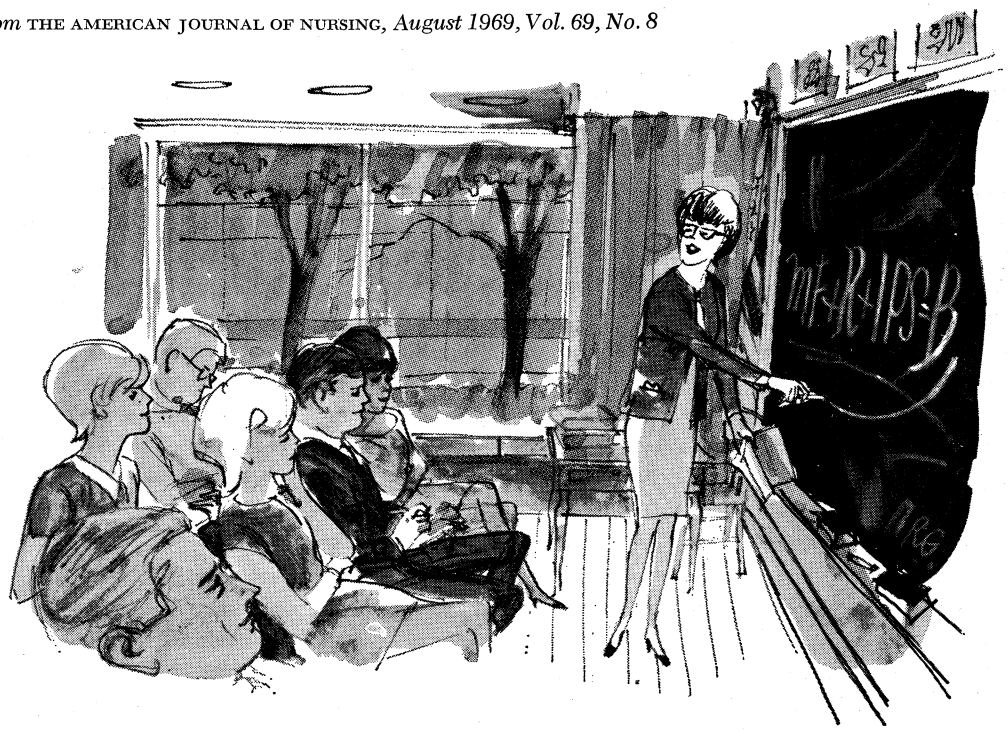

MF+R+IPS=B (Motivating Force plus Resources plus Immediate Physical Setting equal Behavior) was the equation used to teach aides to work with psychiatric patients. As a result, work satisfaction replaced dejection.

Tuning Out Hopelessness

Recognizing a need for additional education on the job for psychiatric aides, the administration of Fairhill Psychiatric Hospital secured a federal grant. The author was given freedom to select a method which she believed would enhance the therapeutic potential of the aides. She chose the causal framework, a preventive psychiatry approach. When it became evident that patient care would be further improved with nurses in a new resource role to aides, the program was extended to those in the nursing department. The result has been a decrease in judgmental thinking and an increase in team peer relationships, based on greater self confidence and motivation for continued learning.

DELORES B. PYE

In spite of sincere efforts by aides to give good patient care at Fairhill Psychiatric Hospital, interactions between them and patients were by and large ineffectual. A general feeling of hopelessness, an attitude of "forget it" prevailed. Aides were observed voicing arbitrary judgmental reprimands to patients, isolating patients on a choice basis, arguing, using policies to coerce patients, and forgetting important details of nursing care. Aides seemed unaware of priorities of patient needs, socialization cliques were common as were long coffee breaks, and purposeful, therapeutic outreach toward patients was minimal. Complaints of fatigue, and of lack of discipline and respect from authority figures were heard. There was a high incidence of sick time, "because I deserve it," and a notable use of the phrase, "it's hopeless!"

What produced all these symptoms of hopelessness? Was it Glasser's "failure identity" or what Redl, Fritz, and Wattenberg maintain, a puncture of self-respect that leads to lethargy? (1,2)

Continually questioning the genesis of this atmosphere did not make a significant difference in the morale of the aide staff. Obviously, some action was needed.

Some years earlier I had experienced an insightful revision of my own attitudes regarding child rearing, after being exposed to the causal approach to behavior, an approach that can be viewed as one that stresses an appreciation of the complex interacting forces affecting human behavior. It includes developing an ability to see things from another person's point of view, exploring possible causes of behavior, thinking in terms of alternative problem-solving methods, becoming aware of the immediate and long-range consequences of these alterna-

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tives, and suspending judgment until sufficient, logical information is accumulated for considered judgment to be made(3).

This approach to behavior was originally formulated by the Preventive Psychiatry Program, a research project at the State University of Iowa of which Ralph H. Ojemann was chairman. The committee included representatives from such disciplines as medicine, psychology, history, economics, agriculture, sociology, anthropology, home economics, education, and child welfare. The theory was systematically tested in a number of experimental and control classroom groups for its effect on children's behavior. The purpose of the school program was "to test the assumption that a causal or dynamic approach toward human behavior, toward social situations and toward problem-solving and conflicts will bring about insight and increased understanding which will foster psychological adjustment, emotional well-being, and mental health"(3).

A teacher using this approach would recognize the experiential situation of the child. She would then assist him in searching for alternative methods of handling his feelings in terms of the probable consequences of each alternative available, thus providing greater behavioral flexibility for the child, when faced with a problem.

To facilitate learning a causal approach to behavior, a behavior equation was developed: M.F. + R. + I.P.S. = B. Spelled out, this means: motivating forces (need or feeling an individual is trying to work out) plus resources (an individual's available psychologic and physiologic resources) plus immediate physical setting (immediate surroundings) equal behavior (immediate and long-range consequences)(4).

I arranged an interview with Dr. Ojemann, then director of the Child and Educational Psychology-Preventive Psychiatry Department of the Educational Research Council of America, and members of the Fairhill staff to consider the possibilities of implementing the causal approach in the aide training program.

Dr. Ojemann discussed with us some of the results of his 15 years of research. He suggested that Muuss' 1960 summary concerning the effects of teaching the causal approach to behavior was especially pertinent to our situation:

1. The causal nature of human behavior can be taught, even at the elementary school level.
2. The research studies give support to the hypothesis that a causally oriented subject is less punitive, less anxious, more tolerant, more democratic, more responsible, more secure, has fewer conflicts and shows better school adjustment.
3. The findings strongly suggest that a more lasting effect involving behavioral changes should not be expected until at least two years after the beginning of training in causality.
4. The teaching is more effective if it is integrated into all subject matter areas and if the teacher can interact causally with her students.(5)

Data regarding the successful use of the causal approach in school settings appeared to justify an experimental project using this method with aides.

We decided to test the following hypothesis: "The aide may be trained to see himself as a valuable, causally oriented resource person on the psychiatric ward." This new role concept on the part of the aide, we hoped, might begin to remove the effects of Glasser's "failure identity" and its concommitant atmosphere of hopelessness.

With training, we believed the psychiatric aide could become an "experiential facilitator" if his basic orientation was toward learning and toward the verbal identification of what was seen, felt, thought, and done as a participant in the immediate physical setting. He then, rather than judging the situation experienced, would be able to help the patient question the possible causes, alternatives, and results of all behavior, including his own.

The advantage of defining the aide as a resource person is that the term carries more success identification with other staff and thus frees the aide to engage in valuable team peer relationships on a thinking basis.

In such a program, the aide then becomes not only a significant resource person using specialized communication skills and methods in a specific setting, but also begins to experience effective methods of setting and coping with short-range goals. Daily experience in successful problem-solving situations enables an aide to feel more confident about his ability to approach and think through his own role in the more formidable long-range goal of helping patients to change. Under the grant structure, I held classes 3 hours a week for a total of 100 hours. In addition, I was available five days a week for clinical supervision and conferences with students. After the initial presentation of experiential learning theory and causal thinking, all nursing units provided the students with causal reinforcement opportunities. Methods used to elicit student involvement included anecdotal note-taking, communication skills assignments, tape recordings of nursing reports and planning conferences, causal Teacheze transparancies, films, and guest speakers. The anecdotal notes and the tape recordings were especially valuable in improving data collection awareness and they were a source of material for conferences and classroom discussion.

The first causal concept we used was Muuss' concept of first-aid training in human behavior. This is analogous to first aid in physical medicine: the use of a variety of methods to obtain immediate con-

trol, "to get rid of the danger, to stop the fight, to calm the disturbance"(6). Learning to anticipate disciplinary problems, knowing how to intervene in destructive behavior, and to rechannel ineffective behavior became especially rewarding to aides. Just knowing that specific measures existed seemed to meet a real security need; aides seemed to fear less loss of their own self-control or of that of patients.

Use of the first aid concept also limited responsibility to the immediate situation and allowed a realistic behavioral focus. Setting limits became more of a reasoning process, rather than an impulsive, punitive response, and consistency of aide-staff response became more predictable. Aides were simply less willing to stereotype behavior.

As aides, now better prepared to handle social emergencies, experienced success and felt more secure, the goal of becoming active, meaningful, psychiatric team members who engaged in the "dialogue" of long-range planning with the patient and the team could be realized.

The framework of the behavior equation was particularly helpful in assisting aides to grow in obtaining a level of successful "dialogical capacity." Each began to consider the following: (1) my behavior and the patient's behavior have complex interacting and motivating forces that can be identified only in terms of probability; (2) each person involved in the interaction has his own special psychologic and physiologic resources; and (3) the immediate physical setting exerts an influence on all behavior. The last of these includes multiple uncontrollable factors, such as the existing division of authority on the unit, time scheduling of personnel, whether or not there are floating nursing personnel, the lighting and furniture, individuals present, et cetera, all of which must be included by the aide as influential data. Furthermore, the causal orientation implies that aides are capable of developing a sensitivity to thinking through "probable future consequences" of both their own and patients' behavior. Thus, it becomes possible for an aide to discuss with a patient in the immediate setting various alternative ways of handling a problem in terms of the probable short- and long-range consequences.

RESULTS WITH AIDES

The most significant result of the use of this tool was aptly stated by one of the aides in evaluating his own growth—"I am working harder". The fact is that those who were using the causal tool actively actually sought involvement and dialogue with patients, apparently because through its use some risks had been reduced for them. For example, curiosity about the reason for a patient's hospitilization was channeled into the working focus of "What resources is the patient presently using?" and "What skills in problem solving does the patient have?" thus freeing, perhaps, energy previously used in generalized guilt feelings. The burden of problem solving was put back onto the patient, with the aide functioning as an experiential facilitator in the immediate situation, once again freeing energy previously tied up in feeling responsible for "solving the patient's problem."

With the aides better equipped to make some testable hypotheses, unconditional acceptance of and respect for patients as persons also in the process of "becoming" became a hopeful and exciting reality. The aides began to feel useful because of these successful interactions.

Aides also displayed noteworthy growth in their ability to face patients with their own behavior. For example, an aide might say, "Are you aware of how you handled your angry feelings toward Mr. B.?" or "Is there anything else you could do besides call Mr. B. names?" From here, a further discussion of other alternatives could be pursued.

Recognition of their own behavior as causal data in the immediate physical setting provided a pathway for aides to examine their failure experiences, using me as their resource person. Furthermore, the use of the behavior equation became a valuable tool for an aide who needed to face a peer with the results of his behavior. It facilitated a constant experiential learning orientation which said, "I am also open to being changed by you." Greater acceptance among peer figures soon became obvious.

Finally, I noticed strides in the ability of aides to deal with anxiety, hostility, and ambiguity, those ever-present negative forces in a psychiatric ward.

A major barrier hurdled by aides during causality training was their fear of appearing incompetent if they sought me out as a resource person. Once they were secure in testing me, they engaged in considerable testing of other hospital staff so that some of the staff began to recognize their own need to more fully understand the causal approach.

Therefore, an inservice program in causal thinking was begun as the basis for more effective nursing care plans. Persons in all nursing levels and all shifts were included in an attempt to establish a structure for continuity, consistency, and to provide more individualized care to all of the patients.

To insure further reinforcement of the use of causal thinking, a series of seminars were conducted over a three-week period by Karen Pritchett, then assistant director of Child and Educational Psychology-Preventive Psychiatry Department of the Educational Research Council of America. Each nurse developed a project in which she adapted the causal approach to her work area, and then presented it as part of the yearly nurses' inservice program. As nurses became more skillful in using the causal approach, a new and valuable role began to emerge for them—that of resourse persons to the aides in establishing meaningful pa-

tient care plans based on the causal approach the aides were beginning to employ.

PATIENT GROUP

With an aide training program and a nursing care plan program underway, I then became interested in working with the hospital chaplain on his idea of a causal project with a patient behavior group. After several conferences with the medical staff, the chaplain and I began to test out the premise that a young adult patient may be able to learn a causal orientation toward his environment which would assist him in his resocialization experiences. Student aides were included in this structured causal experience when at all possible.

A group of 10 to 12 patients met for an hour and a half three times a week. Once a referral was received from a doctor, the patient was interviewed by the chaplain or me. Interested patients from the group were welcome to assist us with these interviews during which the basic principles of causal thinking were presented along with the use of a behavior equation chart made by one of the aide students.

One group member, who learned that we had been asked to describe the functioning of the group to the staff of another hospital, suggested that she and some of the other group members demonstrate a group meeting. Seven patients volunteered. During the question period following the demonstration, one of the doctors asked what significance group membership held for them. Some of the responses were: "It is helping me to control my impulses"; "I'm learning new ways of handling behavior"; "I'm willing to accept a little more of what my parents say"; "I've been learning to tell people when I'm mad at them"; "I'm learning to think before I say something"; "I'm beginning to be able to think about how the other person might feel"; and, "This has been the most significant help I have received."

Some of the staff have criticized the incorporation of a causal approach to behavior into the aide nursing program, with the comments, "This is nothing new." or "You can't put patients into a formula."

Seeking the cause of behavior and estimating the probable results of alternative forms of behavior is a normal way of coping and, to some degree, all of us use this method. Nevertheless, few psychiatric aides have been systematically trained to apply such a method in dealing with their own behavior, let alone that of patients. Focusing patient groups on this learning process is quite different from allowing groups to share only catharsis.

Of course, we cannot put patients into a pat formula, but the behavior formula does permit an aide to look at a patient's behavior in terms of interacting forces, rather than viewing the situation just as an isolated incident in the life of an irrational person so far removed from normal methods of coping that he seems incomprehensible as a human being.

Furthermore, the classical "understanding approach" to behavior which is expected of a psychiatric aide has not necessarily been equated on a feeling level with his ability to quickly and consistently meet difficult behavioral situations calmly. Neither has this approach had the effect of satisfying his hope of being therapeutic or learning from the experience. I believe that the frame of reference of the causal approach offers an aide a filter through which greater behavioral flexibility may occur.

Subjective feedback from aides indicates that they are developing increasing ability to be less judgmental, are consistently oriented toward learning from their daily ward experiences, have a feeling of greater self-confidence, are more judicious in their use of resource persons for the benefit of the patient, and are showing increasing skill in their ability to make decisions.

Aides who are making their own hypotheses, gathering data, listening and observing more carefully, engaging in dialogue with other staff about setting realistic short-range goals, and assisting patients to think through alternatives based on probable consequences are aides who are tuning out hopelessness.

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