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Nursing Attitude Change as a Variable in Therapy Outcome Measures

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NURSING ATTITUDE CHANGE AS A VARIABLE IN THERAPY OUTCOME MEASURES

by

Richard C. Evenson

A Dissertation Submitted to the Faculty of the Graduate School of Loyola University in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

June 1969
Vita

Richard Charles Evenson was born August 23, 1928 in South Milwaukee, Wisconsin.

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Introduction

There has been a good deal of interest in recent years in utilizing nurses, nursing aides and various nonprofessional volunteers as group psychotherapists (Carkhuff & Truax, 1965; Kaldeck, 1951; Poser, 1966; Rioch, 1966; Sines, Silver, & Lucero, 1961). Similarly, there has been continuing interest in the use of psychotherapy groups as a training device for staff (Kaplan, 1967). Such use includes the utilization of group process within a student group (Deck, Hurley, & Crumpton, 1963; Feinstein & Waxler, 1963; Matarazzo & Small, 1963; Perlman & Barrell, 1958) as well as the use of actual patient groups for the training of student cotherapists (Geller, 1954; Kotkov, 1954; Manaster, Pillar, Drell, & Dykmann, 1966; Patton, 1954). The advantage of the latter, of course, is that the group becomes both a medium of therapy for patients and a medium of training for less experienced staff members.

A program using nursing personnel as multiple cotherapist trainees in group psychotherapy with psychiatric patients was embarked upon by the author and various nursing personnel at Downey V.A. Hospital, Downey, Illinois. The project was aimed at becoming self-sustaining and self-administering nursing projects. The first groups were initiated on a large, open-ward building of approximately 120 male patients who could be characterized as "chronic schizophrenics." The majority of these men had been hospitalized recurrently or continuously for
over five years, many for ten to twenty years. Problems of patient selection, group composition, goals, and expectations were discussed in informal meetings with registered nurses, practical nurses, and nursing assistants assigned to the building on the day shift. Groups were formed, each consisting of nine patients and three nursing personnel, with the author participating in each group. Prior to beginning the group meetings, a brief series of meetings with nursing personnel served to familiarize them with the author's approach to group therapy, which is group-centered (Johnson, 1963) and emphasizes group process (Whitaker & Lieberman, 1964). Semon and Goldstein (1957) point out that group-centered methods do not assume that the therapeutic potential lies in the relationship between patient and group leader, but rather that "motivation for change is contained within the emotional relationship established among the members of the group (p. 319)." The modus operandi of the groups in this project was initially simple and concrete, similar to the goals discussed by Crary (1968) in regard to transitory groups. That is, the immediate goal was simply getting the patients to (1) enter the room, (2) sit, (3) together, (4) in a circle (5) for a given length of time. The next goal was getting the patients to (1) talk (2) to one another (3) about things of interest and concern. And finally, getting the patients to (1) talk one at a time (2) while the rest listen (3) to what the person has to say and (4) respond
to it (5) in a realistic manner. Subsequently, relationships between group members were explored, and the prime function of the groups became problem-solving, particularly as regarded discharge.

Group meetings were scheduled twice weekly, 45 minutes each, followed by postmeeting discussions with nursing personnel. The emphasis of these discussions was on attempts to better understand the patient as a person, to assess the strengths and competencies of patients, and to explore interpersonal relationships between patients and personnel. Questions concerning goals, techniques and resolution of conflict within the group were also dealt with in the post-meetings. After two months in each group, following discussion with both personnel and patients, the author began attending only alternate meetings, and attended no further meetings after four months. By this time, the groups were running quite autonomously, and nursing personnel had become not only comfortable but proficient. The nursing personnel, in fact, were not only able to maintain the groups, but were able to themselves train additional personnel through their use. The first of these open-ended groups (patients were discharged and added with time) met regularly for over eighteen months without a hiatus.

Because of the training aims of the groups, initial interest was in regard to "change" in the nursing participants. Earlier experience had suggested striking changes in attitudes toward mental illness and mental patients on the part of group-
involved personnel.

Although there have been a number of investigations concerning attitudes of personnel in mental health settings (Cantor, 1963; Ellsworth, 1965; Lawton, 1964; Meltzer & Smothers, 1967) and attitude change by such personnel (Appleby, Ellis, Rogers, & Zimmerman, 1961; Lewis & Cleveland, 1966; Ralph, 1968), less attention has been given to attitude changes of staff as a result of involvement in specific treatment programs (Long, 1963; Schmidt, 1964).

If, as suggested earlier, favorable attitude change takes place, it seems likely that it would influence behavioral ratings of patients made by nurses. Since such ratings are often used as criteria of patient change in therapy outcome studies (Cross, 1964), and since nursing personnel are involved in therapeutic programs to varying degrees, such attitude change would constitute an uncontrolled source of variance in respect to patient ratings. In other words, reported differences in therapy outcome measurements may be due at least in part to the degree to which nursing personnel are involved in the therapeutic program and the degree of attitude change that may be reflected in their "objective" ratings.

Therapy outcome studies have often been concerned with the existence of a placebo effect (Nash, Frank, Imber, & Stone, 1964; Shapiro, 1964) and related effects resulting from therapist expectations (Rosenthal, 1964; Williams, Niebel, & McGee, 1962;
Zusman, 1966); as well as the congruence between patient-therapist expectations (Goldstein, 1966; Manis, Houts, & Blanke, 1963; Stone, Frank, Hoehn-Saric, Imber, & Nash, 1965). Ratings of a patient who is known to be in a therapy group may be spuriously high since the expectations of the raters are likely to bias their objectivity. Attitude changes on the part of the raters, as discussed here, would seem likely to increase this kind of expectancy bias. That is, a positive attitude change might result in more favorable ratings of all patients, but the increase for those in therapy would seem likely to be greater than for those not in therapy.

The relationship between various staff attitudes and the clinical course of patients has been studied, both the effects of patients on staff (Kellam, Darell, & Shader, 1964) and the effects of staff on patients (Staunton & Schwartz, 1954) but such studies have not examined the influence of changing staff attitudes on the measurement of the clinical course of patients.

Finally, there have been studies of the influence of rating "sets" by staff (Amble & Moore, 1966; Elstein & Van Pelt, 1968; Goldschmid & Domino, 1967; LaPlace, Stein & Weisman, 1968) and on other factors in the variance in staff ratings of patients (Elstein & Van Pelt, 1966; Klett & Lasky, 1959; Raskin, Schulterbrandt & Reatig, 1966; Raskin & Sullivan, 1963; Spitzer & Cohen, 1968) but little attention has been focused on attitude change as a factor in rater discrepancy as discussed here.
Review of the Literature

Attitudes Toward Mental Illness

One of the first scales used to assess attitudes of mental hospital personnel was the F-scale, a measure of authoritarian attitudes (Adorno, 1950). After World War II, striking changes began to be made in the philosophy and organization of mental hospitals (Belknap, 1956; Dunham & Weinberg, 1960; Greenblatt, York, Brown & Hyde, 1955) particularly after the introduction of the phenothiazine drugs. The zeitgeist was in favor of rapid discharge and decentralization, and against authoritarian organization, and custodial ideology. Middleton (1953) designed a scale to measure prejudices and opinions of mental hospital employees regarding mental illness. He found greater prejudice towards mental patients among older, more experienced aides. As clinicians became conscious of the power and influence of the nursing infrastructure of the psychiatric hospital, they become more and more concerned with the attitudes of the "old, hard-core, traditional aide." Middleton found prejudice inversely related to intelligence and education, and that the smarter and better educated aide quickly leaves for more remunerative work. Canter (1963) investigated attitudes of nurses in their psychiatric affiliation, using both the F-scale and the related Dogmatism Scale (Rokeach, 1960). In addition, Canter devised a test of Attitudes Towards Mental
Patients (AMP). He found that the authoritarian scales were related to negative attitudes toward patients. Fishkin and Wolfgang (1962) devised a 10-item empathy scale and found that scores for psychiatric aides were related to performance evaluation on the Soulem Scale (Imre & Wolf, 1962).

Gilbert and Levinson (1956) constructed an attitude scale specifically to measure custodial ideology, the Custodial Mental Illness Ideology Scale (CMI), and the Custodial Role Performance Scale (CRP). They found that aides had higher CMI scores than the "professional" staff, and that scores by aides on the CMI were highly correlated with performance as measured on the CRP. Carstairs, Gilbert, Heron, Levinson, and Pine (1957) found that aides who endorsed custodial attitudes on the CMI were rated by supervisors as handling interpersonal relationships with patients by restrictions, control and punishment. Appleby, Ellis, Rogers and Zimmerman (1961) found that CMI scores of aides remained stable over a one year period, despite changes in ward organization and effectiveness. Their results also suggested that clinical staff was less authoritarian and more humanistic than aides, and that old and new aides were similar in attitudes but differed in role conception. Klett and Lasky (1961) studied attitudes by means of a scale based on factor analysis of the CMI and the Chemotherapy Attitudes Scale (CAS). They found aides to be more authoritarian, restrictive and custodial than nurses and other staff members, and that aides saw drugs providing the treatment.
Deck, Hurley, and Crumpton (1963) studied nursing students during their psychiatric affiliation, using the F-scale and the CMI. They found that the students became less rigid in their attitudes and more realistic in their conceptions of mental patients. Long (1963) found that CMI scores of aides changed toward a less custodial ideology after being involved in a remotivation program (Long, 1960). Schmidt (1964) found a trend for CMI attitudes of nurses and aides to become more positive following the introduction of a remotivation program. Meltzer and Smothers (1967) combined the CMI with fourteen items from the F-scale, six items from the Traditional Family Ideology Scale which measures autocratic views of family relationships, and several original items reflecting a humanitarian viewpoint. They found significant differences between professional staff, nonprofessionals and patients, in that order, with professionals least custodial. Ralph (1968) compared prescores and postscores on the CMI for college students who had volunteered for a recreation group and those who had volunteered for a companion group with mental patients at a V.A. hospital. He found that, initially, the companion volunteers were more humanitarian and less custodial, but no changes from pretest to posttest for either group.

Cohen and Streuning (1962) developed a factor-analytically devised set of scales made up of fifty-one Likert-type items with the following five dimensions of attitude toward mental
illness: A-Authoritarianism; B-Benevolence; C-Mental Hygiene Ideology; D-Social Restrictiveness; and E-Interpersonal Etiology. There is some tendency for A-D and B-C to form negatively related clusters. The scale, Opinions About Mental Illness (OMI) was used by Cohen and Streuning (1963) to study occupational profiles at mental hospitals. Their data suggested that patients as a group are closer to aides as a group than they are to the professional staff. Also, correlations between .50 and .60 were found between education and authoritarianism. Cohen and Streuning (1964) subsequently identified seven V.A. hospitals as high in authoritarianism and social restrictiveness, and three hospitals low in this cluster, of twelve hospitals studied. The low-cluster-profile hospitals were also found to be more effective, using the criteria of time spent in hospital during one year after admission. Lawton (1964) found that aides judged to be superior were seen on the OMI as nonauthoritarian and benevolent, while those judged inferior were high on authoritarianism and more likely to reject mental hygiene ideology. Lawton (1964), however, found no relationship between the OMI and therapeutic role conception. Vernallis and St. Pierre (1964) measured volunteer workers on the OMI, and found benevolence and authoritarianism related to education and age. The authors found volunteers to be nonreceptive to mental hygiene ideology, but positive towards unsophisticated benevolence and a "love deprivation" theory of mental illness. Ellsworth (1965) found that aides who scored high on the OMI in authoritarianism and
restrictiveness were described by patients as being rather controlling and uninterested in the welfare of patients. Lewis and Cleveland (1966) found nursing students to develop more positive attitudes on OMI scales for authoritarianism, mental hygiene ideology and interpersonal etiology.

Hicks and Spaner (1962) developed a 6-point, forced-choice Likert scale using items from the CMI, OMI, Prejudice Test, plus original items. The Opinions About Mental Illness Scale (OAMI) was developed by item-analysis of responses made by student nurses before and after an eight-week psychiatric affiliation, utilizing a number of control groups in an institutional cycles design. Test-retest reliability, based on control group data, was .82. Internal consistency reliability was estimated as .87. The study itself found that nursing students were uniformly more favorable in attitude after a psychiatric affiliation of eight weeks, and changed relatively more than did a control group.

Barell, DeWolfe and Cummings (1965) developed the Philosophy of Treatment scale (POT) for measuring staff attitudes towards patient care, using both general medical and psychiatric samples. The scale was rationally developed from a pool of 185 items through unanimous agreement of three judges as to seven attitudes tapped: 1 - interprets rules in an authoritarian way; 2 - believes patients should be informed about their condition; 3 - accepts idea that staff behavior affects patients; 4 - is
aware of patient needs; 5 - perceives need for congeniality among staff; 6 - views patients unfavorably; and 7 - thinks staff should be self-critical about performance. Kuder-Richardson reliability estimates ranged from .74 to .93. One week test-retest reliabilities ranged from .51 to .89 over eight small samples.

The Use of Lay Therapists

The shift to treatment orientation at state hospitals, plus the expansion of community-centered services, has created an ever-increasing mental health manpower shortage. Accordingly, there has been greater interest in exploring the use of non-professional or lay therapists.

Sines, Silver and Lucero (1961) chose aides at random and assigned them patients for twice-weekly individual sessions. No training or supervision was provided. Patients received a pre-test and posttest on the MMPI and the L-M Behavior rating scale. No significant differences were found.

Carkuff and Truax (1965) found significant differences between control patients and patients seen in group therapy by trained lay hospital personnel. Eight therapeutic groups of 10 patients each were seen twice weekly for 24 sessions by five aides trained in judging therapist empathy, warmth, genuineness and depth of patient self-exploration. Improvement in ward behavior of the patients was measured by the "Gross rating of patient behavior" scale, consisting of four items on a 9-point scale.
Poser (1966) examined the effects of therapists training on group therapy outcome with 295 patients after five months of group therapy by untrained undergraduate summer students and by psychiatric social workers and psychiatrists. The students were viewed as a placebo group. By comparison to an untreated control group, the lay therapists achieved slightly better results than the staff therapists. Criteria measures included perceptual, psychomotor and verbal psychological tests, plus the Palo Alto Hospital Adjustment Scale (HAS).

Rioch (1966), discussing changing concepts in the training of therapists, questioned why professionals are slow to use these new resources. She has pioneered the use and training of housewives as lay counsellors, and felt that their effectiveness has been demonstrated. She recommended that professionals should identify themselves with the advancement of knowledge and leave more of the practice of crafts to new categories of workers.

Rosenbaum (1966), however, has criticized the design of studies showing the effectiveness of lay therapists. Particularly in regard to chronic psychiatric patients, he suggested that we differentiate between "help" and "change." He also noted that trained psychotherapists may not care to acknowledge their boredom in working with chronic schizophrenics.

Objective Patient Rating Scales

Outcome studies have frequently employed global psychiatric impressions or ratings (Boenheim, 1959; Phillipson, 1958) but there has been increasing interest in the use of more objective
rating scales for assessing patient change or improvement. Frequently, studies have constructed special scales or rating devices for their immediate purpose. Truax, Wargo, Frank, Battle, Hoehn-Saric, Nash, and Stone (1966), for example, in relating therapist qualities to outcome, constructed scales for global improvement as seen by the therapist, global improvement as seen by the patient, reduction of target symptoms and alleviation of discomfort as judged by the patient, and a scale of social ineffectiveness based on interview behavior. A plethora of individualized scales, however, makes comparisons across studies quite difficult, and there has been continuing interest in carefully constructed and standardized scales meant for more generalized use, and usually based on behavioral observation within the hospital setting.

One of the earliest is the Palo Alto Hospital Adjustment Scale (HAS) based on interpersonal relationships within the hospital ward (McReynolds & Ferguson, 1946). The scale has been used to measure interpersonal relationships in therapy groups (Finney, 1954) and as an outcome measure for group therapy (Semon & Goldstein, 1957). The HAS subscales include (1) communication and interpersonal relations, (2) care of self and social responsibility, and (3) work, activities and recreation. Semon and Goldstein found significant but small changes on the first two subscales combined for patients in leader-centered and group-centered therapy groups as compared with
control groups. There were no differences between the two
group methods. Grinspoon, Ewalt and Shader (1967) used the HAS
and the Behavioral Disturbance Index (EDI) to study the outcome
of long-term treatment of chronic schizophrenia. They found
that psychotherapy alone, even with experienced therapists, did'
little or nothing for chronic schizophrenics in two years time.
However, a combination of drugs and psychotherapy had beneficial
results. The EDI (Cohler, Grinspoon, & Fleiss, 1965) is a 54-
item scale which reflects the degree to which a patient's
behavior, thinking processes and affect are disturbed.

The Multidimensional Scale for Rating Psychiatric Patients
(MSRPP; Lorr, Jenkins, & Holsopple, 1953) is a 62-item rating
scale describing various aspects of psychopathology. It yields
a total morbidity score derived from 11 factor scores, and is
based on factor-analytic studies carried out by Lorr (1953) and
Lorr, Rubinstein and Jenkins (1953). Forty items are based on
an interview, usually by a psychiatrist or psychologist, and
the remaining 22 items are based on ward observations, usually
by nurses or aides. Klett and Lasky (1959) reported intraclass
correlations to determine agreement among raters on 563 patients
to range from .63 to .80 for the subscales, and .82 for total
morbidity. Lewinsohn (1967) used the MSRPP as a measure of
psychoticism, one of several patient outcome measurements. He
states that factor-analytic studies have reported finding a
number of different and independent dimensions of patient change,
indicating that improvement is a multidimensional phenomenon. Lewinsohn's data supports this notion in that there were wide differences between improvement criteria in relation to a constellation of prognostic variables. Sherman, Eldred, Bell and Longabough (1966) had nurses and aides fill out the entire MRSFP on the basis of ward observation alone. In comparison with the regular interview ratings, this revised use of the scale showed inter-rater agreement ranging from .63 to .87 with a mean correlation of .76.

Lorr, McNair, Klett and Lasky (1962) identified ten psychotic syndromes and three second-order factors based on factor-analytic studies made of primarily chronic mental patients. These investigators (Lorr, Klett, McNair, & Lasky, 1963) developed the Inpatient Multidimensional Psychiatric Scale (IMPS) utilizing a combination of interview and observational data as with the MRSFP. Despite Eysenck's (1963) criticisms, in which he pointed out the limited pathology range in the samples and the rather gross and somewhat tautologous nature of the items, Lorr and Klett (1965) confirmed the IMPS factors on both sexes in a national sample. Lorr, Klett and Cave (1967) identified five higher-level psychotic factors measured by the ten IMPS syndromes: disorganized hyperactivity; schizophrenic disorganization; paranoid process, anxious depression and hostile paranoia.

Lorr, O'Connor and Stafford (1960) constructed, field-
tested and standardized a multidimensional behavioral inventory for the description of observable psychotic patient behavior in a hospital setting, known as the Psychotic Reaction Profile (PRP). They planned to match nine factors and four higher-level constructs identified earlier by rationally distributing various items into nine syndromes and using the method of homogeneous keying. However, the nine subscales were too highly correlated for this method, and four scales representing the second-order constructs were derived instead. The four essentially independent subscales are: Withdrawal (W), Thinking Disorganization (T), Paranoid Belligerence (P), and Agitated Depression (A). The last subscale is the least reliable, consisting of only five items. Vestre (1966) examined PRP ratings for closed wards with and without privileges, open wards and open wards involved in pre-discharge planning. The first three subscales showed significant between-group differences. The W-scale showed complete between-group discrimination, the T-scale did not discriminate between the two open wards, and the P-scale did not discriminate within the open and closed ward groups.

Burdock, Hakerem, Hardesty and Zubin (1960) published the Ward Behavior Rating Scale (WBRS). Raskin and Clyde (1963) factor analyzed the WBRS using the IMPS for marker variables. They found 11 factors with good correspondence to the IMPS psychotic syndromes. They found no "withdrawal" factor, and
found factors of self-care (19 items), social participation (11 items) and irritability (10 items). Goldberg and Mattsson (1967) examined the prediction of global, clinical judgements of improvement by linear combinations of various elements of symptom reduction. Ratings were obtained by using psychiatrists and nurses, utilizing the IMPS and the WBRS. The investigators found psychiatrists to be more influenced by interview behavior, hostility, slowed speech and movements, and ideas of persecution. Nurses were more influenced by social participation, irritability, feelings of unreality, and confusion. Both were influenced by indifference to environment.

Domino, Goldschmid and Kaplan (1964) developed the Sonoma Check List, a list of 210 adjectives. Goldschmid and Domino (1967) asked various disciplines to describe patients who were good therapy candidates. Psychiatrists and psychologists look for patients with strengths and pathology; nurses were more concerned with affiliative tendencies; aides emphasized behavioral management.

DeVries (1968) described the Patient Activity Checklist (PAC). It is a 24-item scale of pathology as defined by specific overt behaviors of patients in a ward dayroom setting during free-time periods. The study showed significant improvement in patient behavior when patients were moved to new wards, although participation by patients in planning the move did not result in greater improvement.
More recently, with increasing interest in the problem of institutionalization, a survey instrument has been devised to measure the Social Breakdown Syndrome (Zusman, 1967) both within the hospital and in the community. The Social Breakdown Syndrome can, in a sense, be viewed as the antithesis of "actualization," and the survey instrument emphasizes socialization and productivity.

The Placebo Effect

One of the perplexing problems in therapy outcome strategies is to provide controls for the expectancies of therapists, patients and raters. In drug studies, the patient's expectancy of finding relief often results in relief despite the impotency of the drug (Shapiro, 1964). A similar phenomenon is association with the expectancies of the therapist (Rosenthal, 1964), presumably a kind of self-fulfilling prophecy in which the therapist's attitude is subtly communicated to the patient. Even in double-blind studies (Williams, Niebel, & McGee, 1962) therapists are more likely to rate their patient as "improved" and thus also more likely to rate him as receiving the actual drug. Further, the congruence of patient expectations and therapists expectations have been shown to influence the outcome of therapy (Stone, Frank, Hoehn-Saric, Imber, & Nash, 1965).

Since a double-blind study for group therapy is quite difficult, if not impossible, it would seem important to examine the effect of expectancy on the raters of group therapy out-
come. Finally, evidence is inconclusive as to whether the placebo effect is related to attitudes of the therapist (Nash, Frank, Imber, & Stone, 1964).

Statement of the Problem

Since a good deal of evidence has been shown that various nursing personnel tend to develop more favorable attitudes toward mental patients as a result of participation in diverse mental health activities, and since there is additional evidence that therapist's expectations are influential in subsequent assessments of patients, the following hypotheses were considered in the present project:

**Hypothesis 1.** That nursing personnel involved in a group therapy project (IP) show a more favorable change in attitudes toward mental illness and mental patients during a 4-month period than will noninvolved nursing personnel (NIP) who participate only in the more usual psychiatric nursing routine for the same period of time.

**Hypothesis 2.** That there is a more favorable change in patient behavior ratings made by IP than in ratings made by NIP for the same patients over the same period of time; and that the difference between IP and NIP ratings will be larger for patients in group therapy than for control patients not in groups.

It should be noted that the major interest in this study lies in differences between raters (IP vs. NIP) rather than differences in patient outcome (group vs. control). The study, however, has implications for outcome studies in general.
Method

Six therapy groups, utilizing nurses, practical nurses and nursing aides as multiple cotherapists, were organized by the author on three treatment wards (A, B, and C) at Downey V.A. Hospital. Data was also utilized from three similar therapy groups on two additional areas (D and E). Ward "A" is a 3-story, open building housing male patients with ground privileges, all of whom have been transferred from "acute" wards and who can generally be described as "chronic schizophrenics" (average length of hospitalization averages about eight years). Ward "B" is similar 2-story, open building for chronic female patients. Ward "C" is one of the "acute" male wards in the same unit as wards A and B. Ward "D" is the hospital's alcoholic unit, and the "E" groups were part of a Nursing Education project which drew patients from several wards.

Subjects

Nursing personnel to be involved in the group therapy projects (IP) were selected by the head nurse on the basis of availability and heterogenity. In each group, the involved nursing personnel (registered nurses, practical nurses, and aides) represented a wide-range of prior job-evaluations. All were from the day shift. Each group involved two to four nursing personnel as cotherapists, with the author participating in six of the nine groups. Noninvolved personnel were defined as nursing personnel on all three shifts of the experimental wards.
who were not involved in group therapy with the patients (NIP).
In addition, nursing personnel from three wards of another Unit
where no nursing personnel at all were involved in group therapy
with patients were utilized as a control group. For testing
Hypothesis 1, this latter control group provided the most com­
parable baseline. For testing Hypothesis 2, the NIP group was
utilized as a control, since they would be able to rate the
same patients on their ward as did the IP group.
Two patients were selected at random (actually drawn from
a hat) from each therapy group, and two patients were selected
at random from a pool of patients who had been selected as
candidates for a group but who were not group members at the
onset of the project. These control patients were not taken
into the therapy group during the course (four months) of the
study.
Measurements
Attitudes of all nursing personnel (IP, NIP, and Control)
on all three shifts were assessed by means of the Opinions
About Mental Illness Scale (OAMI) developed by Hicks and
Spaner (1962). The scale is a Likert scale developed by re­
sponses of student nurses during their psychiatric affiliation
at Downey V.A. Hospital. The initial item pool was drawn from
the CMI Scale (Gilbert & Levinson, 1956), Middleton's (1953)
Prejudice Test, the OMI (Cohen & Struening, 1959), as well as
original items derived from notes, records and interviews on
wards at Downey V.A. Hospital. The OAMI scale seems particularly suited to the Downey nursing personnel involved in this study. The attitude study was done when the therapy groups were initially formed, and was repeated four months later. Subjects were informed that the study was part of a hospital research project, and were allowed to substitute birthdate or other coded data (to enable pretest to posttest matching) for their names. The project face sheet, OAMI form used and the scoring key are shown as Appendix A.

Both experimental (group therapy) and control patients were rated on the Psychotic Reaction Profile (Lorr, O'Connor, & Stafford, 1960) by all nursing personnel (IP and NIP) on all three shifts. These ratings were made at the initiation of the group therapy project and after four month's duration. This rating scale was developed and used extensively in V.A. psychiatric hospitals, and seemed particularly applicable to the patient population in this study. The PRP generates five scores, four sub-scales (Thinking disorganization, Withdrawal, Paranoid belligerence and Agitated depression) and a total score which can be thought of as an overall "pathology" index. All five scores were calculated for this study. The rating face sheet, PRP form used and the scoring key are shown as Appendix B. As part of the rating face-sheet, personnel were asked to make a global judgement of the patient over the previous four months in terms of "much improved, slightly improved, no
noticeable change or changed for the worse."

Procedure

Data were collected according to what Campbell and Stanley (1963, p. 183) refer to as the "pretest-posttest control design," and can be illustrated by the following paradigm:

\[ \begin{align*}
R_0^1 & \times O_2 \\
R_0^3 & \times O_4
\end{align*} \]

Such a design consists of pretest \((O_1 \text{ and } O_3)\) and posttest \((O_2 \text{ and } O_4)\) for randomly selected experimental \((R_0^1)\) and control \((R_0^3)\) groups. The experimental variable \((X)\) is introduced between pretest and posttest for the experimental group only.

Campbell and Stanley pointed out that "the most widely used acceptable test is to compute for each group pretest-posttest gain scores and to compute a \(t\) between experimental and control groups on those gain scores (p. 193)."

In order to test Hypothesis 1, attitude \((OAMI)\) change-scores (posttest score minus pretest score) were computed for all nursing personnel. Hypothesis 1 predicted that mean change-scores for IP are significantly larger than mean change-scores for control personnel.

In order to test Hypothesis 2, rating \((PRP)\) change-scores (pretest minus posttest) were computed for all nursing personnel. Hypothesis 2 predicted that mean change-scores for IP are significantly larger than mean change-scores for NIP. Hypothesis 2 further predicted that the difference in mean change-scores
(IP vs. NIP) are greater for ratings made on experimental (group therapy) patients than control patients.

Since the study included nine therapy groups on five wards, data for each ward was examined separately before pooling.

Results

Initial or pretest mean scores on the Opinions About Mental Illness Scale (OAMI) were computed for 26 nursing personnel involved in conducting therapy groups on five different ward areas (IP). 45 nursing personnel employed on three of the same five wards but not involved with therapy groups (NIP), and 64 on other wards where no nursing personnel were involved with therapy groups (Control). The data are presented in Table 1, and the involved personnel had significantly more positive attitudes than either the non-involved or the control personnel at the onset of the project.

Mean change-scores (posttest scores minus pretest scores) on the OAMI for the same groups of nursing personnel over the four-month experimental period were computed and are shown in Table 2. Number of subjects (N) differs between the pretest data and the change-score data since some personnel that filled out pretest forms were not available for posttesting. Positive change-scores indicate a change in the direction of more positive attitudes toward mental illness. The hypothesized positive change by IP over that of Control subjects was not found. In fact, both IP and NIP groups showed a change in the negative direction,
although only the NIP mean change was significant as compared with the control group.

To be sure that relevant changes were not masked by pooling of data from various experimental wards (most of which differed in terms of patient population and program) the data for each ward were examined.
Table 1

OAMI Pretest Scores for NIP, IP, and Control Subjects

<table>
<thead>
<tr>
<th></th>
<th>NIP</th>
<th>IP</th>
<th>Control</th>
<th>(NIP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>45</td>
<td>26</td>
<td>64</td>
<td>—</td>
</tr>
<tr>
<td>M</td>
<td>36.66</td>
<td>42.50</td>
<td>34.90</td>
<td>—</td>
</tr>
<tr>
<td>SD</td>
<td>9.81</td>
<td>8.06</td>
<td>8.83</td>
<td>—</td>
</tr>
<tr>
<td>t</td>
<td>2.67*</td>
<td>3.88**</td>
<td>0.95</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>5.83**</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p < .05

** p < .01
Table 2
Mean Change in OAMI Scores During the 4-month Experimental Period for NIP, IP, and Control Subjects

<table>
<thead>
<tr>
<th></th>
<th>NIP</th>
<th>IP</th>
<th>Control</th>
<th>(NIP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>35</td>
<td>25</td>
<td>52</td>
<td>-</td>
</tr>
<tr>
<td>Mean Change</td>
<td>-2.23</td>
<td>-1.76</td>
<td>+0.78</td>
<td>-</td>
</tr>
<tr>
<td>SD</td>
<td>4.94</td>
<td>5.56</td>
<td>5.83</td>
<td>-</td>
</tr>
<tr>
<td>t</td>
<td>0.33</td>
<td>1.60</td>
<td>2.56*</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>3.26*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p < .05
## TABLE 3

Mean Change in OAMI Scores for IP, NIP, and Control Subjects, by Wards.

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean Change</strong></td>
<td>-1.88</td>
<td>-0.34</td>
<td>-2.60</td>
<td>-2.00</td>
<td>-2.58</td>
<td></td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>6.00</td>
<td>2.86</td>
<td>7.41</td>
<td>5.00</td>
<td>4.23</td>
<td></td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>8</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td><strong>Mean Change</strong></td>
<td>-1.65</td>
<td>-3.29</td>
<td>-2.77</td>
<td>+4.00</td>
<td></td>
<td>+0.78</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>5.31</td>
<td>4.86</td>
<td>4.29</td>
<td>0.00</td>
<td></td>
<td>5.83</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>14</td>
<td>7</td>
<td>13</td>
<td></td>
<td></td>
<td>52</td>
</tr>
</tbody>
</table>
There was a consistent tendency for personnel on all experimental wards, involved or not involved in the project, to show small negative changes in attitudes as measured by the OAMI.

It is conceivable that personnel attitudes might systematically vary according to work shift, especially since percentage of registered nurses is usually higher for the day shift. Therefore, experimental (IP and NIP) and control pretest data were combined and recalculated according to work shift (day, P. M. and night) for comparison. The results are shown in Table 4, and it is clear that attitudes of nursing personnel on the night shift were significantly less positive than personnel on the day shift.

It is also conceivable that attitudes might vary according to level of formal training. Therefore, pretest data were pooled and recalculated for registered nurses, practical nurses, and aides. The results are shown in Table 5. It is clear that registered nurses, at the onset of the project, had significantly more positive attitudes than either practical nurses or aides. In fact, the group means suggest a regular relationship between attitudes toward mental illness and level of professional training.

Data from the Psychotic Reaction Profile (PRP) was examined for differences between raters on the experimental wards who were involved in the group therapy project (IP) and those who were not (NIP). Two patients were selected at random from each therapy group that was established. Rated scores on the PRP for both
Table 4

OAMI Pretest Scores by Work Shift for IP, NIP and Control Subjects Combined

<table>
<thead>
<tr>
<th></th>
<th>Day</th>
<th>PM</th>
<th>Night</th>
<th>(Day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>38.75</td>
<td>36.00</td>
<td>34.41</td>
<td>—</td>
</tr>
<tr>
<td>SD</td>
<td>8.05</td>
<td>8.17</td>
<td>9.19</td>
<td>—</td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>30</td>
<td>39</td>
<td>—</td>
</tr>
<tr>
<td>t</td>
<td>1.49</td>
<td>0.75</td>
<td>2.38*</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>3.11*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p > .05
Table 5

OAMI Pretest Scores by Level of Nursing Training for IP, NIP and Control Subjects Combined

<table>
<thead>
<tr>
<th></th>
<th>Registered</th>
<th>Practical</th>
<th>Aide</th>
<th>(Registered)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M</strong></td>
<td>46.60</td>
<td>39.16</td>
<td>34.80</td>
<td>—</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>5.54</td>
<td>7.73</td>
<td>8.28</td>
<td>—</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>25</td>
<td>12</td>
<td>98</td>
<td>—</td>
</tr>
<tr>
<td><strong>t</strong></td>
<td>2.79*</td>
<td>1.76</td>
<td>8.23**</td>
<td></td>
</tr>
</tbody>
</table>

\[ F = 21.42** \]

* \( p < .05 \)

** \( p < .001 \)
patients were then pooled and averaged across raters (IP and NIP) on each ward. The results for pretest and posttest ratings are shown in Table 6, with the ratings representing mean scores for all wards. Only total PRS scores are shown here. The mean difference in pretest ratings by IP and NIP is not significant. Thus, both involved and noninvolved personnel rated the experimental patients similarly at the beginning of the group psychotherapy project and after four months.

The crucial test of hypothesis 2 is seen in Table 7. Change-scores (postratings minus preratings) for the IP and NIP are shown for the four subscales of the PRP (Thinking Disorder, Withdrawal, Paranoid Belligerence and Agitated Depression) and total PRP scores. Change-scores were calculated in such a way that a positive change-score indicates "improvement". None of the differences were significant. Thus, nursing personnel involved in group therapy project and those not involved saw similar changes in the experimental patient's behavior over the four months of group therapy. Here again, number of subjects varied from the pretest and posttest data due to some personnel being unavailable for both sets of ratings (new employees, termination of employment, assignment transfers, etc.).

Change-scores for total PRP ratings of patients in therapy groups are shown by ward in Table 8. It can be seen that neither IP nor NIP differed consistently in their ratings across wards. Thus, there is no support for the hypothesis that nursing
Table 6

PRP Ratings (Total Score) by IP and NIP for Patients in Group Psychotherapy

<table>
<thead>
<tr>
<th></th>
<th>IP</th>
<th>NIP</th>
<th>Difference</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretest</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>29.42</td>
<td>32.36</td>
<td>2.94</td>
<td>0.82</td>
</tr>
<tr>
<td>SD</td>
<td>15.19</td>
<td>16.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>33</td>
<td>47</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>26.53</td>
<td>29.57</td>
<td>3.04</td>
<td>0.84</td>
</tr>
<tr>
<td>SD</td>
<td>16.05</td>
<td>14.68</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>32</td>
<td>47</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 7

Mean Change in PRP Ratings by IP and NIP on Patients in Group: Psychotherapy

<table>
<thead>
<tr>
<th>PRP Scales</th>
<th>T</th>
<th>W</th>
<th>P</th>
<th>A</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP Mean Change</td>
<td>0.93</td>
<td>1.09</td>
<td>1.09</td>
<td>0.46</td>
<td>3.57</td>
</tr>
<tr>
<td>SD</td>
<td>3.87</td>
<td>19.28</td>
<td>5.72</td>
<td>3.92</td>
<td>23.03</td>
</tr>
<tr>
<td>N</td>
<td>32</td>
<td>32</td>
<td>32</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>NIP Mean Change</td>
<td>-0.46</td>
<td>1.40</td>
<td>1.34</td>
<td>0.15</td>
<td>2.43</td>
</tr>
<tr>
<td>SD</td>
<td>5.86</td>
<td>13.85</td>
<td>4.99</td>
<td>4.42</td>
<td>20.42</td>
</tr>
<tr>
<td>N</td>
<td>44</td>
<td>44</td>
<td>44</td>
<td>44</td>
<td>44</td>
</tr>
<tr>
<td>Difference</td>
<td>1.39</td>
<td>0.31</td>
<td>-0.25</td>
<td>0.31</td>
<td>1.14</td>
</tr>
<tr>
<td>t</td>
<td>1.23</td>
<td>.08</td>
<td>.20</td>
<td>.32</td>
<td>.23</td>
</tr>
</tbody>
</table>

1 Positive change-score indicates patient seen as "improved".
Table 8

Mean Change in PRP Ratings (Total Score) by IP and NIP for Group Psychotherapy by Ward

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Change</td>
<td>-1.13</td>
<td>9.00</td>
<td>3.66</td>
<td>14.50</td>
<td>3.53</td>
</tr>
<tr>
<td>N</td>
<td>8</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>NIP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Change</td>
<td>4.34</td>
<td>10.99</td>
<td>-5.20</td>
<td>11.50</td>
<td>0.85</td>
</tr>
<tr>
<td>N</td>
<td>11</td>
<td>7</td>
<td>10</td>
<td>2</td>
<td>14</td>
</tr>
</tbody>
</table>
personnel involved in therapy groups would see more favorable patient change than nursing personnel not involved in the therapy groups. It is interesting to note, however, that, only on wards A and B (where therapy groups appeared to the author to be most successful) did involved personnel see therapy patients progressing less well than did noninvolved personnel.

Data for mean pretest and posttest FRP ratings of control patients not in group therapy are shown for IP and NIP in Table 9. Ratings shown are total FRP scores. As can be noted, involved personnel initially saw the control subjects as "more pathological," however the difference was not significant. There was no significant difference between posttest ratings by involved personnel as compared with noninvolved personnel after the four-month therapy project. In fact, the ratings are almost identical.

Specifically, it was predicted that involved personnel would rate the change in behavior of control patients more favorably than would noninvolved personnel, although the difference was not expected to be as great as that in rating behavioral change in experimental (group) patients. Table 10 presents the data for ratings of control patients on the FRP subscales by involved and noninvolved personnel. It can be seen that NIP raters, in general, see control subjects as getting "worse" during the four-month period as compared with IP raters. The difference in IP ratings of mean change in control subjects as compared with NIP ratings is significant for the
Table 9

FRP Ratings (Total Score) by IP and NIP for Control Patients. 1

Not in Group Psychotherapy

<table>
<thead>
<tr>
<th></th>
<th>IP</th>
<th>NIP</th>
<th>Difference</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>48.37</td>
<td>42.03</td>
<td>6.34</td>
<td>1.17</td>
</tr>
<tr>
<td>SD</td>
<td>17.19</td>
<td>16.59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>16</td>
<td>30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Wards A, B, and C only.
Table 10

Mean Change in PRP Ratings by IP and NIP Control Patients Not in Group Therapy

<table>
<thead>
<tr>
<th></th>
<th>PRP Scales</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mean Change</td>
<td>-0.44</td>
<td>1.43</td>
<td>0.93</td>
<td>0.37</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>2.14</td>
<td>6.84</td>
<td>2.65</td>
<td>1.21</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>NIP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mean Change</td>
<td>-2.90</td>
<td>-2.97</td>
<td>-0.68</td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>4.22</td>
<td>7.86</td>
<td>2.63</td>
<td>1.61</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>28</td>
<td>28</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Difference</td>
<td>2.46</td>
<td>4.40</td>
<td>1.61</td>
<td>0.34</td>
</tr>
<tr>
<td></td>
<td>T</td>
<td>2.50*</td>
<td>1.89</td>
<td>1.89</td>
<td>0.77</td>
</tr>
</tbody>
</table>

Wards A, B, and C only.

Positive change score indicates patient seen as "improved".

* p < .05
total (morbidity) scale and the Thinking Disorganization Sub-scale.

Since raters, after the four month therapy period, made a global assessment of "much improved, improved slightly, no noticeable change or changed for the worse" for the same patients rated on the PRP, it was decided to examine the global data as well. "Much improved and "slightly improved" ratings were pooled as "improved," while "no noticeable change" and "changed for the worse" were pooled as "unimproved." Table 11 shows the global assessments made by involved and noninvolved personnel for patients in group therapy, and Chi Square was calculated from the resulting 2 X 2 matrix. The resulting Chi Square of .0014 was not significant. Similar data for control patients not in group therapy is shown in Table 12, and the resulting Chi Square of .0004 was not significant. Thus, global assessment of both patients in group therapy and control patients not in group therapy were very similar whether made by involved personnel or noninvolved personnel.

Inspection of the data suggested that, although this was not an outcome study, considerably more patients in group therapy were seen as "improved" than were control patients. Table 13 pools the global assessments by both IP and NIP, and compares therapy and control patients for "improvement." The resulting Chi Square of 17.02 is significant at the .001 level of confidence. Table 14 pools the IP and NIP change-scores on
Table 11

Comparison of IP and NIP Global Ratings of Patients in Group Psychotherapy

<table>
<thead>
<tr>
<th></th>
<th>IP</th>
<th>NIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved</td>
<td>18</td>
<td>48</td>
</tr>
<tr>
<td>Unimproved</td>
<td>11</td>
<td>26</td>
</tr>
</tbody>
</table>

Chi Square = .0014

\(^1\)Data includes Wards A, B, and C only.
Table 12

Comparison of IP and NIP Global Ratings of Control Patients Not in Group Psychotherapy¹

<table>
<thead>
<tr>
<th></th>
<th>IP</th>
<th>NIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Unimproved</td>
<td>19</td>
<td>43</td>
</tr>
</tbody>
</table>

Chi Square = .0004

¹Data includes Wards A, B, and C only.
Table 13

Comparison of Total Global Ratings of Patients in Group Psychotherapy and Those Control Patients Who Were Not

<table>
<thead>
<tr>
<th></th>
<th>Therapy</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved</td>
<td>64</td>
<td>30</td>
</tr>
<tr>
<td>Unimproved</td>
<td>37</td>
<td>62</td>
</tr>
</tbody>
</table>

Chi Square = 17.02*

1 Data includes wards A, B, and C only.

* p<.001
Table 14

Mean Change-scores in Total PRP Ratings by All Nursing Personnel \( (N = 45) \) for Patients in Group Psychotherapy and Control Patients Not in Group Psychotherapy

<table>
<thead>
<tr>
<th></th>
<th>Mean Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Therapy Patients</td>
<td>+2.50</td>
</tr>
<tr>
<td>Control Patients</td>
<td>-3.34</td>
</tr>
</tbody>
</table>

\(^1\) Data includes wards A, B, and C only.
the PRP for patients in group therapy and control patients not in therapy groups. It can be seen that Total scores on the PRP for therapy patients "improved," while those for control patients became more pathological.

In summary, nursing personnel involved in a four-month group therapy project showed no significant change in attitudes toward mental illness as compared with controls on wards where nursing personnel did no group therapy. The experimental personnel and noninvolved nursing personnel on the same wards actually showed negative changes, with noninvolved personnel showing a significant drop in attitude scores as compared with control personnel. Involved personnel did not rate symptomatic behavior of patients in group therapy significantly different from noninvolved personnel. The involved personnel, however, tended to see control patients as initially "sicker" while noninvolved personnel saw control patients as getting significantly "worse" during the four-month period. Both groups of raters rated the control patients similarly at posttest. It should be noted, however, that both involved and noninvolved personnel saw patients after four months of group therapy as significantly more improved than control patients.

Discussion

The hypothesized positive increment in attitude by involved personnel (IP) as compared with the control group was not supported. In fact, nursing personnel (both involved and non-
involved) on wards where the group therapy projects took place showed small negative changes. The negative change on the part of noninvolved personnel (NIP) was statistically significant as compared with the control group.

The results, however, were equivocal in that the IP mean attitude was initially six to eight points higher than the NIP and Control groups. Thus, although the IP and NIP groups showed a small attitude decrement during the course of the project, the IP mean attitude was still about five points higher than both the NIP and Control groups after four months.

It seems likely that the initially more positive attitudes on the part of the IP group was due to the selection of IP subjects from the day shift only. Analysis of the data showed that night personnel differed significantly from day personnel. Further analysis showed that registered nurses differed significantly from nursing assistants, and the proportion of nurses is usually less on the night shift than on the day shift.

Nevertheless, there actually proved to be a consistent decrement in attitude in the part of nursing personnel on those wards where the group therapy projects took place. Since hypothesis 1 was not supported, a number of related questions come to mind. Was it that this type of involvement was not sufficient to change attitudes? Were the attitudes measured actually stable personality configurations not easily amenable to change? Was the instrument insensitive to change that
actually occurred? Were there situational artifacts that obscured actual change? Or, as will be suggested later, must the basic concepts of what constitutes positive attitudes toward mental illness and mental patients be reexamined?

Schmidt (1964) found a trend, but no significant changes in attitude (as measured by the CMI) in psychiatric nurses and aides following the introduction of a remotivation program. Long (1963) found that CMI scores of aides changed toward a less custodial ideology after being involved in a remotivation program. Examination of the Long data, however, indicates that the remotivation participants and controls were not initially matched, with the remotivation aides' mean score on the CMI 11-points higher initially and still 2½-points higher at post-testing. In addition, Long found a significant change on chronic wards but not on acute wards, and that change was not uniform by shift, presumably because 3rd-shift personnel did not see enough of the patients.

Appleby et al. (1961) found that over a one-year period, during which there was marked changes in leadership, orientation and ward programs, there was no significant change in CMI scores or OMI scores.

These relatively unsuccessful efforts to measure attitude change are in marked contrast to those studies that have shown significant differences in sampled attitudes from various hospitals and programs (Cohen & Streuning, 1964; Gilbert &
Levinson, 1956). This suggests that we may actually be dealing with relatively stable personality configurations rather than attitudes.

Further, a number of studies (Cohen & Streunung, 1963; Lawton 1964; Middleton, 1953, Vernallis & St. Pierre, 1964) have shown that the various attitude scales and subscales are significantly related to such factors as age, intelligence, education, and years of experience. In other words, the differences in attitude scores seem to be related to long-term changes such as would be the case with personality and characterological measurements.

However, the danger of inferring, for example, an "aide" personality has been pointed out by Siskind and Drake (1967). These investigators attempted to replicate earlier studies suggesting that psychiatric aides showed specific need structures. They concluded, after failure to replicate these findings, that employment opportunities rather than personality variables were the major factors in determining who becomes a psychiatric aide. A study by Ralph (1968) suggested, however, that particular kinds of programs may attract particular kinds of workers or volunteers. Students who volunteered as companions for mental patients were shown to be more humanitarian and less custodial than students who volunteered for more structured (and distant) recreation groups.

Appleby et al. (1961) found that, for instance, both old
and new aides were similar in attitudes (CMI, OMI, Q-sort) but markedly different in role conception. Lawton (1964) found no relationship between the OMI and therapeutic role conception. These results suggest that "attitude change" may actually hinge on situational artifacts, such as the philosophy, program and organization of the ward or treatment area.

Finally, there is additional evidence that suggests that attitudes are not necessarily related to the clinical effectiveness of ward personnel. Lawton (1964) found no relationship between the OMI and performance evaluations of aides. Canter (1963) found that authoritarianism scales were related to negative attitudes toward patients and to lower effectiveness, but that negative attitudes towards patients were not related to clinical effectiveness. Canter concluded that authoritarianism represents a deeper and more stable personality characteristic, while negative attitudes toward patients may be more superficial and represent a stereotype that is changed by experience. A crucial point, it seems, is that if the attitudes measured are not related to clinical effectiveness, then it is necessary to question the concept of what constitutes "favorable" attitudes.

In considering what kinds of attitudes should be considered "favorable," it quickly becomes clear that what is usually meant is actually "values," and it is in this context that one can best see how situational artifacts come into play. For example, when we judge an attitude item to be favorable,
we make a value judgement that is strongly influenced by our personal mental health philosophy. Further, such a value judgement is strongly influenced by the institution and the program within which we function. An example of an "institutional value" is Imre's (1962) finding that hospital personnel and volunteers are more favorably disposed towards mental hospitals than are the patients. Similarly, when a supervisor rates the clinical effectiveness of a psychiatric aide, the measurement actually reflects the degree of consonance between attitudes (values) of the aide and the supervisor. Thus, an attitude item that we judge as favorable, may not necessarily be consonant with the operational values of the ward in which the aide works, his supervisor, or the institution itself. We might speculate that many of the reported attitudinal differences between institutions and change within institutions is related to striking changes in values that began occurring in the 1950's in psychiatric hospitals. These institutional changes would, of course, be especially pertinent to such scales as authoritarianism (Adorno, 1960) and custodial ideology (Gilbert & Levinson, 1956). The question, however, is whether such scales (or items) can reflect more sophisticated changes within institutions or programs that have already become far less authoritarian and custodial.

In examining items in the OAMI used in this study (see Appendix A) one class of items (cf., 13, 14, 19, 80) suggested
that patients are "just like you and me." Still another class of items indicate an accepting (cf., 6, 52, 55), benevolent (cf., 54, 56, 64) and humane (cf., 22, 39, 47, 60) posture. Some items tap a willingness for personal relationships with ex-patients (cf., 10, 16, 23) while others assess the competence of ex-patients (cf., 3, 5, 32, 86). A great many of the items (cf., 18, 24, 57, 59, 68, 69, 74) can probably best be described as rather unsophisticated mental hygiene concepts from the reform era of some decades ago. Further, 40 of the 57 items are presented negatively, making ideal straw-men to be marked "disapprove."

Similarly, the five subscales of Cohen and Streuning's OMI, can be summarized as follows: Factor A, Authoritarianism, stresses the difference of the mentally ill from normal, sees the patient as inferior, suggests patients should submit to authority and require restrictive handling; Factor B, Benevolence, represents the attitude of "Christian kindness towards unfortunates," views the patient as childlike, but still admits some fear of patients; Factor C, Mental Hygiene Ideology, views patients as much like normal people, differing in degree rather than in kind, suggests that "mental illness is an illness like any other" and that society has a responsibility for treatment; Factor D, Social Restrictiveness, sees restriction of movement and rights of patients as necessary for protection of society and family, reflects a pessimistic outlook for future of the
patient; Factor E, Interpersonal Etiology, suggests mental illness results from faulty interpersonal experiences, especially early love deprivation, includes belief that abnormal behavior is motivated and avoids additional life stress. Note that each subscale seems to be a curious amalgam that most treatment program directors would find difficult to assess as favorable or unfavorable.

Lewis and Cleveland (1966) found clear-cut changes on OMI Authoritarianism and Interpersonal Etiology scores for student nurses in a psychiatric affiliation as compared with control subjects, but less clear change on Mental Hygiene Ideology (groups were not initially matched) and no significant changes on Benevolence and Social Restrictiveness. Vernallis and St. Pierre (1964) found hospital volunteers nonreceptive to Mental Health Ideology, yet positive towards "unsophisticated benevolence" and a "love deprivation" theory of mental illness. Ralph (1968) found that volunteer "companions" became more comfortable in their relationships with patients over time, yet became more pessimistic about how much change could be accomplished as a result of their relationships. Lawton (1964) found that aides who were judged inferior, saw themselves as quite different from patients, were high on authoritarianism and more likely to reject mental hygiene ideology. In addition, these aides actually spent most of their time on janitorial-custodial duties, and spent the least time on informational and thera-
peutic duties. It seems clear that what has often been regarded as "favorable" or "unfavorable" attitudes are actually not so easily categorized.

The most striking example of "contrary valuation" of familiar attitude scales is a recent study by DeWolfe, Barrell and Spaner (1969). Using the Philosophy of Treatment form (POT), the authors found that four subscales successfully discriminated between four autonomous treatment units, comparable in composition of staff and patients, in a large psychiatric hospital. The four subscales were: A-interprets rules in an authoritarian way; B-believes patients should be informed about their condition; C-accepts the idea that staff behavior affects patients; and F-views patients unfavorably. All of the correlations between unit means on Scales A, B, and F were positive and statistically significant (.98 to .99) indicating that units high on one variable were high on all three. Various disposition variables were also measured for a two year period, and the following measurements significantly discriminated between the four treatment units:

1. number of maximum-hospital-benefit discharges;
2. average hours of restraint and seclusion;
3. number of trial visits (total number of dispositions did not discriminate).

Surprisingly, the authors found that attitudes A, B, and F correlated between -.24 and -.41 with hours of restraint and seclusion. They also found correlations ranging between .95 and
.97 for attitudes A, B, and F with increased use of trial visits.
Thus, attitudes usually assessed as "unfavorable" were found to
be related to dispositions usually assessed as "good." The
authors suggest that those who endorsed items reflecting
authoritarianism and unfavorable views of patients are probably
frank and open (areas with this profile also generated more
responses). They suggest that staff who are willing to inform
patients about their condition are also frank and open, and
that these qualities are usually found in conjunction with trust
of others. They point out that frankness, openness and trust
are the antithesis of protective benevolence. Edwards (1965)
found that aides who endorsed attitudes of protective benevo-
rence were seen by patients as aloof, distant and noninteracting.
Such an aide tends to "go along" with the patient, accepting
him without trying to change him. It is, thus, an attitude
that provokes little confrontation, and assures superficial but
comfortable relations. DeWolfe et al. suggested that frankness,
openness and trust involve acceptance of a more authoritarian
and less laissez-faire approach; less acceptance of patients
as they are but greater trust in their abilities to handle
stress; in short, an orientation to helping patients change.
Three recommendations may help suggest a more precise
evaluation of "attitudes towards mental illness." First, as
suggested by Cook and Selltiz (1964), we might adopt a multiple-
indicator approach to attitude measurement. This would in-
clude self-reports toward objects, observed overt behavior toward
objects, reactions to partially structured material relevant to the object, and psychological reactions to the object. Second, we might construct scales that would be congruent with the treatment programs, objectives, philosophy and organization of the institution in question. In other words, an attitude would be considered "positive" if congruent with the program. To construct such scales, it would be necessary to have the program administrators and leaders judge items from an item pool to be congruent, incongruent, or irrelevant to their particular program, philosophy and organization. Third, in comparing attitudes with clinical effectiveness, it might be fruitful to have the rating supervisors also fill out an attitude scale, endorsing those items that they felt were important for an aide to have. This would enable us to study congruence between attitudes or values of aide and supervisor.

It was predicted that, after four months participation in the group therapy project, IP would rate all patients more positively than would the NIP raters, and that the difference would be more marked for patients in group therapy than for control patients not in group therapy. No significant differences between IP and NIP were found in rating experimental patients at pretest, posttest nor in mean change. No significant differences were found between IP and NIP in rating control patients at pretest or posttest. However, in terms of mean change, NIP raters saw control patients as getting significantly "worse" on the Thinking Disorganization subscale and on the
Total or morbidity scale as compared with patients in group therapy.

Although overall differences in ratings of experimental patients were not significant, it is interesting to note that personnel on the wards which appeared to the author to be the best organized and most involved (Wards A and B) rated the group patients most severely. LaPlace, Stein and Weissman (1968) found, for instance, that more experienced staff continued to see patients as severely distressed right up to discharge, although such personnel have high expectations regarding prognosis.

The failure to find the hypothesized positive increment in therapy patient ratings by IP as compared with NIP must, however, be considered somewhat surprising since it would seem predictable in terms of "placebo" response alone. One possible explanation is that the Psychotic Reaction Profile (PRP) tends to be a symptom checklist and is probably most sensitive in measuring symptom remission with an acute population. For example, in a validity study by Vestre (1966) the PRP showed some success in discriminating between closed, open, and pre-discharge wards. There was some question, however, as to the PRP's sensitivity in discriminating within a chronic population, such as used in this study. Perhaps more appropriate rating scales would be those such as the Social Adjustment Behavior Rating Scale (Aumack, 1962) which measures work and socializa-
tion levels; the Minimal Social Behavior Scale (Dinoff, Raymaker, & Morris, 1962) which has been shown to differentiate within a chronic regressed population; or the Nurse's Observation Scale for Inpatient Evaluation (Honinfeld & Klett, 1965), which was specifically designed to detect change in the chronic patient who is often relatively asymptomatic and often characterized by apathy and indifference.

Eysenck (1963) has pointed out that rating items used by Lorr and his associates are often somewhat tautologous, as is so often the case with scales (such as the PRP) which are derived by homogenous keying, and that the items tend to be those of gross pathology. Also, in constructing the PRP, Lorr et al. (1960) noted that the scales derived by homogeneous keying for the hypothesized nine first-order factors were too highly correlated, and they subsequently centered on the four second-order factors represented in the PRP. Lorr's subsequent work with the hypothesized factors of the "psychotic syndrome" has been carried out with a new scale based primarily on interview ratings (Lorr & Klett, 1965; Lorr, Klett, & Cave, 1967; Lorr, McNair, Klett & Lasky, 1962). These studies have suggested that some of the scales are actually bipolar (eg., excitement vs. withdrawal) and changes on such a subscale might cancel each other. Then, too, as noted by Goldberg and Mattsson (1967), ratings by nursing personnel are more influenced by ward behavior than interview behavior, and thus might be insensitive
to relevant changes. Finally, Raskin and Clyde (1963) factor analyzed the Ward Behavior Rating Scale (Burdock, Hakerem, Hardesty, & Zubin, 1960) using the Inpatient Multidimensional Psychiatric Scale (Lorr, McNair, & Lasky, 1963) as a marker variable and did not find a factor of "withdrawal," which is a major source of variance on the PRP.

The results of this study indicated substantial variance of ratings for the same patients on the PRP, and steps to increase the reliability of such ratings might be considered. For instance, Ryder (1962) has increased inter-rater reliability by training with flashcards, and Fleiss, Spitzer and Burdock (1965) have done the same by training with recorded practice material.

Pattison (1967) has pointed out that the difficulty with clinical evaluative criteria is not their validity but their reliability. Amble and Moore (1966) have noted that increased variability of rater judgement is associated with limited training and experience. Studies by Raskin, Schultebrandt and Reatig (1966) and by Raskin and Sullivan (1963) found both level and random differences in patient ratings that were related to experience of raters and level of pathology of patients. Elstein and Van Pelt (1966) found that global agreement in patient ratings seldom exceed .50, especially over time. Georgas (1964) found that rater reliability was not only related to training and experience but that it varied according
to whether the rated items were more behavioral or more inferential. He suggested using a hierarchy of ratings, from concrete and behavioral to inferential and theoretical.

Thus, it seems important to maximize inter-rater reliability (probably through training and selection) in studies requiring patient ratings. Intraclass correlation, as pointed out by Spitzer and Cohen (1968), is the reliability measurement of choice, since it reflects rater agreement with regard to discrimination between patients.

Another area of difficulty is in relation to the nature of control groups. LeMay and Christensen (1968) pointed out, for example, that a mail-survey follow-up of an outcome study indicated that many Ss in control groups received counselling that would normally be unknown to the investigator. Similarly, some control personnel in this study may have actually participated in groups, and some control patients may have received various formal or informal therapies.

Despite these post hoc suggestions, however, there is also the possibility that the placebo response in therapy ratings has been overemphasized. Although the present paper was not an outcome study, both the global and behavioral ratings consistently suggested that patients in group therapy showed improvement as compared with control patients.

Most of the difficulties in therapy outcome research are related to confounding both within clients and within treatments, with particular problems associated with relatively
stable personal-social characteristics of clients and therapists (Paul, 1967). The placebo effect is a special form of confounding within treatment (Rosenthal & Frank, 1958). Actually, the placebo effect consists of several components. The most common placebo effect is the patients' own psychological reaction to the treatment, with particular emphasis on his pretherapy expectations (Gardner, 1964). A related effect is that of the therapists' expectations (Zusman, 1966) which is, presumably, subtly communicated to the patient. Finally, the placebo effect has also been shown to be related to the congruence between patient and therapist expectations (Goldenstein, 1966).

Of particular concern is the effect of knowledge that the patient is being treated may have on subsequent ratings by staff. Williams, Niebel and McGee (1962) have pointed out that there are systematic therapist rating effects even in double-blind drug studies, for instance. Poser (1966) examined patient change while in group therapy with lay therapists. Supervisor's ratings showed a significant change, but ratings by aides did not. This was attributed to the greater ego-involvement of the supervisors, whose wish to see the project succeed might have influenced their ratings.

In the present study, however, there was consistency by both involved and noninvolved personnel in both global and behavior ratings of experimental and control patients. All
personnel knew which patients were in therapy groups, but it seems plausible to assume that placebo effects would be more influential for those raters who were actually involved in the therapy groups. Since no such difference was found, the therapist-placebo effect on ratings may be less significant than has been generally assumed.

Stone, Frank, Hoehn-Saric, Imber and Nash (1965) have suggested that rating expectations are related to views of the patient's appropriateness for therapy and the "attractiveness" of the patient. Elstein and Van Pelt (1968) found a favorability factor (related to evaluation and prognosis) in patient ratings. Mulaik (1964) found similar factors for ratings done for real persons, stereotype persons, and select trait words. Shrauger and Altrocchi (1964) found that authoritarians were more favorable in person perception of non-peers than peers. Goldschmid and Domino (1967) found that patient perception by nurses is usually focused on affiliative tendencies. Although these studies all suggest factors influencing patient ratings, none of them would predict a differential rating between experimental and control patients.

Further, it can be argued that placebo effects during therapy ought to be maximized because of their positive nature. The placebo effect as regards therapists, for example, might well be encouraged. That is, since positive therapist expectations have been shown to enhance the patient's self-comfort
or relief, an increase in positive therapist expectations might well be a perfectly acceptable goal.

Shapiro (1964) defines placebo as any therapeutic procedure which is given deliberately to have an effect on a patient, symptom, syndrome or disease, but which is objectively without specific activity for the condition being treated. Such a definition, of course, would serve for any form of psychotherapy. Shapiro emphasizes that these placebo (psychical) factors should no longer be allowed to play their part unwittingly, but are themselves becoming the subject of study towards the growth of a rational system of psychotherapeutics. Similarly, Nash, Frank, Imber and Stone (1964) have pointed out that the effects of psychotherapy are based on two primary factors: the nonspecific expectation of help and a process of attitude modification. The first was found to be reflected in the relatively prompt relief of symptoms, while the second was related to the amount and method of therapeutic contact. A prior interview was found to increase what Nash called the catalyst (placebo) effect.

The placebo effect, as relates to patient expectations, is actually a valid and therapeutic factor. Rosenthal (1964) has pointed out that the mortality rate of delirium tremens seldom exceeds 15 percent, but that any treatment leads to a drop in mortality rate. Rosenthal suggested that therapists should treat as many patients as possible with the new treatments while
they still have the power to heal. Shapiro has pointed out the following examples of the therapeutic potency of the placebo effect: (1) placebos can be more powerful than, and reverse the action of, potent, active drugs; (2) the incidence of placebo reactions approaches 100% in some studies; (3) placebos can have profound effects on organic illnesses, including incurable malignancies; (4) placebos can mimic the effects usually thought to be the exclusive property of active drugs; (5) the results in uncontrolled studies of drug efficacy are reported effective four to five times more frequently than results in controlled studies; (6) placebo effects are so omnipresent that if a controlled study does not report some measure of placebo reaction, it is likely that the study is unreliable. Perhaps a worthwhile goal is to strive to increase such effects.

Because researchers have attempted to control for so many possibly relevant variables, the various strategies for outcome validation have been less than satisfactory. Paul (1967) has reminded us of the criticism that psychotherapy is still "an undefined technique applied to unspecific problems with unpredictable outcome (p. 93)." Zubin (1964) has noted that contemporary research has avoided the problem of outcome by concentrating on the measurement of process within psychotherapy. Paul (1967) has pointed out, however, that the importance of variable, process, or theory to outcome cannot be established without concurrent outcome assessment.

Pattison (1967) has reviewed group therapy outcome studies
and pointed out two specific difficulties. The first concerns the use of bipolar rating scales (like the Withdrawal Sub-scale on the PRP) in which therapeutic shifts toward the center from either end are canceled out in the analysis. The second concerns group process which may be phasic in nature, and which may be related to contemporary group conflicts rather merely a function of time. Bergin (1967) has emphasized the notion that psychotherapy may cause clients to become better or worse adjusted than controls. All of these factors, however, would actually increase the significance of the findings in the present study. In short, the fact that all nursing personnel on the ward saw patients in group therapy improve as compared with controls may be viewed as a positive therapeutic outcome even if the factor of therapist expectations is given full credit. Finally, as noted earlier, such expectation bias may be overestimated since no differences between involved and noninvolved personnel in favor of therapy-improvement were found in this study.

Summary

It was hypothesized that participation by nursing personnel in therapy groups as cotherapists would create favorable attitude changes as compared with more routine nursing duties, and that such attitude changes would influence subsequent patient ratings. Since nurses are involved in treatment programs to varying degrees, such systematic effects would con-
stitute a source of uncontrolled variance in therapy-outcome studies utilizing ward ratings. Attitudes of nursing personnel who were involved in therapy groups with chronic psychiatric patients and those who were not involved in such therapy groups were measured with the Opinions About Mental Illness Scale (OAMI) at the beginning of a group therapy project and four months later. No significant changes in attitude were found when involved personnel were compared with controls. However, involved personnel were found to be initially more positive than controls, apparently due to attitude differences by shift and by level of training. Both the involved and noninvolved personnel rated two patients who were in group therapy and two control patients, initially and after four months. Patients were rated on the Psychotic Reaction Profile (PRP) and by a global assessment of improvement. There were no significant differences between ratings of improvement made by involved personnel as compared with noninvolved personnel for patients in group therapy. Noninvolved personnel, however, saw control patients as getting significantly worse during the experimental period. By pooling the ratings, however, it was noted that patients in therapy groups showed significantly greater improvement than control patients. It was concluded that it might be profitable to re-examine the concept of what constitutes "favorable" attitude change, and suggestions were made for creating more useful attitude scales. Recommendations were also made in relation to selecting or constructing more sensi-
tive and applicable patient rating scales, and towards increasing their reliability. Finally, it was suggested that the placebo effect, as regards its influence on ratings, might be less influential than generally assumed. It was also recommended that the placebo effect, as regards its influence on the patient, be considered a legitimate part of therapy, and should be enhanced.
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Group Therapy Project General Information Sheet

This opinion poll is part of a hospital research project. Your help will be greatly appreciated, and this material will be used for research purposes only.

Name: ____________________________ (If you prefer, use birth date instead of name)

Date: ____________________________

Position (RN, Practical, Assistant, Supervisor, etc.): ____________________________

Building or Ward Number: ____________________________

Day or Night Shift (usually): ____________________________

Age: _______ Years

Sex: ____ Male ____ Female

Education (circle highest grade completed): 
Elementary 1 2 3 4 5 6 7 8
High School 1 2 3 4
College 1 2 3 4

Special Training:

Are you currently participating in group therapy meetings with patients on your building or ward (other than patient councils, activity groups or remission groups)? Yes ___ No ___ How long? ___ Months

Do you meet regularly after the group therapy meeting in order to discuss the meeting with other psychology or nursing personnel? Yes ___ No ___

How many patients are in your group? _____ (approximately)

Are you working mainly with male or female patients? ____ Male ____ Female ____ Both

Have you ever participated regularly in group therapy meetings with patients before? Yes ___ No ___ How long? ___ Months

How long have you been working on your present building or ward? ____ months ____ years

How long have you been working with mental patients? ____ months ____ years

How long have you been employed in your present position? ____ months ____ years

How long have you been employed at Downey VA Hospital? ____ months ____ years

Please fill out the attached questionnaire. Thank you.

VA FORM 10-59(5105)
AUG 1965
OPINIONS ABOUT MENTAL ILLNESS

By Jack M. Hicks, Ph.D. and Fred E. Spaner, Ph.D.

NAME: _______________________________ Date: _______________________________

DATE OF BIRTH: _______________________________

EDUCATION: (Circle highest grade completed)

- Elementary 1 2 3 4 5 6 7 8
- High School 1 2 3 4
- College 1 2 3 4

The statements that follow are opinions or ideas about mental illness and mental patients. By mental illness, we mean the kinds of illness which bring patients to mental hospitals, and by mental patients we mean mental hospital patients. There are many differences of opinion about this subject. In other words, many people agree with each of the following statements while many people disagree with each of these statements. We would like to know what you think about these statements. Each of them is followed by six choices:

- strongly agree
- agree
- not sure but
- not sure but
- disagree
- strongly disagree

Please check ( ) in the space provided that choice which comes closest to saying how you feel about each statement. You can be sure that many people, including doctors, will agree with your choice. There are no right or wrong answers: we are interested only in your opinion. It is very important that you answer every item.

1. Unusual behavior and peculiar ideas are almost always present in mental patients.

[ ] strongly agree [ ] agree [ ] not sure but [ ] not sure but [ ] disagree [ ] strongly disagree

2. Mental patients need the same kind of control and discipline as an untrained child.

[ ] strongly agree [ ] agree [ ] not sure but [ ] not sure but [ ] disagree [ ] strongly disagree

3. Persons who have been in mental hospitals should be allowed to raise their children.

[ ] strongly agree [ ] agree [ ] not sure but [ ] not sure but [ ] disagree [ ] strongly disagree

4. One major advantage of institutionalizing the mentally ill is public safety.

[ ] strongly agree [ ] agree [ ] not sure but [ ] not sure but [ ] disagree [ ] strongly disagree

5. The fact that a person has undergone treatment in a mental hospital should not interfere with plans for marriage.

[ ] strongly agree [ ] agree [ ] not sure but [ ] not sure but [ ] disagree [ ] strongly disagree

*Questionnaire developed at VAH Downey, Illinois.
6. In working with mental patients an accepting attitude is more important than an understanding of their disease.

| strongly agree | agree | probably agree | not sure but | probably disagree | disagree |

7. Few mental patients are dangerous.

| strongly agree | agree | probably agree | not sure but | probably disagree | disagree |

8. It gives a person self-confidence to work with mental patients.

| strongly agree | agree | probably agree | not sure but | probably disagree | disagree |

9. Abnormal people are ruled more by their emotions than normal people are.

| strongly agree | agree | probably agree | not sure but | probably disagree | disagree |

10. I would be willing to room with a former mental hospital patient.

| strongly agree | agree | probably agree | not sure but | probably disagree | disagree |

11. Once a person has been mentally ill he can never lead a completely normal existence again.

| strongly agree | agree | probably agree | not sure but | probably disagree | disagree |

12. I can imagine myself falling in love with a person who has been mentally ill.

| strongly agree | agree | probably agree | not sure but | probably disagree | disagree |

13. Mental patients look pretty much like anyone else.

| strongly agree | agree | probably agree | not sure but | probably disagree | disagree |

14. Mental patients are as likely to appear neat and tidy as anyone else.

| strongly agree | agree | probably agree | not sure but | probably disagree | disagree |

15. The conditions of mental hospital wards are about as good as they can be considering the type of disturbed patient living there.

| strongly agree | agree | probably agree | not sure but | probably disagree | disagree |

16. I would be willing to have a former mental patient as a personal chum.

| strongly agree | agree | probably agree | not sure but | probably disagree | disagree |
17. As soon as a person shows signs of mental disturbance he should be hospitalized.

**strongly agree** not sure but **disagree** strongly agree
**probably agree** probably disagree probably disagree strongly disagree

18. Mental illness is an illness like any other.

**strongly agree** not sure but **disagree** strongly agree
**probably agree** probably disagree strongly disagree

19. Mental patients are as trustworthy as anyone.

**strongly agree** not sure but **disagree** strongly agree
**probably agree** probably disagree strongly disagree

20. By normal standards most patients are polite and not lacking in social graces.

**strongly agree** not sure but **disagree** strongly agree
**probably agree** probably disagree strongly disagree

21. Former mental patients should never be elected to high government office.

**strongly agree** not sure but **disagree** strongly agree
**probably agree** probably disagree strongly disagree

22. It is difficult to insult or offend a mental patient.

**strongly agree** not sure but **disagree** strongly agree
**probably agree** probably disagree strongly disagree

23. I would not feel any differently about a friend of mine if I found out that he had been in a mental hospital.

**strongly agree** not sure but **disagree** strongly agree
**probably agree** probably disagree strongly disagree

24. Most mental patients are curable.

**strongly agree** not sure but **disagree** strongly agree
**probably agree** probably disagree strongly disagree

25. We should strongly discourage our children from marrying anyone who has been mentally ill.

**strongly agree** not sure but **disagree** strongly agree
**probably agree** probably disagree strongly disagree

26. I would hesitate to work for anyone who had been mentally ill.

**strongly agree** not sure but **disagree** strongly agree
**probably agree** probably disagree strongly disagree

27. Most mental patients eventually return to society and lead useful, happy lives.

**strongly agree** not sure but **disagree** strongly agree
**probably agree** probably disagree strongly disagree
28. It is natural to regard a person released from a mental institution with a certain amount of distrust.

- strongly agree - agree - not sure but probably agree - probably disagree - disagree

29. Some people act insane to receive government support.

- strongly agree - agree - not sure but probably agree - probably disagree - disagree

30. We should be sympathetic with mental patients, but we cannot expect to understand their odd behavior.

- strongly agree - agree - not sure but probably agree - probably disagree - disagree

31. When dealing with patients in a mental hospital, one should remember that they are different from normal people in their thinking and feeling.

- strongly agree - agree - not sure but probably agree - probably disagree - disagree

32. When a patient is discharged from a hospital, he can be relied upon to carry out his responsibilities as a citizen.

- strongly agree - agree - not sure but probably agree - probably disagree - disagree

33. You can usually tell whether a man is insane by the look in his eyes.

- strongly agree - agree - not sure but probably agree - probably disagree - disagree

34. Mental patients are seldom likely to attempt sexual offenses.

- strongly agree - agree - not sure but probably agree - probably disagree - disagree

35. Most mental patients do not know what is going on around them.

- strongly agree - agree - not sure but probably agree - probably disagree - disagree

36. Mental patients can be relied upon to run their own affairs much of the time.

- strongly agree - agree - not sure but probably agree - probably disagree - disagree

37. I would feel differently about a relative of mine going to a mental institution than I would if he went to a regular hospital for a physical illness.

- strongly agree - agree - not sure but probably agree - probably disagree - disagree
38. People who like to work around mental patients are usually a little odd themselves.

strongly agree not sure but probably agree probably disagree strongly disagree

39. Regrettably though it is, such things as straitjackets and padded cells must very frequently be employed in mental hospitals.

strongly agree not sure but probably agree probably disagree strongly disagree

40. By and large, mental patients are passive and harmless.

strongly agree not sure but probably agree probably disagree strongly disagree

41. I would hesitate to dance with a person who I know to be a former mental patient.

strongly agree not sure but probably agree probably disagree strongly disagree

42. I would undergo surgery from a doctor who I knew to be a former mental patient.

strongly agree not sure but probably agree probably disagree strongly disagree

43. There are probably more peculiar people working in mental hospitals than other places.

strongly agree not sure but probably agree probably disagree strongly disagree

44. Mental patients sometimes behave purposelessly.

strongly agree not sure but probably agree probably disagree strongly disagree

45. If given a chance, currently available precautionary measures can prevent most mental illness.

strongly agree not sure but probably agree probably disagree strongly disagree

46. Working with mental patients is more challenging than working with other types of patients.

strongly agree not sure but probably agree probably disagree strongly disagree

47. The "snakepit" aspect of mental hospitals has not entirely disappeared.

strongly agree not sure but probably agree probably disagree strongly disagree
48. The psychiatric nurse has a difficult and thankless job.

strongly agree not sure but probably agree not sure but disagree strongly disagree
agree probably agree probably disagree disagree

49. Eccentric people should strive to be more like others.

strongly agree not sure but not sure but disagree strongly disagree
agree probably agree probably disagree disagree

50. Unfortunate though it is, psychiatric nurses are really not in a position to contribute significantly to therapy.

strongly agree not sure but not sure but disagree strongly disagree
agree probably agree probably disagree disagree

51. Mental patients frequently say meaningless things.

strongly agree not sure but not sure but disagree strongly disagree
agree probably agree probably disagree disagree

52. All forms of overt homosexuality should be made illegal.

strongly agree not sure but not sure but disagree strongly disagree
agree probably agree probably disagree disagree

53. Spending time to help correct public misconceptions about mental illness should not be expected of the psychiatric nurse.

strongly agree not sure but not sure but disagree strongly disagree
agree probably agree probably disagree disagree

54. Mental patients who thrive on receiving attention tend to take up too much of the nurse's time.

strongly agree not sure but not sure but disagree strongly disagree
agree probably agree probably disagree disagree

55. We should be quite firm in our demands that mental patients always conform to hospital rules.

strongly agree not sure but not sure but disagree strongly disagree
agree probably agree probably disagree disagree

56. The best methods of dealing with aggressive mental patients is to remove their privileges.

strongly agree not sure but not sure but disagree strongly disagree
agree probably agree probably disagree disagree

57. Most mental patients are oversexed.

strongly agree not sure but not sure but disagree strongly disagree
agree probably agree probably disagree disagree
58. Mental patients usually do not know what is best for them.

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59. Masturbation is one of the principal causes of mental illness.

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60. Punishment often convinces a patient that he should behave more normally.

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61. Many mental patients have homicidal tendencies.

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62. "Everybody is a little crazy" at times and all of us have had serious doubts about our sanity at one time or another.

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63. People who were once patients in mental hospitals are more dangerous than the average citizen.

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64. If a patient in a mental hospital attacks someone, he should be punished so he doesn't do it again.

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65. The patients of a mental hospital should have something to say about the way the hospital is run.

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66. When a person has a problem or a worry, it is best not to think about it, but to keep busy with more pleasant things.

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67. Mental illness is usually caused by some disease of the nervous system.

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68. One of the causes of mental illness is a lack of moral strength or will power.

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69. Nervous breakdowns usually result when people work too hard.

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70. Every person should have complete faith in some supernatural power whose decisions he obeys without question.

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<th>Not Sure but Disagree</th>
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71. Most patients in mental hospitals don't care how they look.

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72. Many patients of mental hospitals don't want to leave because their life in the hospital is so easy.

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73. The small children of patients in mental hospitals should not be allowed to visit them.

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74. Most mental illness is inherited.

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<th>Strongly Agree</th>
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75. Many patients in mental hospitals make wholesome friendships with other patients.

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76. If children of normal parents were raised by mentally ill parents, they would be more likely to become mentally ill.

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77. It is to be expected that working around mental patients would make one a little uneasy.

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78. All other things being equal, it is preferable to work with mental patients than physical patients.

    strongly agree not sure but not sure but disagree strongly agree
    probably agree probably disagree probably disagree

79. Insults and obscene language are found more frequently among mental patients than among normal people.

    strongly agree not sure but not sure but disagree strongly agree
    probably agree probably disagree probably disagree

80. There is something about the mentally ill which makes it easy to tell them from normal people.

    strongly agree not sure but not sure but disagree strongly agree
    probably agree probably disagree probably disagree

81. Most mental patients are liable to attack you unless proper precautions are taken.

    strongly agree not sure but not sure but disagree strongly agree
    probably agree probably disagree probably disagree

82. In general, mental patients have low moral standards.

    strongly agree not sure but not sure but disagree strongly agree
    probably agree probably disagree probably disagree

83. Mental illness may strike even those in the best of mental health.

    strongly agree not sure but not sure but disagree strongly agree
    probably agree probably disagree probably disagree

84. Former mental patients are actually less likely to commit crimes than others.

    strongly agree not sure but not sure but disagree strongly agree
    probably agree probably disagree probably disagree

85. Mental patients tend to be below average in I. Q.

    strongly agree not sure but not sure but disagree strongly agree
    probably agree probably disagree probably disagree

86. It would be risky to hire a former mental patient as a babysitter.

    strongly agree not sure but not sure but disagree strongly agree
    probably agree probably disagree probably disagree

87. One must admit that the actions and speech of the majority of mental patients are revolting and disgusting.

    strongly agree not sure but not sure but disagree strongly agree
    probably agree probably disagree probably disagree
FORM E
PSYCHOTIC REACTION PROFILE*

Patient's Name ________________________________ Code # __________________

Rater's Name and Position ________________________________

Date of Rating ________________________________

Rating Period: Circle One:

First (Pre-Study) Second Third Fourth Fifth Sixth (Post-study)

Talk with and observe the patient carefully for three days preceding each
rating. Then read each statement on this check list and decide whether you think
the behavior described is mostly True (T) or mostly False (F) for the patient you
are rating. Make a circle around one or the other of these two choices for each
statement. Do not skip items. Comments on any item may be written in.

W T F 1. Usually stays by himself.

P T F 2. Tells the other patients what to do.

A T F 3. Shows real sadness.

T T F 4. Occasionally talks to himself.

W T F 5. Ignores the activities around him.

P T F 6. Sometimes does the opposite of what he is asked to do.

A T F 7. Seems to be unhappy.

A T F 8. Answers sensibly when talked to.

W T F 9. Never says more than three or four words at a time.

P T F 10. Acts as though the ward attendants are against him.

A T F 11. Usually looks tired and all worn out.

A T F 12. Sees and hears things that are not there.


A T F 14. Resists suggestions and requests from aides.

VA Form 10-55 (5105)
September 1964
15. Seems scared all the time.
16. Sometimes uses words that aren't understandable.
17. Doesn't take part in back and forth conversations.
18. Resists treatment from the doctors.
19. Usually looks worried and nervous.
20. Spends a lot of time talking to himself.
21. Has to be pushed to follow routine.
22. Acts as though the hospital is persecuting him.
23. Talk is mostly not sensible.
25. Is likely to hit someone for no apparent reason.
26. Usually knows what time it is.
27. Asks for things; doesn't wait for things to be given to him.
28. Blames the hospital for lack of attention and care.
29. Talks whether anyone is listening or not.
30. Is slow thinking and a little confused.
31. Often shouts and yells.
32. Talks to himself about imaginary or real faults.
33. Interested in nothing.
34. Bosses the other patients.
35. Sometimes giggles in a silly way.
36. Is able to talk about his own problems.
37. Acts superior to other patients.
38. Does not know the names of ward aides.
39. Is always doing something.
40. Quick to fly off the handle.
41. Repeats words and phrases in a meaningless way.
42. Shows no response to entertainment.
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<tr>
<th></th>
<th>43. Yells at attendant when he is dissatisfied.</th>
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<tr>
<td>T</td>
<td>44. Makes faces and strange movements that do not make sense.</td>
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<td>T</td>
<td>45. Has to be helped along to stick to any activity.</td>
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<td>T</td>
<td>46. Becomes easily upset if something doesn't suit him.</td>
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<td>T</td>
<td>47. Does not know where he is.</td>
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<td>48. Says thanks when something is done for him.</td>
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<td>T</td>
<td>49. Becomes noisy and hilarious at times.</td>
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<td>T</td>
<td>50. It is difficult to understand what he is saying most of the time.</td>
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<td>T</td>
<td>51. Never volunteers information about himself.</td>
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<td>T</td>
<td>52. Upsets other patients by the way he talks to them.</td>
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<td>T</td>
<td>53. Smiles a lot to himself without any sensible reason.</td>
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<td>T</td>
<td>54. Acts dead to the world; doesn't seem to care what is going on.</td>
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<tr>
<td>T</td>
<td>55. Has a sarcastic way of talking to other patients.</td>
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<td>T</td>
<td>56. Drifts off the subject when he talks.</td>
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<td>T</td>
<td>57. Starts conversations with aides to become better acquainted.</td>
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<td>T</td>
<td>58. Often swears and uses obscene language.</td>
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<td>T</td>
<td>59. Often messy in eating habits.</td>
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<td>T</td>
<td>60. Never asks for anything; waits for things to be given to him.</td>
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<tr>
<td>T</td>
<td>61. Demands the attention of doctors.</td>
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<tr>
<td>T</td>
<td>62. Usually is slow moving and sluggish.</td>
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<tr>
<td>T</td>
<td>63. Often irritable, grouchy, or complaining.</td>
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<tr>
<td>T</td>
<td>64. Is backward about talking to you.</td>
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<tr>
<td>T</td>
<td>65. Doesn't swear or curse in the presence of doctors and aides.</td>
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<td>T</td>
<td>66. Speaks softly, often difficult to hear</td>
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<tr>
<td>T</td>
<td>67. Complains about the food and care he receives.</td>
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<td>T</td>
<td>68. Reads newspaper.</td>
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<td>T</td>
<td>69. Loses temper when dealing with other patients.</td>
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<td>70. Will do anything for recreation that comes up.</td>
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**HAVE YOU ANSWERED EVERY ITEM ON ALL FOUR PAGES? Leave no Blanks.**

Comments:

*These scales (slightly revised) were developed by M. Lorr, Neuropsychiatric Research Laboratory, Washington, D. C.*
The dissertation submitted by Richard C. Evenson has been read and approved by members of the Department of Psychology.

The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given full approval with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

6-20-69

Date

Ronald E. Walker
Signature of Advisor