AIDS TO PSYCHOLOGY FOR NURSES

A. ALTSCHUL

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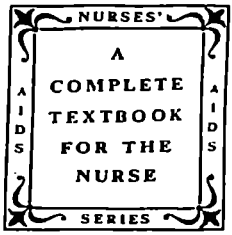

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AIDS TO PSYCHOLOGY FOR NURSES

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AIDS TO PSYCHOLOGY FOR NURSES

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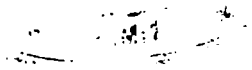
THE NURSES' AIDS SERIES

The Nurses' Aids Series is designed to provide a series of textbooks in the various fields of knowledge required by the modern nurse. It covers the subjects included in the syllabus of the General parts of the Register and, in addition, includes volumes on certain specialized subjects such as pre- and post-operative nursing, tropical nursing, ear nose and throat nursing and theatre technique. New volumes are added to the Series from time to time.

Each volume is a complete textbook on its subject (the title 'Aids to' indicates that the books are aids to knowledge and not aids to the study of larger books) and is written, except in a few instances by a Sister Tutor at a prominent hospital. The whole Series aims at providing concisely, clearly and simply just that quantity of information which the nurse needs to possess, gathered together in well-illustrated, easily read and easily carried volumes at a price within the means of any nurse. Judged by the welcome it has received, this aim has been accomplished, and the student nurse has at her disposal a set of convenient, up-to-date, comprehensive textbooks.

THE GENERAL EDITORS



FOREWORD

All nurses will find this book both interesting and challenging, for while technical advances in medicine tend to encourage the view that the patient is merely a complicated anatomical structure, he is, and must always be, a living person with family responsibilities, personal worries, hopes and fears.

Miss Altschul, therefore, asks her readers to study their patients carefully and furthermore demands that they should study themselves, because one of the great truths in nursing is that the patient is affected not only by what is done for him, but by what is said to him and indeed by how those tending him feel about him. On reading her manuscript I was tempted to suggest an alternative title—'The Patient in the Bed by the Door'—but a descriptive title of this nature would belie the fact that this is a textbook giving details of scientific facts, experiments, conclusions and theories—a book as important and useful as any other in the nurse's reading list.

Unfortunately, because the book is concerned with ordinary people living their daily lives, there is a danger that the ready acceptance of the general theme may cause the factual importance of specific topics to be overlooked. The common sense ordinary everyday happenings are often worthy of critical examination. What, for instance, is the effect of the phrase, 'He's getting on as well as can be expected', upon a household awaiting news of a loved one in hospital?

I was once told that a psychologist's laboratory is the street, the home or the factory. This, of course, is an over-simplification, for even observation of people working on a ward demands training in observation itself. In fact, many psychological researches have required the use of extremely delicate apparatus; but because the subjects of many of our psychological investigations are just ordinary people the student of psychology is given an opportunity not possible to have with other sciences. He can say, 'Are these facts in accordance with my experience?' 'What is the situation on my ward?' The conclusions drawn from such questions are not in the least likely to be reliable, but the importance of such queries is that a valuable attitude of mind has been set up.

This book, therefore, demands more of the reader than mere study; it suggests that nurses should discuss its arguments with their fellows and above all that they should read as widely as possible. Some nurses may be puzzled to discover that there appears to exist a divergence of views among psychologists concerning the theoretical conclusions to be drawn from their experimental data. There are indeed many 'schools' of psychology, for experimental psychology is a young science and has attracted many workers who received their basic training in other sciences. Psychology moreover is a "bridge" science linking the seemingly exact sciences such as biology and chemistry with those which appear less amenable to statistical measurement—sociology for example. But because psychology deals with human beings in all their activities this bridge should also link the traditional sciences with immensely important topics involving philosophy and the fundamental questions of religion. All these studies have sooner or later to face the problem of the possible relationship existing between mind and body.

Some workers save themselves all thought by either denying any relationship or by stating that such questions should be the business of philosophers and not hard-working nurses. Where this is so, Mr. Jones in the bed by the door becomes just a diseased appendix.

Other workers do seek to find a relationship between Mr. Jones's mind and his body. They, however, state that his mind is one of the results of his evolution from a much simpler organism. To them Man is indeed a complicated mechanism, wonderful in its intricacies, but nevertheless a mere machine controlled partly by its structure and partly by the circumstances of its environment.

There are other workers in the field of psychology who do regard Mr. Jones as a unique personality whose mind is worthy of our most detailed study. Many investigations into the nature of the unconscious activity of the mind have been carried out, and stress is rightly placed upon the need to recognize that many of our motives originate in such unconscious activity. Sometimes, however, the writings of

workers in this field of psychology appear to give the nurse little help with her patient; indeed, the mind appears as a veritable bear garden of warring factions. In this connection I have been much encouraged by the words of the late Professor Jung who stated that ability to recognize consciously the dark side and the evil within us is not enough. . . . 'Man has not yet been able single handed to hold his own against the powers of darkness, that is of the Unconscious. Many have stood always in need of that spiritual help which each individual's own religion holds out to him.' The importance of this spiritual factor cannot be overstressed. Some patients derive much strength from their religion because this can give the three great therapies of comfort, hope and courage. The spirit within the man is truly a force to be reckoned with when sickness comes to him.

All schools of psychology therefore can put forward only tentative explanations of human behaviour. This is why psychology is so exciting. Progress is very rapid in many branches of it, but all workers are finding the need to co-operate with the other biological sciences. The important fact to remember is that this progress should prove of real value in the lives of everyone of us.

And what of Mr. Jones in his corner bed? I would say to every nurse—Does the patient feel reasonably secure both with yourself as his nurse and with his fellow patients? Whatever status you may have in the hospital you have some control over both these factors. Furthermore, is he among friends? (I may feel perfectly secure in a crowded railway carriage but I am not necessarily among friends.) Do you respect him as a person in spite of his foibles? Has he, with due regard to his physical or mental condition, much opportunity to help himself? All such questions are good psychology and Miss Altschul will help you to answer them.

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October, 1961

PREFACE

Psychological knowledge forms the basis of good nursing, for nobody can nurse well who does not have some understanding of the psychological working of the human personality. To no one is it more important than to a nurse that she should understand how people react to their upbringing, their environment, their health or sickness and their social contacts. The study of psychology is therefore an essential and most interesting part of the nurse's training for, from such study, she learns how she herself and all whom she meets in hospital, doctors, nurses, patients, patients' relatives and many others react to the changing circumstances of life.

I have divided my book into three parts—'Psychology and the Patient', 'Psychology and the Nurse', and 'Psychology and the Hospital'. The first part traces the development of the human being from infancy to old age, the second part introduces the nurse to the part that psychology plays in her daily work among the patients, the third part deals with the relationships the nurse has in hospital with all those around her.

It is my hope that every nurse who reads my book will find in it not merely the information she needs to help her pass her examination but, more importantly, a body of knowledge which will be a standby to her throughout her life. If, in addition, I succeed in so catching her interest that she discovers for herself the continued enjoyment to be gained from further reading and from more extensive study of the subject I shall feel well rewarded for the work entailed in the preparation of this book. Like other basic subjects, psychology is usually taught early in the nurse's training. This book is however intended to be used throughout training because practical nursing experience will help the student to understand it more clearly and to collect from her own experience examples to illustrate the text.

To Dr. Caws I am deeply indebted both for writing the foreword to the book and for the very great help he has been to me in the preparation of the manuscript. He not only read every page but he also provided numerous wise and valuable comments which were of great assistance to me. To all those who with patience listened to me while the book was being written, and helped with their advice and criticism I also tender my thanks.

A. ALTSCHUL

The Bethlem Royal Hospital
and the Maudsley Hospital.
October, 1961

Publisher's Note

This is the second book in the Nurses' Aids Series to bear the title *Aids to Psychology for Nurses*. It is an entirely new book and replaces that written by Miss Norah Mackenzie and published in 1951.

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PART II

Psychology and the Nurse

PART III

Psychology and the Hospital

DEFINITIONS AND SCOPE OF THE SUBJECT

Psychology is a scientific study of behaviour and experience. This definition by Thouless is only one of the many attempts to define a relatively new subject. Many people use the word 'psychology' quite loosely. They believe that they are using psychology in their efforts to cope with difficult people, their skill in understanding others, their method of getting their own way. Most people believe themselves expert in the art of living and of coping with their fellow men, and therefore believe that they in fact are psychologists of a sort. Only when they find themselves in difficulty, when they feel misunderstood, or when it is evident that ordinary methods of approach are unsuccessful in dealing with others, do people become aware of a need for more or better psychology.

It is the purpose of this book first to show what psychology really is about and, second, to examine if nurses in any part of their work can benefit from a knowledge of psychological facts.

Nurses, however well read in psychology and however thoughtful about themselves or other people, never become psychologists. A psychologist is a scientist. He or she has obtained a University Degree in Psychology and spends his working life either in carrying out scientific research, thus adding to the body of psychological knowledge, or, alternatively, in applying his special scientific knowledge to the investigation and solution of practical problems in various fields.

In education, for instance, among much other investigation, psychologists have carried out research into the advantages and disadvantages of intelligence tests given to school children,

into problems arising when children are grouped in school according to intelligence, or when children of all intelligence levels work together. Psychologists have studied children with special reading difficulties, and they have tested various ways of overcoming these. Psychologists have studied the effect of reward or punishment on learning. Work done on rats and work with human beings has helped them to discover how learning takes place. The findings of the psychologists are available to teachers, who may or may not make use of them, but perhaps become better teachers when they do. However fervently a teacher takes psychological theory into account, he does not become a psychologist but merely a better informed teacher.

Throughout this book there will be examples of psychological research and summaries of psychological findings which may or may not help nurses to become better nurses. Perusal of this book cannot and is not intended to turn nurses into psychologists.

Psychology is a SCIENTIFIC *Study*

Sciences are distinguished from other studies by the methods employed, not by the nature of the subject matter, nor the degree of certainty with which knowledge is held to be true. In physics, for example, one of the oldest sciences, or in chemistry, many of what appeared to be definite facts have recently been disproved. Nevertheless, physics and chemistry remain sciences though truths are no longer proclaimed with the same dogmatic certainty as they formerly were.

Scientific methods consist largely of controlled observation and experiment. Casual observation of striking episodes or events often gives rise to scientific study, but in itself is misleading rather than helpful. For instance, Dr. C. Burt observed that many young offenders were of low intelligence. Though Dr. Burt did not himself suggest it, this observation

was first held by many people to indicate a causal relationship between low intelligence and delinquency. Careful scientific research, however, indicated by Dr. Burt's observation has shown that this is not so. At the same time, psychologists have become interested in much more important aspects of juvenile delinquency, and have provided many useful data on this problem.

It has been observed that some children on leaving hospital have returned to bedwetting or have had nightmares. Some mothers have observed that their children are more clinging than before their entry to hospital. These casual observations are useful in that they point to the need for scientific research into the effect of hospitalization on young children. When psychological findings are available, nurses will be influenced by them in their handling of children in hospital.

The scientist forms a hypothesis, namely, a general statement that he believes certain events to be connected. He then tries to think what would follow:

(*a*) if his guess were right,
(*b*) if his guess were wrong.

The experiment or scientific observation is then planned to test the hypothesis. For example, you may believe that the smell of gas you detect in a room comes from a faulty gas pipe leading to the cooker. There is in the same kitchen also a gas water heater and a gas ring. If the hypothesis is right, turning the gas off at the main will stop the smell, turning off the cooker will also do so, but turning off the other two taps will not have any effect.

In the experiment to test the hypothesis, one operation after the other is performed, care being taken to ensure that no unknown variations occur. If, for instance, a friend turns off the main while you are testing the oven, or if someone turns

the other two taps off at the wrong moment, the experiment is spoilt.

You could, of course, carry out a different experiment, you could put a match to the supposed gas leak in the oven. This would be a suitable experiment to disprove your hypothesis if you were mistaken; but if you were right, it would cause an explosion. It would be a satisfactory experiment, but one which is indefensible in its effect.

In psychological study, many experiments must be ruled out because even if they proved the hypothesis right they would be indefensible and unethical.

It is for example a hypothesis of psychologists that children deprived of mother love grow into emotionally stunted individuals, but it is clearly impossible to carry out an experiment to prove that this is so. This is why controlled observation is a method much more frequently used in psychology than are experiments.

Some experiments, however, have proved possible and very profitable. It was, for instance, casually observed that some people allowed a good deal of time to elapse before responding to a visual stimulus. A number of hypotheses were formulated, for instance:

1. There is always a measurable time interval between the moment when a light is shown and when a person reacts to it by pressing a button. This is called 'reaction time'.
2. People differ in their reaction time.
3. Reaction time is slower if the individual being tested is tired or under the influence of alcohol.

If these hypotheses are true, they are of interest to motorists, for example, and to pilots, and to nurses, who must react quickly to patients' signals or to danger signs.

Experiments can easily be set up to prove or disprove the hypothesis. Suitable apparatus can be constructed, reaction

times carefully measured, volunteers found for the experiments, and care taken that only one variable is introduced into the experiment at a time, e.g., the subject must not be hungry, cold, drunk or tired simultaneously. Books on psychology describe many interesting experiments, carried out on people and animals, on learning, forgetting and other mental activities, the experiments being just as carefully conducted and as valid as those in other sciences.

An interesting experiment, often referred to as the Hawthorne experiment, was carried out in a factory to find out in what circumstances production could be increased. Five girls participated. One by one, factory conditions were altered. Temperature of the room was increased, then decreased; noise was reduced, then increased; rest pauses, seating arrangement, lighting were altered one by one. Every single alteration in environment resulted in increased output. This experiment showed that psychologists were probably mistaken in believing that only external environment affected work to any great extent. Instead, they drew the conclusion that output rose because of the interest which was being taken in the girls' progress. The fact that change is introduced conveys to the worker the interest of management.

The findings of this experiment have led industrial psychologists into an entirely different field—that of industrial 'morale'. Psychologists are now widely employed in industry to help raise the morale of the workers. Hospitals are finding some of the industrial research very relevant.

Controlled observation is, however, the most widely used psychological method. Instead of setting up experiments designed to bring about a particular result in people, people who already show the characteristic are observed.

If, for example, juvenile delinquency were to be studied, no attempt would be made to create delinquents, but instead those who already were delinquent would be studied.

In a school, every child who had been before a juvenile court might be matched with a child having no record of delinquency, efforts being made to ensure so far as possible that the two groups were alike in age, sex, intelligence, social and economic standing. Having found a suitable control group with which to compare the experimental group, enquiries about the family of each child would be instituted and it might be discovered that significantly more of the delinquent group came from broken homes. This would provide one possible clue to the causation of delinquency, but the relationship would not in every case be true. There may be some delinquent children whose parents are happily married, and some normally adjusted children in very unhappy homes. But if the percentage of broken homes in the delinquent group were found to be so much greater than in the control group that it could not possibly be due to chance, the discovery would be sufficiently important to be taken into account.

A great deal of psychological knowledge has been gained by the method of comparing groups of people. Answers in this case can postulate that there is a very high probability that children who do well in intelligence tests will do well at a grammar school; that nurses who have been selected because of their high score in a particular selection test will do well in the State Examination. There is evidence that patients suffering from gastric ulcer more often have personal difficulties than patients suffering from, say, appendicitis.

Because psychological findings apply to groups and are stated in rather cautious terms, people applying psychological knowledge must be careful in the use they make of it. It is a statement of fact that many mentally disturbed people have had an extremely strict upbringing. It would be wrong to interpret this statement by saying either that all mental illness is caused by strict upbringing, or that in every case strict

upbringing causes mental illness. This latter interpretation was at one time accepted, and license was advocated as the correct method of bringing up children, though not by psychologists, but by those teachers or parents who had failed to understand psychological findings.

Psychologists can never be made responsible for any particular course of action to be taken by the public or by a professional body or any individual. Psychologists might be able to show in terms of probability that flogging is likely to arouse resentment and increase rather than decrease violent activities. Whether or not we abolish flogging in the home and in schools as an official form of punishment must be decided by individual fathers, by teachers as a professional group, and by the nation as a whole. Again, psychologists might be able to show in terms of probability the relationship between the visiting of children in hospital and the incidence of various forms of maladjustment after the child goes home. Whether or not hospitals allow or encourage visiting, and whether mothers take advantage of the facilities, must be decided by the people concerned taking psychological findings into account.

Psychology is the Science of BEHAVIOUR *and* EXPERIENCE

When small infants are studied it is only possible to observe *behaviour*. We can describe the infant's crying, how long he cries, how loudly he cries, his movements, which part of the body he moves, how vigorously he moves. We can also attempt to discover which stimuli in the environment are related to the infant's response. If, for example, we put a finger in the infant's palm, he closes his hand; if we put a finger into his mouth, he sucks; if we stick a safety pin into his skin, he cries.

We are describing a system of stimuli and responses. With care and training, and with suitable apparatus to measure

muscle tension, salivation, and skin resistance to electricity, we could describe stimuli and responses in considerable detail. All this is termed behaviour. Some psychologists believe that behaviour is in fact the only thing which psychologists should study. The American psychologist, Watson, has put forward this proposition most strongly and has founded the school of 'behaviourist psychology'. Behaviourists study not only human infants but also all varieties of animals, particularly rats, and have contributed a large amount of knowledge. Nurses frequently have to confine their observations to behaviour. When a patient is unconscious or too ill to speak, his behaviour leads the nurse to discover the stimulus which is troubling him.

On the whole, however, as nurses we would find the study of psychology dull and unrewarding if we could not include the study of experience. *Experience*, in psychological language, refers to the mental phenomena occurring directly to the individual; in Spearman's words, 'something lived, undergone, enjoyed and the like'. Thinking, feeling, seeing, hearing, wishing, planning are all 'Experiences'. Experiences cannot be observed by others, they can be reported only by the experiencer.

When we stick a pin into an infant, this stimulus causes the behaviour of crying. We assume the infant experiences pain. We cannot really say anything about his experience, but we can hardly refrain from thinking that the infant's experiences may be similar to our own.

It is the study of experience in addition to the study of behaviour which makes psychology interesting and relevant to nursing. We are interested in what our patients and all the other people we meet in our life feel, think, suffer or enjoy, and we select from the science of psychology that which helps us in understanding human beings in the particular situations in which we meet them as nurses.

The Scope of the Subject

Psychology studies many more aspects of behaviour and experience than are of immediate interest to nurses. Each individual psychologist must restrict his work to one small section of the science. Some psychologists are concerned with the study of learning. Some are interested in phenomena of perception; namely, the laws which govern how stimuli arriving at the sense organs are interpreted into something meaningful, how past knowledge affects perception.

Some psychologists study the behaviour of animals; others are concerned with the study of child behaviour or development; some are concerned with investigation of the effect of early childhood experiences; and yet others are interested in the interaction of people with each other in small and large groups. Some psychologists are interested in social phenomena, such as racial prejudice, and they try to relate these phenomena to the personality development of the people concerned; others work in industry.

The fact that psychologists differ in their interests, that there are many different ways of approaching the subject, many methods of study and many ways of presenting the findings has resulted in various 'schools of psychology' emerging. Behaviourism, the gestalt school, and analytic schools of psychology are examples of these. Some people sometimes believe that a multiplicity of schools must mean that nothing is known about psychology, and that therefore everybody's guess is as good as anyone else's. This is, of course, a totally mistaken view. Different schools of psychology represent different spheres of interests and occasionally different ways of interpreting or applying the same facts. Facts there are in plenty. It is the task of the nurse to be informed of as many as possible of the facts which relate to her work and her life, to understand how these facts were established and with what predictive value.

The nurse should understand the significance of the facts and the interpretation which psychologists have put forward. In her work, the nurse's own interpretation and her own ability to sift, to select and to criticize will help her to apply what she has learnt to the best advantage.

SUGGESTIONS FOR FURTHER READING

There are many good textbooks of Psychology. They are too detailed to be read in their entirety and go more deeply into the subject than some nurses may wish to go. They should, however, be consulted for reference. Some of these contain excellent illustrations. Students should note how carefully the authors quote exact references of experimental work. Here are some suggestions:

THOULESS, R. H. *General and Social Psychology*. (University Tutorial Press.)

WOODWORTH, R. S., and MARQUIS, O. G. *Psychology, a Study of Mental Life*. (Methuen.)

MUNN, N. L. *Psychology*. (Harrap.)

HILGARD, E. S. *Introduction to Psychology*. (Methuen.)

The following are short, simpler, introductory texts:

CATTELL, R. B. *Your Mind and Mine*. (Harrap.)

KNIGHT, R. and M. *A Modern Introduction to Psychology*. (University Tutorial Press.)

ZANGWILL, O. L. *An Introduction to Modern Psychology*. (Methuen.)

The following are recommended to those who enjoy reading about the historical development of the subject:

WOODWORTH, R. S. *Contemporary Schools of Psychology*. (Methuen.)

FLUGEL, J. C. *A Hundred Years of Psychology*.

BRETT, G. S. *Brett's History of Psychology* (edited and abridged by R. S. Peters). (Allen & Unwin.)

All the above books have extensive bibliographies which will help students who wish to read more.

PART I

Psychology and the Patient

1. INTRODUCTION

Nursing is a very skilled job. It requires knowledge and manual dexterity, but most of all an interest in people and the ability to understand and help them.

The nurse meets people every moment of her working day: patients, colleagues, patients' relatives, any members of her own community whose continued good health is in some way or other dependent on the nurse's job. Some of the people the nurse meets are old, some young, some mature, some immature, some are people whose personalities are agreeable, others have personality characteristics which make them difficult to get on with. Some behave appropriately to their age, others appear rather childish.

The nurse must carry out her nursing duties, whatever obstacles other people may put in her way. Indeed, the obstacles created by others are part of the nursing task. It is futile to say that a nursing procedure could be carried out if only the patient was more co-operative. Rather, it should be said that gaining the patient's co-operation or co-operating with the patient is part of the nursing procedure.

Again, it is idle to complain that junior nurses do not carry out instructions and that the senior is left to do the job herself. It is part of every nurse's job to learn how to delegate, instruct and supervise.

The relationships with others into which a nurse enters in the course of her work make her job interesting and rewarding, and success in this is partly brought about by the nurse's own personality. The right kind of person often instinctively creates confidence in the patient and has an understanding of other people's needs. The personality of the nurse directly or indirectly affects the well-being of the patient. The manner of

calming an anxious relative or dealing with a disgruntled member of the lay staff will be felt indirectly by the patient.

It is, however, not possible to recruit to nursing only people who have already acquired the necessary personality and also possess all the required skills. Those who have not yet done so can learn by studying how people behave, how they differ from each other, how they develop and how their development is influenced by social pressures and environment. The study of personality is, therefore, an essential part of the nurse's preparation for her work.

Personality is the term used to describe the complex pattern of integration and interaction of psychological and physical characteristics, which make each person a unique individual. To study any one 'personality' it is necessary to acquire a detailed record of all he does, his ambitions, his wishes and desires, his thoughts, his dreams, and a knowledge of his manner of experiencing the world around him. His feelings have to be studied, as have his temperament and his attitude to people and events.

All these various aspects of mental life have to be described and if possible measured. Their consistency over a period of time must be noted. The psychologist looks back over a person's life to try to understand how he came to acquire his present personality, and looks forward to see where the present personality traits are taking him.

Later on we shall take another look at the study of personality and its various components. At the moment it suffices to note how complex and varied adult personality is—how simple and almost uniform, by contrast, the behaviour of the new-born infant. How the change occurs during the process of growing up is the subject matter of the next few chapters.

2. INFANCY

The most striking experience when observing a newly born infant is the awareness of his complete helplessness. Mothers, of course, see in their own infant all the possible virtues, all perfections, all miraculous achievements. Independent observers, however, can see that the newly born infant is capable of only a very small number of actions in response to a very small number of stimuli.

An infant moves his body and limbs in a generalized, non-purposive sort of way; he is not able to carry out any precise movements of any part of his body with the exception of very few reflex actions.

When something, a finger for instance, is placed into the palm of the infant's hand, the hand closes in a grasping movement which is so firm that the child's whole weight could be suspended by his arm. If the cheek is touched, the infant turns his head towards the stimulus, a useful reflex enabling the baby to find the nipple of the breast. When the nipple, or the teat of the bottle, or the fist arrives in his mouth the infant sucks.

It is possible to make the infant cry by making sudden loud noises, by suddenly withdrawing support. Often a baby will cry when his mother passes him on to father, possibly a reaction to sudden loss of support rather than an awareness of mother's maternal skill or father's clumsiness. After a little while in his father's arms, the baby probably settles down again just as he did with his mother.

An infant may also cry in other circumstances; namely, when a pin sticks into him, when he has not been fed for several hours, when the nappy is being changed.

We are apt to say then that the baby is in pain, or perhaps

hungry or cold. These statements are, strictly speaking, unjustified. It is not really possible to know what a baby experiences. Hunger, pain, discomfort are states of conscious experience which generally we can communicate to others only in words. Babies cannot speak. Their only method of communication is crying. In everyday language it is, of course, quite acceptable to attribute to the baby experiences which we believe we would have if we were short of food, had a pin sticking into us, or were wet and cold. In psychological language, however, it is worth while to distinguish clearly between 'behaviour' which can be easily observed—in this case crying—and interpretation, about which we may easily be wrong. Nurses have to do this frequently, i.e. they must observe behaviour and make tentative guesses about the patient's experience, not only with babies but with any patient who is unable to speak; such as the unconscious patient, or the patient who has lost his speech due to cerebral hæmorrhage or laryngeal damage, or the patient suffering from depression or schizophrenia who will not speak.

Just as we cannot really say what is an infant's feeling when he cries, we cannot really say how he feels when he lies awake in his cot or snugly in his mother's arms. Yet we feel that the words 'contentment', 'satisfaction', 'pleasure', 'gratification' somehow describe what it must be like to be warm, well wrapped up, rocked, securely held, adequately fed, and we feel justified in talking about 'needs' which must be satisfied if the infant is to develop normally. Most infants have all their needs satisfied, because the mother's needs, which are to love, to comfort, to support, protect and to nurse, correspond completely with the needs of her infant. In the interaction between mother and infant, the two are so completely at one that for the time being it is impossible to see the child as having a separate personality at all. This unity of mother and infant, the emotional and physical bond which exists at the time

of birth, appears to be necessary for the infant's development.

No infant could possibly survive if he were denied all forms of care and protection. If after birth a child is denied some of the emotional warmth, love and affection most infants receive, we then speak of him as a deprived child—deprived of love and security. A mother may not have looked forward to her baby's birth, she may have resented pregnancy, or have suffered ill health during pregnancy, or she may have grown to dislike the child's father or may perhaps not even know who the father is. If her child is deformed or ugly, it may be difficult for the mother to feel wholly accepting. Some mothers suffer from physical or mental disorders following childbirth, and the mother's admission to hospital may make it impossible for her to give all the emotional care to her child that she may desire. For any of these reasons a child may be 'deprived', and it is now often believed that the best thing to do is to provide the baby with a mother substitute. Grandmother, father, a neighbour, an aunt or a nurse can by devotion and continued presence satisfy the baby's emotional needs.

In many hospitals or nurseries, every endeavour is made to allow one nurse to care for the infant, for he appears to need personal care, loving, cuddling, holding, as much as food and bodily attention. He thrives best if one person gives him the whole of herself.

There is still too little evidence to show how soon after birth the continuity of care becomes essential. Some people feel that the first few days do not matter very much and that the hospital routine just after birth does not affect the infant. Others, however, believe that the mother establishes a bond with her infant right from birth, or rather that it should never be severed by removing the infant from her. For this reason, delivery at home rather than in hospital is favoured by many so that a mother with help, preferably from the father, can

care for her baby from the start, and that the infant never suffers from the changes in nursing staff to which some babies born in hospital are exposed.

Even in hospital it is sometimes possible to keep each infant with its mother and so help the bond between mother and child to grow and strengthen. It is, therefore, very necessary to know details concerning the mother's mental health prior to pregnancy.

Breast feeding is often thought to be essential to the healthy growth of the infant. During breast feeding unity between mother and infant is greatest, satisfaction of motherhood is experienced to the fullest extent, the infant is completely relaxed and satisfied. When breast feeding is established easily it provides a uniquely satisfying experience both to mother and child. If there is difficulty however, either because the mother finds she has not sufficient milk, or the infant does not suck well, or the mother resents the infant and his demands on her timetable, then breast feeding is probably harmful, as tension and anxiety affect both mother and child. Bottle feeding, if the baby is well held, well supported, and properly nursed before, during and after feeding and if the same person nurses the baby each time, can satisfy the infant's needs, while insistence on breast feeding increases difficulties.

Nurses, whose duty is to help and advise the expectant or the young mother, should know how important is the mother's love and care, and how satisfying it is to most women to gratify the infant's need.

Encouragement and understanding help the mother to develop a healthy attitude toward her infant if her difficulties are understood and anticipated. Many young women are afraid of motherhood; afraid they may not be equal to it, that something may go wrong, or that they have made a mistake in starting a family. Some have mistaken ideas about the

physiology of pregnancy, are reluctant to give up their freedom, or resentful about men and guilty about their own behaviour.

If a woman has to deal with her emotional difficulties, it is not easy for her to look forward to motherhood and to welcome her child with the serene loving acceptance which the infant requires. It may be difficult for a mother to express in words the anxieties she feels, difficult for her to understand them, and even more difficult for her to communicate them to the nurse.

Some antenatal clinics arrange educational programmes, films, discussions, lectures, which aim at allaying many of the most common anxieties without giving voice to them. Yet every mother's problems, however similar they may be to those of others, are peculiarly her own, and need the special understanding of the nurse. In her anxiety to do the best for the child, the nurse must guard against creating guilt feelings in those women who find the new experience of motherhood too difficult at first.

In many instances, the young mother seeks the advice of the nurse about the way in which she should feed and nurse her baby. If she is doing well, is happy, confident, relaxed, and if the baby is satisfied, the mother, though she is asking for advice, does not really need it. She needs the approval of the nurse, the confirmation that all is going well. When the baby does not thrive and the mother is anxious, she is more clearly in need of help. But before advising her, it is well to remember that an anxious person seeks advice from as many sources as possible and is apt to obtain conflicting counsel. Moreover, in her anxiety she may not fully understand the advice given to her and be able only partially to follow it.

There is no clear-cut advice, applicable to all cases, that psychologists can offer. For example, to the questions whether to feed the infant regularly, or whenever he appears to demand

food, whether to let him cry, or respond to his crying by picking him up—there is no answer.

When mother and baby are both well and attuned to each other, it appears that the baby will establish a regular pattern of waking and sleeping. The pattern may not be precisely four-hourly, nor exactly at 2, 6, or 10 o'clock, but the baby will not lack all rhythm if his mother allows *him* to establish the routine. Certainly some routine appears necessary to the infant, the most important routine of all being the regular appearance of food and of mother love; comfort and food are all part of the same experience, representing the satisfaction of needs. Infants who do not establish regular rhythms of sleeping, waking and feeding may lack the sense of security which the normal mother-child relationship gives. A mother who is too anxious or too troubled to fulfil her role adequately cannot benefit from advice. She needs help in the form of a willing listener, and encouragement to develop strength and confidence in her own ability as a mother.

Discussion with a nurse, who is interested but not critical, or with other mothers who have similar problems can help a mother to gain understanding and to modify her attitude. She may recognize, for example, that her own inability to love and be loved causes her to treat her infant as if he were inanimate and refer to him as 'it', and attend too rigidly to physical care to the exclusion of emotional relationship. Recognizing her difficulty, and having her own need accepted by the nurse, she may be able to let her feelings develop. Some mothers become excessively attached to the infant. At the time when the infant might be ready to develop some independence, the mother may become more possessive and protective in order to satisfy her own need for affection. Discussion of her problems may help her to realize the danger to the child of excessive attachment and may help her to satisfy her own emotional needs elsewhere.

Very rapidly, during the first few months, the infant's behaviour changes. New responses appear almost daily, new knowledge is acquired and the infant develops a personality of his own and his own way of influencing others. Every new achievement is greeted with joy and admiration by the mother and father, and the rapidity of learning seems nothing short of miraculous. Yet few parents know how their infant's development compares with that of others. They measure their child's progress against their own expectations and ambitions rather than by the standards exhibited by other children. During the first few months, the child's rate of progress often exceeds expectation, so that many mothers are amazed to see how far advanced are their babies. Later, parents' expectations are often unrealistically high and disappointment leads to excessive pressure on the child. It may be helpful to a mother if a nurse can tell her how her own child stands in comparison with others. Mothers' meetings in postnatal clinics, informal gatherings of mothers in the park, or ordinary social contact between mothers all serve to exchange information but frequently result in great anxiety when a mother becomes aware that her own child is less advanced than a friend's, and when she feels unable to express her fears or discuss her difficulty. The nurse's knowledge of many children, and her awareness of the norms of development may enable her not only to reassure the mother who worries unnecessarily, but also to draw attention to delayed development which the parents may be unwilling or unable to acknowledge.

It is only relatively recently that a systematic survey of children's behaviour at various ages has begun. Muscle activity is being observed in detail, and development from generalized movement of the body as a whole to the detailed movement of finger and thumb has been listed, described and photographed. Development of eye movements and of posture have all been

studied. Similarly, eating habits, sleep and elimination have come under scrutiny and, at a later age, growth of social behaviour, development of thought and language.

NORMS FOR DEVELOPMENT

Described by Arnold Gesell

16 weeks: Eyes focus on mother or dangling toy.
Turns head on hearing noise.

28 weeks: Sits alone.
Reaches out for toy.
Grasps with palm of hand.
Begins to articulate sounds.

40 weeks: Can grasp toy between fingers and thumb.
Pulls himself up and stands holding furniture.
Imitates syllables.

52 weeks: Creeps about freely.

15 months: Begins to walk.
Speaks a few words—da, no.

18 months: Bladder control almost established during the day.

When hundreds of babies have been observed, it is possible to state at what precise age 50 per cent of all babies have mastered any particular skill. This age is then taken to be the norm for the particular activity. It is an average figure obtained by taking into account the slowest and the most rapidly developing children. No parent should worry because his child's performance falls below or above the average. Variations within normal limits are great. It is only when a child differs so greatly from the norm that some help is obviously required, that the nurse should draw attention to it. More frequently, she may have to explain to parents that norms are merely rough guides, not absolute standards of perfection.

Parents may indicate their sense of responsibility for the child's progress by asking many questions about development. They may, for instance, wish to know how much of a child's

future is determined by heredity, how much by the environment they will be able to provide. They may also wish to know how actively they should help their child to learn, how much of the child's development is simply due to maturation, not to learning.

All these are difficult questions to answer and, again, the nurse's greatest contribution may lie in encouraging parents to express their fears and beliefs rather than in making authoritative statements.

It appears fairly certain that some hereditary factors determine personality development. Right from infancy some children are placid, some more active. Some normal children sleep a great deal, others very little. These temperamental differences are probably innate. The infant's temperament, however, determines from the very first moment how he is handled, how people feel towards him, and how he in turn experiences his environment. Human development is so slow, experiences between infancy and adulthood are so numerous that it is very difficult to distinguish how much environment has affected the individual, and how much the individual has caused the environment to be as it is.

In animals which reach maturity rapidly, and particularly in those animals which hatch after their parent's death, such as insects, or which are deserted by their parents, such as cuckoos, it is easy to see that certain behaviour patterns are non-learnt. We call them instinctive if they are universal to the whole species, perfect from the beginning and cannot possibly have been learnt. The nesting behaviour of birds, the mating rituals of certain fishes, the egg-laying behaviour of some insects are clearly instinctual. There is some doubt as to whether the instinctive behaviour is always perfect or precisely the same in every member of the species. When it is not perfect, the animal may not survive, so we cannot see imperfect examples. Whether or not it is infallibly the same may

nowadays be observed to some extent with improved photographic techniques. It appears that the nearer the animal's behaviour is to its goal the more stereotyped it becomes. Although the beginnings of nest building or of sexual dances may vary, the finishing touches of the nest or the consummatory act of sexual behaviour is invariable. The instinctive acts are carried out as specific responses to absolutely specific stimuli. The term 'innate release mechanism' has largely replaced the term 'instinct', because the point that specific stimuli result in specific behaviour is made much clearer by the former expression. Some herring gulls, for example, peck specifically at a red spot on the mother herring gull's beak; a pencil with this colouring pattern could alert the same response. Some female fishes respond to the red surface on a cardboard fish even better than to the coloured undersurface of a male fish. Some birds take flight when shown a figure that resembles a hawk in flight when moving in one direction, but they remain calm when the figure moves in the opposite direction, resembling an aeroplane. There is in animals an innate ability to notice certain stimuli and to react to them.

If this *definition* of an instinct is used, we find that human beings hardly ever behave instinctively.

Most behaviour in human beings is so much modified by learning that it is hardly ever possible to discover instinctive reactions. The nearest perhaps to this form of Innate Release Mechanism is the infant's tendency to smile when shown a round disc with a hole in it, perhaps a figure similar to that of the mother's face when she bends over the cot and smiles. Adults, too, smile at certain patterns, and Tinbergen has studied what features babies, puppies, kittens and other young things have in common which evoke smiling and protective behaviour in adults. Smiling is instinctive, not an imitation of the mother.

On the whole, however, the term 'instinct' is not a useful one when describing human action.

Human beings have certain emotions and sensations in common, such as fear, hunger and thirst. They learn to perceive the stimuli which evoke these emotions. But the behaviour of human beings who experience these emotions varies so much that it is not profitable to look for instinctive reactions. McDougall, who tried to classify instinctive behaviour in human beings, failed to find any consistent pattern other than the emotions experienced and the tendency to pay attention to certain kinds of stimuli. He decided to talk of 'propensities' rather than 'instincts', but some of the people who read McDougall's earlier works still insist on using the term 'instinct' for the generalized and very variable behaviour of human beings who are hungry, afraid, angry, or in a state of sexual excitement. The variations in behaviour are the result of interaction between environment and heredity, making it impossible to estimate the effects of either.

Careful observation of infants has led us to pay increased attention to the process of maturation. Human beings, unlike most animals, take many years to reach adulthood. During these years the body develops and changes take place in behaviour, both these following a characteristic sequence. Some people develop more rapidly and some more slowly. The rate of development is partially determined by heredity; partly, however, it is affected by the extent to which the child's needs are met at each stage of development. Maturation really means 'ripening', and just as it is possible to speed or delay the ripening of fruit by favourable or unfavourable conditions, so it is possible for human beings to be helped or hindered in their development. It is not possible to change the course, each stage must be successfully completed before the next step forward can be taken.

At each stage of development, the child is able to learn a variety of skills. His actual achievements then depend on the cultural influences which have been brought to bear on him at the appropriate stage of development, but it is important to remember that it is useless to teach any particular skill before the appropriate stage of development is reached. The child cannot be taught to speak until he has reached the appropriate stage of maturity. When he is able to learn, progress depends on the amount of interest taken by his mother, on whether she speaks much or little, on the effect the child produces on others when he is able to speak. The kind of language he learns is obviously related to the language he hears.

Understanding of the stages of maturation helps the approach to such important matters as toilet training, weaning and feeding habits, play and education. It should help the mother to refrain from making excessive demands and to give encouragement when the child is ready to learn. The rate of maturation is so characteristic for each individual that it is actually possible to gain some understanding of an adult's personality by enquiring when and how the main phase changes of maturation occurred. The age at which a child raises its head, sits, stands, walks, begins to speak, the way in which weaning and habit training were accomplished are significant. The speed of maturation and the ability to learn once the appropriate stage of maturation is reached are, to a large extent, innate. Ability to learn is often referred to as 'intelligence'. We shall later discuss more fully what is meant by intelligence and how it can be measured.

In considering child development, there must be awareness of individual differences in the ability of children to learn. This affects not only the manner in which the child accepts and interprets those things that are deliberately taught, but also how much he learns incidentally and how far he under-

stands the world around him. At a very early age only those achievements which are incidentally acquired by the child are used as an indication of the degree of intelligence. Those skills which any child acquires, given the opportunity, and having the necessary level of maturity, are those which are expected of him. At an early age it is, therefore, difficult to separate 'maturation' from intelligence. Indeed, the rate of progress of maturation is taken as an indication of intelligence. Excessively slow development should certainly cause low intelligence to be suspected, and expert advice should then be sought to establish whether physical defect or adverse environmental influence is hindering the child's development. Children who are sub-normal in intelligence may retain primitive reflexes well beyond the usual age.

The new-born infant's time is largely spent in sleep. Complete relaxation during sleep is an indication that one of the infant's needs is being met. During waking hours, the infant frequently shows a restless, irritable type of behaviour which may not be specific. Comfort can be restored by feeding, rocking, cuddling and sometimes sucking. These activities satisfy other needs of the infant. During these activities the infant begins to discover his environment (although we cannot know for certain what the infant knows, or which of his senses he uses to learn). Ideas and impressions of the world around him gradually develop, unknown to the adults who minister to him. Conclusions can be drawn from the careful observation of infants, from experiments carried out on people in conditions similar to those of infants and from recollections of adults who, by special techniques, seem able to recall very early phases of development. Observation of the infant's behaviour shows that very soon, before he reaches the breast, his mother's touch, her voice, her footsteps seem to satisfy him. Very soon he raises his eyes. His mother believes that he can see, because his eyes follow her, follow

moving lights and can converge and apparently focus on a toy.

Some of the infant's 'learning' may be described as 'conditioning'. This is a process first demonstrated by Pavlov using dogs. A new stimulus becomes associated with a response previously associated with another stimulus.

Pavlov showed that a dog first salivated only when it was given food. If a bell were persistently rung before every meal, the dog began to salivate at the sound of the bell. This only continued, however, if—at least from time to time—food followed the bell. If, however, the bell was rung too often without food following, salivation ceased, the dog having become 'deconditioned'. 'Reinforcement' of the conditioned response must take place if the behaviour acquired is to remain.

The infant soon begins to suck when he is picked up before he reaches the breast. He stops crying at a sound from his mother before he is fed. These are probably conditioned responses, the earliest forms of learning. Obviously, the mother must continue consistently to feed the baby if deconditioning is to be avoided. The infant begins to be able to anticipate what his mother will do. Her consistent response, her repeated appearance, her invariable ability to satisfy the infant's needs is what promotes 'security'.

Security is the ability to predict what will happen in the future. 'Secure employment' means that the worker can predict that he will not be sacked at a moment's notice and that he will not be long without work. He feels secure in his work when he has grasped the routine and can predict what will be expected of him. On the first day in a new job the novice feels insecure because he does not yet understand the environment in which he moves. Newly admitted patients are insecure because they do not yet know the way of life in a hospital ward. The infant is unable to understand anything

about his environment. He is at first completely passive, all kinds of incomprehensible happenings go on around him. His security lies in the fact that at least one thing can be understood and relied on—his mother's love and her ability to satisfy his needs.

A child needs security throughout his development. At all stages the chief factor in feeling secure consists in being able to rely on love, affection and approval. If these remain constant it is possible to enjoy variable and unpredictable adventures in an unknown world.

Experiments have shown that perception by sight is most complex and difficult; and that size, distance and shapes can be meaningful only when their relationship to each other has been learnt, and when other senses have been used in combination with sight. People whose sight is restored late in life have to learn to see shapes. It is unlikely that the young infant can use sight as a means of knowing about his environment, though eye movements in response to light stimuli occur early.

Sight and hearing tell us about distant things, whereas touch is the most immediate source of knowledge. It occurs within our own body although language tends to confuse the source of the stimulus with the awareness of it. We say that the fire is warm, but when we get too near, heat and pain manifestly are felt in the skin. Knives are sharp, it is said, but in fact it has been learned that pain is suffered in the finger when cut. The infant's earliest knowledge of his surroundings certainly occurs from his sense of touch particularly in his mouth. The mouth, lips and tongue are throughout life very sensitive organs of touch. A slight roughness of the fingernails, for example, can be easily detected with the tongue. Very small holes in a tooth, very small ulcers in the mouth, feel quite large when explored with the tongue. Very small lumps or foreign bodies in food are easily

detected. The texture rather than the taste of food often determines whether a child accepts a new food or not.

The infant's increased knowledge of his surroundings is accompanied by an awareness of his own separate identity. When he sucks the breast or bottle, his sensations are in his mouth. When he sucks his own fist, he has twofold sensations —in his mouth and his fist. As he begins to move about his cot, knocks his body against the sides, plays with his own limbs, puts his toes and fists into his mouth, he is learning about his own boundaries, becoming aware of his own 'body image'. For a long time to come he will develop his body image through play, so that although his size and shape are constantly changing, he is constantly aware of himself. He can use his body—any part of his body later on—and he will become aware of the continuity of his 'self' in spite of the constantly changing circumstances.

To have an accurate body image, activity of the body in relation to the environment is essential. Skill in games and grace of movement are the result of accurate body image. Some children whose movements are restricted, whose opportunity for play is curtailed, or who suffer from disorder of the nervous system have difficulty in acquiring an accurate body image. Some idea of the magnitude of the infant's task can be gained when it is realized how difficult it is for adults to change their body image. A deformity or disfigurement, for example, is very difficult to accept. Patients who lose a limb or whose limb is in plaster often find it difficult to change their body image.

The infant's body is constantly changing in size, in weight and in ability to move, so that the growing awareness of 'self' is a slow and complicated process. Not only the physical boundaries have to be learnt but also how far the body image extends. It is difficult, for example, to decide when the food that has been eaten becomes part of the consumer. While in

the mouth, it is still separate. Does it become part of the body when it is swallowed or only when it is in the stomach or not until it is absorbed? Are fæces part of the human being?

Some psychologists believe that the process of learning to distinguish the 'self' from the 'not self' is very important in development. A very young infant cannot distinguish clearly between himself, his mother and the food she provides. It is as if the infant were taking the mother into his own body image. As he grows he perceives his own identity and separates it from his mother. Knowledge of growth and development as described in this and subsequent chapters may be helpful to nurses who have any dealings with children or with young parents. Another reason for learning about development is the belief of many psychologists that early childhood events partially determine what kind of adult personality will finally emerge. It is interesting to find out how much people remember of their early experiences. Some psychologists claim that special techniques of psychoanalysis enable people to recall events from the earliest months of life. Because the infant has no speech, no thought in terms of adult concepts, it must be assumed that his early experiences are recalled in the realm of feeling.

3. EARLY CHILDHOOD

During the first year, the infant's progress is most rapid. Careful observation of photographs and films taken at regular intervals and detailed records of behaviour are now available showing how muscle control progresses, in what order the infant learns new movements, and when co-ordination takes place between eyes, grasping movements and movements of arms towards the mouth. When this stage is reached, the infant is ready to explore his environment in play.

One of the most important achievements is the opposition of the thumb to the hand. Without this, use of tools and fine work would be impossible. It has been suggested that in this ability lies the most far reaching difference between man and animals.

At about six months the infant is able to pick up bricks, beads, spoons or any other object within his reach, and very soon he learns more about their size and texture by putting them into his mouth, and banging them to discover what noises can be made. He puts small objects into boxes, moves them about, fits them together and generally becomes familiar with the characteristics of the material world around him.

It is necessary for his development that he should be allowed to explore, not only with his eyes, but by trying out what he can reach, how much effort is required and all the possible uses to which things can be put. The adult really know about objects only when he has used them in various ways. When he sees exhibits in a museum, he often feels tempted to pick them up and handle them. If this is not allowed, he may feel that his appreciation of the exhibit is incomplete. Men take their cars apart, boys get as much joy from assembling or

dismantling toys as from playing with them. The need to try out how things can be used is ever present. The young infant's need to handle everything he sees, to bang and throw, to suck and bite must be satisfied if he is to learn and to become a lively, inquisitive child.

His curiosity is not confined, however, to harmless actions. He tries to suck things which are dirty, throws things which are breakable, attempts to touch a fire or pull the tail of a cat. Some of his activities could be dangerous, others cannot be allowed because the objects might be damaged.

It becomes necessary at times to restrict the infant. The mother does this either by physically removing the object or the infant, or by showing her disapproval. To avoid trouble by keeping dangerous objects such as pills, matches or pins out of the child's reach is an obvious act of child care but often sadly neglected.

A great deal of success in upbringing depends on the mother's skill in conveying disapproval without making the child feel that he is losing her love. The infant is learning to give up gratification of some of his wishes in order to avoid losing his mother's approval.

Obedience to the mother's prohibitions is essential to protect the infant from dangers, and the mother must give commands absolutely clearly indicating that she means to be obeyed. Commands and firm prohibition should be given on rare occasions when obedience can be enforced. If it is done too often and when urgency is less compelling, it is easy to become inconsistent. Often it is easiest and wisest to divert the infant's attention and bring up a new interest rather than forbid the undesirable activity. Awareness of his mother's disapproval is the infant's first step towards an appreciation of right and wrong. It can only take place if the infant is secure in his mother's love and if his compliance with her prohibitions reinforces the feeling of being loved.

Speech

Throughout his first year of life the infant experiments with sound. The bubbling noises which delight every mother become repetitive and suddenly begin to sound like da-da, or ma-ma. These sounds, of course, are instantly repeated by the father or mother who believe that the infant has uttered his first word. Parents show great delight in the child's first utterances. Their reaction to sounds which vaguely resemble words is different from their reaction to other noises. They often repeat the word after the infant who, in turn, gradually acquires the skill of repeating articulated words after the adult.

Repetition of sounds for their own sake or in order to please the mother is the beginning of language. Meaningful sounds develop rather slowly, and there is still much research to be done in order to discover how children acquire the ideas which we associate with language.

In adulthood, language is the main tool of communication. Often it is inadequate to convey precisely the thoughts which have been formed. Thoughts develop as they are put into words. It has been suggested that thought without language is impossible. Indeed, complex thought processes result in modification of language; acquisition of new words leads to clearer thought.

The infant's first form of communication occurs not through language but through action. Crying, gestures, expressive movement, are the infant's way of indicating his feelings. The mother communicates her feeling by caressing, cuddling, rocking, humming, singing, cooing and making general approving noises. By the time the infant has begun to articulate definite sounds (between 18 months and 2 years), his world of ideas includes his mother, knowing how to get her when he wants her, being fed, carried, rocked when he indicates his need. His first association between language and

idea concerns his own activities and his mother's reactions to his demands. He may, for instance, learn to say 'more' or 'up', or use a variety of sounds recognized by his mother only, usually expressing something he wants to do or needs from her. His first words are very often nonsense words.

Mothers often point out an object and begin to tell the child what it is. There is no evidence, however, that the child means the same object or any object at all when he uses the word. 'Spoon', for example, may stand for eating; 'bed', for going to bed; 'pussy', for 'I want to catch this', or 'I am afraid of this'. When pictures are given titles, the child may try to say he wants to sit on his mother's lap looking at a picture. Objects are very difficult to name because the same object is rarely presented in the same way. The visual impression of any object differs according to distance or the angle at which it is perceived. Its texture is different when dry or wet, it may feel warm or cold to touch, part of it may be rough, part smooth. It may take a very long time before any particular object assumes identity, and much longer before a word can be attached to it.

Some words express concepts which are so difficult that it is miraculous that the child ever understands. How, for instance, can he understand the word 'dog'? It may be anything that runs, or barks or growls, or has a tail to pull, or anything that has four legs. How can a child understand that Alsatians and spaniels are both dogs? There is hardly any similarity between the two. Other mammals may look much more like a dog, yet have different names. How can the picture of a dog possibly be connected with the real animal in the infant's own home? Names are often given generalized meanings; for example, 'bus' may be anything that moves. The process of discovering when a certain word is used by others is essential to learning language. This is still done when the new languages of medicine or the more specialized

concepts of particular sciences are learnt in adult life. The child makes many mistakes when he starts using words, but only by practising words can he make them his own and use them in communication.

Those who are speaking to young infants may use single words, but very soon adults begin to talk to children in complete sentences and they then pick up whole phrases. The child imitates and understands intonation but he is often totally unaware of the individual words involved in any particular phrase. His misunderstandings and mispronunciations are often very amusing. Sometimes they do not become obvious until the child learns to write or to read.

When the child has learnt to pronounce words, he begins to enjoy using language. He repeats all he hears, talks to himself or any audience he can find and begins to widen his vocabulary by asking questions. He appears very inquisitive at this time, but a little observation shows that the questions may not be as searching as at first they appear to be. He rarely listens to the answer and no answer really satisfies because the question is not really meant to be interpreted too literally. He may, for instance, ask for names. This is partly a way of keeping the adult's attention. Partly, it is an experiment with sound. New words are joyfully accepted. Partly, this represents an attempt at finding out how many things have the same name, or what the word stands for.

When the question 'why' begins, the child is rarely able to understand the relationships of cause and effect. He is not really asking for a cause—he is trying to express his surprise at observing something new and unexpected. The more involved the explanation by the parent, the more the child repeats the question 'why'. It would be more satisfactory to ignore the grammatical form in which the question is asked and instead of answering 'because', simply discuss or give a commentary on the fact raised by the child. For a very long time the child

has difficulty in understanding words which express relationships in time and place, or in cause and effect. Words like 'tomorrow', 'yesterday', 'inside', 'outside', 'I' and 'you' are confusing because they keep changing their meaning. It is also very difficult for him to understand what happens to things when he cannot see them. Children often cover their eyes and think that nobody can see them. The child's difficulty in understanding the meaning of time, and his inability to realize the continued existence of things which are not in sight, must be remembered when the effects of separation from the mother are considered. Toddlers need their mothers' presence all the time. During play they periodically return to her, or they cry to bring her back when she is out of the room.

When the mother goes away to have another baby, for example, or into hospital, or when the child has to be admitted to hospital, the one secure factor in the child's life—his mother's presence—is suddenly removed. He cannot understand the future. Assurances about tomorrow, or soon, are useless. He cannot believe in his mother's existence when she is not there and he believes himself to be lost. He feels that his mother has lost or abandoned him. Separation of the small child from the mother should be avoided whenever possible. It may not always be possible, but we shall later discuss whether it may not be sometimes advisable to keep a sick child at home, rather than admit him to hospital, and whether home confinements rather than hospital confinements may not be preferable from the point of view of the older child.

Some children begin to speak rather later than others. This may not have any serious significance if the child appears to develop normally in other ways and is not unhappy. Some children omit altogether the period of babbling of meaningless sounds, of baby talk or repetition of single words. When they begin to talk they surprise everybody with their clear articulation, large vocabulary and accurate grammar. It may

be that they practise silently or when they are unobserved. There are, however, many reasons for delay in speaking which should be investigated.

Some children manage so well to communicate without speech that they do not find it necessary to use speech. Position in the family can affect speech development in a variety of ways. Older children may learn to speak early because the mother has plenty of time to speak to them. Younger children may learn more slowly, often because their mother is busy and has less opportunity to speak to them. On the other hand, the reverse may happen, older children may find they can prolong babyhood and retain their mother's attention by not speaking; younger children may learn more rapidly if the older children help to teach.

Children whose general development is slow and whose intelligence is below normal begin to speak rather late. If the child makes no attempt to repeat words or play with sounds by the time he is 2 or 3 years old, his intelligence should certainly be investigated. Some children are slow to learn speech simply because no one takes the trouble to speak to them. The mother may be too preoccupied with the physical care she gives the child to think about speaking to him. If she does not love him or is afraid to show any affection, she may treat the infant as if he were a doll without realizing how necessary her speech is to him. Children who grow up in institutions are in much greater danger of not learning to speak at the proper time. At home, a child hears the same sounds made repeatedly by the same person. There is consistency in tone of voice, in vocabulary and in the occasions when words are used. In hospitals or children's homes, a great number of nurses may be attending to the child, all of them too busy to speak, or if they do speak, unable to provide the necessary repetition.

Nurses who care for small children or who help mothers with their difficulties need to know the importance of speak-

ing often to these children making sure that the child learns to associate words with every one of his activities. When the child begins to speak he should be encouraged by being given a quicker and more accurate response to his needs than if he has to try to make them known without speech. Children love to play with adults who sing nursery rhymes to them, help them to repeat verses, and tell stories which have striking repetitions of words. They insist that precisely the same words be used on every occasion and gradually begin to join in at appropriate points.

Among the children who do not learn to speak are, unfortunately, some who are deaf or partially deaf. Deafness is extraordinarily difficult to detect during the first two years of life. Often, failure to articulate is the first indication that all is not well. Deafness is a great handicap to development. Some children have been thought to be defective and were later discovered to be deaf. Hearing aids, where possible, and special help from speech therapists and special schools are necessary to help the child to develop with a minimum amount of difficulty.

Toilet Training

During the first year of life, elimination occurs automatically. Bowel action depends on the food the child is taking and on his general health. Sometimes, while the infant has chiefly milk, bowel action is so regular that observant mothers manage to prevent nappies being soiled. As soon as mixed feeding begins or whenever the infant is slightly unwell, bowel action becomes irregular. Toilet training is not possible until sphincter control is established and until the child is able at least to understand if not use language. The bladder empties by reflex action whenever it is full, and learning can only begin when the child can learn to recognize fullness of the bladder and 'communicate' before reflex emptying occurs.

Most people learn to control bowel and bladder at some time during childhood. The anxiety so many parents experience in their attempt to speed up control is quite irrational. Because parents believe that they should train their children in toilet habits as soon as possible, they show strong emotional reaction to the child's elimination. When the child is constipated, his mother becomes worried. She is pleased when the bowels function properly, yet upset when the child makes a mess or plays with fæces.

Very soon the infant realizes that it is in his power to influence his mother's reaction by his elimination. It is believed by some psychologists that the infant comes to regard his fæces as a product of his own which is his to give or retain as he pleases. However hard his mother may try to influence the child's natural functions, he cannot be forced to give up fæces or to conform to rules, and he may experience his first victory, his first awareness of independence, in relation to elimination.

Some mothers show disgust at the sight or smell of fæces and cause the child to have a feeling of guilt associated with bowel action. Some mothers who are able to be reasonable and objective about the problem do pot their children early with good results. When toilet training begins, the infant may fail to understand the mother's intentions. Sitting on a pot for long periods may be fun or may be a most unpleasant experience but may remain totally unconnected with micturition.

The child may not understand why his mother is sometimes pleased when he passes urine and at other times the reverse. The association between place and action of elimination can only be formed if it is possible to make the two events coincide. Generally, it has been found that children are clean soon after nappies are left off, because at that moment it becomes possible to catch the child in the act of elimination

and to sit him on the pot at once. It is easier to train a child in the summer months and much easier when he is able to talk.

Bedwetting often occurs for some time after training has been established in the daytime. This is partly due to the very long night, and it may help to pot the child late in the evening. Usually, the child wets at the moment of waking. When the child moves from cot to bed and is old enough to get out and reach the pot by himself he usually begins to have a dry bed and is proud of it.

There is no need to worry if a child is later than is usual in establishing toilet training. Psychologists believe too rigid toilet training to be positively harmful. Frequently the child reverts to enuresis later in childhood. It is also very possible that personality characteristics such as, stubbornness, meanness, rigidity in outlook may be derived from the attitudes acquired in relation to elimination.

Enuresis or encopresis may have organic causes, in which case a doctor should be consulted. Excessively deep sleep may prevent waking when the bladder is full. This may occur even in adults. Drugs to reduce depth of sleep are sometimes prescribed or other methods may be used to assist waking.

The Family

Close relationship between mother and infant is so important that we have mentioned the need of it in every chapter; later capacity to love, to experience deep and warm emotion depends on it. Only in the security of love is it possible to explore the environment and learn about the complexities of life. The mother's love and approval make it possible for the child to give up gratification of some wishes and to learn to adapt his behaviour to the demands made by society. The father enters the child's world in at least two different ways. The first experience may be of the father as a person who takes the mother away. The infant may feel

jealous of the attention his mother pays to his father and may resent his presence. Awareness of the existence of a group of three people may in later life affect the attitude adopted to other triangular situations. The way in which the child copes with his feelings of resentment and jealousy of his father may be very important in his sexual development. We shall discuss this more fully in a later chapter.

The father very soon becomes an important person in his own right. He may establish a rhythm for the child's day; bedtime, meals, play, story telling, outings may all be associated with the father's presence. The regularity of events with which he is associated may become a factor in providing security. The mother may feel that the father sees the child only in favourable circumstances. He is spared participation in the many frustrating conditions which make up the mother's day. She may feel that it is unfair that the child should feel only love and admiration for his father, while inevitably, feelings of hate are frequently aroused towards the mother who is responsible for maintaining order and establishing discipline.

Sometimes the mother may be tempted to lay the restrictions she places on the child at the father's door: 'Wait until your father comes home', or 'Don't make a noise; father is tired', may be her way of associating the father with the idea of authority and of retaining the child's love.

Many mothers find it difficult to understand how strong a child's emotions can be and how vigorously and promptly these emotions are expressed. A feeling of anger, resentment or hate is quite natural when the child is thwarted, and the stronger his love for his mother, the deeper the feeling of anger against her when frustration occurs. Feelings of hatred and anger are very frightening, but the child can be helped to learn to manage his emotions by his mother's understanding and acceptance. Awareness that his mother still loves him and

is still in command of the situation helps him to gain self-control and to lose the terror of his own temper. If the child is made to feel guilty, wicked and unloved, he cannot learn to control his feelings; instead, he learns to hide them. He may become docile and polite, but full emotional development may later become more difficult.

The father's frequent appearance, regular play, friendly interest help the child to tolerate periods of separation from his mother. It has often been noticed that the child is angry with his mother, but not with his father, after an enforced removal from home.

Younger brothers or sisters may sometimes be the next people to enter the child's world. If the infant is less than 18 months old, it is extremely difficult to prepare him for the event. If he is more than 3 years old, he can be helped to develop a sense of co-ownership and take an active part in preparation for the new arrival. Before the age of 3 years, the appearance of a new infant simply means separation from the mother and a feeling of being neglected and unloved because she devotes time to the little brother or sister. However clearly the mother may know that love is infinite and indivisible, the child believes that there must be less love to spare for himself if the new baby receives some of his mother's love. The child's resentment is shown in his behaviour both to his mother and to the new-born baby. At times, hostility to the newborn can entail physical danger, and the mother's protective attitude increases the infant's resentment against his mother. In order to regain her attention, the older child may become more babyish in his behaviour. He may again wet and soil his pants or bed, may suck his thumb, cry or whine, and generally behave like the younger child. Extra attention and care may quickly reassure him and help him to enjoy the companionship of his sibling. (This word is used to denote brothers and sisters.)

The emotional turmoil of the first few years of life finds expression in the stories which the child makes up for himself or to which he likes to listen. In his play, too, he gives vent to his feelings. The treatment meted out to a doll often gives an indication of the fate which the child would like his siblings or parents to suffer. He may solve some of his problems of family living by inventing 'dream companions' with whom he has lively discussions. He can escape from the harsh reality of his real family by creating a phantasy family of his own which he can order about to his own liking.

Play

In an earlier chapter, reference was made to the child's need to play. The infant plays with his fingers and toes, arms and legs, and thus gets to know about his own body. He plays with every object he handles and learns about the material world in which he lives. As he grows older he uses most of his energy in the active exploration of his environment. He grows in strength and develops neuromuscular co-ordination in the process of playing, climbing, jumping, gymnastics of all kinds, and all this is essential to his physical development and thoroughly enjoyable to him.

As he plays, he meets many new and strange situations. Whenever he feels unsafe or startled, he rushes back to his mother whose love and support provide the security he needs for his explorations. Children who lack love and security play much less vigorously and with less inventiveness and variety. The psychologist, Harlowe, has recently shown that the same holds true of monkeys. Only those monkeys who at least had a substitute mother in the form of Turkish towelling played freely. They rushed to the towel-mother and vigorously rubbed against it whenever they were startled by unexpected noises or movement. Monkeys reared without any substitute

for their mothers remained apathetic and inactive although surrounded by play material. It is clear that the basic needs are closely related to each other. The need to play, to be active and to satisfy curiosity depend on fulfilment of the need to be secure.

During play the child begins to discover not only the physical characteristics of his environment but also the feelings of the important people in his life. In his play and in his demand for stories, he tries to come to grips with emotional difficulties. The stories which he enjoys most at an early age are tales of good and bad characters, fairies and witches, bad people and good children, stories in which his growing ideas of moral values are clearly thought out and good always triumphs. The sameness of the stories, the rituals, the repetitive intonations all contribute to the child's security.

Ritual plays an important part in the child's life. There are fixed rules for almost every activity. Bath, meals, bedtime stories, dressing and undressing, tucking in and good-night kisses must all conform to the daily pattern. The child is learning the rules of life and needs a rigid framework in which to move.

At the same time, there is little difference between phantasy and reality. The child's play consists of animating the environment, surrounding himself with imaginary playmates with whom conversation is sustained. The adult world of material objects is still unknown. So when he calls an upturned chair a car or a boat, he is not pretending—this to him is absolutely real. Adult models of cars or boats may not even be recognized as such. As the child plays, ordinary objects which surround him, for instance boxes, cups, saucepans, garden tools and tins, provide him with endless material for amusement and learning. Water, sand, plasticine, and later paint and clay are essential play materials which permit expression of feeling, creative activity and satisfying sensations.

Not until the end of the third year is companionship with other children needed or appreciated. Before that, the toddler plays alone or alongside others, but there is no co-operative effort. During the fourth year of life, children begin to take notice of each other, respond to each other's needs, communicate with each other and begin to enjoy social intercourse.

Although the child's play is still very egocentric, mutual help is often given. Bigger projects can now be undertaken. Large objects can be moved or lifted by joint action, group activities, such as organized party-games, sing-songs and tug-of-war, are now enjoyed. The child is beginning to learn that it is necessary at times to give way to others. When there are several children in the family, early social experiences are provided at home. If there is no opportunity to play with other children at home, as in the case of an only child, and when no suitable playmates can be found in the neighbourhood, much benefit can be obtained from attendance at a nursery school.

Day nurseries and nursery schools have come under severe criticism in recent years. It was felt that young children needed their mother's continuous presence and should not be separated from her for long periods of the day. By the age of 3 or 4 years, however, the intelligent, active child needs the companionship of other children and thus to be provided with more outlet for his energies than he can be allowed in his home. By attending a nursery school for a few hours a day the child becomes used to being away from his mother for short periods and has the opportunity of using suitable play material which cannot always be provided in the house. He stays at the nursery school for much shorter hours than is necessary when real school starts, and he learns social adaptation before the more serious change to school life begins. Teachers in nursery schools function to some extent as mother substitutes. The child's attitude to this teacher pro-

vides a gradual transition to the later approach to school teachers.

Role-playing games become important. Children in turns take the part of mother, father, baby, of doctor, nurse and patient, or later on of teacher and child. Not only do they learn in this way to co-operate, to understand each other's point of view, to settle quarrels and differences of opinion, to fight and make peace, and generally live with each other, but they also begin to appreciate the feelings and experiences of adults. The child's desire for power finds an acceptable outlet; reversal of roles gives practice in learning to accept power in others.

Throughout life we ascribe to people certain roles we wish them to play in life and we have fairly well defined ideas of the kind of behaviour befitting each role. We think of policemen as powerful, just, incorruptible; of professors as brilliant, benevolent, absent-minded. Certain characteristics appear to be essential to each role, some are permissible but not essential, others are incompatible with it. Motherhood, for example, entails loving kindness and consideration towards children as an essential part of the role. Attitudes to father, grandparents, friends are less well defined. Neglect, cruelty, disinterest, prolonged absence are incompatible with the role of a mother. In role-playing games, children interpret and learn what is expected of a mother and other grown-up people. When they become the mother in the game, they behave towards the children in the way in which they understand a mother's role. The children, in the game, are bathed, fed, taken for walks, put to bed. They are also scolded and punished often in the most severe way. This is not an imitation of mother's behaviour towards them, but an attempt to understand the mother's anger and the punishment she gives. It is at the same time a way of accepting the mother's standards and making them the child's own, and a method by which the child learns to cope with feelings, to express his own fears

and anxieties and to become sensitive to other people's feelings. In the game, children are much more exacting, much stricter and more punitive than their parents ever are. The standards they set for each other are infinitely higher than their parents' standards and their wrath much more uncontrolled. In reversing roles, they learn how it feels to do things which usually are done to themselves and they change the actions in the game to make responses more and more realistic.

Mother and child games may become very detailed and complicated as the child becomes more and more familiar with the mother's real life: cooking, shopping, housework, concern for the father and for other children, the need for order and cleanliness, preparations for visiting—all these become part of the child's reality and are associated with the mother role. The fascination of dressing up is an important aspect of role-playing games. When the child wears different clothes, he feels that he is now a different person.

Other people who enter into role-playing games are never as well known as mother and children. Acquaintance with them is restricted to a particular situation. (Shopkeepers are only known to sell goods. What they do with the rest of their time never becomes known to the child.) In much the same way, fathers may only have the function of going out and coming back. What they do at work remains a mystery. They may be entitled to special privileges because they work, but their duties and responsibilities cannot be rehearsed in play.

If role-playing games are thought of as a preparation for life, it is easy to see that children's preparation for life may remain inadequate. Adulthood in games consists largely of the right to tell other people what to do and not oneself having to obey. Work consists of going out and coming back; parenthood, largely of privileges and only to a small extent of duties. Adults who enter into role-playing games can help considerably in preparing the child for the role he will be

expected to play. By adding detail and realism to the part played by the adults, one can help to prepare the child for the fact that growing up brings with it increased duties as well as increased scope. Role-playing games continue until well into school age. The parts played by each child become more complex and often more carefully scripted and rehearsed. They continue to take the child a little way ahead, and thus to prepare him for the next phase.

Before the child goes to school it is advisable to initiate 'school games'. Before admission to hospital, each aspect of hospital life could be played out so that the child enters a familiar routine and understands the part each person in hospital has to play. The hospital game may have to be played many times, in different ways, with the child acting patient, doctor, nurse, matron, visitor. Many likely events and attitudes are thoroughly understood and anticipated, and the child's fear and anxiety are recognized and conquered.

At school, role-playing games are used as a means for much factual learning. Games of shopping may involve valuable arithmetic lessons, for example. Knowledge gained in this way about people continues to make acting valuable, whatever other information may be involved. Even as adults, role-playing may be a useful device for preparing for forthcoming ordeals. Examinations become less terrifying as experience in taking them is gained and may well lose much of their terror when the candidate has acted as examiner to others. This is an activity which even student nurses would be well advised to carry out. Acting patient, during practical nursing procedures is invaluable in learning to anticipate the patients' reactions to the real thing. Playing at applying for jobs, being interviewed, interviewing and selecting others are generally practised techniques in the preparation for administration.

As the child grows older the characteristics of play change. Before the child goes to school it does not distinguish between

work and play. The small girl who dresses her doll, washes dolls' clothes, or helps her mother to bake a cake puts intense effort and concentration into what is play at the time but will soon become work. The child's absorption in a construction game, or in painting or woodwork is indistinguishable from later attitudes to work. Many lifelong interests have their origin in the enjoyable experiences of childhood play. When the child goes to school, play becomes a relaxation from work associated with the more serious aspects of life, purposive yet subject to fewer external rules and restrictions than work.

Real group-games now become important. At first these are usually such games as 'cops and robbers'; a few years later these are replaced by organized games such as football, cricket, hockey. In these games, the child learns the rudiments of rules and standards of the adult world. Piaget has shown that children have some difficulty at first in distinguishing between different types of rules. If they are shown how to play a game (in Piaget's example, a game of marbles), they accept the rules as absolute and become indignant at the suggestion that rules could be changed. Later when they play team-games at school, they can understand that the rules of the game are simply social agreements, convenient ways of arriving at co-operative effort and subject to change when all players agree. They understand the difference between 'social rules' and 'moral rules' which cannot be changed. Group-games are thought to be valuable in providing an opportunity for learning moral rules. Cheating at games, for example, is not allowed; 'playing the game' means competing in a friendly way; 'it is not cricket' means it is unfair. Children learn to lose without being upset, to admire achievement in others and to submerge their own interests in the interest of the team.

When children meet difficulties in their development, they often express this through play. An observant mother knows from the way her child treats her doll that she is hurt or

upset. Children's moods are often reflected in their painting. Pictures tend to be all dark and grey when all is not well at home; they are brilliantly coloured and full of sunshine when the painting is happy; sometimes very red when the child is angry. The fact that play expresses so well what the child may feel while words may not easily come to him, has led to play therapy as a form of treatment for severely disturbed children. Observation of a child at play with a doll's house may help to diagnose where the problems lie; for example, in the play the baby doll may be thrown out of the window or the mother doll may have pins stuck into her. The child's comments about his painting, or even the painting itself, may help to understand the problem. In the painting, for example, the family may be inside the house except for the child who is left outside—an indication, perhaps, of the child's loneliness and sense of exclusion from the family.

In play therapy, the child is encouraged to play freely in whatever way he likes provided, of course, that he is safe. The presence of a kind, helpful, accepting adult helps the child to feel safe, and as he acts out his problems he begins to understand them. He learns to vent his emotions freely, yet safely, in the playroom. Instead of hiding his anger about his baby sister, he can safely be angry in play and learn how to control his emotion in real life. In the play therapy room, he is free to play with material with which he may have wished to play earlier in life but was prevented. Water, dirt, mud may not have been allowed because of his mother's excessive desire for cleanliness. In play therapy, these materials are safe and permitted, and however childishly he uses them he need not fear any ridicule or criticism. Finger painting provides an exciting alternative to mud or dirt. The emotional release which accompanies play, and the improvement in the child after he has obtained satisfaction from play, show how basic a need is involved.

4. SCHOOL

In this country the child is thought to be ready for school at about the age of five years. In those countries where school begins at an older age than five years, attendance at nursery school is much more common than it is in England. On starting school the child enters an entirely new phase of development.

Learning facts and skills is only a very small part of the child's new life. Much the most important aspect of school life is the social learning which it provides. For many children this may be the first time they have been obliged to submit to discipline imposed by someone other than their parents or other members of the family. Authority suddenly becomes dissociated from those the child loves most, and often for the first time parents are seen to be subjected to the same kind of rules as the child. Many parents still retain their fear of and respect for teachers and readily convey this fact to their children. What the teacher says suddenly becomes much more important than what the mother says. There are times when small children find their dual loyalties to teacher and parents very confusing. Small children cannot understand half measures or compromise. To the child people are either good or bad, right or wrong. It is impossible to believe that the teacher may sometimes be right, the mother at other times. As the child begins to accept the teacher's authority he may become critical, defiant and badly behaved at home.

His account of what a teacher has said is not always accurate; nevertheless, his mother may believe what he says about the teacher, may blame the school for the child's deterioration in behaviour at home and may become resentful of the school. It may be difficult to discuss fully with the

teacher what the problems in the home are; parent-teacher contact may be rare and the parent's critical attitude to teachers may in turn result in hostility towards parents. When antagonism occurs between school and home it is created by the child who exploits the situation, enjoying the fact that parents and school feel possessive about his person. Yet lack of co-operation and understanding between home and school may leave the child bewildered, unable to settle down to work and may begin an ambivalent attitude to authority which may hamper adjustment throughout life. Parent-teacher associations can help to establish co-operation between home and school if the problems are clearly understood.

Parents, friends, aunts and uncles can help the child in the difficult stage of transition by taking an interest in all that he chooses to tell them about school without prying, criticizing or belittling. Many of the child's activities at school are never discussed at home. It is important to the child to have for the first time a life of his own about which his mother need not know everything. He enjoys sharing his experiences with his mother, but it makes him feel big and important to be able to keep something back.

Relationships with other children at school are very different from those of the nursery years. For the first time the child's work and performance are judged on their merits and compared with those of other children. The teacher's approval is related to good work or good behaviour. At home the child is loved simply because he happens to be the child of his parents. Love is not conditional on performance, however much love and approval may be associated with conformity to rules. At home the standards set for the child are not competitive. Allowances are made for age, for feeling unwell, tired or cross. At all times the child at home is in a very special position. At school he is merely one of a large number of children treated as equals by the teacher until they prove to be

otherwise. Experience of an independent figure of authority who treats all children in the same way is closely connected with appreciation of justice. Justice means that no exception is made of anyone, not even of oneself.

During the first years at school the child learns to form real friendships. Playmates before school age are rarely of the child's own choice. At school it becomes of utmost importance to make special friends. In the characteristic way of young children a 'best friend' is found who lasts a few days and then becomes a 'worst enemy'. Friendships at this early age are completely exclusive, guarded with jealousy and bought by special favours. The criterion for the choice of a friend varies rapidly; the best behaved may be chosen on one day, the naughtiest the next. Then may come the turn of the one with the nicest books or pencils, or the one who has talked about his home or his dog. Topics of conversation between friends are great secrets and the shared secret becomes the symbol of friendship.

These short-lived friendships form valuable experience for later more stable relationships. Because friends invite each other home, meet each other's parents, borrow each other's books or toys, the child's experience of the world expands beyond its own family circle. The other child's possessions may appear to be much more valuable and other children's parents much more exciting than the child's own. Sometimes parents reciprocate this feeling and may tend to think all other children are better behaved and much nicer than theirs. They have little idea how angelic their own offspring can be when away from home. Sometimes, of course, children who are well-behaved at home have difficulties in adjusting at school. Most people would consider it to be the proper function of school to teach basic subjects; such as, writing, reading and arithmetic. In fact this is only a small part of the school's purpose. Teachers would prefer not to feel that they were

teaching these subjects, but that these were learnt incidentally. The essence of modern methods of education is that opportunity and incentive for learning is provided at all stages, and that learning is an active process of the child rather than of the teacher.

The older outlook of impressing the child with the seriousness of learning led to a division in children's thoughts between work and play, between the unpleasant burden of learning and the carefree enjoyment of out-of-school activities. Modern schools maintain that learning is pleasurable, and that children are more than anxious to acquire knowledge if it is presented in an interesting way at the right time. There may be practical difficulties in presenting to all children at all times interesting information of just the right sort, especially if classes are too big. If the teacher is successful however, he may well help the child to seek knowledge and to enjoy work throughout life. Children vary in intelligence and in social maturity. Not all children are ready to learn the same things by the same method when they first enter school.

Later on it is an accepted practice to 'stream' classes in such a way that the children in the same form benefit from competition with each other. In the earliest years it is more common to encourage each child to work at his own rate and frequently at whatever subject interests him most. It may be more difficult for the teacher if each child in the class reads a different page in the book but more rewarding in the long run.

Small children cannot sit still for long, and learn best if they are allowed to be generally active. Reading and writing are learnt more easily if large cards are handled, sentences pinned up on the board, exhibits labelled, and words made with blocks and plastic letters, rather than by sitting still at a desk. The more practical use the child finds for the written word, the greater the interest. The child's movements are at

first big and bold. He can write on the blackboard, and only much later can he learn to write on paper. It is also easier to make vertical movements on a board than horizontal ones on paper. This is why walls prove irresistible for early writing practice.

The ability to understand and use numbers tends to develop rather later than understanding of written words. Although many children can count when they start school, few have any real concept of numbers. Small children can think of numbers only in sequence. They can count fingers or beads and add one at a time, but they cannot think of numbers as entities or configurations. In a practical way, by using money, giving change, serving in the school shop, counting out bottles of milk or giving out books, the child learns to use numbers without acquiring a fear of arithmetic.

The method of teaching which allows each child to progress at his own speed, to develop interests and to learn by doing rather than by sitting still is often referred to as the 'free activity method'. This term is often misunderstood by parents who think that their children are not taught anything at all, and also by those who confuse free activity with bad behaviour. Where free activity methods are used, behaviour, as a rule is no worse—if it is not better—than in a more formal classroom. Moving about, talking and handling equipment are approved of where free activity is the method of choice. These activities are natural to a child and can be suppressed only by methods which may create fear and are therefore not conducive to learning.

Discipline

Most children want to conform. They do not always know what is expected of them; they have to be told, or they may know but have forgotten. However, they only need to be reminded and will immediately correct their behaviour.

Sometimes it is great fun to be difficult, and to see just how far it is possible to go in order to establish a right to be contrary. All children play this game at some time; and in every class, with every teacher, it must be played at least once. This is a way of getting to know the teacher, leading to a very clear understanding of the teacher's personality. Each teacher has a reputation of sternness or lenience, of being just or erratic, of being bad-tempered or placid, which is the result of the manner in which he deals with those children who try him out. It does not much matter how soon he draws the limits or what methods he uses, his peculiarities will become known and the class will settle down to a particular pattern of accepted behaviour. When the class has settled down, however, bad behaviour must be taken seriously because it may be an indication of more deep-rooted trouble. Persistent bad behaviour may be the only way in which some children succeed in gaining recognition. They may be so discouraged, that they no longer try to do good work or to impress by their good behaviour. To be noticed at all they must be bad.

Some children may have failed to establish sufficiently satisfactory relationships with the teacher to want to please. Some may find that they can gain esteem among other children only by being a hero in taking punishment. When a child's behaviour is persistently out of step with the others, punishment cannot really help, and an attempt must be made to understand the underlying cause. This does not mean that punishment is necessarily wrong. It might be argued that good teachers do not need to resort to physical punishment, but their reprimand or other forms of punishment can be more hurtful than corporal punishment.

A growing awareness of right and wrong carries with it the belief that a choice can be made between the right and the wrong act. Freedom of choice to behave badly gives the wrongdoer the right to be punished. We punish only when

we think the child could have acted other than he did. If we do not think that he could have chosen any other action we absolve him from blame. A child who deliberately chooses to act wrongly may ask to be punished, and it may be necessary to respond to his demand. He may, in fact, feel guilty about something unknown to the teacher, and his subsequent naughtiness may be a device for getting punished for two things at once. Or he may be trying to confirm in his own mind his judgment about right or wrong. If, for example, he thinks he is doing the wrong thing by arriving late and yet nobody takes it seriously, he becomes confused about his own standards, and he has to try again until eventually he is punished.

Inconsistency by the teacher may lead to bad behaviour which could have been avoided without much punishment. Small children like to conform. They feel secure when there are firm limits to their behaviour. They enjoy the approval of the adult. Later they accept adult standards as their own, and self-discipline can be encouraged. Inconsistency in parents and teachers early in the child's life leads to confusion of standards.

Learning, Intelligence

Progress during school years depends among other factors on the child's intelligence and on his motivation for learning.

It is well known to teachers that in spite of all efforts children learn at different rates. The French psychologist Binet was one of the first to attempt to determine whether ability to learn is innate or whether methods of education can affect the child's progress. He tried to choose questions and tests which were, as far as possible, independent of the educational achievements of the children he tested. He selected tests for the youngest age groups in such a way that a child with normal physique and normal opportunities could not fail to learn the required response. Such skills as tying up

laces, copying a square, cutting paper, stringing beads according to a given pattern are among the test items. For older children there are pictures in which some essential part is missing, questions about the correct thing to do in common circumstances. For adults or very much older children some of the test items require the ability to read, but apart from this, educational achievement is not tested.

Items for the test were finally selected in such a manner that when 50 per cent. of the children of any given age successfully completed them they were considered to measure the normal intelligence of that age group. Children who only completed tests for a younger age group were considered to have the 'mental age' of a younger child. Those who succeeded in tests beyond their age had a higher mental than chronological age. The comparison of chronological and mental age, calculated in the following manner was called the intelligence quotient.

$$\frac{\text{Mental Age}}{\text{Chronological Age}} \times 100 = \text{Intelligence Quotient}$$

When mental age and chronological age are the same, the intelligence quotient is 100.

Since Binet's tests were first published many others have appeared; some are more accurate, some easier to administer, some more suitable for adults or for more intelligent people, but basically the principles of intelligence measurement are those which Binet devised.

Binet discovered among the children he tested that the relationship between mental age and chronological age remained fairly constant however often he tested the children; the intelligence quotient was apparently innate. We know now that different tests give somewhat different results. Apparently they do not all measure the same thing. Psychologists refer to the 'validity' of a test when trying to explain

what the tests really measure. We know that they measure something which is closely related to the ability to learn.

Spearman, an English psychologist, described intelligence as consisting of several factors, one which he called 'g' representing a general overall ability to learn. The others, grouped under 's', are specific factors, enabling people to learn one special subject, for example, music or geometry or languages more easily than other subjects. Tests differ in the extent to which they are able to measure 'g' or 's'.

Children with high intelligence usually have high 'g'; they are generally more able to profit from teaching and are good at most subjects. Contrary to popular belief, many intelligent children are good at school subjects as well as sports, arts, and practical subjects such as cooking and sewing. They may develop special interests or receive more encouragement in some of their activities than in others, but high intelligence would enable them to be more successful than less intelligent children in whatever subject they chose to study. Intelligence remains fairly constant throughout life. Good assessment even at a fairly early age could give a reasonable reliable indication of a child's chances at school.

There are, however, few reliable tests, and the administration of tests to small children is so difficult that most people feel doubtful about test results before the age of about 11 years. If the child is unwell or in a bad mood, results may underestimate the child's intelligence. Children develop very rapidly during the first few school years, there are sometimes sudden bursts of developing insight into the kind of problems which intelligence tests present. Increased interest in the child's progress at home and changes in home environment may increase test scores considerably over a period of one or two years; however, practice or coaching in the use of intelligence tests produces only a very small amount of improvement.

High scores in intelligence tests can almost certainly be accepted as a measurement of high ability. Low scores may underestimate the child. Fifty per cent. of all people have an intelligence quotient of or near 100 (see Fig. 1). Twenty-five per cent. are more intelligent, and twenty-five per cent. less intelligent. The top 5 to 10 per cent. are of outstanding ability, often referred to as 'genius'. The lowest 3 to 5 per cent. of all children have such low intelligence that they require special care throughout life. Binet's findings have influenced educational practice in most countries.

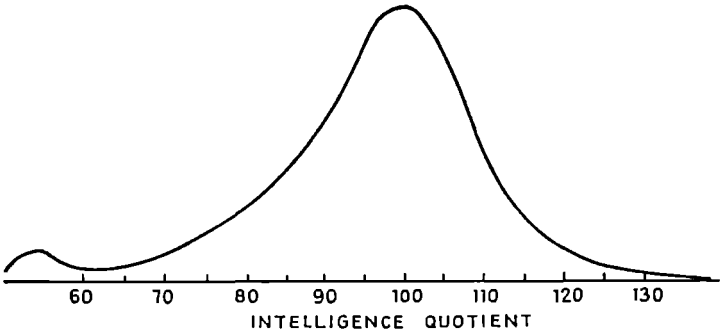


FIG. 1

In this country we believe that all children should be educated according to their ability. There are special schools or classes for those whose slowness in learning require special methods of teaching. Many people believe that the brightest, too, may need special schools if their interest in learning is to be maintained. There is some controversy about the education of the largest group of children whose intelligence deviates only a little from the average. If children in one class are evenly matched in intelligence, teaching is easiest; some authorities prefer to encourage children of varying ability to learn together.

In order to learn effectively there must be adequate motivation for learning. In infant schools and among university students the subjects are of such intrinsic interest that learning carries its own reward. The most powerful incentives are success and approval. Punishment, criticism, ridicule can act as incentives for only a very short time. Encouragement, praise, rewards and success stimulate learning indefinitely. Those who favour careful streaming in schools believe success comes more easily to children in such classes. It is bad for the child to remain constantly at the bottom of the class and to be doomed to failure in competition. Those who feel less favourable to streaming believe that each child's success should be measured in relation to its own previous performance, and that it is wrong to encourage children to compete with each other, that it is possible to teach children without encouraging competition. Controversy about selection reaches its climax at the time when children move from primary to secondary schools.

Grammar schools aim to prepare children for entry to the university. Subject matter taught in grammar schools is adjusted with this aim in mind. Rate of academic progress and teaching methods used make it essential that the 15 to 20 per cent. of the brightest children should be selected to benefit from the course of study. Secondary modern schools and technical schools are able to adapt their syllabus and teaching methods to the interest and ability of the pupils so that each pupil obtains the education best suited for him.

Some people, for one reason or another, favour comprehensive schools. Among those who use psychological arguments are those who believe that 11 years is too early for reliable selection, and that in some children sudden, rapid development occurs later than this age. Others believe that the social pattern in which children are taught should be the same irrespective of intelligence and academic progress. They

prefer not to rely on intelligence tests at any particular age, and to encourage all children to progress according to their ability and rate of maturation. In their view, children benefit from each other as much as from teachers. It may be that the former method is best for the brightest, the latter may be best for those near the average.

Whatever the form of selection for secondary schooling, it is essential that encouragement and optimism should prevail at both home and school, and that the child should steadily widen his interest, knowledge and skill in order that he may approach adulthood with confidence.

5. ADOLESCENCE

There is no precise definition of adolescence. Adults refer to adolescence as the age in which young people are no longer children but are not yet grown up. Children looking to the future do not contemplate adolescence, only adulthood. Adolescents may not recognize themselves as such, preferring to be known by some other term, such as 'teenager'. Growing up is a gradual process involving physical, intellectual, emotional and social growth. Development in these various ways does not always occur smoothly. Around the age of 14 intelligence reaches its maximum and physical development may be very advanced or, on the other hand, may be very much retarded. Emotional and social development are very incomplete.

The young person may find this period one of special difficulty, but there are many people whose secure early environment enables them to pass through adolescence without difficulty. The rapid development of intelligence may create conflicting situations between parent and child. The adolescent who is conscious of his intellectual superiority may at the same time become aware of the occasional faulty judgment of his elders. He has not yet gained the necessary experience of life to apply his intelligence well, nor the maturity to make allowances for the older generation. He suddenly realizes that his knowledge and power of reasoning are equal or superior to his parents' and becomes aware that parents, who hitherto had been thought of as paragons of perfection, can be fallible. The adolescent is still sufficiently childish to believe that if parents are wrong in one thing they must always be wrong; that if he himself is right in one thing, he is always right. This attitude of absolute self-confidence in

his own judgment is sometimes irritating to older people. When parents are in fact of lower intelligence than their children, or less well educated, they may strongly resent the intellectual superiority and the cocksure manner of their children; they may feel that their children are beyond their control. Adolescents delight in catching the older people out, and can be quite merciless to teachers or other adults once they have lost confidence in their judgment. On the other hand, they unreservedly admire those superior qualities which they most desire for themselves. Hero-worship is a characteristic of the adolescent stage.

Physical development is particularly erratic in adolescence. Sexual maturity may occur as early as 11 or 12 years, and as late as 16 to 17 years. Physical growth occurs suddenly and unevenly. Proportion of feet and hands to limbs or limbs to trunk, may change rapidly; facial growth may radically alter the appearance. The result is often seen in a physical awkwardness which makes life almost intolerably miserable. Unthinking adults may aggravate the situation by commenting on the adolescent's clumsiness, gawkiness or ungainly appearance. To a certain extent participation in sports can help to overcome physical awkwardness. Clothes become extremely important in making the adolescent feel comfortable. There is no greater humiliation than clothes which have become too tight or too short, or look too childish or too dowdy. Many adolescents, especially girls, feel so strongly about clothes that they prefer to leave school as soon as they can rather than wear school uniform, which they believe accentuates their physical disadvantages.

During adolescence, detachment from family ties occurs and independence is established. In the most favourable circumstances detachment from the home is gradual while interests widen, friendships are formed from among people of the same age, and adult models are found outside the family circle.

Frequently, however, the period of detachment from home is stormy and disturbed.

Adolescents who are still in the habit of making wild generalizations, of seeing issues in black and white, of wholehearted acceptance or rejection, may suddenly experience a most powerful rejection of all that their family stands for. They may go to opposite extremes from parental values in their views about religion, morals or their future careers. They may fight their battles with parents on these important issues or they may do so on relatively unimportant matters, such as clothes, tastes in interior decoration, methods of spending their leisure or opinions about music. Some adolescents find in religion the support they require. The search for absolute values, trust in God and the understanding of metaphysical concepts may be of immense value to them during this period of emotional insecurity. The ultimately accepted religious beliefs and ethical codes may not be those of the parents but rather those arrived at by the adolescent's own struggle for truth. Most adolescents gain support in their struggle for independence from others of their own age. The approval and admiration of members of their own age group becomes much more important than the approval of adults. Adolescents need to form groups and to belong wholeheartedly to them. At school there is evidence of gang formation and complete conformity to the standards of the gang is essential. The word 'gang' may not denote undesirable group formation, it expresses the peculiar adolescent way of forming rival units distinctive in dress, in speech or in some other outward sign in such a way that members of the gang can recognize each other instantly and also recognize members of rival groups.

Each member of the group accepts and adopts unquestioningly the mannerisms, opinions, habits of the other members. Unless conformity is absolute there is no way of indicating

loyalty to the group. Fashions in hair styles, in clothes, in popular songs and in spare time activities are created in this way by adolescents. The ethics of the gang are in marked contrast with the self-centred thinking of the small child. Whether the fashions are socially acceptable or not depends partly on the leadership and opportunities of the group, partly on the extent to which adults create antagonism in the adolescent.

Crazes about ballet, concerts and visits to art galleries are as much the manifestation of adolescent gregariousness as are dance halls and street corner gatherings. The latter tend to evoke more criticism from adults and thereby may become more obviously antisocial. Youth clubs may sometimes satisfy adolescent needs for recognition. Some social organizations, the Scout movement for example, deliberately attempt to satisfy the need for uniform and instant recognition of members who belong. Badges, rituals, sign language all make it easier to identify members of the group. Very often, however, young people feel dissatisfied with the organizations of the Scout kind because it is too formal. They like youth clubs organized by themselves, not for them. At the time of their greatest antagonism to adults, they cannot tolerate adult patronage.

The adolescent's position in society is very ill-defined. Parents and teachers expect adult behaviour and attitudes, yet they are unwilling to treat the adolescent as an equal. He resents being treated as a child, yet he finds comfort at times in behaving like one. If the adolescent is still at school, he feels inferior to those who until recently were his equals but who have entered the adult world of work and are earning money. Those who start working find that they are not really accepted as adults by the world in general. Youth, inexperience and lack of knowledge are constantly held against them in a reproachful manner. In some primitive societies, transition from childhood

to adulthood is made easier by definite prescribed 'initiation rites'. In our social structure, adolescents belong to neither adult nor childhood fraternity, and the path to adulthood has to be found by trial and error. It is difficult for children to have any clear conception of adulthood.

The fact that adults have duties and obligations as well as rights, is quite unknown even to adolescents. Their choice of work or careers may be based on completely unrealistic ideas and their first experiences of adult life very disappointing. Children and adolescents are not held entirely responsible for their actions. Adults are not only expected willingly to accept responsibility for their own actions, but sometimes, indeed, for the actions of others.

Emotional development as well as social development may reach an unstable point in adolescence. Children experience rapidly changing strong emotions and are able and allowed to express these freely and immediately in words or action. Adults can control the expression of emotions and experience lasting rather than rapidly changing ones. Children react rapidly to people and things, showing strong liking or disliking of people, and sometimes anger at objects which happen to be in their way. Adults differentiate in their emotional reaction to people—they love some very deeply but are emotionally unaffected by others. They may devote deep feeling to ideas, such as patriotism, pacificism, justice. Children need to be loved and adults need to give love.

The adolescent's emotions lie somewhere between childhood to adulthood. He feels deeply but often indiscriminately. He may not yet be able to control expression of feelings, yet, in trying to do so, may give the impression of being cold and hard. He is beginning to feel strongly about ideas but covers his feeling with bumptiousness or the appearance of being opinionated. He still needs to be loved but cannot

accept it without feeling selfconscious. He is beginning to give love, but not yet for the satisfaction of other people's needs, but rather because he obtains emotional satisfaction from giving. At this particular moment of emotional turmoil, the adolescent may become aware perhaps for the first time of sexual urges and desires. He may be unsure of the way to deal with his sexual feelings and unable to discuss them. In the next pages we shall refer again to sexual development, and to the help which may be needed in the form of sex education. Sexual feelings are mentioned here only as yet another difficulty in the adolescent's experience of life.

With so many problems reaching their climax in adolescence, it is surprising how successfully most children pass on to adulthood. Recognition by adults of all that is good and positive in young people contributes perhaps more than anything else to the self-confidence necessary in adolescence.

Sexual Development

During adolescence, physical development reaches its maturity. Changes in glandular functions, in physique, voice and facial expression, may increase the adolescent's self-consciousness and emotional turmoil. With the awareness of bodily readiness, the adolescent may experience sexual urges and emotional changes which may be frightening and profoundly disturbing. The climax of sexual development is reached later, in adulthood, when bodily maturation is accompanied by the ability to love and to choose a partner with whom a permanent relationship of marriage and the foundation of family life is wholly satisfactory. Adult sexuality consists not only of the unique relationship between one man and one woman which makes intercourse a profoundly satisfying experience to both, but also consists of being able to love the partner to the exclusion of all others. To enter

into a permanently binding relationship entails a complete reorientation of attitudes, interest and social adjustment, changes which make it possible later to enter into parenthood and to give children the love and affection they need. Physical relationship without an accompanying emotional development cannot be considered complete. It is very likely that sexual urges and sexual behaviour do not suddenly manifest themselves in adolescents, but that adolescent and adult sexual behaviour are stages of a gradual development which begins at birth.

For a long period during the early school years, the child is entirely engaged in social learning. Not until he reaches early adolescence is his interest in his body reawakened. The young adolescent has sufficient factual knowledge to associate his genital organ with sex, he is aware of his bodily tensions and recognizes them as being sexual. He may have developed sufficient inhibitions to make it difficult for him to obtain sexual information from his parents or to discuss sexual problems with them. This becomes even more marked at the next phase, when emotionally he becomes interested in people of his own sex. This homosexual phase in development is normal and needs to be understood as such by the adolescent, so that he can see it as a temporary phase leading to adult heterosexual interest.

Quite suddenly, the adolescent may become interested in the opposite sex. For a long period boys and girls consider each other to be stupid and friendships, therefore, are made almost entirely with their own sex. At that stage there is little concern for appearance. Those, for instance, who are interested in clothes or cosmetics are ridiculed. Suddenly interest in the other sex is aroused or rather the adolescent seeks to awaken interest in the opposite sex. Emotionally the need is still to be loved and noticed, rather than to give love. Girls begin to take care of their clothes, hair and personal

hygiene, become interested in fashion and seek advice about beauty in women's magazines. Boys smarten up in appearance and both sexes give up childhood's games and interests.

This phase strikes adults as awakening of sexual urges. In fact it should be seen to be only one phase, though at times it may be a particularly stormy one. The adolescent is still groping for standards of beauty and moral behaviour. He is conscious of his looks but does not know whether his looks appeal to the opposite sex. Attempts at choosing clothes, at using cosmetics, at selecting jewellery often meet with derision from adults instead of evoking encouragement and offers of help. The result often is that parental standards are deliberately rejected, and that adolescents find each other attractive because of the obvious effort each makes despite the fact that there may be little that could be called æsthetic success.

Adolescents usually want to do the right and proper thing, but they find it difficult to discover what is right. They give up playing childish games and pursuing childish interests because these seem obviously out of place, yet they have nothing to substitute so they spend hours doing nothing at all. Adults are bored and irritated by this refusal to develop interests, and it gives rise to friction in the home and to deterioration in school work, sometimes at the age at which effort at school may be most desirable. Many people are worried about the apparent waste of time which occurs during the last year in secondary modern schools, but forget the need for a period during which boys and girls may discover what is likely to be expected of them when they have grown up.

General interest in the opposite sex usually gives way to a specific interest in one person of the opposite sex. While there is general interest, mixed social gatherings in dance halls, clubs or coffee bars are attended and enjoyed. Couple formation disrupts social gatherings. The two concerned are

interested only in each other, so they usually leave the group and find enjoyment where they can be alone. Most youth clubs suffer constant depletion from among their senior and more reliable members, and because of this come to rely on adult leadership. There may be many rapid changes in the attraction felt towards a person of the opposite sex, for dating and flirtations are necessary experiences before the right person for marriage can be found. At this stage, the adolescent is learning to give love as well as to receive it. It may be given profusely and gushingly and often may be unacceptable to the other. At this stage, the emotion of love often overflows and embraces society as a whole. There is an overwhelming desire to do good, to be of service, to care for others.

By the time sexually mature relationship is possible, love is given to satisfy the needs of others rather than purely selfish needs. Interests become adapted to those of others, opinions change in accordance with others and activities cease to be self-centred.

Adult sexual and emotional relationships are completely satisfying. Some people believe that this is so to such an extent that there is little energy left for activities of social usefulness. They believe that wholehearted devotion to the arts, or science or business, or the care of other people's children is possible only as a substitute for sexual satisfaction. The term 'sublimation' is used to describe this feeling for some cause which is entirely satisfying and not consciously connected with sexual satisfaction.

Many people, however, if they fail to find sexual satisfaction, retain a longing which they are unable to admit even to themselves and which leaves them angry and dissatisfied. In order to lead a full normal life, each stage of development must give rise to satisfaction. This does not mean that people should be encouraged to give way to all sexual urges and impulses. It means that in the early stages, the child's need for

love and food must be satisfied. Later he must learn to recognize his feelings and deal with them consciously. If guilt feelings are associated with sexual thoughts, this makes it impossible to talk about and control difficulties. Instruction in sexual development is essential in order to avoid the confusion in standards which results from guilt feelings and secrecy. Most parents believe that the best way of teaching their children about sex is simply to answer all questions frankly and simply when they arise. It must be remembered, however, that children's questions may not fully reflect their misconceptions, and they may ask questions so badly that the parents' answer becomes irrelevant. Even simple answers can be very bewildering. Many young people reach adolescence without full knowledge of biological facts, or secretly afraid that they are not fully informed. Many moral problems may trouble the adolescent, and he needs an opportunity for full and free discussion of sexual matters.

Parents inevitably have anxious moments and thoughts about the sexual problems of their children. The solution of this dilemma does not consist of warnings against possible dangers before the true significance of sex is understood, but by building up over the years a relationship of confidence, trust and understanding. Frankness is essential but tact and understanding are also necessary. Sometimes it is better for a person outside the family to advise the adolescent on such matters. Emotional reactions may be quite strong even in families which pride themselves on their open frankness on most topics.

6. MATURITY

In childhood and adolescence there is a looking forward to adulthood. Yet when this is reached it may still be felt that something is lacking. The sense of satisfaction, of completeness which for so long has been anticipated is not experienced, and there remains a feeling that there must be some way in which the purpose of human maturity can be more adequately fulfilled. 'Maturity' is spoken of as being the highest aim. Because most people aim higher than their current achievement, maturity is elusive, always to be aimed at, never to be reached. The more mature an individual's behaviour is, the more he is likely to be aware of those qualities within himself which are still undeveloped, and often doubt is expressed as to whether anyone can ever be said to be mature, or whether any definition is entirely adequate.

It may be easier to speak of 'integration' of personality rather than of maturity, because the concept of 'maturing', which means 'ripening', implies that an optional stage may be reached and that later a decline sets in. This is true of 'intelligence' which reaches optimal values in adolescence and declines from the middle thirties onwards. Integration of the various aspects of personality, however, may continue throughout life.

Since it is difficult to describe a mature person, it may be helpful to consider trends in development which lead towards desirable stages of adulthood and to examine the ideals which should be kept in mind when maturity is sought. The most important changes which take place during growth lie in the range of emotional experiences and the manner in which emotions find expression. Infants react to a very small number of stimuli; adults, to a very large number. Infants have a very

limited selection of emotional responses; adults, a large range of emotions. Infants react with immediate response; adults can delay and control emotional expression.

In childhood, emotion is aroused equally by objects, people and events. As the individual gets older, emotional response is increasingly evoked by abstract concepts and ideas. Infants and small children react irresponsibly; adults take responsibility not only for their own actions but, indeed, for those of their subordinates.

Emotional maturity, then, entails ability to withhold or delay emotional responses and to display and express emotion in a socially accepted manner. Temper tantrums, for example, are disapproved of in most societies, but grief or pleasure may be freely displayed in some cultures. Some English circles, however, evidence, by reason of training, a minimum of emotional display. It is, however, necessary to retain the ability to feel emotions deeply, strongly and lastingly. To do this people must learn to recognize their emotions and not to deny that they exist. While it is wise to help children to control their behaviour, it is dangerous to make them feel guilty about their feelings. If the strength of a child's emotion becomes too frightening, the child grows up as if he had never had the emotional experience, and emotion becomes unconscious and inaccessible. Many adults are motivated in their behaviour by emotions which properly belong to childhood, but which have never been adequately dealt with because they were too rapidly pushed into unconsciousness. It is a part of maturity to recognize that actions are not always entirely rational. Since a large area of personality is unconscious, much of what appears to be well-reasoned behaviour results from unconscious motivation.

The object of emotion changes during the maturing process. Inanimate things no longer arouse feelings; instead, the individual feels strongly about people. In childhood, the

mother, later the father, and then relatives and friends matter a great deal. There is a great need to be loved. All emotion is self-centred. All new knowledge is evaluated according to the child's own feelings about it. People are seen as good or bad according to the way they impinge on his emotions.

The adolescent is still preoccupied with his own feelings and is critical of others because they do not sufficiently satisfy his emotional needs. However, he experiences a change from the need to be loved by his parents to a need for acceptance by a community of peers. The feeling of belonging to a group becomes most important, and with this develops the ability to assess how others feel, what others expect, what pleases them, and to assess to some extent how others will react to his own behaviour.

During adolescence the need develops to give rather than to receive. At first this is all embracing. The adolescent feels strongly for all the members of his group. He obtains satisfaction from giving, and searches for people on whom he can bestow his love. Children, animals, helpless people, become the object of his emotional bounty. Soon he becomes more selective and seeks reciprocity for his emotion until, in marriage, there is complete satisfaction in the love given to and received from his partner.

Parenthood entails a change in emotion towards an entirely altruistic attitude of giving. Mothers who are possessive love their children because they need to be loved in return, and because they derive satisfaction from being able to give. Completely mature motherhood would make it possible to give all the love the child needs without taking anything in return, and for the child's sake entirely, not for the mother's own satisfaction. It is difficult to say whether this completely unselfish love is ever possible. Whenever the question arises whether an unloved or orphaned child should be adopted or placed in a foster home, effort must be made to find out how

far the prospective mother is able to satisfy a child's needs and to what extent her desire to take in a child results from her own need to be loved by a child. There is a great danger that children who were deprived of love early in life may take a long time before they can respond to mothering. If the motive for taking in the child is not entirely altruistic, the mother, disappointed by a lack of response from the child, may reject him, regret her decision and blame the child for the failure.

In mature years it is possible to widen the scope for emotion and to feel strongly about ideas and causes as well as about people. The psychologist Shand called this 'sentiment' and spoke, for example, of the sentiment of 'patriotism' or of 'pacificism'. A sentiment comprises all the emotions which may be felt in relation to a particular idea. Patriotism, for example, evokes pleasurable feelings when the patriotic country does well in competition; fear, if it is threatened; anger, if it is attacked. Perhaps the most mature people have the greatest number of sentiments, and the widest fields of interest. They have formed sentiments attached to more abstract ideas. This concern for events beyond the individual's own experience might be called a philosophy of life. The ability to become interested in people and ideas far removed from daily experience is closely related to one other aspect of maturity; namely, integration in society.

In our particular society, adults have formed a fairly characteristic pattern of social grouping around themselves. They have a very close emotional bond with one other person, a bond different from any other relationship in its intensity and in the extent to which it is reciprocated. The relationship between husband and wife, or between mother and baby are examples. A little further removed but still very close is a circle of a small number of people very important to one another; for example, the rest of the family and a set of close

friends where the relationships are mutually reciprocated. Any disaster occurring to any person in the circle would greatly affect every other person in it.

This circle is formed during childhood, adolescence and early adulthood and does not change much after that. As people grow older it becomes progressively more difficult to admit new people into this very close relationship and, of course, the loneliness of old age results from the gradual thinning out of this circle. Within it, emotional bonds are so strong that they survive differences of opinions and separation in space and time.

A little further distant is a more populated circle of good friends, workmates and well-liked relations. These are people about whose welfare the individual still cares very much but whose disappearance causes him less concern, and whose own constellation of friends does not include many of his own. Behaviour towards this group of people is governed by social convention and learnt with difficulty during childhood. We can all think of examples of children's failure to distinguish the appropriate behaviour towards friends of their parents or even towards total strangers.

Apart from these closer relationships there are many people with whom the individual has some kind of social contact in a more and more distant way: the people with whom correspondence is maintained, people with whom Christmas cards are exchanged, people met on the way to work, tradesmen, bus conductors. Adults know how to behave towards all these people but think about them only during actual social contact. There is no reciprocity in relationship. The relationship between customer and salesman, for example, is totally different for each of the two people involved. Opportunities for forming friendships and making acquaintances vary in different social strata.

Maturity can to some extent be measured by the extent to

which a person cares about the people in the distant circles of his social field and by finding out how far his social field extends. Children do not care about anyone they do not know personally. Adults begin to care about people in their street, or village, or club, even if they do not know them personally. An accident, or a case of cruelty to children, or poverty matters if it has happened to a friend. As maturity is reached such occurrences still matter even if they happen in some other part of the country or even in a foreign land. The sense of personal involvement in all that happens to human beings anywhere is again an expression of a philosophy of life.

One other aspect of maturity will receive only brief mention in this chapter, as it is more fully dealt with later. This is the mature person's attitude to work.

Late in adolescence or early in adulthood, a decision is made about work or choice of career. The way people decide on the work they wish to do is usually complex. Family influence, teachers' opinions, the glamour of propaganda talk, all enter into the choice of work but rarely succeed in the long run in deciding what is to be the individual's working life. Most people find it difficult to state what caused them to make their choice. The truth is that many factors enter into it, most of them unconscious.

Work is a contribution towards the well-being of society. Most people find it necessary to work because only in that way can they justify their existence. Many people say they work only for money, but in fact to be out of work even if there is no shortage of money is extremely demoralizing. Disabled people, old people, and those without work during slumps have expressed their feeling of uselessness and of their loss of self-respect during periods of idleness. Some people gain satisfaction from being useful to their family, rather than from a contribution to society in general. Women often gain sufficient satisfaction from their usefulness to husband and

children, and feel that they do not need other work. Their work, however, is carried out in the home, and may be all the more rewarding for being unpaid. The extent to which the work is seen to be useful gives it a certain amount of prestige. Many people gain satisfaction from their work because of the status it confers upon them. Anyone who feels that his work lacks prestige, must either change the work or convince others of the importance of what one is doing.

The mature person may be one who has found satisfaction in his work and whose personal plans and ambitions have either found fulfilment or been submerged in a concern for the general well-being of the community. He is looking forward and backward at the same time, plans for the future are related to past achievements. Plans for the future are realistic, and the ambitions and ideas of others are taken into account.

7. OLD AGE

Just as it is difficult to define adolescence and maturity, so also old age defies definition.

To children, parents in the thirties appear old; grandparents, ancient. As the years advance, old age recedes, and some people of 70 and 80 years do not consider themselves old at all. Maturity in social and emotional development may not occur until late in life, and by that time the body may begin to lose its efficiency and intelligence may be declining. Damage to the brain tissue, owing to lack of oxygen, brain injury or infection may cause premature and exaggerated manifestations of ageing which are in no way characteristic of the ageing process of normal people.

Most people feel that they are getting old when they are physically unable to do all the things which they still feel inclined to do. With advancing years breathlessness supervenes more easily, tiredness may be felt in the middle of the day. The older woman finds increasing difficulty in carrying out the chores at home in a reasonable time. This is often upsetting to her husband who may have retired but finds the house less relaxing than he had anticipated.

Gradually eyesight and possibly hearing become less acute. It is easier to become aware of failing eyesight. Often the onset of deafness is not perceived and many old people complain of other people's lack of consideration in not speaking clearly, not realizing that the fault lies in their own deafness. It is even possible for them to become suspicious when people are laughing, and to create hostility in others by their inability to hear. The suggestion that hearing aids might be used is often vigorously rejected, partly because the realization of a disability is too painful, partly because old people are embarrassed

by wearing these aids and also, after trying to use one, by the very strange noises they experience. When we hear well we succeed in picking out voices and speech from the general background noise and ignore the rest. As deafness advances, more and more noises become inaudible. Hearing aids magnify all sounds, and after a period of silence, the irrelevant noises may become unbearable.

With increasing age the daily activities of washing, combing hair, pulling on stockings, become more and more strenuous. These activities, which during adult life are habitual and therefore accomplished without thought, become important activities occupying conscious thought.

It may become more difficult to remember what is happening although gross memory defect for recent events occurs only in the dementia of old age. However, the elderly person finds it more difficult to attend to too many things at the same time and consequently fails to take in some information which may later be required, appearing then to have forgotten the information, but in reality never having grasped it. It happens often, on the other hand, that the apparent forgetfulness of the aged in fact represents refusal to accept information, especially if it is not in accordance with accepted ideas.

Some old people tend to think of everyone younger than themselves as children, just as children consider everyone to be old. This attitude of old people results in a certain amount of selfishness, condescension, and what may appear to be interference in the life of younger people. In homes where grandparents, parents and children live together, relations are sometimes strained by the fact that the grandparents treat the parents as if they were children.

On the other hand, old people and young children usually get on extremely well, as their relationship is quite natural, uncritical and accepting. Parents often feel that grandparents spoil small children, but there is no reason to believe that the

genuine love and understanding which passes between alternate generations is in any way harmful.

Old people's habits are fairly well fixed, an asset at the time when conscious efforts become difficult. Interference by younger people is quite understandably resented. The problems which must be resolved by the aged are related to their increasing loneliness as their contemporaries die, one by one, to the realization that they must retire from work and accept the fact that they are no longer needed, and to the need to think about death, and to come to terms with this thought.

We live in an adult centred society which thinks most highly of the productive section of the community. The purpose of childhood is to get over it as fast as possible, and we talk of the problem of 'old age' as if old people served no purpose and were merely a burden.

This is not the case in all societies. There are people who consider childhood of supreme value, the function of adults primarily to support the young. In some Eastern societies old age is the period of life most cherished and esteemed and the time looked forward to throughout life.

If we are to solve our problem of old age, we must try to stop looking at people as valuable only as long as they can work, and put greater value on the fund of knowledge and experience old people have to offer.

The personal loneliness of the very old cannot be avoided, but the feelings of isolation can be overcome by widening as early as possible the circle of friends and acquaintances, and by developing as soon as it can be done a sense of responsibility for the welfare of others. There is ample scope in voluntary work in local government or other local organizations for those who are still interested in others and free from personal obligations.

Retirement can be very traumatic, especially if too many

years have been spent in the same job and too much interest has been given to work, to the exclusion of outside interests.

The problem of when to retire is often discussed. Some people believe that work should be continued as long as possible. This may, however, lead to many difficulties, including not only the uncomfortable awareness of blocking promotion for younger, perhaps abler people. Old people's methods cannot be readily changed and although their own work may still reach a very high standard, their rigidity may have adverse effects on the efficiency and morale of the people with whom they are working. If retirement is left entirely to the decision of the individual he may reach a stage at which he is no longer capable of recognizing his limitations. Most damaging, however, is the fact that late retirement makes it impossible to take up new interests, and a good deal is to be said for early compulsory retirement at a time when the individual is still young enough to start making new friends and taking up new ideas.

In preparing for old age it seems wise to have so many interests and friends that life is still full even when some activities have to be given up. Much is being done by education authorities, and much more could be done to encourage hobby activities for older people. Too many are restricted to gardening and knitting for their hobbies. Sewing and craft classes, cookery classes, are held for older people in some areas. Townswomen's Guilds and social clubs for the aged often provide valuable meeting grounds and interesting activities, but encouragement and participation by younger people is necessary to ensure success. Some recent housing developments make it possible for the aged to live near their families, as used to be the case in older communities. Frequent visits from the 'extended family', that is grandchildren, nieces and nephews, sons-in-law and daughters-in-law, help to keep the aged interested in the events of the time.

There is now greater recognition of the ability and willingness of some older people to continue working. Many firms now reserve some jobs especially for older employees whom they find reliable and conscientious and often very methodical workers. Some employers arrange for shorter working hours and sheltered working conditions. It is difficult for some older people to accept positions of less responsibility with lower status and pay than those to which they have been accustomed. Many, however, make an excellent adjustment and are glad to postpone complete retirement.

Old age is the time when there is an increasing tendency to look backward and to be aware that the future is short. Planning ahead is normally the most exciting and most stimulating part of life. Planning a holiday, planning work, planning a visit to friends are important considerations to most people. When we are very young, plans for the future are vague and unrealistic because the future appears infinitely long. Later in adulthood, planning is realistic and down to earth. There are short-term and long-term plans, plans concerning the individual's own future, plans for others, or for the development of the daily sphere of action. Only on rare occasions in adult life may it suddenly be realized that these plans may not come to fruition. When a young friend dies at the height of his powers, or when a dangerous venture is about to be undertaken, for example an operation or a flight, the healthy adult suddenly thinks of death. But this is momentary and does not interfere with any long-term plans.

In old age there is an awareness that death may take place before plans can be fulfilled. Consequently less thought is given to the future and there is a great tendency to live in the present and in the past. Life becomes somewhat disorganized if there is too much concentration on the present. Houses are not redecorated or gardens replanted, new clothes are not bought or holidays arranged by those who believe they may not live

to enjoy the results. The house, garden and clothes become shabby, and the old person becomes more and more detached and isolated from others and finally loses any sense of purpose and self-regard. It is the duty of the younger people to include the older generation in their plans. Talking of the future, though not of the very distant future, is a great help. It may be useful to help the old person to realize how much there is still to be done, how much to be enjoyed and that it should all be done soon.

If the younger people show by their attitude that they are confident of the older person's future, active old age becomes possible. Inevitably, however, the time must come when the older person thinks of death and must accept the fact that the future is limited—at any rate on this earth. To many people the thought of unlimited life after death and their general religious beliefs are of an importance which cannot be stressed too much.

The thought of dying is often more uncomfortable to the young than the old; often, therefore, the old person's attempt to discuss death is pushed aside, even ridiculed. It is not helpful to deny the possibility of death or to deprive the old person of the opportunity of talking of it. Old people die more contentedly if all is in order: if a will has been made, if they can be certain that their property will be well disposed of, that their family is provided for, that all arrangements are made for the burial. To discuss these matters freely and openly need not imply that death is imminent, or that the younger one wishes the old person dead. On the contrary, guilt feelings about these wishes often prevent younger people from discussing death.

By the time old age has arrived, the prospect of completing life is not usually terrifying. It is made easier if the younger people succeed in conveying to the old their admiration of their past achievement and a determination to carry on where the old people have left off.

8. ATTITUDE TO SICKNESS

To most people, illness comes as an unwelcome intrusion. It is a nuisance, an obstacle in the pursuance of some aim in life.

Some people, however, regard illness as a challenge. Their efforts to overcome illness and weakness may lead to greater achievements than would otherwise have been possible. The term 'compensation' is sometimes used to indicate the mechanism of overcoming a weakness. Some patients exercise weak muscles until they become stronger than they would ever have been without the illness. Others, realizing that perhaps the leg muscles are weak and will never be able to achieve great strength, exercise shoulders and arms, learn to move skilfully by using new sets of muscles, and to excel in sports and games where the arms can be used, such as archery or draughts. Some people use their period of illness for study and reading, develop new interests and gain in education. Suffering helps many people to find a new faith in religion, to discover their purpose in life. Illness can be turned into an asset, helping the development of most desirable characteristics.

Many people's attitude to illness is much less constructive, and many nursing problems arise because sick people often behave not as adults but as if they were much younger. Sickness represents to them a 'stress situation'. Under stress people often revert to earlier patterns of behaviour, they 'regress'. This chapter is concerned mainly with those attitudes to sickness which are determined by childhood memories, by irrational fears and by unexpressed anger. Sickness often causes changes in behaviour which are quite irrational. The patient cannot help himself because he is reacting unconsciously, and some of his troubles lie in the past rather than in the current illness.

In previous chapters we have described the stages through which people must pass in their endeavour to develop a normal, healthy, mature personality. In describing 'norms of behaviour' for each age group, we have simply stated how most people behave, without giving much thought to how they 'ought' to behave. In sickness patients may revert to earlier forms of behaviour.

In our modern age attitudes to sickness have largely been modified and are to a much lesser extent than formerly coloured by disgust and rejection. Some illnesses, however, still bear a stigma. People suffering from mental disorders, from epilepsy, from tuberculosis or from venereal diseases are still occasionally treated as outcasts of society. There are many people who attach value judgments to the concept of health. Physical and mental health are looked upon as good, desirable and praiseworthy. Ill health is often looked upon as punishment. In many cultures it is regarded as shameful and wicked. Any judgment which influences behaviour, looking upon illness as if it were blameworthy, results in behaviour appropriate to being punished.

It is certainly not at all uncommon for people to adopt this attitude of guilt and shame towards their own suffering,* so much so that they find it impossible to discuss the illness, even with a doctor or nurse. Anyone who thinks badly of himself tends to believe that other people share this attitude. Some people reach the conclusion that everybody shuns them, everybody looks at them with disgust, suspicion or disapproval. In the extreme form, this attitude is found among those mentally ill who believe that they 'smell', that they are 'covered with germs', or that they emit harmful rays. These patients, consequently, cut themselves off from society believ-

* It is interesting to remember that our word pain probably comes from the Greek *Poine* which means penalty.

ing themselves to be unwanted and a danger to others. In less extreme forms, this attitude is very frequently found among all types and classes of men and women. The general practitioner is particularly aware of the fact that some patients are reluctant to come to him and often delay seeking advice until the condition has deteriorated. They attempt to deny their illness because they feel it is unacceptable.

Health visitors meet people who simply will not accept care or advice because they cannot admit to being ill. It is strange that certain illnesses are much more frequently hidden or hushed up than others, because the feeling of guilt is more marked. Sometimes the guilt feeling is almost rational and associated with the belief that the illness could have been prevented. Tuberculosis, for example, is often believed to be the result of unhealthy living, irregular hours, scanty food, all of which might have been prevented with proper care. Scabies or infestation is often considered to be the result of dirt, and although infestation can occur in spite of all hygienic precautions, patients feel guilty.

The attitude to venereal disease shows how much our moral judgment is tied up with attitude to illness. Here it is partially rational; on the other hand, when women refuse to consult a doctor about a lump in the breast, a vaginal discharge, or pruritus vulvæ, the connection between sex and illness becomes less rational and the feeling of guilt more disturbing. The fear and shame about mental disorder show irrational attitudes in their most highly developed form. Because early diagnosis and treatment are important, the patient's feeling of guilt and shame must be taken into account by those who meet people in the early stages of their illness. Nurses working in the community have much opportunity of eradicating these harmful attitudes among the general public, among the prospective patients whom they meet in clinics and homes, and particularly among their own colleagues.

Often there is a belief that illness is a punishment for some misdeed. Some patients who feel guilty look upon the illness as a punishment they deserve; others feel that they are unjustly treated or wonder what they have done to deserve suffering.

The idea of illness being a form of punishment is very frequently expressed in words, either by patients themselves, or by anxious relatives who keep assuring themselves and the nurses of the injustice which is being visited upon the patient. The idea that illness is punishment for bad behaviour is found quite naturally in the small child. A mother may, for instance, repeatedly tell the child not to get his feet wet. On one occasion she says, 'If you step into the puddle I'll smack you'; on another occasion, 'If you step into the puddle you'll catch a cold'. What more natural than that catching cold and being smacked are regarded as alternative forms of punishment? In fact, some illnesses are the natural consequences of foolish actions and the parental threat may be good health education. Some deficiency diseases, for example, may follow inadequate food intake, road accidents may follow careless driving.

Unfortunately, there is a tendency to regard any illness as punishment even when it is unavoidable and in no way attributable to individual negligence or wickedness. One way of helping the patient to overcome these feelings is to encourage free conversation about the subject, dealing with it in a factual way. The nurse's accepting, unemotional attitude to the discussion of illness and her acceptance and understanding of the patient's feelings will do much to reassure him.

When patients or relatives adopt the attitude that the illness must be regarded as punishment and seek to find the guilt for which the punishment has fallen upon them, they adopt an outlook which is not conducive to recovery and which the nurse should learn to recognize and understand. Patients who

look at illness as a form of punishment react to it in much the same manner as most people usually react to being punished. Some patients are resentful, angry, rebellious; others are submissive, apologetic, passive.

If the patient regards his illness as punishment, he may easily begin to look for someone responsible for his suffering. Some patients turn to God and derive comfort from experiencing God's special interest. Some patients associate the people concerned with the illness with the idea of punishment. They see the ward sister, or matron, the nurse carrying out treatment, or the doctor, as people to be feared and respected. Often the attitude of submission to hospital staff is quite unrealistic. Some of the rules which patients talk about do not really exist: for instance fear of the ward sister, which is so often expressed by patients and visitors, has nothing to do with the sister's real personality. Some treatments are more commonly associated with the idea of punishment than others. Surgery, injections, tube feeding, enemata and tests involving electricity, such as electrocardiograms, often give rise to phantasies of punishment with all the appropriate reactions of fear and submission or resentment. Any treatment which renders the patient helpless, for example, by immobilization of limbs or by causing unconsciousness, may increase his feelings of being punished. Patients do not often express these feelings to the nurse, but their attitude to illness or treatment gives an indication of them. In retrospect, patients are sometimes more able to express how they felt, and dreams and nightmares sometimes show the connection between the treatment and the phantasy of being punished.

Whenever people are ill and receiving treatment and nursing care, they must to some extent give up independence and submit to the authority of doctors and nurses. In many respects their position resembles that of a child who is looked after by his mother. Once again, just as in childhood, the

patient is relieved of responsibility but at the same time deprived of freedom of action. Someone cares for him just as his mother did once. He experiences once again tenderness and love but at the same time the frustration of having to do as he is told and of being childishly dependent. The patient sometimes reacts to this situation by using the type of behaviour which he found useful in childhood. Nurses may become targets for hostility and criticism, or may receive the patient's complete trust, so much so that at times it may be embarrassing to an inexperienced nurse.

When a nurse sees a patient in hospital or in his own home, she rarely sees the patient's very first illness. Most children become ill, or at least may feel unwell, at some time in childhood and the mother deals with such illness without the help of a nurse. Attitude towards illness and towards the person who helps the patient to get well is often learnt in childhood. At the time the nurse meets the patient in hospital, she often sees a repetition of this early pattern.

Some children find that in illness they gain sympathy and attention which is denied to them when they are well. In adulthood there is still the feeling that there is entitlement to special consideration during illness. Children discover quite early what kind of behaviour is most effective. Crying, moaning, complaining may help some children. Others gain the admiration of their parents by their patience and fortitude. Adult patients use well tried behaviour patterns quite unconsciously. Some moan, cry, complain and display their suffering; others appear to be able to tolerate a great deal of discomfort without complaint. Sometimes they succeed in gaining special consideration just as they did in childhood. Often the behaviour appears misplaced and fails to fulfil its purpose. Crying and complaining may result only in irritating the nurse or in discouraging visitors. Remaining too silent may result in being ignored by a busy staff.

All sick people need attention, but their method of seeking it may not be appropriate. It is helpful to understand 'attention seeking' behaviour and to satisfy the patient's need so that he can more readily give up his childish attitude and adopt a more adult reaction to his circumstances.

9. ADMISSION TO HOSPITAL

Any suggestion of admission to hospital causes anxiety and fear in most people. All nurses are aware of the need to do everything in their power to help a new patient to settle down quickly and to carry out admission procedure as encouragingly and reassuringly as possible. To succeed in this it is necessary to try to understand the patient's anxiety and to detect the signs of it. Only a few patients express their worries openly. Many are unable to do so because they are not clearly aware of it themselves. People feel comfortable and relaxed when all their physiological and psychological needs have been satisfied. The physiological needs for food, water, warmth are usually satisfied in health. In sickness, difficulty in breathing or thirst are always accompanied by anxiety which is easily recognizable.

The psychological needs of the patient are less easily identified. People need to feel secure in their environment. They must understand it and must understand the part they themselves play in it. They need to love and be loved, to be respected and to respect themselves. They need to feel that they are able to master the situation in which they find themselves. None of these needs can be fully satisfied on admission to hospital.

Security means the ability to predict what is going to happen and how to make things happen. Hospital routine gives security to nurses and later in the patient's stay gives great security also to him. On arrival, however, he knows nothing at all of the events which are to follow. People around him move, appear busy, do things to him, but he feels completely bewildered and left out of it. The greatest anxiety occurs in relation to his own behaviour. He does not know

what is expected of him, what will happen if he does not behave as he is supposed to. He does not know in which way he can influence events, what is the procedure for obtaining attention or whether it is permissible to get out of bed and how to address the nurses who attend to him. His insecurity is all the greater because he finds it difficult to distinguish one nurse from another. It is always difficult to remember people and their names when many new people are met simultaneously, and it is all the more confusing when all wear the same uniform. Anxiety due to lack of security can be alleviated by keeping the patient fully informed of what is going on. Nurses often tell the patient what *they* are going to do—the patient is concerned only with himself. It is even more helpful to tell the patient what *he* is going to do, and what precisely is going to happen to him, how he is going to experience the events around him.

It is a mistake to tell the patient too much at a time and to give too many explanations on admission. He will be anxious and therefore unable to pay attention or to remember much of what he is told. If a patient knows what is going to happen, but not when, he becomes increasingly anxious while he waits and wonders. Explanations are best given in the form of a running commentary as events in the ward take place.

Some information about the geography of the ward, times for meals, the routine of the day, can be given early even if it is not remembered at once. The fact that the nurse is willing to give information is in itself reassuring. Some hospitals give this information in the form of a pamphlet. This may make the patient feel happy in the knowledge that the hospital cares about him, and it makes him feel important. It is, however, also an indication that the nurses do not wish to be bothered, and represents a way of giving information without taking into account what the patient really wants to know or whether

he has clearly understood. Personal communication has great advantages.

Specific information can be given only when the patient asks for it. Before this he must be helped to feel that the nurses are willing to be asked, are reliable and interested and have sufficient time to pay attention to his needs. There is usually a phase of testing in which the patient asks several nurses the same question, or asks the same nurse many times over. He may ask about trivialities without listening to the answer. These actions are not deliberate attempts to be difficult. They are symptoms of anxiety; and they serve the purpose of finding the particular nurse who, by her manner, gives him the impression of being the right person with whom to discuss really important matters.

Anxiety may manifest itself in some of the bodily symptoms presented by the patient. Rapid pulse, flushing or pallor of the face, tremor, sweating, widely dilated pupils, dry mouth, nausea, diarrhœa, raised blood pressure, headaches are all symptoms which occur in anxiety. These may mislead the doctor in making his diagnosis, and it is therefore very important to help the patient to lose anxiety symptoms as soon as possible. If the patient feels anxious and apprehensive he is unable to concentrate, fails to appreciate the books and magazines offered to him, starts many activities without completing them, asks for many things he does not really want.

He can be helped if there is one special person whom he can recognize, who devotes her time to him and comes to him. Introduction to *one* person is important. This can be the patient in the next bed or one particular nurse or a domestic assistant. One person who represents stability in the chaotic new world into which he has entered. Nurses often believe that the patient's anxiety is primarily related to his disease or his worry about the home situation. This may not be so on admission. There may be a very real cause for alarm, yet the

patient cannot give his thoughts to the big problem confronting him while he is learning to understand the little problems around him. His most urgent task is getting to know his new environment. Reassurance must, therefore, be concerned with the patient's immediate need to orientate himself adequately in his new surroundings. To refer to the family, the work, the financial matters before the patient has done so is far from reassuring. In fact it may well add to his anxiety and make him feel guilty about his selfishness in thinking of himself.

While the understanding of events and routine helps in creating security, confidence in people is the most important aspect of feeling safe. When the patient is newly admitted, his general state of bewilderment is such that he is desperately in need of people and therefore in the best possible position to develop confidence in staff.

The greater people's needs are, the more inclined they are to accept help without questioning the competence of those who offer it. A healthy person may critically discuss the relative excellence of several doctors or nurses, but an ill one accepts without question the ministrations of whoever is at hand to give help and assumes that that person is capable of giving care. This phase of uncritical acceptance is an important and valuable factor in initiating treatment. The nurse's manner, her ability to remain unaffected by the patient's anxiety, her confidence in herself and in her colleagues helps the patient to believe that his trust in the hospital is well founded.

Later, during the patient's stay in hospital, as he becomes more secure and settled, he is better able to compare staff, to use rational criteria for assessing the nurses and to become more critical of the people around him. Confidence in nurses, then, must be created by the quality of service which is given to him and which he observes being given to others. Nothing undermines confidence in staff more rapidly than to notice lack of attention to detail in the care of other people.

During the phase in which a patient accepts unquestioningly that doctors, nurses and treatments are good, he is said to be highly suggestible. His own judgments are in abeyance, other people's are accepted. It is very important indeed for the nurse to be fully aware of the impact of all she says to a patient at a time like this, and to learn how to use voice, gestures and words in such a way that they suggest comfort, hope, progress and optimism. Patients usually seem to prefer the nurse who was present at the time of his admission. This may be because she is the only one clearly recognizable in the general chaos which surrounds the patient, and the only one accepted entirely uncritically. All the more important that during the admission formalities the nurse should be fully aware of the responsibility her position carries.

Sudden admission to hospital, for example after an accident, may result in anxieties even more inappropriate than those normally observed on admission. People tend to worry about tasks which are not completed and to think about them until they are finished. Everybody has the urge to finish what he is doing and enjoys the satisfaction of seeing the job done. It is difficult to put a book away in the middle of a chapter or to stop knitting in the middle of a row. Nurses like to stay on until all the beds are made, or all temperatures are taken. Lecturers like to feel they have covered all the ground. If anyone is suddenly stopped in the middle of a task, he experiences an urge to return to it. Patients suddenly admitted to hospital worry about the things they were about to do. A letter which was meant to be posted, a telephone call, an appointment, a planned visit to a theatre, the fact that his desk has not been tidied up—all these can be of utmost importance to a patient when he is suddenly taken off to hospital, so important in fact that he may refuse to remain in hospital if it is in his power to refuse.

It may be obvious to the nurse that the patient has more

important troubles that he could or should worry about, but what appears trivial to others may seem of utmost urgency to the patient. It is useless to say, 'Don't worry about that now.' No one can stop worrying when commanded to do so, nor can worries be postponed. Problems must be resolved, and the nurse is the person to resolve these urgent difficulties for the patient.

When the patient feels secure in the hospital he becomes more aware of his other psychological needs. The need to be appreciated, loved and to think well of himself, the need to be of use to others becomes very important. In a helpless state it is difficult for the patient to think well of himself. The attitudes adopted by the staff and relatives may help, particularly if the patient expresses his fear of being a burden and useless, by apologizing for trouble he is giving, or worrying about the fact that he needs attention. The more helpless the illness renders the patient the more his self-esteem needs to be boosted. Incontinence is a symptom which is particularly distressing and so is the need for bedpans, the need to be fed or washed or lifted. The more the nurse has to do for the patient, the more she must remember to assure him of her respect so that he can respect himself.

When the patient begins to think of his family he usually expresses concern about their welfare and the wish to return to his position of responsibility as soon as possible. While a realistic appreciation of the family's welfare is a good sign, the patient's anxiety is sometimes not so much for his family as an expression of his fear that he might not be as necessary to them as he had thought. Every family must adjust itself to the sickness of one of its members. Work and responsibilities have to be reallocated so that the least suffering is caused to all concerned. The patient's place in the family circle is not left wide open, the gap is filled by one or more members of the family who assume it.

The patient begins to realize that the family can do without him. He is glad and yet upset by his loss of status. He worries about them to convince himself that he is really needed and is not at all reassured by being told that all is well. The same feelings occur in relation to work, an unconscious fear that he may not be indispensable after all, and an increased preoccupation with all the work he ought to be doing.

It is difficult for the nurse to help the patient to feel important in relation to his family. She can do it only by helping visitors to see how best they can increase the patient's feeling of participation in outside affairs, and she can raise the patient's self-esteem by making him feel important within the hospital in asking his help with other patients, asking his advice, making him feel he belongs. Conversation about home and work is important as soon as the patient is able to think of it. The nurse should remember that the patient derives no help from being told not to concern himself with the problems of others. His rehabilitation becomes increasingly difficult the more he has detached himself from his former ties.

During the patient's recovery his independence and his need for mastery becomes more pronounced. While at first he may be content to let events take their turn and merely try to understand them, his return to health makes him feel that he needs to be able to influence and change events if he wishes. He begins to ask questions about his treatment, he expresses doubts, asks for explanations. He begins to remind nurses that his medicine is due or to tell them how he wishes treatment carried out. He may begin to ignore rules, to refuse to eat the prescribed diet, or to smoke though it is not permitted. This growing independence is a most encouraging sign of improvement. Just as children learn gradually to become independent so the patient too takes one step at a time waiting to see what the results of his initiative may be. Part of this process results in a better knowledge of other people's individual

reactions. Patients, like children, learn when it is safe to break rules, when not to, which members of the staff become hurt or bad-tempered when contradicted or reminded of something, which of the staff appear to welcome help and encourage independence. Just like children, patients may try out how far they can go without disrupting the environment, before they can settle and assume responsibility for their own action, bearing in mind the needs of others.

The more secure the staff feel in their ability to maintain the right atmosphere and to satisfy the individual needs of each patient, the more they encourage a return to independence as soon as the patient is ready.

10. THE PATIENT'S FAMILY

Sickness always has far-reaching effects on the patient's family. Even a mild short illness in the patient's own home causes marked emotional reactions.

In the early stages of the illness the patient may be reluctant to give in and though clearly unwell he tries to continue his activities. His family feel concern, sympathy and solicitude and try to persuade him to allow himself to be looked after. Gradually, however, they may experience irritation at the patient's obstinacy, and withdraw sympathy just at the moment when the patient, unconsciously perhaps, begins to enjoy the concern people show for him. When eventually the patient is forced to give up, both he and his family may feel guilty about their previous attitudes. The family may feel that they have not taken the symptoms sufficiently seriously, and the patient may have begun to feel doubtful about the support his family is able to give.

If the patient is to be nursed at home considerable stress may arise. There is much extra work which is worrying to the patient who has caused it and is often resented by the family. In prolonged illness this is often realized. In the early period of sickness the family are, however, unable to admit their resentment, and their guilt feeling about it may make them behave as if they were martyrs, doing much more work than necessary and depriving themselves of all opportunity to rest or take time off away from the patient.

Patients who are not so ill that they must be admitted to hospital are often able to retain more independence than hospitalized patients. This may make nursing difficult, as the patient may refuse to obey doctor's orders, may get up though not permitted to do so, refuse treatment or drugs and may

even feel that he should retain some say in the management of the home. The relationship between the patient and the relative who nurses him is to some extent maintained at the normal level, but the patient reacts to being nursed as he would if he were in hospital by becoming helpless and dependent. Relatives are less able than nurses to enforce a therapeutic regime, partly because of their dual role, partly because they tend to become too worried about the patient's illness.

Nurses are able to assist better than relatives because they are not too emotionally involved. This means that, though she cares very much for the patient's welfare, the nurse's private life and emotional balance are not affected by the patient's progress, be it favourable or not. Relatives cannot avoid being involved. To them the patient's recovery or deterioration is a matter of personal concern. Their joy or anxiety about the patient's condition is bound to affect his progress.

One of the problems of nursing a member of the family is related to the reluctance of the patient to allow relatives to carry out any intimate nursing care or to let them see him in any condition in which he would not normally allow himself to be seen. Patients and relatives may feel embarrassed about the use of bedpans, disposal of vomit, changing of bedclothes or personal hygiene. This may result in inadequate care, either because the patient may be reluctant to ask for help or because the relative cannot overcome the discomfort of nursing the patient.

Prolonged illness in the home results very often in increasing isolation of the family as a whole. Visiting by friends tends to be frequent at first, but after some time people find the company of invalids distressing and they eventually withdraw. The family who is busy nursing an invalid becomes uninteresting to others and is increasingly ostracized. Although help or

relief may be urgently needed it may be difficult to take the initiative of making the need known, and the result may be bitterness and hostility.

When the patient is admitted to hospital all the family's difficulties may be even more considerable. It may result in increased work in the home, depending on the patient's position in the family. In any case complete reorganization of routine is necessary. If the breadwinner is in hospital, financial worries may be added to those resulting from sickness. If the mother is away, children may have to be cared for by neighbours or distant relatives. Details of family life which have been kept strictly private become known to relative strangers. Members of the family become aware of and fear criticism, even if it is not voiced, of the way in which the home is run, the children brought up, and personal affairs managed. If it is necessary to obtain financial assistance, details about family life must be disclosed which hitherto may not even have been known even to all members of the family.

Visiting in hospital is a major problem for patients and relatives. Patients look forward to visiting time, and yet often find it disappointing when it happens. There may be so many visitors that the patient is unable to establish contact with any of them. He may find visiting too tiring and still feel he should make the effort to take an interest. If visitors are late or if the patient is without visitors he becomes angry and distressed and then finds his visitors even less satisfying when they do arrive. Relatives often find visiting a great strain. If visiting hours are infrequent they may have the greatest difficulty in being free just at the time when visiting is allowed and may find it difficult to arrange for all those who would like to visit to be able to take turn. If visiting is short and frequent, they may feel obliged to come each time, which may be most upsetting to family routine. If the journey is long, it is very difficult to

time the departure from home in such a way as to arrive in time. Whichever way visiting is arranged, relatives feel worried by the time they arrive in hospital, they worry about the visit itself, worry about the patient's condition and uncertainty about the way in which they can obtain information, and the feeling that information may be incomplete may be added to their troubles. The visiting period passes quickly and relatives may share with the patient a feeling of disappointment and dissatisfaction about their contact. It is difficult to be affectionate in an open ward. There is usually a time-lag before emotional rapprochement can be made, and the number of interruptions make it more difficult.

Many visitors find conversation with the patient very difficult. They ask the patient questions about the way he feels and what is happening to him. If the patient is fairly ill, he cannot answer adequately. If he is well enough to talk he does not have much news to tell and in any case should not be expected to keep on talking about his symptoms and treatment or the condition of his neighbours. The patient may become silent, and the visitors in their embarrassment turn to each other for conversation. It may be necessary to help visitors to realize that they have much more news to give the patient than the patient has for them. Their reluctance to talk of home or the outside world may be caused by fear of worrying the patient, or of making him feel envious of the interesting time they are having. The patient should be kept in touch with what is going on. He has much greater incentive to get well if he knows that he is missed. His return home is made much easier if he is kept fully informed of events. His interest should at times be focussed more on other people than on himself. It is all too easy for a patient in hospital to lose interest in the fate of others and to have as his sole topics of conversation himself, the nurses and hospital routine. All the small happenings of the hospital ward become magnified in importance

and significance. His preoccupation with the little world of the hospital contributes to his relatives' discomfort when they visit unless they can be induced to break into it by talking about themselves. Relatives may feel reluctant to burden the patient with their own problems, perhaps not realizing that it may be more worrying to the patient to feel completely useless than to know that his absence is felt and that he is being consulted.

When relatives experience emotional difficulties about visiting, they either find excuses for coming less often or they may attempt to deal with their feelings by becoming critical of the hospital, the treatment and the staff. When this happens they need an opportunity of discussing all their worries about the patient's illness at length with the doctor, the ward sister or the almoner. Nurses may find it difficult to see how they can influence relationships between patients and visitors. They may feel uncomfortable at visiting times and take the opportunity of disappearing from the ward, therefore depriving themselves of a most prolific source of information about the patient and of an opportunity to help him. Information about the patient's condition can, of course, be given only by one person. If all the nurses were permitted to do this, conflicting or inaccurate information might be passed on.

The nurse's presence at visiting time may, however, be helpful in discovering when relatives feel uncomfortable or worried. The fact that the nurse knows who has visited the patient may help him to talk about his feelings in relation to his family. It may be possible to mention to the relatives that the patient is interested in their news. An occasional word to visitors may direct conversation away from the patient.

It is usual for visitors to take some present to a patient in hospital. Nearly always they bring food. This is partly tradition, but partly it results from the belief that hospital food is bad and partly from the fact that social convention

suggests gifts of food to indicate a love of the visitor for the patient. Although hospital food is usually quite good and adequate, patients appreciate anything which is brought in by visitors. The association of food with people one likes is so strong that food tastes quite different when it is offered by someone whom the patient loves. Even though food may not be needed, it is unwise to tell visitors not to bring it in, as they and the patient feel the need for a tangible exchange of gifts. Nurses should not feel any implied criticism in the fact that relatives enjoy giving pleasure to the patient. If too much of the wrong kind of food accumulates, it is more helpful to make positive suggestions as to what might be brought, than to tell the patient's relatives not to bring anything.

A suggestion to bring the patient something to do may occasionally be helpful. Puzzles, amusing pictures, books, paints, magazines, photographs, needlework may help the patient to regain interest. Many relatives fail to appreciate this when they visit adult patients.

When the patient is critically ill and visiting is unrestricted, the conflict in the relatives is at its maximum. There is a feeling that the patient ought not to be left, combined with a sense of helplessness and uselessness that makes visiting extremely painful. All nurses are aware of the intense emotion which arises while visitors are at or near the bedside of a patient on sick notice. The greatest comfort is activity. Whenever relatives can assist in doing something for the patient or be of some use in the ward, they feel very much better. There is a widespread belief that the ward must always be in perfect order before visiting time and that visitors should leave whenever any attention is given to the patient, but there is no indication that this is at all helpful to the visitor. It is much easier for the visitor to appreciate how well a patient is being nursed when he is allowed to witness some of the procedures or even to give a helping hand.

It is always difficult to decide how much to tell when a patient is seriously ill. Often the doctor tells the relative but not the patient, thus putting a tremendous burden on the relative who tries his utmost to remain cheerful and optimistic when talking to the patient. Often the patient knows, even if he has not been told, how serious his illness is but he tries to hide it from the relatives. Both may long to speak of their anxiety but be afraid to do so. Responsibility for giving information rests with the doctor, but the nurse is the person who becomes aware of the tension which results from attempts to hide feelings, and she is also the one who can assist patients and relatives to find someone in whom each can confide.

Discharge from hospital requires a reorganization in the home and reorientation of the patient's interest. The whole family needs time to prepare and an opportunity to sort out their feelings about each other and about their position in the community as a whole. Sudden discharge may be as upsetting as sudden admission to hospital. Whenever possible ample time should be given to the family and every help to the patient to prepare himself for separation from the hospital and for resumption of his role in the family.

11. CHRONIC SICKNESS AND INVALIDISM

When an illness is acute and of short duration the sudden changes in the patient's needs and the rapid reorganization of family relationships cause difficulties in the care of the patient. Chronic, long-standing illness and permanent disablement create problems of a different nature.

In the course of growing up people develop ideas about themselves which determine how they behave in different situations. They get to know their capabilities and in their daily lives undertake only those activities of which they know themselves to be capable. Interests develop according to individual ability to understand the subject and take an active part. People, for example, compete in sports only when they can approximately equal the performance of others; they study only those subjects which are within their competence and present themselves for examinations only if there is at least a chance of passing. Choice of friends is often determined by mutual interests. Friends are made at work, or amongst those who play the same games, share a particular interest, or are equally energetic in climbing mountains.

People's estimate of their own ability usually becomes surprisingly accurate, although some may have been so profoundly discouraged during childhood that they consistently underestimate their ability and lack confidence. Some people who grow up with a handicap devote most of their energy to its overcoming and excel in the use of precisely those skills which they have found hardest to acquire. Others cope with their disability by ignoring it and concentrating on excelling in some other sphere of activity. These methods of compensating for some real or imagined inferiority are part of the

driving force in people's way of living. Gradual changes in ability as it increases during growth and declines in old age are incorporated in people's ideas of themselves.

Illness is regarded as a temporary interference in the normal process of life and does not, at first, lead to a change in outlook. Prolonged and chronic illness and permanent disablement, however, necessitate complete reconstruction of the patient's ideas of himself, and a complete reorganization of relationships. The ordinary expectations of the family and of society as a whole must be changed. This process is slow and painful and requires considerable assistance from those who are nursing the patient.

When the patient first realizes that he cannot get completely well, he may become depressed. He may feel that in such circumstances life is not worth living. He may lose interest in himself, his treatment and the conditions surrounding him. In this frame of mind it is very difficult to nurse the patient, as he himself does nothing to help. He may refuse to take sufficient nourishment, neglects his personal hygiene, loses all interest in any activity. All nurses know that the will to live is essential to recovery, and they must help the patient to see that in spite of his handicap he is needed by those who love him, and that he can still be useful to the community.

Often the patient who realizes that he is permanently disabled becomes furiously angry with himself and with everyone whom he feels he can blame for his predicament. He may express his feeling in his criticism of the treatment and care he is receiving in the hospital, possibly even in litigation against the hospital or those he thinks responsible for his condition, or he may accuse his family, or people in general of being hard-hearted, of disliking him because he is a burden to them, of looking down on invalids. At some stage of the illness, most disabled people project their anger on to other

people. They refuse to meet people, refuse to be seen or to go out. This phase of self-consciousness increases the difficulties, because, while originally people may not have harboured any of the feelings ascribed to them, the patient's attitude creates in them embarrassment, discomfort, and eventually rejection.

It is inevitable that a disabled person must lose some of his former friends. For example, if he can no longer play golf he loses interest in the conversation of his golfing friends; if he can no longer work he loses interest in discussion about his former job. After an initial attempt to keep in touch, he becomes increasingly isolated from all those whose interests he can no longer share.

The greatest isolation occurs in those who lose sight, hearing or speech. We rely in our social contacts on communication by speech, and we keep informed about our environment mainly by sight and hearing. It is important for the nurse to learn how to communicate with the deaf by gesture, mime, writing and demonstration, how to help the friends and relatives to continue their efforts to communicate in spite of deafness. She must remember the suspiciousness of the deaf that someone might be talking about them. Partially deaf people may be even more handicapped because they may be less conscious of defective hearing and more inclined to blame others for failing to make themselves clear.

People who have become partially sighted or blind need constant interpretation of their environment while they are learning to use their other senses. It is possible for the nurse to pay more attention to noises and movement and to explain their meaning to the blind person before he becomes startled by someone's presence. The total isolation of those who cannot see may lead to a period of confusion, disorientation and a terrifying feeling of being lost which may result in uncontrolled, sometimes aggressive behaviour.

Patients who cannot speak can make their wishes known by

sign and non-articulate noises. It is a great effort for them, however, to attract attention, and having done so, to make themselves clear. It is easy to become impatient with the person who is aphasic but very necessary to take all the time needed to understand. Nurses can learn to anticipate the patient's needs and to save him the effort of trying to speak; each patient's individual language of mime can also be learnt. However, in the long run the patient's speech difficulty may lead other people to stop speaking to him and thus deprive him of intellectual stimulation and social contact. To avoid this, every effort should be made to teach the patient new methods of communication.

One-sided conversation may be a very useful way of maintaining contact. The deaf can be encouraged to speak while the nurse merely nods; the aphasic patient can be spoken to and needs only to nod his assent or disagreement.

The nursing care and rehabilitation of the disabled must aim at helping the patient to accept his disability as soon as possible, to create a new idea of himself which includes his handicap. It is sometimes difficult to know how soon the patient should be confronted with the fact that prognosis is not too good. Often in a well meaning attempt to spare him suffering, it is not mentioned for a long time. By then, the patient has already begun to realize that all is not well and, sensing other people's reluctance to face facts, he keeps his worry to himself and begins to see himself as an object for pity and despair. It may be much wiser to encourage talk of the future as early as possible, and to help the patient to get to know himself as a different but in no way inferior person to the one he used to be.

This can best be done by emphasis on what the patient can do rather than on what is no longer possible for him. If he has lost the power of his legs, he can work with his hands, he can paint or learn a new craft. He can use artificial limbs to perform skills he may never have realized he possessed. It may

not be very wise to emphasize too much progress in the use of the disabled part of the body. Improved use of the muscles is at the same time a reminder of the deficiency of movement. However helpful physiotherapy for example may be it is a constant reminder of disablement. Creation of new interests, new skills, in no way connected with the disabled part of the body gives a positive purposive direction to life.

Many patients are able first to accept that they may be useful to other sufferers of their own kind. Associations for sufferers from poliomyelitis, paraplegia or epilepsy may for example offer the opportunity of doing useful work and of developing the ability to meet people again. Help is more easily accepted from those who suffer similarly because there is no need to feel that help is given only out of pity. There are opportunities of working with other disabled people in special workshops and clubs. Competition in sports can be encouraged. Many paraplegic patients for example excel in archery. Many disabled people take interest in collecting funds for research into and treatment of their illness for the benefit of future patients. Gradually, however, the disabled person must be led to feel equal, though different, to other people; able to hold his own in a newly formed circle of friends and fellow workers.

The process of becoming used to the idea of a new and different self must be accompanied by parallel changes in the expectations and attitudes of the family. During the patient's illness, it is easy to make allowances for his deficiencies and excuse all he says or does by reference to his condition. This cannot be done forever, and gradually the family realize that changes in the patient may be permanent. They must learn when to stop considering the patient as the focus of all attention, and begin to expect from him a certain amount of consideration.

When the family begins to treat him as a responsible person, he may respond by accepting responsibility and becoming

interested in living once more as full a life as possible. Some families, of course, find it difficult to readjust themselves to the patient's resumption of his position. The patient's illness may have served as a convenient excuse for them to explain their failure to cope with acceptable standards of living. For the patient, disablement may be a respectable way of explaining his failure to cope with the stresses of life. When illness is used by the family in this way, the whole family must be interviewed rather than the patient alone, for all are in need of help, support and encouragement.

In the rehabilitation of chronically disabled persons, the most difficult task for the nurse is to know when not to help. There is always on her part a great temptation to assist those who are fumbling to do things for themselves because she can do them better and more quickly, and to relieve people of actions which are obviously painful and difficult for them. It is, however, necessary to let disabled people do as much for themselves and for others as they are able, if their self-respect is not to be damaged and their progress impeded. At the same time it must be made as easy as possible for them to ask for help, and when it is asked it must be given in a matter of fact way. Help given as an equal in a difficult task is acceptable; help given in such a way as to make the patient feel a passive recipient of care, is humiliating.

Much of what is involved in the rehabilitation of the disabled is similar to the way in which we help children to grow up. We encourage every sign of independence, helping only where help must be given, but without making the child feel small or insignificant. All the time the child is growing up he develops new and changing relationships with the people around him, until eventually he considers himself to be an adult in an adult society, different from all others but with a special contribution to make.

Many chronically disabled people can be helped to return

to gainful employment. Sometimes it is necessary for them to change their occupation and undergo a course of training. Some patients may be able to return to their former type of occupation, providing they find work in suitable premises, for example, where there is a lift or the work is on the ground floor. Adjustment may have to be made in working hours to allow for rest breaks, or in working conditions to enable the man to carry out his work from his wheel chair, or with specially designed equipment. Sympathetic employers may considerably assist rehabilitation, or it may be necessary to register for employment under the Disablement Resettlement Acts.

Return to work needs long and careful preparation. It may take many months before a patient is willing to see the disablement resettlement officer, or before he can bear to discuss the possible need for retraining. Close contact between the patient's family and the hospital and between employer and hospital may considerably help the patient. Close co-operation, good communications and complete frankness by all concerned is required during rehabilitation, with the emphasis on an optimistic but realistic outlook on life.

12. PSYCHOLOGICAL DISORDERS

So far we have concerned ourselves with the effect of illness and hospitalization on those whose personality development had progressed normally prior to their illness.

Frequently nurses are called upon to care for people whose illness is partly or wholly due to psychological difficulties. The nursing care of psychiatric patients requires special skills, the discussion of which is beyond the scope of this book. Here, only those psychological difficulties which do not necessitate admission to a mental hospital are considered.

In the course of her work in general hospital wards, the nurse may meet three broad groups of psychological disorders: patients who suffer from psychosomatic disorders; patients whose symptoms are neurotic; and patients who in the course of illness become confused and disorientated. The needs of the last group have already been to some extent discussed. Many nurses find confused, restless patients frightening and need to be reminded that the patient's symptoms are largely the result of his feelings of insecurity. The main contribution the nurse can make to the patient's comfort is to help him to orientate himself. She can try to simplify the environment until the patient can understand it, and she can make full use of all those non-verbal methods of communication which the patient may be able to understand.

Psychosomatic disorders is the name given to those illnesses in which emotional factors play a major part. Improvement occurs when the patient feels happy and relaxed; exacerbation, when the patient is tense and worried.

In all psychosomatic disorders there is physical dysfunction which may require treatment. The treatment remains ineffective, however, if the patient's psychological needs are

not met. Asthmatic attacks, for example, occur more frequently in children who are under pressure to work harder at school, and often cease when the child changes to another school. During an attack the child needs all the drugs which are prescribed to relieve spasms. Between attacks care must be taken to avoid exposure to those agents to which he is known to be allergic. Above all the child needs to feel that his potentialities and limitations are recognized and that he is loved in spite of his limitations. If love and recognition are missing, other treatments fail.

The patient's psychological difficulties usually lie outside the hospital setting. Attitudes towards members of the family may cause an emotional state in which psychosomatic symptoms occur. When the patient is removed to hospital his home problems may recede into the background and symptoms improve, only to become worse before, during or after visiting, or as soon as discharge from hospital is envisaged. On the other hand the frustrating feeling of being removed from the scene of difficulties, of being prevented from taking an active part in resolving them, may cause the patient increased anxiety and increased manifestations of symptoms.

Some nurses find it difficult to understand why the patient's symptoms bear no relationship to the care and treatment given in hospital. It is easy to feel angry with the patient, almost as if he were to blame for not responding to treatment. New tensions are then set up which have their origin within the hospital setting and make recovery even more difficult. Generally speaking, patients with psychosomatic symptoms respond better to treatment if they can be helped to relax and to free themselves from worry and anxiety. But, as we have already said, worry does not disappear just because the patient is told not to worry. At times it is necessary to resolve difficulties by thinking about them, facing them, and actively doing something about them.

The nurse's task lies in reducing causes for anxiety to a minimum within the hospital and in trying to understand the underlying anxiety in the patient's own life. Observation of the patient's reaction to visitors, to the letters he receives, sometimes listening to the patient's stories about his family or work may help to give her some understanding of his difficulties and will prevent her from becoming irritated with the patient and his relatives.

Some patients are admitted to hospital for investigation of complaints which turn out to be neurotic in origin. Some of the symptoms are exaggeration of anxiety symptoms which can affect any part of the body. The patient may complain of circulatory disturbances such as palpitations, rapid pulse, raised blood pressure, flushing or excessive perspiration. He may have tremors and muscle pain, gastro-intestinal disturbances such as nausea or diarrhœa, or urinary dysfunction such as frequency of micturition. The symptoms may become very severe. As the patient goes from doctor to doctor for investigation without any positive diagnosis being reached or any alleviation of symptoms, his anxiety becomes focussed on the symptoms themselves. He no longer realizes that he has these symptoms because he is anxious; instead he feels anxious because he has symptoms. He begins to observe himself and to notice physiological changes. Before long he is labelled as 'hypochondriacal' because he is so preoccupied with his own health. Repeated negative investigations create anxiety in both patient and staff. After initial enthusiasm for making tests, the doctor may lose interest when he realizes that no organic disorder is present. The doctor's decreasing interest increases the patient's preoccupation with symptoms. A new hospital or a new doctor is sought, or a sudden crop of new symptoms starts the cycle of events again.

Sometimes nurses may be heard to say that 'there is nothing wrong with the patient, he is only neurotic'. This kind of

thinking is of course totally erroneous. The patient has a great deal wrong with him, even if his troubles are not organic. His neurotic disorder is more severely disabling than many organic diseases. The patient can be helped if his neurotic disorder is treated positively, instead of being disguised. The cause of his anxiety needs to be taken into account. It may be too deep-seated to respond to simple nursing measures. The help of a psychiatrist may be required in order to help the patient to reform his personality pattern, to gain insight into his problems and finally to cope with his feelings of inadequacy.

Meanwhile the patient's hypochondriacal symptoms are the nurse's concern. Emphasis on symptoms is the patient's way of indicating that he needs attention and sympathy. The nurse must acquire the art of convincing the patient that he can gain attention and sympathy more easily by being well than by being ill. She must show her readiness to give care generously without it being asked for, show her enjoyment in the patient's company when he is not complaining, show her solicitude for him though he has no symptoms. When symptoms arise, they must be dealt with effectively but unemotionally, quickly before they increase, without making the patient feel guilty about having them and without suggesting more symptoms to the patient.

It would be wrong to say—as may occasionally be heard—that the symptoms should be ignored. Rather, there should be an endeavour to take more interest in the patient than in the symptoms, and to allow this interest to reach a climax when the patient is symptom free. This is difficult enough even where the patient's original symptoms are unrelated to hospital care, and more difficult still when the patient reacts to the hospital by producing new symptoms. Anxiety symptoms manifest themselves in physiological functions of the autonomic nervous system.

Other physical symptoms of neurotic character are called 'hysterical conversion symptoms'. These symptoms resemble organic disorders of the peripheral or central nervous system. Pain, loss of sensation, blindness, deafness, are among the sensory symptoms; paralysis of arm or leg, inability to produce sound, tics, tremors, and fits are some of the motor symptoms. A patient who develops hysterical conversion symptoms, quite unconsciously solves an emotional conflict by being ill. Having done so, the patient is unaware of his emotional difficulties, denies having any conflict and appears to treat his apparently physical defect with indifference.

A man whose intellectual level may make it difficult for him to hold a skilled, well paid job but who feels it to be a disgrace to change to a less demanding occupation, may solve his difficulty by developing a paralysed leg, thus providing himself with a good reason for giving up his work without losing face. A woman may feel furiously angry with her child, longing to hit it, yet feeling guilty about her attitude which she may consider incompatible with maternal love. Paralysis of the arm prevents her from hitting the child.

Patients suffering from hysterical conversion symptoms often find their way into general hospital wards for investigation. When organic disorder is excluded, they often meet with an attitude of scorn, contempt and irritation. Hysterical symptoms are always purposive. The purpose they serve is never clear to the patient but may be so obvious to others that they find the patient irritating. The patient needs someone to help him solve his conflict so that he no longer needs the symptom. He cannot give up the symptom while his problems remain pressing. The nurse cannot usually help to solve an emotional conflict, but she can try to understand it. It is the patient himself, not his symptoms, who needs her attention.

Patients who suffer from neurotic disorders have not learnt

to solve their problems in an adult or rational manner. Instead they behave childishly, attempting to gain sympathy by a demonstration of suffering or avoiding action by being sick. Their behaviour in an environment where all the staff are busy and all the patients are preoccupied with themselves can be a source of irritation. Recognition of the patient's need for help, and giving help before the patient resorts to demonstrative symptoms of sickness can help to establish sufficient confidence to initiate psychiatric treatment if this is necessary.

One of the greatest challenges to the nurse is the care of the patient who has attempted suicide. Because of the physical damage the patient has inflicted upon himself, he may be nursed in a general hospital though the desperate nature of his act and the depression which has led him to it makes psychiatric treatment imperative. It is often difficult for one who is happy and contented with life to imagine the intensity of suffering of the depressed patient. Because most nurses—just as do most other people—disapprove of suicide and perhaps consider it sinful, they may not find it easy to give the patient the sympathy and understanding he needs.

The patient's suicidal attempt indicates the utter loneliness and hopelessness he has experienced. His illness may cause him to suffer from totally unjustified feelings of unworthiness or guilt. His ideas are then said to be 'delusional'. They are none the less real and unbearable to the patient. Alternatively the feeling of hopelessness may be a reaction to his difficulties in real life. A bereavement, a great disappointment, separation from a loved person, great misfortunes may cause the patient to give up the struggle and to prefer death. The suicidal attempt in a way represents a call for help. The hospital and the nurse may be in a position to provide help if the urgency is clearly understood.

Occasionally the patient's suicidal attempt itself results in a solution of the problems. Relatives may become aware of his

difficulties and rally around. Husband, children, parents may become more sympathetic and understanding when they realize how serious the patient's condition is. More often, particularly when the cause for the depression lies within the patient himself, admission to hospital does not make the patient feel better. His wish to die continues and makes nursing difficult. He may repeat suicidal attempts, and great vigilance is required. Or he may simply not accept the nursing care he is offered and lack the will to recover. It requires special skill to convey to a depressed patient the conviction that his life is precious, that he matters and that people care about him. The first step towards achieving this is for the nurse to recognize the problems confronting both the patient and herself. The patient's unresponsive attitude should not obscure the fact that a definite effort must be made to give genuine emotional support.

Many hospitals have psychiatric out-patient clinics. The nurse's work there differs greatly from her usual duties in out-patient departments. Patients' interviews with psychiatrists are private and confidential and, except for the physical examination, the nurse is not usually present when the patient is seen. Her support is needed while the patient is waiting, or while his relatives are being interviewed, or on those occasions when the patient's anxiety is so great that he cannot wait for his next appointment, or when he has missed an interview and comes to the department later when he is not expected. The nurse has opportunity to talk to the patient before and after the interviews and to provide the doctor with much information about his behaviour and attitude. She gets to know the patient well enough to become aware of what particular approach is likely to be reassuring. She observes changes in the patient which indicate his improvement or relapse, and she needs the skill to control him when his anxiety becomes too great.

Emotionally disturbed patients need emotional care as well as physical help. The nurse cannot prevent her own feelings from being aroused by the patient. Sometimes her feelings are uncomfortable because they may relate to some problem the nurse herself has not yet fully apprehended. Thoughts about death or suicide may arouse uncomfortable feelings, or problems related to marriage, or to family tensions. Sometimes the nurse feels uncomfortable because hostile feelings to the patient have been aroused. In her training she has learnt to like patients and feel sympathetic. Dislike of patients or anger appears wrong, and she may find these hard to accept herself. In the presence of psychiatrically disturbed patients it is inevitable that such feelings should arise. When the nurse has learnt to accept them and to recognize her feelings rather than deny them, she can begin to control them and to use her entire personality to support the patient.

13. CHILDREN IN HOSPITAL

In recent years much attention has been given to the experiences of small children while in hospital. There is widespread belief that great harm can be done not only at the time but in the child's subsequent development, if the child's basic psychological needs are not recognized.

Very small children who have not yet developed any understanding of the world around them have one overriding need: the security of the love and presence of their mother or the person who substitutes for her. Up to the age of about 1½ years to 2 years, some believe even up to 4 years, the child cannot bear to be separated from his mother for long, least of all when new, unusual and perhaps unpleasant things are happening to him. As he is constantly learning new things he can cope with the new experience of sickness, even hospitalization, providing he is with his mother.

In recent years this fact has been stressed to such an extent that some people believe it to have been overstated. They hold that perhaps damage is not as deep or permanent as Dr. Bowlby, for example, has led us to believe, and that excessive emphasis on the danger of separation leads to guilt feelings in the mothers who have had to leave their babies in nurseries or hospitals, guilt feelings which are not good for the child's relationship with his mother either.

However this may be, there is strong evidence that very small children suffer from a sense of loss, mourning and grief when away from their mothers. It is as if they felt that the mother must have rejected, forgotten or lost them. At first they may be tearful or angry, later there is a stage of resignation with lack of interest and an inability to accept love or return affection. How much this affects the child's develop-

ment, his ability to form relationships with other people, his later enjoyment depends on the duration of the separation from his mother and on the mother-child relationship before separation. Nearly always, however, the child's rate of progress, both physically and mentally, is retarded when there is separation from his mother. On returning home the child may refuse to recognize his mother, may remain detached, irresponsive for some time, often he reverts to earlier forms of behaviour. Bowel or bladder control, for example, which may already have been achieved may again be lost, there may be nose picking, thumb sucking, or other indications of emotional disturbance.

Many hospitals now make arrangements for very young babies to be admitted with their mothers if hospitalization cannot be avoided. Contrary to fears expressed by hospital staff, admission to hospital with the mother has not increased the incidence of infection. Small infants respond better to treatment if their mothers attend to their basic needs.

Older children can bear separation from their mothers more easily, but their security is still dependent on the knowledge that their mothers are available and frequent visiting is important.

When a mother is admitted to hospital with her child she feels relieved to be able to carry out all those nursing measures she normally gives him. It is comforting to both mother and child if the mother can feed and wash her baby, play with him, hug and hold him whenever he is upset, tuck him in at night. The child's routine is not altered and the mother feels useful and appreciates the fact that she is fully in touch with the child's progress.

Any setbacks of course are most upsetting to the mother, and she may become very anxious if she sees her child suffer. She would, however, feel equally worried about him were she at home, unable to get adequate information. If the

mother is in hospital, the doctor and nursing staff can help her to express her worries, to feel secure in the knowledge that the child is having good nursing care. Her contact with other mothers, too, and the fact of being useful to the hospital, are a great help.

If it is impossible for the mother to be admitted to hospital, unrestricted visiting is the next best thing. The more frequently mother comes, the less disturbing her departure and the more her repeated absences and reappearances are taken for granted. Most hospitals which have tried to allow unrestricted visiting have not found that the mother's presence interferes with the work. On the contrary, the help mothers can give especially at meal times and bedtime, gives more time for the nursing of those children who are very ill or who are not visited.

Small children who are admitted to hospital may need the comfort of some tangible reminder of home. A teddy bear or a favourite piece of ribbon or cloth taken to bed with him may establish a link with his previous experience during his mother's absence. His own personal baby language and signs for toilet should be used by the hospital staff. Information about details of the child's life should be available.

If it is impossible for the mother to be present, the nurse must attempt as far as possible to replace her. Ideally, one nurse should look after the child throughout his stay, but as this is obviously impossible, the fewest possible number of nurses should share in his care. It is very bewildering for the child to have a large number of strangers handling him, each giving a small part of the total care. However kind the nurses, the child cannot establish emotional bonds with too many people. He needs one person who is his special nurse. Fear of showing favouritism sometimes deters nurses from singling out a particular child for attention. There is no danger of favouritism for small children unless one child were everybody's favourite, which is as impersonal a relationship as being

no one's favourite. Each small child must feel he belongs to someone. If his mother has temporarily deserted him someone else, the nurse for example, must take her place.

Hospitals are sometimes afraid of the adverse effect on the child when his favourite nurse has to leave. This is of course a bad thing, but better than if no favourite nurse had ever existed. It is easier for a child to form a new relationship if his previous experiences have been satisfying, just as it is easier for the child to form a satisfactory relationship with the nurse if he is secure in his relationship with his mother.

There is inevitably some disturbance when visitors leave, and fear of children's tears has in the past led to restrictions on visting by parents. It seems though as if tears and a show of emotion were much to be preferred to the restrained, detached behaviour of those children who appear to have settled down in hospital.

One of the greatest difficulties of the small child is his inability to understand the concept of time. He cannot measure the interval between his mother's visits, and so he needs to be kept informed about her actions throughout the day. The nurse can give a running commentary to the child of what his mother is probably doing. 'She is cooking the dinner now for your brother, she is mending daddy's socks, she has gone out to do the shopping.' These remarks help the child to realize that life has not changed much at home. The future is measured in all the activities the child will carry out before his mother's return; for example, 'you will have your lunch, then you'll have a sleep, then the doctor will come, then we shall play, then your mummy will arrive.' Some of the hospital events can be rehearsed in play before the child's admission or before a specific treatment is carried out.

The period in hospital is not the time for a child to give up well established habits however deplorable the nurse may think these to be. Some children suck dummies when they are

upset, some are fussy about food, some make a noise when they are being washed. There is no point at all in nurses being critical of the child's upbringing and in trying to change ways of behaving of which the mother does not disapprove. When this is attempted, the child may conform during his mother's absence to the nurse's request. When his mother comes, however, the conflict between nurse and parent results in more pronounced disturbance in the child and an increasingly critical attitude between parents and nurses.

Older children once they have recovered from the most acute phase of the illness enjoy the companionship in the ward. They may benefit from the independence from parental control, from the fact that nurses represent an impartial authority. Freedom from the pressures of the educational system and being the centre of attention owing to illness may all contribute to a constructive use of hospital experience during development. Some children derive great benefit from the individual attention a school teacher is able to give and return to school later with enhanced prestige of increased attainment as well as having been in hospital. Children who do not like school benefit particularly from individual tuition.

One of the dangers of long illness in childhood lies in the fact that the child may have difficulty in settling down at home. A few months in the life of a small child is a very long time. A child's development is closely linked with people and things in his environment. While in hospital he is learning about things which are not of great use to him outside. Social conventions, language, routine, are totally different from the child's family culture. Meanwhile people at home change, develop new interests, start on ventures of which the child remains ignorant. When he gets back home he returns to an unfamiliar world, to an environment in which he is a stranger. He has not learnt any of the relationships he should have developed with members of his family. During illness he is

the focus of all attention. Whenever he sees his family they are all concerned with his welfare. On his return home he finds people concerned with each other, interested in the welfare of others rather than in himself. Once he is well there are no special favours, no allowance made for bad behaviour. He is expected to fit in with a way of life which is quite unfamiliar to him. It is important to remember that he needs extra love, care and attention on returning home.

It is a difficult task to help a child to use his period of sickness constructively. He must be helped to realize that there is greater advantage in being well than in being sick. It is easy for a child to learn how to use sickness as a means of tyrannizing over others and of gaining attention and affection. It takes firmness and much love and patience to give affection without waiting for the child to demand it, and to treat sickness in the detached manner which makes it not worth while. Small children do not understand the meaning of sickness very clearly. They cannot understand cause and effect, symptoms and treatment. They may appear to blame the nurse or the doctor for their pain. It may be necessary to separate the functions of the nurses so that the nurse who gives the child his daily care is never associated with causing him pain. Some children appear to associate the nurse's uniform with the unpleasant experience of sickness and pain.

The child's early experiences with sickness, pain, hospitalization, separation from his mother and being cared for by nurses, may influence attitudes to sickness later in life.

SUGGESTIONS FOR FURTHER READING

Student nurses may wish to consult some of the textbooks on the practice of nursing, for examples of the way in which psychological knowledge can be applied.

WILLIAMS, J. *Psychology for Student Nurses.* (Methuen.)

MCGHIE, A. *Psychology as Applied to Nursing.* (Livingstone.)

ODLUM, D. *Psychology, the Nurse and the Patient.* (Nursing Mirror.)

Books by GESELL, A., for example *The First Years of Life*, give detailed account of observations on child development. (Methuen.)

ISAACS, S., *Intellectual Growth in Young Children*, is an example of this author's method of reporting her observations. All her books are of interest. (Routledge.)

PIAGET, J. *The Language and Thought of the Child.* This is an example of a different approach to the study of development. (Routledge.)

A book which will guide further reading:

VALENTINE, C. W. *The Normal Child.* (Pelican.)

All the above books deal in general with the study of child development. Students will have no difficulty in finding books dealing in a more specific way with various age groups.

There are not many books written in this country about the patients' needs and psychological problems. The difficulties of deprived children are discussed in:

BOWLBY, J. *Child Care and the Growth of Love.* (Pelican.)

ROBERTSON, J. *Young Children in Hospital.* (Tavistock.)

Some very moving stories written by patients themselves are found in:

Disabilities and How to Live with Them. (Lancet Publication.)

There are numerous pamphlets published by Her Majesty's Stationery Office which help to understand child development and behaviour.

14. MOTIVATION

In the last few chapters, progress from childhood to old age has been described but no attempt has been made to explain why people develop in the way they do. Explanations of differing personality development have been put forward by various psychologists, and later in this book an attempt will be made to describe some of their theories in more detail. At this stage it is only intended to look briefly at the factors involved in explaining behaviour.

Heredity must first of all be taken into account. People are born with varying hereditary potentialities, and even if environment were completely uniform for all children, people would differ in their experience of the environment.

Heredity almost certainly accounts for differences in temperament; that is in the predominant emotional tone and the speed of reaction. It is also largely responsible for intelligence and possibly for tolerance to stress situations. The particular manifestations of disturbance which a person displays under stress also appear partly determined by heredity. We are generally more concerned with the effect of *environment* than that of heredity. In bringing up children, parents assume that they can influence development whatever may be their child's hereditary make-up. Similarly, when we treat patients in hospital, we try to bring about change by influencing their environment.

When we try to find out 'why' a person behaves in the way he does, we are searching for 'motives' for his behaviour. Motivation can be looked at in three different ways. When for example a patient asks for a glass of water, we can explain his action:

(*a*) By stating that he is thirsty. We are stating what is the

patient's internal 'drive'. Explanation is given solely in terms of the patient's own mental state.

(*b*) We can describe the circumstances which have led to the patient's thirst. The fact that he has had no drink for a long time, that he has lost blood, that he is perspiring profusely and has lost fluid.

(*c*) We can explain that he is asking for water in order to obtain satisfaction, in order to feel cooler, refreshed, or in order to keep the nurses busy. This is an explanation in terms of purpose or aim. This kind of explanation is often referred to as the 'teleological' explanation.

All these forms of explanation may be useful at times. All three types of explanations can be given in answer to the question 'why'. The question 'why' is not, however, the best kind of question to be asked concerning motivation. Instead, it is more useful to ask more specifically for the kind of motivation regarding which information is sought.

'How did you feel?' gives an answer in terms of 'drive'.

'What happened before you did it?' asks for antecedents.

'What were you trying to do?' asks for purpose.

It is wise to guard against trying to explain behaviour by reference to 'faculties', a method which was once popular. If a person remembers instructions easily, nothing at all is explained by saying that he 'has a good memory'. There is no such thing as memory. The explanation is much more meaningful if reference is made to interests, attitudes, ambitions and feelings of curiosity which help him to remember. There may be a strong feeling of need for the particular information, a strong liking for the lecturer, a feeling towards other students which makes it essential to succeed at that moment. All these are emotional states which determine behaviour. Emotional states are also important in explaining physiological changes such as high blood pressure, increased blood supply to the gastric mucosa or a high rate of pulse beat.

Often people do not recognize their emotional state. It is possible to be very angry yet not to be consciously aware of it. Hidden or unconscious anger can cause a person to break something, to be sarcastic or rude, or to perspire and become flushed. Blood pressure or pulse beat may be raised without any awareness of the feelings which have caused this to happen.

Unconscious emotional *motivation* is a very important driving power. Nurses and patients may at times behave in the way they do without consciously being able to explain their feelings.

The second type of explanation tries to establish how behaviour is determined by past events. In simple experimental situations, it is easy to see how behaviour is related to cause; for example, depriving a rat of food leads to rapid learning of the path through a maze. As soon as we begin to study more complex human behaviour we find that cause and effect are not nearly so easy to connect:

1. The effect may be delayed so that by the time it occurs, the cause is forgotten. For example, a mother's absence from her child in early infancy may much later cause reluctance to allow the mother out of sight. By that time the early separation may have been forgotten by the mother.
2. Several events in combination may produce a particular effect; each alone might not have done so. For example, sickness and separation from his mother combined may have ill effects on the child, while sickness at home may well be coped with, or a holiday away from his mother may be enjoyed. We say that behaviour has 'multiple causation'. Human behaviour is so complicated that we must always look for multiple causation rather than believe that one particular line of action has any one definite result.

3. It may be difficult to understand cause and effect because so much of our behaviour has 'unconscious' motivation. Early events and all the feelings about them have become unconscious by the time we are adults, yet adult actions seem to some extent to be determined by childhood experiences.

We like to believe that all our actions are well thought out, logical, intentional, that we are in complete control of our behaviour. In fact this is not so. Our behaviour is largely dependent on our feelings, and over these we are not entirely in control. When our feelings become too strong, our ability to think clearly and logically vanishes completely: we may be blind with rage or with love, paralysed with fear, made totally irresponsible by happiness. Our thinking and our way of looking at things is dependent on interest, on mood, on feelings of acceptance or rejection, all of which are outside our personal control. We may be aware of the way in which feeling colours behaviour, but it may be difficult to trace back how these feelings originated. Our attitudes to older people may be repetitions of our attitudes to our mother, father, or teacher; attitudes to our colleagues may resemble our attitudes to brothers and sisters. We could say that our current behaviour is determined by our past experience, but without special techniques we are nevertheless unable to trace the connection.

The third method of explaining behaviour by reference to its purpose is sometimes the most profitable. People do not always know what they are hoping to achieve, their aim may be unconscious, just as the origin of their action is unconscious. Frequently it is quite obvious that a child or an adult is trying to attract attention, or that he is trying to look big. It may be obvious that a person is trying to dominate his family by behaving as if he were an invalid, or that a mother's helplessness is designed to keep her children at home.

It would be tactless and useless to try to make people

aware in a direct way of the purpose of their action. It is, however, often useful to indicate that the purpose is understood and appreciated, and that it can be achieved by normal and socially acceptable methods.

Many people are completely unaware of the fact that their behaviour is at times determined by their feelings rather than their rational thoughts. Even those who do have some insight into their unconscious mental state refuse at times to recognize the emotion in some of their reactions. People develop an ideal picture of themselves which they endeavour to keep intact. When feelings or attitudes do not fit in with their own idea of themselves, they resort to a variety of defence mechanisms.

Defence Mechanisms. These occur in everyone to a greater or lesser extent. They are mentioned in order to assist recognition of the problems confronting nurses and patients in understanding themselves and each other. The most useful mechanism is '*rationalization*'. This is a process of giving a good, logical reason for one's action, leaving out the unconscious, emotional one. The rational explanation may, of course, also be true but it may be only a partial explanation of behaviour.

Parents say that they punish children for their own good, when in fact they may be relieving their own anger. A nurse may explain that she forgot an unpleasant task because she was too busy. The fact that it is an unpleasant and not an interesting task which is forgotten shows the emotional cause of forgetting. A patient may explain that she could not see the doctor sooner because she had to look after her children, in fact she was afraid of seeing a doctor. The reason people give for choosing their jobs or for leaving nursing are often examples of partial rationalization. The emotional reasons are difficult to express and often unconscious.

Another important mechanism is '*repression*', a method dealing with uncomfortable feelings by forgetting them. At

any one moment only a very small portion of one's total knowledge is conscious. While these lines are being read nothing other than their form and content is in the reader's consciousness. Many more things could become conscious if attempts were made to make them so. At will it would be possible to think of acquaintances, of work in the wards, of poetry that has been learnt, of simple arithmetical operations, or of a pleasant meal. All these ideas and thoughts are readily accessible. They were acquired by learning and can be remembered.

Many things which have been equally well learnt or have formed vivid experiences are, however, forgotten. There is practically no recollection of the events of the first few years of life, and from then onwards memory is patchy. Even of the more recently acquired knowledge some items are mysteriously forgotten. Careful analysis of the difference between those things which are remembered and those which are forgotten shows that many of the forgotten things are unpleasant and uncomfortable. Forgetting of this kind is an active process, a pushing out of consciousness of those memories, and the feelings associated with them, which are hard to bear. People may forget to turn up for appointments which they did not relish in the first instance, mistakes one made in nursing patients may be forgotten, as may also any humiliating experiences suffered in childhood or, later, at work. Other people's discomfiture is often remembered while our own is forgotten.

This normal process of repression partly accounts for the fact that we remember only a very small selection of personal details. It is helpful in keeping our capacity to think and learn wide open. The total amount of repressed material, however, forms part of the unconscious aspect of the personality and may affect behaviour without the person being aware of his own state of mind. When emotions remain very strong but

the events are not consciously linked with them, the repressed material can become a hindrance to normal development. A child for instance may feel angry with his mother because she punished him. If he feels too guilty about his anger, he may repress the whole complex situation. He forgets about his anger and also about the events which led up to it. The behaviour he shows is gentle, kind, solicitous, submissive. Unconscious anger, however, may remain in him and either show itself in his accidental breaking of his mother's favourite things, or in his bedwetting, refusal of food, or in his inability to let his mother out of sight.

Projection. This is a device we use in interpreting the environment around us according to our own personality. We see into pictures more than is really justified by objective facts. Clouds, for example, can be made into faces or animals. We see stars in constellations representing bears or swans, when in fact any other constellation is equally possible. Mountain ranges are named according to the patterns that can be seen in them. Pictures, sounds and events are always perceived as they are presented by the mood of the moment. Interest and expectation determine what is noticed from among a much greater choice of observations, and the mood determines their interpretation.

All these ways of making events meaningful are 'projections'. More commonly, however, the term is reserved for the attempt to deal with our own shortcomings, by seeing them in others and denying them in ourselves. When we feel guilty for example about our dislike for another nurse, we complain that she is the one who dislikes us. People who are dishonest often attribute dishonesty to others. Racial prejudice is often attributed to other people in an attempt to deny it in oneself. The fact that our own attitudes are projected on to others in turn affects other people's behaviour. If we go on thinking for long

enough that a person is unfriendly, that person will become unfriendly even if she did not feel that way at first. Our suspicions are then confirmed and our behaviour justified.

Identification. Our attitude to people depends largely on the unconscious mechanism of identification. In every situation in which we understand precisely how another person feels, we identify ourselves with him. When a film is seen, we live through the plot as if we were one of the characters, experiencing his hope and disappointments, his happiness and pain. Different people seeing the film at the same time may identify it with different people. A young girl may come away knowing exactly how the bride felt, a young man may understand the bridegroom, and an older person may understand the parents' point of view. To a certain extent each person has seen the film differently.

While we grow up we learn the roles we are going to play in life by identification with people we try to emulate. Girls identify with their mother, later perhaps with their teacher, and later still perhaps with a film star. Young nurses identify with ward sisters or matrons. It may happen that a student nurse identifies rather strongly with another student nurse who perhaps is in trouble, so that she is unable to see the sister's point of view. There are nurses who identify so strongly with the patients that they cannot carry out treatment successfully because they share the patients' apprehension and suffering.

Substitution of one emotional outlet for another is a common way of dealing with difficulties. Emotion may be displaced from one person to another. Anger against the ward sister may be displaced on to a more junior nurse or on to a patient.

Sublimation occurs when anyone satisfies his emotional need by devoting his energies to some useful purpose. The need to give maternal care, for example, may find gratification in the care of the sick. Some lonely people give much love and care

to cats and dogs when no opportunity occurs for giving their affection to human beings.

When emotions are so powerful that they become frightening, there may be a resort to '*denial*' of emotions. In hospital so many painful situations occur that examples of 'denial' of feeling can easily be found among patients, relatives and nurses.

Patients may be able to tolerate their anxiety about their illness or about the family they have left behind only by appearing totally calm and unconcerned. Bereaved relatives are often unable to cry and they sometimes say that they have no feeling left at all. It is sometimes suggested that nurses protect themselves from the impact of the numerous traumatic experiences of emergencies, suffering, death and sense of responsibility by developing an unfeeling, apparently callous attitude.

15. SOME THEORIES OF DEVELOPMENT

Freud

In previous chapters we have traced development from infancy to old age. At times a possible connection between early development and later personality characteristics were pointed out, and in discussing motivation it was suggested that unconscious mechanisms may be at work, some of which were described. Some of the ideas and concepts we have used so far are part of a general theory of personality development put forward by Freud and modified and elaborated by some of his followers. We have so far dealt only with those aspects of Freudian psychological theory which are fairly universally accepted and applicable. The fact that we are at times unaware of the motives of our actions, that there is an unconscious part of human personality, and that early childhood influences are of importance are undisputed basic facts though there is some controversy about the precise nature of the causal relationships between childhood experience and adult personality.

In this chapter a brief outline of the main points of psychoanalytic and related psychological theories will be given. Other psychological schools are described in later chapters.

Sigmund Freud, an Austrian physician, died in England in 1939. His main interest during and on completion of his medical studies lay in the investigation of the structure and function of the nervous system, and he had done some valuable work in neurophysiology and neurological disorders before he became interested in those apparently neurological disorders in which no organic lesion could be found. He spent some time in France where he was able to observe phenomena of post-hypnotic suggestion. Although the process of inducing a

hypnotic state was not clearly understood, the hypnotist was able to demonstrate that his subject would carry out later, at a specified time after awakening, any act suggested to her by the hypnotist.

It is, for example, possible to tell a hypnotized subject that at 3 o'clock in the afternoon she will interrupt her work, leave the room, pick up an umbrella in the hall, open it, replace it, and return to her former occupation. The subject is then roused from the hypnotic state and remembers nothing of what has been said to her. At precisely 3 o'clock she becomes restless and eventually carries out the activities mentioned above and returns to her previous occupation.

When questioned, she cannot explain her actions, becomes uneasy, but if there is insistence she finds a perfectly reasonable explanation; for example: 'I thought it was getting worn out, and wanted to look if I needed to buy a new one soon.' This is rationalization, but appears to the subject to be the true reason. The suggestion made to her during hypnosis is not accessible to her conscious thoughts. It is 'unconscious' but nevertheless motivates the behaviour described. It is possible under hypnosis to suggest the loss of power of a limb, to tell the subject that he will be blind or to suggest that he will fail to recognize a particular familiar person or object. On awakening from the hypnotic state, the subject suffers from the symptom suggested to him. He cannot explain how he developed the symptom but is strangely indifferent to it. Under subsequent hypnotic influence the symptoms are easily removed.

The purpose of the demonstrations was to study the phenomenon of hypnosis itself. Freud, however, was struck by the significance of the fact that the subjects were unconscious of the causation of their behaviour and by the similarity between some of the symptoms which could be produced and those displayed by his patients. The most important points of

Freudian theory arise from these observations; namely, the discovery of the dynamic nature of the unconscious. Freud became interested in methods of bringing some of the unconscious material back into consciousness. Under hypnosis it is possible for the subject to remember more and more of his past life. In fact it is possible to relive incidents of childhood which appeared to be completely forgotten, and to experience emotions as deeply as was done at an earlier stage.

Freud used the method of 'free association' to delve into the unconscious. If the individual feels completely relaxed and allows his ideas to wander completely without imposing any criticism or restraint and without any selection of what appears relevant, more and more memories return to consciousness.

Psychoanalysis is the term used to describe this method. Because many people feel frightened at the thought of revealing some of their most closely guarded secrets, of which even they themselves are unaware, it is necessary for the analyst to help the subject to relax. A friendly, non-critical, persuasive attitude is necessary, complete acceptance of anything that is said, and an unhurried atmosphere. Freud felt it was an advantage to lie down on a couch for complete relaxation, and to arrange the furniture so that the facial expression of the analyst could not be observed. By using this method Freud was able to discover more and more about unconscious mental mechanisms. Because he analysed people suffering from neurotic illness, he first believed that some of the events recalled from the unconscious by his patients were responsible for their illness. However, analysis of normal people and some of Freud's discoveries about his own unconscious, convinced him that some of his findings at least were universally true of all people.

During the process of free association many unpleasant, often extremely painful events, are recalled. Freud believed

that these had become unconscious because they had been too painful to be dealt with consciously. He used the term 'repression' to describe the process of forgetting unpleasant, painful material. Repression is not deliberate. It is an active but unconscious way of forgetting, and serves the purpose of leaving the person emotionally undisturbed. At times, however, the repression is incomplete. Events are forgotten but the emotion attached to the event remains and interferes in daily life. Quite inappropriate emotional reactions can occur and can be sufficiently distressing to amount to neurotic symptoms. Irrational fears, excessive hostility, a general attitude of aggression, excessive submissiveness may have their origin in repressed childhood experiences. Repression occurs in everybody. The first few years of life, which are full of important and highly significant events, are almost completely forgotten by all people. Only isolated events can be recalled without the help of psychoanalysis. During analysis, it is possible to recall much of the subject's first few years without any direction or suggestion from the analyst. Recalled material is usually believed to belong as far back as the second year of life.

Freud at first believed that the recollections of his patients were accurate and factual, and he was very perturbed to find that so often experiences of a sensual nature were recalled. However, he later realized that some of the recollections were not based on reality but on phantasy, although they were none the less important to the individual. Children are unable to measure time with any degree of accuracy; consequently, recollections of events are not always accurately timed. There is also a lack of vocabulary during childhood to describe events and experiences clearly, so that people talk of their early feelings as if they were related to the state of tension in relation to their body. In recollection adult language is used to describe events to which such language did not at the time apply and

to which it may be inappropriate, with the result that reference is often made to sexual experiences. Emotions are accurately recalled, and are clearly recognized, and often the event to which the emotion originally referred is described in more adult form than justified.

Freud believed that everything that is unconscious has been repressed. We repress those things which are painful and unacceptable and consequently there must be in each of us a mechanism capable of selecting what ought to be repressed. Freud tried to present his idea in the form of a model, using words which could easily be understood because they did not in fact refer to anything else.

He used the Latin personal pronoun EGO to refer to that part of the personality of which the individual is usually aware, the part referred to as the 'self'. This EGO has developed, Freud said, from the ID. The third person neuter of the pronoun *it* indicates that there is something disowned and not consciously recognized as the self.

Originally, Freud said, the infant is entirely ID, entirely motivated by impulses and urges which seek pleasure in an unrestrained, sensual way. It seeks immediate gratification of its most primitive, instinctive needs. Very soon restrictions are imposed on the infant. He cannot always obtain food or comfort as soon as he wishes. Reality impinges on the ID and restrains it. Gratification must also be postponed at times because the child's mother wishes it. Her approval may depend on some curb on the gratification of instinctive desires. The child values approval and soon begins to accept as his own those standards which are first demanded by his mother. More and more, the standards of behaviour of people whose approval is valued are accepted by the child. He forms a conscience which Freud called SUPER EGO.

Healthy adjustment means that the EGO is well developed and strong, not easily threatened by the forces of the ID, or

by the excessive demands of the SUPER EGO. Whenever there is danger to the defences of the EGO we respond with anxiety. The defence mechanisms previously described, or in some people neurotic symptoms, may be used to deal with strong forces from the ID or with a SUPER EGO which is too severe.

Freud did not explain why some people have more difficulties than others in establishing a satisfactory balance between the various aspects of personality, but he did attempt to trace certain adult personality traits to childhood experiences. In particular he maintained that there is continuity from infancy to maturity in the way in which people derive sensual and emotional satisfaction. At each stage, satisfaction must be obtained before it is possible to progress to the next phase of development. Failure at any one stage to gain satisfaction results in arrest of development. Freud called this 'fixation' or even a return to an earlier method of gaining satisfaction, 'regression'.

Adults obtain physical, sensual satisfaction in heterosexual relationship and orgasm. Freud believed that this special form of satisfaction can be traced back to childhood. Relaxation and satisfaction in infancy is gained during feeding by sucking. This is the 'oral' stage of development. Later, elimination is a profoundly satisfying activity in the 'anal' phase of development. Later still, stimulation of the genital organs by masturbation has the same effect. The next stage of sexual satisfaction is the phallic stage. This term refers to the male sex organ, the penis, but is used for both women and men. Freud did not say that sucking and elimination are sexual activities but that the satisfaction obtained from these activities is similar to the satisfaction obtained by adults during the sexual act. These activities are remembered during analysis with the kind of feeling which in adulthood accompanies sexual ideas. He also said that the earlier phases must necessarily be passed through

during development of adult sexuality. After the phallic stage there is a latency period before more mature sexual interest arise.

The mouth continues through life to have erotic significance, for example in kissing. Psychoanalysts consider that the interest in food, sucking of sweets or pipes or smoking sometimes represent a substitute for sexual gratification. The connection between elimination and sexual development is less clear in healthy people, but the amount of secrecy, shame and guilt which often accompanies thought or talk of elimination strongly supports the connection with sex. Freud drew attention to the fact that the fæcal material is the first product of the infant. He presents the fæces to the mother as a gift. Withholding fæces is a way of depriving mother of the gift, it is the child's most certain way of causing anxiety and anger in the mother, the first opportunity for asserting himself and winning a victory.

Fixation at this level of development, Freud said, not only concerns sexual development but also the adult's tendency to orderliness, his attitude to money, parsimony, or even avarice in adulthood, and the way in which aggression is expressed: for example obstinacy or vindictiveness are, according to Freud, related to fixation at the 'anal' level of development.

Just as adult physical satisfaction has its origin in childhood, so does emotional development. Mature adults are capable of special, warm, emotional relationships with members of the family; for example, husband or wife and children. The particular feeling for a person of the opposite sex, and the protective altruistic relationship with children, is one of the characteristics of healthy adult adjustment. Some people would go so far as to say that the fulfilment of heterosexual love in procreation represents every person's greatest desire. There are, of course, some people who cannot through force of circumstances find fulfilment in marriage, and some who choose to devote their lives to the arts, to creative work or to public

service. Some of the world's greatest works have been produced by people who gained more satisfaction from their work than from their own personal relationships. This may be considered as a higher form of development, but Freud believed that this is 'sublimation' of the emotions which should normally be experienced in love.

Adult love is, according to Freud, a goal which is reached by going through a series of emotional experiences in childhood. The most important of these is the experience of being loved by the mother, or by a mother substitute quite early in infancy. All children need love and protection. The idea of an 'ideal mother' is universal. A sense of deprivation is felt when mother love is absent, or if separation from the mother occurs. However, even the best and most loving mother inevitably falls short of the child's image of the ideal mother. Every mother must at times cause frustration to the child. She may fail to pick him up when he wishes it, may interrupt feeding before the child is satisfied or fail in some other way to respond to his needs. Frustration creates anger and hate in the child, directed against the very person whom he most loves and needs. The problem of love and dealing with it, of experiencing hate and dealing with it without overwhelming feelings of guilt, the ambivalence of feelings to the same person, all these have to be worked through before adult adjustment is reached.

Some people believe that children should be spared the unpleasant experience of meeting frustrations. They believe that Freud having drawn attention to the child's feeling of ambivalence or aggression, advocated that children should never be thwarted in any way. There is no justification for such belief. On the contrary, the child gains security from the knowledge that an adult, not he himself, is in command. But he does experience strong emotions in response to frustration and may learn to deal more adequately with these emotions

if he learns to recognize and control them than if he is made to repress them in order to avoid guilt feelings about them. Adult attitudes to women, particularly to older and maternal women, may depend on the way in which feelings towards the mother are dealt with.

Early in infancy the presence of the father may be felt as a threat and often be resented because he seems to distract the mother's attention from the child. The relationship between mother, father and child provides the first opportunity for feelings of jealousy. This situation is referred to as the 'Œdipus' situation by Freud who draws an analogy between this and the Greek story of Œdipus who, in accordance with the oracle and in spite of all precautions taken against its fulfilment, kills his father and marries his mother in ignorance of their incestuous relationship. Themes similar to that of the Œdipus saga occur in the stories of many cultures and Freud saw in this an indication of the universality of incestuous wishes in human beings. Normally, Freud thought, the Œdipus situation is resolved by identification with the parent of the child's own sex; one becoming like his father to retain his mother's love, another like her mother in order to share in the love of her father. The successful solution of the Œdipus situation results in a healthy attitude to men and women. Fixation at this stage of development may mean that excessive dependence on the mother or on a mother figure and a resentment of men is carried into adulthood—a form of maladjustment termed the 'Œdipus Complex'.

In many families the father represents authority. Adult attitudes to people in authority or to those who are potentially in authority is largely patterned on attitude towards the father, though this may differ with the position fathers hold in varying cultures. Love and respect for the father may lead to an acceptance of reasonable authority and, in turn, to the use of authority in a similar manner. Resentment of the father, or

the belief that the father is excessively restrictive, may lead to fear and rebellion in the face of authority, and to an authoritarian wielding of authority when the occasion arises.

Other children in the family provide an opportunity for competition, rivalry and co-operation. Freud does not say much about the effect of sibling rivalry on social development. This is discussed much more fully by Adler, one of Freud's early collaborators. The arrival of a new baby undoubtedly creates jealousy and a feeling of insecurity which needs to be resolved during childhood in order to develop independence.

When school begins, relationships to people outside the family become important. Teachers for the time being replace parents in the position of authority. They substitute impartial detached authority for the personal one of the parents. It becomes possible for the child to see himself as equal to others, to develop a sense of justice and to dispense with an authoritarian father figure.

Some people, however, continue to feel the need for absolute authority. At a time when they begin to doubt the absolute wisdom of their parents, they obtain support from their belief in God or in the absolute truths of scientific values.

Freud has shown that these few basic attitudes to the mother, father and siblings form the pattern for later relationships. People tend to repeat over and over again the reactions they have learnt to adopt in childhood. It almost seems as if nothing can be done to change people. The emotional tie with the mother determines not only later reactions to other people who play a maternal role in the life of the individual, for example to a nurse, but also the kind of mother that the child later turns out to be. Absence of love in childhood may well make it difficult for a person to accept love from people who are very willing to give it and may also make it difficult for her, as a parent, to give love and security to her own child.

Resentment of the father's authority in childhood tends to

be repeated in the face of any person in authority and leads to the wielding of authority in a manner resented by others. We repeat the attitudes we have learnt in childhood throughout life without being aware of their origin, and often without the person recognizing that his attitude depends more on his own personality structure than on other people's behaviour. We describe others as authoritarian or hostile, fussy or oversolicitous without becoming aware that our own attitude to them makes us see them in that light and elicits from them the very behaviour to which we refer.

This repetition of childhood attitudes to people we meet in adult life is sometimes referred to as 'transference'. Freud first used the term to describe how his patients used him as if he were the wonderful father, the loving mother or the hated authority to which they referred. They transferred on to him emotions which properly belonged to others. A positive transference, that is the feeling of love and trust which the patient temporarily places in the analyst, is helpful during stressful phases of analysis and acts as strong motivation to continue the analysis. Negative transference, that is hate, anger and resentment regarding the analyst, can be utilized to make the patient aware of feelings of which he may have been unconscious and to help him accept characteristics hitherto repressed within himself. Later in analysis, it becomes clear to the patient that his feelings were misplaced. His judgment of the analyst becomes free from the distortion of transferred emotions and the analysis can come to an end when the patient feels he no longer needs the analyst as a target for his feelings.

In analysis, transference is part of the planned process of bringing unconscious material into consciousness. However, in everyday life transference frequently takes place. Patients in hospital sometimes behave as if they were in love with nurses when, in fact, they invest in the nurse the love which belongs

to the mother. Relatives may be afraid to ask doctors for their opinion and treat doctors in a way which might have been appropriate for their own fathers. Parents often transfer to their children's teachers the mixture of fear and respect they formerly had for their own headmaster. Nurses may find that their attitude to ward sister or matron is irrational and represents a transference of feelings from their own family experience.

Transference is often very useful. In new situations, and when meeting new people, it is helpful to be able to use well tried patterns of behaviour and to proceed on the assumption that the old approach will be found useful again. It helps the patient to be able to trust each nurse as if she were his mother. Order in society is more easily maintained if people respect authority automatically just as they used to do in childhood. Transference is a hindrance, however, either if the original attitudes are in themselves abnormal or if they are maladaptive to the present situation. Excessive resentfulness of authority or excessive need for love may prevent the formation of satisfactory adult relationships. Transference also interferes with getting to know people as they really are, because the individual may go on treating them as if they possessed the characteristics which he has projected on to them.

Freud's apparently fatalistic outlook in pointing out that we cannot help behaving in the way we do because we merely repeat what we have learnt has, in reality, led to the awareness that change is possible, providing that people recognize the unconscious mechanisms at work in themselves as well as in other people. In psychoanalysis the analyst helps the patient to re-examine his own attitudes and in tracing them back to childhood, they automatically change. This process of re-examining attitudes can be carried out—though perhaps less thoroughly and less systematically—by anyone who is interested in human relationships. Nurses may find their

attitudes changing considerably the moment they begin to ask why the patients, their colleagues or they themselves behave in the way they do.

Reports written about patients, for example, often reveal much about the nurse's attitude. The nurse may find a particular patient irritating and trying. When she begins to investigate either what part she herself plays in provoking the patient, or what it is about herself which makes her react to this particular patient with irritation, the feeling is often recognized as transference and it then becomes possible to give the patient the care he needs without emotional interference.

During the process of free association, Freud found that people began to talk of their dreams and that dreams became more frequent as analysis progressed. Freud began to investigate dreams and came to the conclusion that some unconscious forces are expressed in dreams. The story which is remembered, he referred to as the 'manifest' content. Behind this is the 'latent' dream content; the meaning of the dream is expressed symbolically in the manifest dream content. During the dream, the dreamer understands the symbolism and often wakes feeling happy and elated. When awake, the dream appears meaningless and the dreamer wonders how the absurd dream content could ever have been thought of. Freud said the 'censor' keeps the latent dream content unconscious and even during sleep only allows disguised symbolic expression of the unconscious wishes. To understand a dream it is necessary to see what association each of the items brings forth. The symbolism used by each person is private and different for each person, but certain characteristics can be observed in the dreams of many people. Sometimes concrete objects represent figures of speech. We talk, for example, of feeling fenced in or of reaching rock bottom. In the dream, fences or rocks may appear to represent these feelings. Often several separate

parts of the dream produce the same association—there is 'over-determination'; at other times one thing in the dream stands for a number of different ideas—'condensation'. Some dream symbols are thought to have a sexual meaning, and some occur so frequently that it is almost possible to guess at their meaning instead of inviting the dreamer to produce his own associations in order to interpret the dream. However, another person's dream cannot be accurately interpreted this way.

Freud believed that all dreams expressed the fulfilment of an unconscious wish. Other psychologists do not entirely agree with this statement, but they do consider dreams important and significant expressions of the unconscious.

Psychoanalysis is both a method of investigating personality development and a theory of personality structure. The method used by Freud has resulted in far-reaching extension of our knowledge of the human personality. It continues to be a valuable method of investigation and represents a useful preparation for those who need to know themselves better in order to learn how to understand their patients. As a method of treatment it has undergone many modifications. Some of these make treatment more acceptable to the patients and some are reputed to speed treatment. Occasionally a psychoanalytic method without modification is used in the treatment of some form of mental disorder, but this usually is too long and costly to be of practical value. Many people doubt whether in fact it is possible to cure mental illness by this method. Psychoanalysis as a method of investigating the unconscious is often criticized as being unscientific, in that the findings are not verifiable by any other method.

The psychoanalytic theory as developed by Freud has aroused a great deal of anger and criticism. Freudians say that the degree of 'irrational' emotion with which criticism is expressed indicates how accurate the theory in fact is. It is profoundly uncomfortable to anyone to be told that he is not

entirely aware of his own personality and to have his unconscious tendencies brought out in the open. Everybody dislikes the thought of his own irrational motivation and tends to react by rejecting and denying it.

At present, more objective criticism is being made by those psychologists who attempt to carry out scientifically conducted experiments to test the separate facets of the theory. There appears to be no doubt that some sound facts will be found among the prolific hypotheses put forward by Freud. Much of the original criticism of Freud's theories are connected with his use of the concept of sex. Many people find it unacceptable to associate sexual concepts with child development, and Freud's description of infantile sexuality has offended some people. Some of Freud's disciples have now re-examined and modified a good deal of his theory. Less emphasis is placed on the instinctual explanations of behaviour and much more on the influence of culture.

Many people doubt some of Freud's theories because the method he used is unscientific. It is difficult to test most hypotheses by experimental work. Usually it is only possible for anyone to practise psychoanalysis after he has himself had a personal analysis, a procedure which leads to bias by those who are analysts, and excludes from discussion all those who are not.

One of the difficulties in using the psychoanalytic theory lies in the fact that it does not explain adequately how the differences in personality development occur. Freud at first believed that the traumatic events which his patients uncovered in analysis accounted for their neurotic symptoms. Later, however, he showed that even normal people recalled the same kind of childhood events. His theory reveals more of the universal patterns of development than of the causation of psychological disorder. It is also argued against the Freudian theory that many examples can be found where the same event causes diametrically opposite behaviour. The

restrictions which parents impose on the child may, for example, cause hostility in later life or may result in reaction formation leaving the child too submissive and passive.

There has been some anxiety about the effect of Freud's 'deterministic' theory on the moral standards of people. If it is true that adult behaviour is caused by what happened in childhood, then people cannot be held responsible for their actions. This fatalistic outlook is uncomfortable and could have detrimental effects on standards of behaviour.

The understanding of other people is helped if it is assumed that they cannot always be held responsible for their actions and opinions. Interest replaces irritation and anger regarding others. Very often it pays for the student to examine his own preconceptions and prejudices and to try to bring into consciousness hidden parts of his own personality. In guiding his own behaviour, however, it is essential for him to believe that there is free will and power to control his own actions.

The main findings of Freud are unchallenged by his collaborators and pupils. However, some deviations from his theory and elaborations of parts of the theory have occurred during the last fifty years.

In this chapter some of the main points of difference between Freud and other psychologists of the Schools of Depth Psychology will be outlined. If only a few names are mentioned and less space is devoted to them than to Freud, it is not because these theories are less important but because they also are based on psychoanalytic theory.

Alfred Adler

Alfred Adler, an early collaborator of Freud and compatriot of his, later became interested not so much in the causation and determination of behaviour but rather in its

purpose. Though he agreed with much of what Freud says about the early influence of environment, Adler was primarily interested in the possibility of change. Environment and heredity, he agreed, are important, but it would be an error to believe that we are the result of what has happened to us through environment and heredity. Rather, we are what we make of our own potentiality and our experiences in the environment in which we live. His emphasis on the wholeness of the human organism is one of the most important contributions to current psychological thinking, though his is not the only influence in this direction.

Adler's psychology can be termed 'teleological' or purposive psychology. The main purpose we all pursue, he said, is the effort to become powerful. We are all born helpless and in the process of growing up we aim to become strong and independent. How we do this depends partly on the view we take of, and the understanding we bring to our own inferiority, partly on the method we use to establish our strength.

The 'striving for power' arising from our 'inferiority complex' is the foundation stone on which Adlerian theory is built. Adler succeeded in explaining almost every kind of behaviour on the basis of this. Some people feel that this is an over-simplified concept of development.

The task of the child is to explore his environment, to organize his experience into a meaningful whole. Very soon, everything the child sees, hears and feels, and his every experience are utilized in the light of the 'scheme' which the child has already formed. He approaches new experiences with certain expectations and in the first few years develops a 'style of life' which makes his behaviour characteristic for himself. Adler assumed—without examining his assumption in any critical way—that a certain style of life is good and desirable, others maladjusted and unhealthy. He believed that people ought to develop 'co-operation' and 'indepen-

dence', and that it is wrong to make use of others by being helpless or excessively aggressive.

Adler was particularly interested in education and was a pioneer of child guidance. The function of the teacher or the doctor who tries to help the child and his family is to discover the child's particular style of life and to make the family conscious of it. The style of life can be changed by a co-operative effort of the family or the school.

One of the causes of the child's original feeling of inferiority is to be found not only in his total helplessness, but in specific organic debilities. Most people are born with some organs more developed than others: there may be defective sight or hearing, a limb may be weak, speech may be impaired, ugliness, variations from the normal in height or weight may be experienced as signs of inferiority. So may sexual differences, a point on which Adler agreed with Freud. While Freud, however, talked of 'castration fears', the anxiety of the boy that he may lose his male organ and of the girl that she may have lost something she ought to have, Adler talked of the 'masculine protest' type of behaviour which leads to increasing competition for power.

The inferior organ is used in an attempt to become powerful. Some people compensate by greater practice and determination to develop the inferior organ. Some develop other skills and make up for deficiencies. Yet others use their deficiency to gain power over others by a show of helplessness. Organs 'speak' before real speech is developed, and 'organ language' should be learnt by those who want to influence the child's development. One source of the feeling of inferiority is found in the way in which a child reacts to his position in the family. The eldest child, for example, suffers dethronement when the next child is born. He feels less important, less well loved than the younger child. His way of becoming powerful may well consist of developing into a trustworthy authoritarian type of

person, adopting for himself the role of the eldest or of parent substitute.

Eldest children, he believed, often have great respect for tradition. Their outlook tends to be pessimistic and they look on the past with regret. The second child may become ambitious, optimistic, forward looking. He may be preoccupied with the need to compete and to catch up with the older child. If he cannot hope to beat the eldest in direct competition, he may strike out into new fields.

The youngest child, who is often petted by the parents, may reach his unique position by particular graciousness. He may dream of being the best, the most useful, the hero of the family, and if he is unable to make dreams come true by using any outstanding ability, he may do so by becoming the favourite as a result of his endearing behaviour.

The only child may develop a style of life characterized by timidity. He does not develop in competition with contemporaries. Instead, the standards of adults and their ambitions for him make the world appear to be a dangerous place. He dare not disappoint by striving and failing. If he makes no attempts to strive forward, he guards against failure and retains the protection of the adult. The position in the family in Adler's view is a very important factor in developing a style of life, but this alone does not determine development. If there is marked difference in ability between children, competition may be abandoned quite early. The child who appears to lack interest and initiative may well be one who has been discouraged in competition. The child who comes from a family in which disharmony exists between parents may become concerned with maintaining his relations with parents rather than with the other children. Those who experience neglect may see the world as hostile and may permanently fight against imaginary enemies or guard themselves against imaginary dangers.

In investigating the style of life, Adler observed the behaviour of the members of the family towards each other. While other workers in the child guidance field tried mainly to understand the child's point of view, Adler saw the whole family and discussed problems openly with parents and child simultaneously.

Like Freud, Adler was interested in the paucity of recollections of the earliest time of life, but he investigated not what was forgotten but what was remembered. The earliest recollections often give an indication of the style of life. The fact that a particular incident was recalled shows what appeared important to the child at the time. The part the child himself played in the remembered incident, whether the child recalls himself as being active or passive, strong or weak, successful or a failure, is an indication of his outlook on life.

Adler paid particular attention to the pattern of behaviour which makes use of helplessness. The most powerful weapon of all is for the individual to demonstrate weakness. It results in holding back others, in gaining attention, in impressing everyone with the immense difficulty of his tasks, provides him with excuses for possible failure and at the same time magnifies his success should it occur.

Adler's own method consisted in showing the child how successful his manœuvres were. By making the child conscious of his effect on his parents when, for example, he is sick in the morning before going to school, he can then only maintain this behaviour deliberately instead of unconsciously. He is more likely to develop a new style of life if he can be shown that power and success are to be gained by more co-operative methods. There is no danger, Adler said, in interpreting to the child what the purpose of his behaviour appeared to be. If interpretation is wrong, it is rejected; if it is right, it clearly strikes home whether admittedly or not.

Adler's general ethical and practical outlook, his description

of the tasks of life as 'Communal Living', 'Work and Sex', into which, he maintained, all our activities could be classified, and his discussion on the meaningfulness of life have made his psychology important.

Many psychologists who base their work on the theories of Freud have in their own work placed greater emphasis on social and cultural factors than on biological ones.

The work of some anthropologists consisted of testing psychoanalytical hypotheses in the very different and more simple cultural environments of primitive societies. An advantage of the anthropological approach lies in the fact that the culture patterns are relatively fixed, social pressures are uniform on all individuals and can more easily be taken into account because of their fairly stable pattern.

Malinowski, Linton, Kardiner and Mead have confirmed some of the findings of psychoanalysts; on the other hand, they have shown that some assumptions which we are inclined to make about the universality of human behaviour are ill-founded. There are, for example, societies in which the men manifest what we should consider feminine behaviour and vice versa. Methods of child rearing, breast feeding, weaning and toilet training vary considerably, and it is not possible to be dogmatic as it was once believed appropriate about the long-term influence on personality development of each method.

In the United States, psychoanalytically orientated psychologists have investigated the extent to which Freud's theory, which developed in central Europe, applies to American culture. It would appear that in the less paternalistic society authority is much less associated with the father figure than Freud believed. Maladjustment and neurotic personality traits appear to the American 'neo-Freudians', to be more related to the individual's position in society than to his instinctive drives.

Horney, for example, talks of people who move 'with', 'away from', or 'against' society. Moreno has developed a sociometric method of measuring people's attitudes to others. Fromm has examined the concept of freedom and independence as the goal of personality development. In England, psychoanalysts have devoted more time to the study of social groups. Psychoanalytic theory and technique have been applied to the study of industrial problems and of social behaviour in school and work. Relationships in hospital among staff, and between staff and patients are being studied by psychologists from the Tavistock Institute of Human Relations.

Psychoanalytic theory has been taken a step further by Melanie Klein, working in England, who has developed the techniques of psychoanalysis to be applied to young children. Melanie Klein's findings about phantasies and emotional development in the first few months of life make it possible to compare these with the behaviour of patients suffering from psychotic disorders, for example depression and schizophrenia, which had not previously been studied by analysts.

Carl Jung

Carl Jung, a Swiss psychologist, was an early collaborator of Freud. His theory soon deviated from Freud's, and in his later writings was mainly concerned with the mythological and religious aspects of human thought. His theory is termed 'Analytical Psychology'. His most important contributions to psychology concern his theory of the unconscious and of personality types.

He, like Freud, realized that much of the personality is unconscious and that repression takes place to protect the conscious ego from unacceptable emotions and ideas. However, Jung believed that only some, not all, of the unconscious

consists of repressed material. The greater part of the unconscious, he maintained, has always been unconscious. During personality development, there is a striving of unconscious material into consciousness as well as repression from consciousness into the unconscious. Jung thus distinguished between a 'personal' unconscious, that is, our own repressed material, and a 'collective unconscious' which we have in common with all other human beings. From the collective unconscious, different ideas emerge into consciousness in different people resulting in the highly individual personality pattern of each person.

The procedure of reaching the unconscious is not unlike the method followed by Freud. Jung, however, went more deeply into the analysis of phantasy and dreams and found symbols of universal meaning which he called 'archetypes'.

Jung believed that during the process of individuation, that is, of developing a conscious ego, only certain aspects of personality become important and well established. Whole personality consists of all these aspects: those which are better developed and also those of an exactly opposite nature which remain unconscious. The total personality is one which is balanced, in which there are present at the same time characteristics of opposite nature.

During the early part of life, the dominant personality characteristics emerge and it is possible to classify people accordingly. The most important classification into extraverts and introverts is widely accepted. Extraverts are people who in the extreme form are easily influenced by other people's opinions of them. They are aware of the effect they have on others and sensitive to other people's expectations. Introverts, on the other hand, are self-contained, relatively unaffected by other people and unresponsive to their environment. Most people are neither extreme extraverts nor extreme introverts. Yet one or other of these characteristics is more fully developed

in the early part of life. The opposite characteristics are present in the unconscious, capable of developing later in life. Other personality characteristics which appear in the conscious ego also have their unconscious counterparts. Masculine characteristics, which Jung called 'animus', have an unconscious feminine counterpart, 'anima'. It is also possible to distinguish characteristic reaction types; for example, feeling-thinking, sensation-intuition, one of each pair could be dominantly conscious with their opposites in the unconscious. Jung believed it to be the task of the second half of life to develop those aspects of personality which have remained unconscious and to endeavour to achieve a well integrated personality by the subject's own efforts.

Treatment of mental disorder by Jung's method does not end with analysis. Throughout treatment there is interpretation by the analyst and an attempt to help in resynthesis and integration. Jung's belief that individuation and integration represent a process which can be achieved by deliberate effort makes his psychological outlook less deterministic than Freud's.

The psychologists mentioned in this chapter are all concerned with the study of people over a period of time. They trace personality back into childhood and predict for the future how this personality will affect people and events. They see people as agents whose actions affect the environment in which they function. Their psychological theories can be described as dynamic schools of psychology.

Jung's classification into personality types forms a link between the dynamic psychologists and those who study personality by other methods which appear to be more scientific.

Description of other schools of psychology will be given in Parts II and III of this book.

SUGGESTIONS FOR FURTHER READING

MILLER, H. C. *Psychoanalysis and its Derivatives.* (Oxford University Press.) This book gives a very simple account of some of the theories of personality development.

HART, B. *The Psychology of Insanity.* (Cambridge University Press.) The various defence mechanisms are well explained.

ZANGWILL, O. L. *An Introduction to Modern Psychology.* (Methuen.) This has a particularly good chapter on analytical theories of psychology.

FREUD, JUNG, ADLER and the other psychologists mentioned in this chapter have written interestingly on many subjects. It is worth while to read their theories in their own original works.

Biographies of these men make fascinating reading:

JONES, E. *Sigmund Freud: Life and Work,* 3 vols. (Hogarth Press.)

PART II

Psychology and the Nurse

1. INTRODUCTION

We have seen in the first part of this book how a study of the development of personality can help us to understand patients' behaviour and attitude to illness.

In this section, we shall examine how knowledge of psychology can help nurses to understand more about themselves.

Much is written about the best methods of training student nurses. In all the discussions about professional standards and qualifications, a number of problems are raised though they are seldom analysed in detail.

These are:

1. Problems related to selection of students.
2. Problems related to the assessment of nurses.
3. Problems related to learning and teaching.

In order to give the patients the best possible nursing service, we need an adequate number of people who are well qualified, and an adequate number of suitable candidates for training.

What makes a candidate suitable? Can suitability be detected in advance? Can good training produce good nurses even if suitability had not been obvious from the start? How can really good nursing be measured?

The next few chapters will deal briefly with some of these points, but no definite answer to any of the questions is possible.

How psychological knowledge can be of help to the nurse in her everyday work will be discussed.

2. THE WORK OF THE NURSE

In recent years a number of work studies have been undertaken. These studies were intended to discover precisely what nurses do.

Only when this is found out will it be possible to decide:

1. What nurses should do—whether in fact they are at the moment using their skill to the best advantage.
2. What staff, other than nurses, could carry out some of this work.
3. How best to prepare the student for the work she is to perform.
4. How to select suitable candidates for training.

Many work studies have been carried out in industry, largely with the aim of simplifying the job and thereby helping to speed up work and increase efficiency. It has long been realized that such matters as the length of the working shift, fatigue, posture, noise, rearrangement of tools and modernization of equipment can considerably affect work output. All work studies in industry have, however, shown that even more important than these physical and organizational influences are the relationships existing between the people who carry out the work, and particularly between management and workers. The method of approach used by those performing work studies also affected the result for good or evil.

Although industrial methods of carrying out work studies cannot be directly applied to nursing, many of the principles apply. Efficiency in nursing is not as easy to measure as it is in industry. However, some attempt can be made to measure the time nurses take to perform various tasks so that they may

then, themselves, reallocate their time as they think would be most beneficial to the patients. Fatigue and posture are just as important in nursing as they are in other jobs. The measurement of morale, job satisfaction and influence of administration on efficiency concern nursing as much as industry.

In a later chapter, more will be said about this aspect of the nurse's work. Here we shall examine what can be learnt from work studies which help us to think more clearly about selection and training. One of the features which has emerged from all studies is the fact that a large amount of each nurse's time is spent away from patients. Some nurses spend much of this time in the preparation of trays and equipment, in sorting and cleaning, and in the preparation of food. Some of these tasks have been described as 'housekeeping tasks'. Some nurses spend much of their time keeping records, measuring and checking of drugs, ordering diets, and other tasks which have been described as 'administrative tasks'.

Yet another group of activities away from the patient consists in talking to doctors, relatives and staff in other departments of the hospital, supervising and instructing nurses, all of which require skills in communication and teaching. It is by no means clear how much of all these activities away from the patient are a necessary part of nursing. One activity, for example, which is rarely recorded or measured is the time taken to think and plan.

Actual work with the patient has been described under two headings:

1. Basic nursing, care concerned with the patient's comfort and personal needs.
2. Technical nursing care, concerned with the specific care which the patient's illness necessitates.

It has become very clear from the work studies carried out that there is considerable overlap in the tasks performed by

nurses of various grades. Nursing orderlies, enrolled nurses, student nurses, trained nurses, all perform some of the housekeeping tasks and give some of the basic nursing care. Enrolled nurses, student nurses, trained nurses, all give technical care and all are concerned with some administrative duties. However, it is fairly clear that very different skills are needed for the various tasks.

This description applies to work studies in general hospitals. If the work of the nurse in special hospitals or on the district, in industry or in health visiting is examined, there is even greater variety in the skills involved. Every work study has emphasized how difficult it is to discover qualitative differences in the way the same work is carried out by different people.

Yet the answer to this problem is essential if good training and good selection is to take place. Efficiency in nursing is not only a matter of speed but also of gentleness, consideration, tact, punctuality, persuasiveness and a number of other personal characteristics which work studies fail to measure.

The most urgent problem with which nurses must concern themselves, then, is to find a way of describing what is good nursing and what is bad, to find out what skills and how much skill is required in the various tasks, and to assess the personality characteristics required of the nurses performing the various jobs.

Work studies can tell us what we do; nurses, themselves, must decide what they ought to do. Details concerning some of the problems will be discussed in the following pages.

3. INTELLIGENCE AND INTELLIGENCE TESTING

Various aspects of nursing appear to require different degrees of intelligence.

The routine housekeeping tasks and perhaps some of the basic and technical nursing skills seem to be well performed by people of relatively low intelligence. Administrative tasks, supervision, teaching, and all those nursing tasks which require initiative, good judgment, variation in different circumstances, require a much higher degree of intelligence. It is possible to devise different schemes of training for those who choose to perform the routine nursing tasks, and for those nurses who wish to devote themselves to the organization of the work and teaching of nurses, but whether it is desirable to do so is debatable.

In this country, we have long believed that the best nurses are those whose proficiency is acquired during a long course of practical training and extensive experience. It is felt desirable that the future leaders of the profession should have a basic training identical to that of all other nurses so that they are thoroughly familiar with the essentials of their work. Advanced training should follow later. Promotion should be granted not only on theoretical knowledge and ability but on sound and long experience.

Many people have criticized this attitude on the grounds that the scheme of training developed in this country is too difficult for the large number of otherwise suitable people who could carry out the less skilled tasks of nursing, and that it is too slow and not sufficiently deep for those who have the aptitude to become teachers and administrators. An attempt has been made to meet this criticism by instituting training for the role

of State Enrolled Nurses. A shorter and simpler course of instruction prepares the nurse to carry out good basic nursing care and to understand the problems in nursing well enough to know when to seek help from better qualified or more experienced people.

Many training schools for enrolled nurses and fewer but better schools for training for the register are advocated by many.

Other countries, for example the United States, have gone much further in this than we have. University courses leading to degrees in nursing and followed by preparation for higher degrees is thought to be the appropriate preparation for nurses who may have had only a bare minimum of practical nursing experience. The actual nursing work is broken down into simple units which can easily be learnt by a variety of less extensively trained workers; such as, aides, attendants, orderlies or practical nurses. The essence of this approach lies in the belief that the highly intelligent, well educated and carefully trained nurse can understand fundamental principles and apply them without wasting time in repetitive performance during her training. As a trained nurse, she can use her ability and intelligence to instruct, supervise and direct others rather than carry out tasks which a less skilled person could perform.

State registration in this country implies that a nurse has acquired the necessary skill and knowledge to practise nursing on her own responsibility—if necessary, unsupervised—and that she has enough understanding of the patient's needs to be able to take the responsibility for nursing care carried out under her guidance. This degree of proficiency can be reached only by those whose intelligence is at least average. Training of approximately three years' duration is designed to give the necessary skill and understanding, provided the student has adequate intelligence and the training is reasonably good.

What exactly is meant by the term intelligence is difficult to define, although everyone uses the term roughly in the same context. As has already been shown from Binet's work, psychologists have found that the IQ of the children tested remained constant over a period of years, and that progress at school was roughly commensurate with the intelligence quotient.

From this work it would follow that intelligence is an innate capacity for *learning*. This concept is, of course, over-simplified. Binet's tests are still in use for the testing of small children. The version now in use is one which was standardized on English-speaking children by Stanford and revised by Terman and Merrill. The performance on the test improves until approximately the age of 14 to 16, remains constant for a few years and then very gradually declines. Binet's test items cover a very wide ground. From these tests it is not possible to establish what exactly is involved in the use of intelligence. Many other tests have since been devised. Some of these require the ability to read and speak the language in which tests are conducted, others rely entirely on non-verbal material; for example, shapes, patterns, colour and figures.

Tests for adults have been graded rather differently from children's tests. Since it is impossible to compare mental and chronological age with each other, comparison is simply made with other people who have carried out the test. When suitable tests are given to a very large number of people, it becomes clear that the performance of the vast majority falls around the same score. As the scores deviate more and more from the average, the number of people who obtain these scores decreases very markedly.

Supposing any particular test has 60 items, each correct answer scores 1. The total score of any one subject could range from 0 to 60. In fact, of a random selection of people, about half might score 25 to 35. On a graph, the scores would be

distributed as shown in Fig. 2. This kind of distribution of scores is called a 'normal distribution' or a normal curve.

The intelligence of human beings varies much in the same way as their height or weight. Examination results, too, tend to be normally distributed if the total number can be compared at all.

Weight of men, or weight of women, would each be normally distributed. If the scores of men and women are put together, there is a 'bimodal' curve; that is, there are two

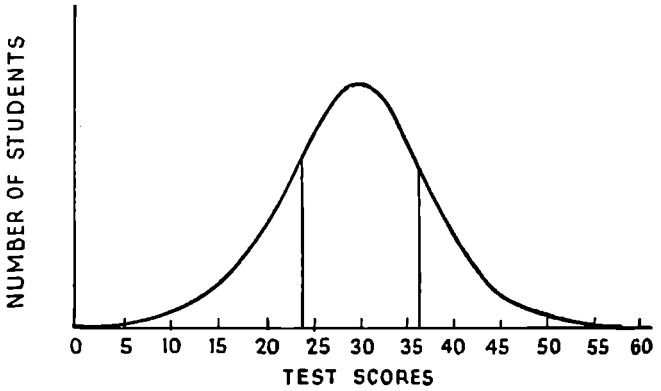


FIG. 2

humps, as shown in Fig. 3. When this occurs, it is clear that two groups are involved rather than one: heights of boys and girls, or of Scandinavian and Chinese people, weights of nuts coming out of a bag of mixed nuts, all would show bimodal distribution. Intelligence scores of the total population are on the whole normally distributed. This shows that there is a measurable characteristic common to human beings. There is no evidence of any difference between men and women or between people of different races.

At the lower end of the scale, among the people of the lowest intelligence, there is a small deviation from normal

distribution. This indicates that the intellectual deficiency of some people, for example those who suffered brain damage at birth or during fœtal development, is of a different kind from the low intelligence of others (Fig. 1, page 61). By and large, intelligence appears to be an hereditary characteristic while some severe deficiency in intelligence is the result of acquired brain damage.

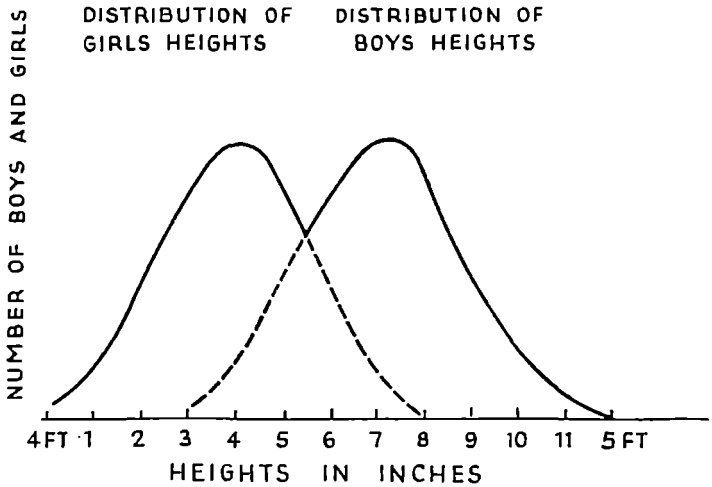


FIG. 3

Comparison of intelligence with that of other people is sometimes expressed in 'percentiles' rather than IQ. 50th percentile means brighter than 50 per cent., less bright than 50 per cent. of all people; 95th percentile means brighter than 95 out of every 100 people Comparison is, of course, made only between people of the same age.

Tests are valid only for those people on whom they were standardized. Tests tried out on children only, for example, are not necessarily valid for adults. To devise a test which is

widely applicable it is necessary to standardize the scores on groups of children, young people, old people, town and country people, representatives of every kind of trade and profession. Standardization means that the grading of the scores is based on knowledge of how large numbers of people actually performed the test. A test standardized in England cannot be automatically applied, say, in the United States of America.

A good test must be reliable and valid.

Reliability means that repeated administration will give the same result. This is like a thermometer which would be expected to show the same reading on successive occasions if circumstances had not altered.

Often with intelligence tests, there is a very slight improvement after the first test; this is the result of becoming familiar with the situation and the type of information required. After the initial practice, however, a reliable test shows no further improvement. For this reason some tests have a short practice test to precede them. Other tests are divided into two similar sections, one of each can be given on successive occasions.

Reliability merely means that the test score itself can be depended on. The test must, however, also be *valid*; that is, it must actually measure something real, beyond itself. It is possible to imagine a thermometer which is so reliable that it always reads 98·4 F.; however, it would not be valid because it would take no notice of changing conditions outside itself. There is good reason to believe that intelligence tests are valid, that there is some real quality which they measure although it is difficult to discover the nature of intelligence.

Spearman, an English psychologist, has attempted to analyse some of the tests which are in use. First, he tried to find out what kind of activities are involved in intelligent behaviour. Second, he devised a method of comparing scores of various test items statistically by a method called factor analysis.

He decided that two main activities constitute intelligence:

1. The discovery of a relationship.
2. The discovery of which other factors have relationships which are similar, thereby possibly discovering new facts.

For example:

Black is to white as *Night is to . . .*

The first test is to find the relationship between black and white. These are opposites. Next, find another word which has the relationship of opposite to night: the answer is *day*. This kind of activity might be called finding analogies, or forming, first deductions, then inductions.

Examples of this process could be given from a wide variety of test items. For example: 1, 3, 5, 7 . . . next item 9. The relationship between these is a difference of 2; the next figure which has such a relationship to the previous figures is 9.

Another example: Pot . . . Top Dog . . .

These are related by reading backwards; the next word is God.

By means of mathematical calculations, Spearman was led to assume that intelligence consists of a general factor which he called 'g', and special factors called 's's. The higher the 'g' the better the performance on all types of tests and the greater the ability to learn.

The specific factors are noticeable by the fact that people do better in certain groups of tests than on others. For example, one person with a high general intelligence may do particularly well in all the tests involving numbers, and less well in those involving words. There are special abilities concerning verbal facility, number sense, space, mechanical ability, musical ability, manual dexterity.

Different tests vary in the degree in which they measure 'g',

and the type of 's' they are meant to measure. Usually it is wise to give a battery of tests which, between them, measure a wide variety of 's's. If only a single test is used it should if possible measure mainly 'g'.

Binet's test consists of such wide variety of items that most 's' qualities are probably covered. Raven asserts that the 'g' factor in his 'Matrices' is very high. This is a test consisting of patterns and designs which are related to each other in special ways. No verbal ability is needed for this test.

People who have a high general intelligence, on the whole, do better in whatever they choose to do than people with low general intelligence. It is a fallacy to believe that people who are good at Latin, for example, must be bad at sewing. They may have more special verbal ability than manual ability; but, even so, the high general intelligence will allow better performance at sewing than will be evidenced by a low general intelligence with relatively high manual dexterity. In fact, however high the special ability, a low general intelligence only allows low level performance. Naturally, interest and encouragement may lead the less intelligent person to develop her skills; discouragement and lack of interest may lead the more intelligent to neglect them. But however unfair it may seem, it is none the less true that high intelligence makes it possible to perform well all round.

Spearman's two-factor theory is probably an over-simplification. In the performance of any one task, there are probably more than two factors operative. Some are group factors acting over and above the specific factors. Speed, fluency, verbal facility, for example, affect any specific ability which may be shown in a test. There is considerable evidence that heredity is an important factor in determining intelligence. This means that a great deal of this ability depends on the intelligence of parents and grandparents from whom have been inherited also other factors, such as colour of eyes or hair.

Twins tend to resemble each other more in intelligence than do other brothers and sisters. Identical twins are more alike in intelligence than fraternal twins. The fact that identical twins raised apart are a little less alike than those brought up together, shows that environment plays some part in the development of intelligence.

Intelligent parents, on the whole, have more intelligent children than dull parents. While it is clear that heredity is involved, it was noticed that some children who changed their environment dramatically improved in intelligence scores. Children moved from orphanages to foster homes, for example, or from bad homes to good ones, made rapid strides and showed much higher scores in later tests. This has led to some doubt about the constancy of intelligence and the extent to which environment plays a part.

It is possible to suppose that 'real intelligence' is unchanged, and that a poor home which lacks opportunity for learning simply delays the effective use of intelligence. But since we cannot measure 'real intelligence' as against intelligent functioning, this is not a very useful argument.

Intelligence, in so far as it is the ability to learn, can be developed only through training. The child who plays, who explores, who is allowed to make mistakes, to handle everything, who is constantly active, has the opportunity to develop his intelligence to the full. But in order to play as described, he needs security, love and encouragement. Children in institutions, such as orphanages or sometimes hospitals, may lack the normal facilities and normal encouragement to learn and therefore may appear unintelligent. In extreme cases of deprivation, children may in fact appear to be severely defective. If love, affection and security are later given and if the child has not suffered to such an extent that he has become incapable of responding, very rapid improvement in intelligence will occur.

The fact that children resemble their parents in intelligence has worried many people concerned with the welfare of society. It is a fact that many highly intelligent people have few children, while many less intelligent parents have large families. There is therefore a fear that general intelligence is declining. Reasons for the difference in size of family are obvious: longer education, higher economic demands for their family, better understanding of birth control, or greater ability to control sex relationships restrict the families of some of the professional people. People of lower intelligence leave school earlier, are more mature at an earlier age, more improvident and less able to practise birth control or restraint. They do not expect a high economic standard and therefore do not mind having larger families.

In fact, however, there is little evidence of any decline in intelligence. Although parents and children are similar in intelligence, children tend to be nearer average than their parents. Outstandingly brilliant children can be born in any family—but they are rare—just as severely defective children can be born to very intelligent parents.

It was believed that people of subnormal intelligence should be prevented from having children. In fact their children are often much brighter than their parents, a factor which makes parenthood all the more difficult for the dull parents and means that some help must be available to them.

Intelligence is obviously one of the personality characteristics which must be taken into account in nursing. Many nursing tasks require the kind of activity which is involved in the use of intelligence. The observation of several things and noticing the relationships between them is necessary in the observation of symptoms, in understanding patients' complaints and in grasping the essentials of certain procedures. It is necessary to be able to draw analogies, to predict what will follow. The nurse needs the ability to utilize various acquired skills in new

situations and apply her previous knowledge to cases where it has not previously been applied. Most of the work of the trained nurse in fact consists of intelligent adjustment to new situations. The unintelligent person can learn to deal with concrete situations but she cannot modify what she has learnt nor apply it elsewhere.

Nurse training should aim at preparing the nurse to act on her own initiative and responsibility. Principles should be learnt during training to be applied as and when required. This means that during training the student has to deal with ideas, she must learn to abstract general principles, she must learn to reason and to apply critical examination. All these are activities which require a fair amount of intelligence.

It is possible for people of varying intelligences to reach similar levels of attainments, though the brighter person takes a shorter time, the less intelligent takes longer. The brighter person can do it unaided, the less intelligent may need more help. It is important in nursing that we should find out how much intelligence is in fact required to carry out the job satisfactorily and to pass examinations.

Past investigations have shown that at least average intelligence is needed to pass examinations with a fair amount of ease. Higher intelligence is needed to progress in nursing to the position of ward sister, administrative positions or tutoring, and for work where no immediate supervision is available, for example, public health.

It would be easy if only candidates of superior intelligence could be selected. In fact, of course, there are few people in that category, and some of them are needed for teaching, research and other academic careers. For nursing, therefore, we must recruit people with sufficiently high intelligence to understand the work without setting the standards unrealistically high and without discouraging the very brightest who are needed as potential leaders.

Intelligence tests are available which can help to detect intelligence well below acceptable minimum. In this country, the educational system is, however, sufficiently well developed for it to be assumed that such low intelligence has already been discovered.

In our state educational system, children who have reached the age of 11 pass from primary to secondary education after an assessment of their general intelligence and achievements up to that time. Children of very high intelligence are offered a grammar school education. Those of average intelligence usually benefit most from secondary modern schools, those of low intelligence go to special schools for the educationally subnormal. School records from grammar schools or secondary modern schools should be as clear a guide to intelligence as a test. People who have sufficient intelligence to cope with nurse training should have managed to obtain passes in a few subjects in G.C.E. and this is required by the General Nursing Council as the minimum educational standard.

True, some children waste time at school, and though they have high intelligence do not achieve great examination success. Intelligence tests may then be of use in selection. In assessing the range of intelligence likely to be compatible with success in nursing, it may be of interest to compare figures relating to intelligence of students in various fields of study. If a fairly wide range of intelligence is compatible with success in nursing, the question to be answered is whether candidates of different abilities should be taught together or in separate classes, whether the same methods of training are suitable for all. In general education there is in this country a tendency to group pupils according to intelligence and attainment; this is referred to as streaming. The arguments in favour of this practice lie partly in the consideration that success is a greater motivation for learning, and that it is preferable to be success-

ful in a less competent class than unsuccessful among a more advanced class.

Teaching and learning can take place at greater speed if students are more intelligent. A mixed class may lead to discouragement of the slowest or a reduction in the general speed of the class and boredom of the brightest. The most important argument, however, is that different methods of teaching are suitable to the most intelligent students, different textbooks can be used, different courses can be followed. They are more able to handle abstract ideas, and can benefit from purely theoretical teaching, because they are able later to apply it to different situations. The less intelligent student is more in need of concrete learning situations. She must deduce the theory from the practical examples rather than the other way round.

While streaming of pupils makes teaching easier, there is much criticism of this practice in some schools on the grounds that both brighter and less intelligent pupils have something to learn from each other, that different methods of teaching are best used side by side and that a separation of the brighter from the less bright pupils leads to just the kind of snobbery which may later in life lead to social difficulties. Both arguments find support among educators in nursing.

In everyday life people of varying intelligence must be able to live with each other. Perhaps particularly in nursing an awareness of the difficulties of the less intelligent and a natural acceptance of the abilities of those of high intelligence are important. Student nurses of high intelligence may have to work with senior nurses whose grasp and understanding are less quick. It is often irritating to these to find their questions brushed aside or inadequately answered. It helps to understand that the senior nurse's greater experience may enable her to show rather than tell, that she may find it difficult to express herself logically but easier to teach by doing. On the other

hand, senior nurses need to be aware of the abilities and limitations of the junior staff and must be able to adjust their expectations and method of instruction.

Many nurses find that patients of very high intelligence tax them considerably. They require training in the approach to people whose superior knowledge and ability might well be used constructively if the nurses do not feel too insecure. It is possible that ease of communication between people of different intelligence levels could be increased if, in training, students were not too rigidly segregated according to intelligence. Their training may have to take place at a slightly different speed, the time-table might have to be flexible and methods of teaching adaptable. The amount of learning expected from the brighter student might have to be greater than that to be expected from the less gifted. Discouragement of the slow has to be avoided and the stimulus of competition must not be sacrificed.

Intelligence declines with advancing years; from early adulthood on, very slowly; after middle age, slightly more rapidly. This decline is, however, very gradual, not noticeable except on testing. The accumulation of knowledge, the wider frame of reference and the greater understanding of the more mature person may make learning easier in spite of the slight decline in intelligence. It is a fallacy to believe that nothing new can be learnt after adolescence. Obviously, too, the higher the intelligence, the less handicap results from the very slow decline of middle age. A very rapid decline in intelligence occurs only when the brain is damaged, either by tumours, injury, by drugs, toxins, chronic infections, alcohol, or by the effects of vascular disturbances.

This decline in intelligence, called 'dementia', is noticeable in the behaviour and conversation of the patient and clearly measured in intelligence tests. One of the characteristics of dementia is the decline in those abilities which involve judg-

ment, discrimination, remembering of instructions. There is relatively little deterioration in the vocabulary. Intelligence tests have their most important use in the diagnosis of dementia. Very often they are used to exclude mental deficiency or dementia before a diagnosis is made of some other illness.

In some mental disorders, for example, the patient's behaviour may be so disordered that dementia is suspected. In schizophrenia, the patient's logic is all his own, other people find it difficult to follow his reasoning. His actions may appear to lack meaning and not to be based on ordinary good judgment. In depression, the patient may be inactive, uninterested, apparently lacking understanding. Yet intelligence tests in these conditions, providing the patient can be persuaded to co-operate, will show that the patient's intelligence is in no way impaired.

Intelligence tests often help in the diagnosis of emotional disturbances in children. Subnormality should be discovered as early as possible in order to begin special training early, and intelligence tests can help to find out if this is necessary. They should also be used when children's bad behaviour at school is not fully understood. Children of low intelligence may respond to the pressure of school and the parents' ambition, with resentment, rebelliousness, or complete discouragement and apathy.

Children with high intelligence may find the work too boring, cease to pay attention and then begin to do badly at school. It is always of interest to find out why children or even some grown up students fail in their studies in spite of possessing superior intelligence. It may be due to emotional trouble which interferes with learning.

In child guidance, student selection and occupational guidance, it is of the utmost importance to assess how effectively the individual makes use of his intelligence.

SOME EXAMPLES TAKEN FROM INTELLIGENCE TESTS

ANALOGIES: Underline the correct answer.

up is to *down* as *high* is to . . .	Book, Sky, Low
fire is to *hot* as *ice* is to . . .	Water, Solid, Cold
cause is to *effect* as *disease* is to . . .	Reason, Death, Life
The day before yesterday is to *the day after tomorrow* as *Saturday* is to . . .	Sunday, Monday, Wednesday

OPPOSITES: Where the words mean the same or nearly the same underline *same*, where they mean the opposite or nearly the opposite underline *opposite*.

Dry . . . Wet	Same, Opposite
Dirty . . . Unclean	Same, Opposite
Haughty . . . Arrogant	Same, Opposite
Relinquish . . . Cede	Same, Opposite
Munificent . . . Parsimonious	Same, Opposite

REASONING: (*a*) Find the two letters or numbers which continue the series.

30, 50, 70, 90, ...
Z, A, Y, B, ...
$\frac{1}{4}$, $\frac{1}{2}$, $\frac{3}{4}$, 1 ... ...

(*b*) Underline the two words which do not belong to the same category as the rest.

Hat, Boot, Head, Shoe, Glove, Hand, Dress, Stocking.
Apple, Plum, Rose, Orange, Apricot, Cabbage, Cherry.

4. PERSONALITY AND PERSONALITY TESTS

It is generally agreed that intelligence is not the only characteristic which determines success or failure in nursing. 'Personality' is often said to be more important than intelligence.

Psychologically speaking this statement is meaningless because intelligence is one of the aspects of personality, just as beauty, height, posture or other aspects of physical appearance are part of personality. What is meant by this statement is that other personality characteristics should be taken into account as well as intelligence. If we try to describe desirable personality characteristics or ask people to describe good or bad nurses they have known, we find that a great variety of method is used.

1. The most common way to describe the ideal nurse is to enumerate a number of qualities she should possess. Such characteristics as patience, tolerance, honesty, perseverance, conscientiousness, thoroughness, initiative, are often mentioned. These are referred to as *personality traits*. A considerable amount of psychological investigation has been carried out to measure personality traits. Traits can be described, their presence or absence in different people compared. A trait is a tendency to behave in a consistent manner in variable situations. The knowledge that a person possesses a particular personality trait makes prediction of behaviour possible.

A nurse who is thorough, for example, carries out a variety of tasks with thoroughness. She is thorough in her studies, in her routine ward duties, in her attempt to know patients, in her dealings with ward management and in her own personal affairs. If she is asked to carry out a job, it can be predicted that she will do it thoroughly whatever it may be.

Of course the question of whether a nurse has a particular trait can be judged only from observation of her actual behaviour; thus to say that she is thorough simply means that she has been observed to demonstrate this trait repeatedly in the past.

Some personality traits have been carefully investigated. Honesty, for example, has been the subject of study in large numbers of children. They were given every possible opportunity to cheat and behave dishonestly in many different situations. During school work they had the opportunity to cheat by looking up the answers or by copying from others. They could cheat in the report of the results or of the time they took over individual items. They also had the opportunity to steal or to tell lies. It became obvious in these investigations that honesty or deceit were not in fact single traits. Some children cheated in their work, but not in their handling of property. Some gave false reports but worked without cheating; some told lies about their work, but not about their behaviour. Some children may cheat at school but not at home.

Most of the traits we look for in nurses have not been as carefully examined, but it is probable that they, too, are more complex than would appear. It is necessary to ask not simply whether or not a nurse possesses any given trait, but rather how much of it she has, in what circumstances she displays it, and whether the trait is specific to particular circumstances or fairly generalized.

2. Another way of describing a suitable or unsuitable personality is to refer to the *emotional state* or *temperament.*

Such characteristics as moodiness, emotional instability, being easily upset, are less desirable qualities. Cheerfulness and possession of an even temperament are more desirable in the nurse.

Temperament is the term used to refer to the way in which emotions are expressed and experienced over a long period of

time. Mood describes the emotion prevailing over a short period.

At the moment of hearing bad news, for example, a person may feel sad. This is a brief experience of an emotion. If sadness persists, it is called depression, which is a mood which may last all day or several days or weeks. Some people become depressed at frequent intervals. They tend to feel happy and elated at times and then plunge into a depressive mood. This is their *temperament*; it is one of mood swings sometimes called cyclothymic.

Classification of personality according to temperament has been attempted many times. It is always recognized that temperament is in some way connected with bodily structure and particularly with the functioning of endocrine glands. Such a description as phlegmatic implies that the calm, unemotional person has large amounts of mucous secretion, a true observation of the parasympathetic activity in a relaxed calm state. The choleric or angry, irritable person who loses his temper frequently was thought to have excessive secretion of bile. The sanguine person who has mood swings and shows excitement and animated passions was thought to be full blooded.

Kretschmer associated different temperaments with body build. He thought that a schizoid temperament, a reserved, shy, withdrawn, emotionally shallow personality is most often found in asthenic people; that is, people who are long and thin in body build. Cycloid temperament, mood swings from elated to depressed and emotional lability, he associated with pyknic body build, a short and stocky physique.

Shakespeare seemed to have similar ideas; in *Julius Cæsar* he says:

> Let me have men about me that are fat;
> Sleek-headed men, and such as sleep o' nights;
> Yond Cassius has a lean and hungry look;
> He thinks too much: such men are dangerous.

Sheldon, the American psychologist, describes a similar association of temperament with body structure but divides bodily types according to the development of various tissues.

The fertilized ovum splits until a ball of cells is formed which then arranges itself into three layers. The outer layer is called ectomorphic; the middle, metamorphic; the inner one, endomorphic. As the embryo develops, the ectomorphic layer forms mainly skin and nervous system; the metamorphic layers, bones and muscle; the endomorphic layer, the internal viscera. Sheldon believes temperament to be associated with the predominance of any one of these layers.

Although people's 'temperament' is often referred to, there is very little to show whether any particular temperament makes one person more suited to nursing than any others. People whose mood varies are sometimes difficult to get on with. Student nurses may find it a strain to have to adjust to the mood of the ward sister. The temperament of the nurse certainly has some effect on the feelings of the patient. However, it would be impossible to say that this is a bad thing. On the whole, it is easier to feel strongly for people whose emotions are strong and who express their emotions. Excessive placidity may become very disconcerting.

In adjusting our general behaviour, we often take into account what emotional reaction it is likely to provoke in others. If other people's emotions are quite erratic, it becomes difficult to take them into account; if emotional response is absent, guidance is missing. Some patients assume for example that the nurse's mood is related to what the patients themselves have said or done. They are frightened at times by what appear to them to be erratic moods in nurses, but they do not find permanent cheerfulness very helpful.

The nurse's inexplicable mood may not be a response to the patient at all, but perhaps to some other situation; for example, bad news from home, or a disagreement with the ward sister.

The patient, however, needs the nurse's emotional response to his own actions, and interprets them as such.

It is true that some people are temperamentally more suited to nursing than others, but except in extremes it would be very difficult to select candidates according to temperament. Temperament is inclined to change somewhat with age. Adolescents are frequently moody. In middle age, probably associated with glandular changes, mood changes again frequently occur. In women, this may become most troublesome at the time of the menopause; in men, rather later. Disorders of endocrine glands, for example, the thyroid glands, are often accompanied by changes in temperament.

3. Another way of describing a nurse's personality consists in referring to *personality type*. There is an overlap between descriptions of temperament and type. Certain temperaments are believed to be associated with body types as already referred to.

Descriptions of a person as shy, reserved, keeping himself to himself, or on the other hand descriptions of hearty, easy-going people who are the life and soul of the party, good mixers, popular, are descriptions of the introvert or extravert personality types respectively. These terms were first used by Jung and introvert and extravert characteristics have been described by many psychologists.

Introverted people do not react very much to other people's feelings. Their own interests and activities are not directed towards others. Extraverts are aware of the effect they have on others, and their behaviour is guided by their relationship to people. Most people are not entirely introverted or extraverted but exhibit characteristics of both.

There is no special merit in being either introvert or extravert. Some extraverts by their ability to respond to other people's moods are excellent company and give valuable contributions to society. The morale and tone of a nurse's

home, sometimes the atmosphere of a ward—certainly the success of a party—depends on the number of extraverts there. On the other hand, extraverts are often inclined to show off, to put themselves in the limelight and to depend on other people's approval so much that they become irritating and overpowering.

Introverts sometimes make other people uncomfortable because they appear too little concerned with what is going on. On the other hand, their thoughtful comment and their strong and stable emotional support, when they are able to give it, can be extremely valuable to their colleagues and to patients. Again it seems as if in nursing there is room for all types except perhaps extremes in any of them.

4. The most common way of describing desirable personality characteristics is to refer to *attitudes* and *sentiments*.

Nurses are expected to show concern for the patient's well-being, to be polite to patients and staff, loyal to the hospital, to have high moral principles, adhere to a code of ethics laid down by the profession and to respect the knowledge of their seniors.

An attitude is an orientation towards an object or situation, a readiness to respond in a predetermined manner. Trust in a nurse, for example, is an attitude in the patient which helps the patient to respond to the care the nurse is proposing to give, without critical awareness and without needing proof of the nurse's ability.

Our attitudes help us to act quickly. Without attitudes to predetermine our actions we would have to examine the facts and merits of every situation before we responded to it. An attitude of obedience, for example, is desirable at times of emergency.

Attitudes are acquired during all periods of development. We have already seen how attitudes to parents may later determine attitudes to other people who are parent-like. Ward

sisters, tutors or matrons are often treated with the same attitude as the mother, teacher or headmistress used to be treated. Patients treat nurses with the attitudes they learnt during childhood play. Doctors are often treated with the attitude appropriate to the father at the time when he seemed to be very big and wonderful.

Some attitudes are learnt later in life. During nurse training the student hopes to acquire useful attitudes to the hospital, to staff, to patients and their families, to the community and to her own friends. Attitudes to suffering, sickness and death are liable to undergo modification during a nursing career. Prejudice is really the same thing as an unfavourable attitude, but because prejudice is an attitude with a very strong emotional factor, it is difficult to change. We talk of prejudice against racial or national groups, prejudice in religion and politics, whenever we refer to tendencies to respond in a predetermined way which interferes with rational judgment. There is prejudice, too, in some people's attitude to mental disorder, or to venereal disease, prejudice to people of certain social class either much above or much below their own, and prejudice in attitudes to people in a position of authority or to people over whom authority must be exercised. Some general statements which are often heard: that all nurses are wonderful, all sisters are dragons, all student nurses are lazy, are clearly evidence of prejudice.

While attitudes can be helpful in facilitating action, they have the disadvantage of covering too wide a field. This is obvious in unfavourable attitudes or prejudices, but it is equally true of positive attitudes. Universal distrust, for example, is as useless as universal trust.

The infant shows the same attitude to a very large number of experiences: interest, curiosity, approach, indicate a positive attitude to people and objects; fear, withdrawal and crying, a negative attitude. Gradually the child learns to discriminate

and attitudes become more specific. Some basic attitudes remain with us through life unless very special efforts are made to change them. Attitudes to such figures in our lives as our mother and father, brothers and sisters, tend to be repeated, especially in times of stress, and are characterized by a return to more childish behaviour. It is the function of training to develop and change attitudes and to help students to adopt a more discriminating approach.

Measurement of attitudes is necessary in order to define the aim of training and to measure progress, but it is unreasonable to suppose that all the right attitudes should already exist before commencement of training.

The term *sentiment* is sometimes used in discussion about attitudes. Sentiments are emotional attitudes to particular events, objects or ideas. Love, hate, loyalty and patriotism are examples of sentiments. If people are in love they experience a tremendously wide range of emotions which depend on their circumstances. There is elation while they are together; sadness when apart; hope, confidence, curiosity when things go well; despair, resignation, despondency when they go badly; anger about anyone who threatens the loved person; protective feelings to the loved person.

Sentiments strongly influence a person's actions, even if at times he is not entirely conscious of them.

In childhood, sentiments for only a few people motivate behaviour. Quite strong sentiments can also exist for such objects as teddy bears, dolls and toys. Often conflicting sentiments occur: love and hate for the mother and father occur at the same time. Gradually the objects to which we have strong sentiments change, and many sentiments merge and form an integrated pattern. Sentiments are no longer experienced for dolls, but perhaps for the home, street or village, or for the part of the country in which we were born. Later the whole country or the whole nation can become the object of our

sentiments. Some vestige of early sentiment often remains. It may be recognized as belonging to the past and the experience of the sentiment may become consciously pleasurable. 'Sentimentality' is the term used to describe enjoyment of sentiment. There are three important kinds of sentiments in adults: sentiments about themselves, about other people, and about abstract ideas.

It is essential to have a certain amount of self-esteem. Without it all initiative, all interest and all esteem for others vanishes. To some extent this is self-love, with all the characteristics of love: pleasure in success, sadness in failure, admiration of our own ability, alternating with criticism and disgust at our own shortcomings.

This regard for self is essential if an individual is to have any regard for others, and is also dependent on the regard in which he is held by others. It is not at all incompatible with humility, self-abasement and self-criticism. All these attitudes are an indication that anyone cares enough about himself to look seriously at his own actions.

Self-esteem is essential to nurses and patients alike. The nurse's function is to foster the patient's self-respect in every possible way, remembering that sickness, helplessness and dependence tend to make him lose his self-esteem very quickly. Loss of responsibility during illness, humiliation at having lost control, the indignity of having to submit to the ministration of doctors and nurses, all tend to lower self-respect. In mental illness particularly, self-respect is easily lost. To build it up again constitutes one of the most difficult tasks of the nurse. To be successful the nurse, herself, must have enough confidence in herself. In relationship with others, a systematic building up of self-respect is essential.

Sentiments about abstract ideas include hatred for suffering, love of service to others, sentiment for justice, for freedom and for democracy. Sentiments are all-pervasive. They affect the

individual's attitudes in all his work, his choice of friends and his interest in world affairs.

The strength of generalized abstract sentiments varies during adult life. Often sentiments are strongest in adolescence, waning perhaps while strong sentiments for particular people develop, for example during courtship, marriage and early parenthood, but growing strong again in mature adulthood. Strong sentiments of this kind are often a powerful motivating force in nursing. However, it is possible to give excellent nursing care to patients without a sentiment embracing universal suffering, and there are people whose very strong and genuine concern for the welfare of humanity as a whole prevents them from giving adequate thought to the detailed attention required in nursing a particular patient.

5. *Interests and Aptitudes* are important personality characteristics. These are closely related to attitudes and ability. Often students are asked why they have chosen nursing. Their usual answer is that they are *interested*. The interest may be in people, or in disease, or in the theoretical study of biological sciences. Students may be able to express these clearly. Others find it difficult to know where exactly their interest lies, but conversation about the work itself will reveal whether they are attracted by the curriculum or by the prospect of doing practical work in the ward. Interest is essential to the acquisition of knowledge and it grows with knowledge.

People interested in stamp collecting invariably know enough about the subject to maintain long conversations about it, and with every contact they make, interest grows. Conversation about the subject in which a person claims to be interested reveals as a rule how far the interest goes. Some interests develop because special skills make it possible to go more deeply into the subject than is possible for other people.

Manual dexterity, for example, may perhaps be an essential skill for anyone who wishes to take his watch to pieces and

develop an interest in watch repairing. Technical aptitude is necessary for an interest in motor mechanics. Nursing requires a certain number of special aptitudes: manual dexterity helps with practical bedside nursing and tray and trolley setting; speed is useful in all nursing tasks. Ability in language makes examinations easier, musical aptitude is an asset in a nurse's home life. Some special aptitudes in sports, music or art may be of the greatest value to mental nurses in the rehabilitation of patients. No one special aptitude is used all the time in nursing and, on the whole, average endowment in most respects makes training possible.

Having enumerated the personality characteristics that nurses may need, it remains to find out how these characteristics can be measured.

Methods of Testing Personality

A *criterion* is needed by which good nurses may be measured, some standard on which people agree against which to measure the success or failure of others. The first difficulty in arriving at a suitable standard is to find out on whose judgment reliance can be placed.

The same nurse may be thought excellent by the ward sister and much less so by her colleagues and the patients. The reverse is also possible in that nurses who are particularly kind, considerate and courteous to patients are criticized by senior staff for being slow and forgetting some of their work. The best way to find a suitable standard is to approach the problem from different angles.

1. *Reports*

These are most widely relied on. The assumption that ward sisters know which of their students are good is, on the whole, well justified.

One method of writing reports consists of using blank paper and writing whatever appears to the writer as being important. This method will highlight the candidate's faults and merits and its overall tone gives an indication of the student's general ability. Details, examples and episodes may be mentioned. There are some serious drawbacks to this method. First, it is possible to leave out statements about large areas of the candidate's personality. This happens either deliberately about unfavourable characteristics on which the sister prefers not to report, or it may happen unwittingly about all those aspects which are unspectacular yet may be the essential ingredients of a good nurse. Another drawback is the emphasis every sister places on those aspects which to her appear to be of particular importance. One sister may always comment on tidiness and punctuality; another one never thinks of mentioning these but always refers to an ability to teach others or to co-operate. This bias about certain aspects of the work makes comparisons of successive reports difficult.

Halo effect is a further drawback of this method of reporting. Any one outstanding characteristic may influence the opinion of the reporter to such an extent that the whole report is coloured by it.

2. *Rating*

These difficulties can be overcome if the report is made in form of a rating scale.

The reporter is not given an entirely free hand. Instead, he is given a number of headings and asked to state how far the characteristic is present in the candidate.

In an open report, for example, the sister may mention that the student is not always punctual. This may mean that she arrived late on one occasion, or on the other hand it may mean the student is unpunctual so often that it had to be mentioned in the report.

If the method of rating is used, the matter of punctuality must always be filled in because the heading already appears on the paper. The sister may be asked to rate each item on the report on a 5-point scale:

(i) meaning that she is always punctual,
(ii) usually punctual,
(iii) average in punctuality,
(iv) frequently unpunctual,
(v) always unpunctual.

On some report forms the questions are all set out and the sister ticks the answer which applies. This makes it possible to give detailed examples of what is meant by the rating, for example:

Her work is always accurately done, without any need to supervise.
She usually works accurately, occasionally asks for guidance.
She works well with only cursory supervision.
She works well only when supervised.
She does nothing at all unless closely supervised.

This kind of reporting makes it necessary for the sister to think about every aspect of the nurse's work, even those she would otherwise have thought unimportant.

Guidance in rating will give a fairly clear picture as to whether a student is average, above or below average, or quite outstandingly good or bad.

Although this has been discussed here in relation to the personality assessment of the nurse, the method of reporting under pre-set headings and with some idea of rating has much to recommend it in reporting patients' progress, and particularly on the behaviour attitudes and interests of mentally ill patients.

The method of drawing up *questionnaires* should be mentioned. In drawing up a report form, for example, careful consideration is given to the selection of questions which may be important in distinguishing good from bad nurses. The first step in this is to listen to conversation about nurses wherever it may take place, and to note the things people say about them. Favourable and unfavourable comments are included: statements made by patients or former patients in hospital or later after discharge; statements made by relatives of patients about the way nurses treated them; statements nurses make about each other; press comments and statements made by people in other jobs about nurses.

This long list of statements—some very flattering, some very condemning, and all shades in between—is given to a number of people for ranking. In this case it is not people who are ranked according to statements, but the statements themselves according to whether they express relevant opinions about nurses. Only those statements about which there is general agreement constitute the questionnaire which the sisters can then use as report forms.

Systematic and careful reporting at regular intervals can give a good indication of a nurse's ability and personality. The reports will show how good she was at the beginning, how much improvement occurs as a result of training, how good she may be expected to be by the end of training. The comparison between beginning and end should be either a measure of the success of training, or should make it possible to detect which characteristics are so essential to training as to make their presence a necessary condition for selection. There are obvious difficulties in evaluating the results of reports however carefully they are designed and however well the reporter is instructed. However, some measure of agreement about the best and the worst nurses can usually be established.

The next stage consists in finding tests or other methods of assessment which might enable the hospital to select potentially suitable candidates and reject unsuitable ones. Such tests have been developed by asking students for this purpose to undergo extensive psychological investigation soon after arrival. Results of these investigations were kept and checked later against the students' progress. Several types of investigation are possible, as described below.

1. *Interviewing*

This method is the most popular of all methods, yet it is probably not the most effective. At an interview one person or perhaps a committee endeavour, by questioning and assessing the answers, to gain an impression of the candidate's personality. Appearance, bearing, speech can be noticed from the candidate's behaviour. Questions can be asked about attitudes and interests and many answers allow the interviewer to gain some knowledge of the candidate's emotional approach. Interviewing can be very effective providing it is well prepared and the questions asked cover a wide ground in order to make possible an assessment of all aspects of personality.

There are great drawbacks, however, in this method. Interviews take place in stressful circumstances and great skill is needed to put a candidate at ease. The interviewer's manner, facial expression, attitude of approval or disapproval may influence the candidate's answers. It is difficult to avoid asking leading questions, and candidates often try to give the answer which they think may be the favourable one. Only a very long interview could give a comprehensive picture of the candidate's personality. In business, interviews are sometimes conducted over lunch, and the more relaxed atmosphere and unbusinesslike setting makes it possible to cover ground far beyond the immediate questions of work. On the whole,

while some people are shrewd interviewers, the method has little to recommend it. Some people believe that the interview helps the candidate more than the employer in enabling the candidate to see the place of work, ask questions and feel more at ease by the time work begins. Interviewing techniques can be greatly improved by training and by introducing structure into the interview.

2. *Testing*

Some of the characteristics required in a nurse can be assessed by psychological tests specifically designed to do this. Accuracy, speed, perseverance, manual dexterity are some of the personality characteristics which enter into the performance of some tests. High scores on certain tests are often obtained by students who later prove themselves to be successful; low scores by those who give up training, or prove to be poor nurses. The tests are then said to correlate highly with success, or to have a high predictive value.

It is never possible to predict with absolute certainty, nor would any one test alone be sufficient. However, the aim would be to try out a very large battery of tests, discover which few, or which combination, has the highest correlation with success in nursing, and later base selection on these tests.

In doing this, a very useful test is sometimes found which does not, however, appear to show any obvious connection with the skills which may be required in nursing. A test consisting of holding one leg up a few inches above a chair for example has a high correlation with success in some jobs. This test measures a personality characteristic of perseverance which may affect much of the nurse's work. This type of test could not be developed by planning selection tests ahead. It is discovered by long use of large numbers of tests on many groups of students and analysing results of the tests by statistical methods.

Tests of this kind probably could not be used by themselves in selection, because students might have little faith in them.

3. *Miniature Situations*

It is sometimes said that the only real way of knowing how suitable a person is for a job, is to let her try it for a while. There are many reasons why this practice is not desirable in selecting student nurses. It is expensive, disrupts people's plans and is most distressing to those who are not successful. Instead, it may be possible to devise miniature situations which resemble the real tasks a nurse may have to carry out. Her manual skill, speed, ingenuity, might be tested by asking her to move or clear away some equipment. Her ability to work with others can be tested by giving a group of candidates a group project to carry out. This may reveal who assumes leadership, with how much authority they state their view, how easily they co-operate with others or how submissive they are.

Emotionality can be tested by giving conflicting instructions, criticizing performance, stressing the importance of failure. Some tests of this kind have been successfully used in the selection of officers in the Services. Too little is known about personality requirements in nursing to be able to use such methods without much more research.

4. *Questionnaires*

This is by far the most common tool in personality measurement. Questionnaires are quick to apply. A great deal of information is rapidly available. The subject simply reads through the questions and puts the appropriate marks against each. Some questions require the answer 'yes' or 'no', and space is left for the expression of doubt. Other questions are put into alternative form and the subject is required to tick the one to which his answer is 'yes'. There are questionnaires

in which the subject is required to underline statements with which he agrees, cross out those with which he disagrees, leaving blank those about which doubt or indifference exists. Answers to questionnaires can be readily checked and scored.

SOME EXAMPLES OF THE TYPE OF QUESTIONS USED IN PERSONALITY INVENTORIES OR QUESTIONNAIRES

1. Are you inclined to keep quiet when out in a social group?	Yes	No
2. Are you more interested in athletics than in intellectual things?	Yes	No
3. Do you adapt yourself easily to new conditions?	Yes	No
4. Do you have frequent ups and downs in mood?	Yes	No
5. Do you usually take the initiative in making new friends?	Yes	No
6. Would you rate yourself as a lively person?	Yes	No
7. Do you prefer to work alone rather than with people?	Yes	No

Questionnaires of this kind may be composed of as many as 200 questions, carefully worded to obtain information about the same personality characteristic in several different ways.

EXAMPLES OF SELF-RATING TYPE OF QUESTIONNAIRE

In your own opinion, which of the following words apply to you? Underline them, and use two lines for emphasis. Put a cross, or two crosses, through any that do not. Leave the rest blank.

hardworking; businesslike; energetic; steady; lively; impulsive; easygoing; unobservant; aimless; untidy; ambitious; pushful; determined; serious; self-reliant; quiet; shy; hesitant; sensitive; moody; discontented; cheerful; self-confident; popular; a leader; tactful; critical; rebellious; solitary; worrying; humorous.

Many people feel that reliance cannot easily be placed on the answers given in self-rating. The desire of the subject to

put himself in the best possible light always influences the answers. More serious still is the fact that the same question may lead to very different interpretation.

Some personality inventories, for example ask, 'Do you feel diffident when you meet strangers?' As it is impossible to know how diffident other people feel, and as everybody feels diffident at times, any one person may quite honestly say 'yes', though he only rarely feels diffident; or answer 'no' because he does not always feel diffident. If questions are carefully worded and well selected, however, questionnaires can have a very high degree of validity. In fact it is not really necessary to examine the meaning of the answer at all. The value in questionnaires lies in comparing the answers many people give to the same questions. Some personality characteristics such as neuroticism, introversion and extraversion can be assessed with some considerable success by the use of questionnaires.

5. *Projective Tests*

These tests make use of people's tendencies and willingness to make up stories about things they see. When shown an ink blot for example, people see butterflies, dancing girls, pictures of skeletons or many other images. When a vague picture is shown, depicting for example two people, a story can be invented about their relationship to each other, their difficulties and troubles. The stories people make up about pictures reveal something about their own personality; they project on to the picture feelings and thoughts of their own. Projective tests will be referred to in the chapter on perception. In nursing, suitable pictures might be devised to test attitudes to patients, work or hospital.

In summary, this chapter has shown how a psychological knowledge about personality measurement could help in achieving better selection of nurses. In the first instance, it

might be possible to find among the applicants those who are likely to be successful, and to reject those who seem very unlikely to succeed. As more knowledge is gained, it might be possible to differentiate between those whose special aptitude is for special fields of nursing, such as public health nursing or psychiatric nursing.

So far, the techniques of personality assessment have been applied only to the selection of nurses in few hospitals and in an incomplete manner. Full investigation of personality is a long and expensive procedure and, perhaps for this reason, not widely practised. In other fields of work, much more extensive studies have been carried out.

The two stages of fitting people and jobs both involve the use of various techniques for the measurement of personality. The first stage consists of applying tests to existing nurses and finding measurements to determine what kind of personality is possessed by the best and the worst nurses. The second stage consists in applying suitable selection tests to candidates.

There are many more uses for the personality studies described in this chapter. Reporting or interviewing, for example, enter into many situations between nurse and patient. Much of the information sought from patients is obtained by the use of questionnaires. Research into the effect of some drugs may necessitate the use of attitude tests. Projective tests are frequently used in the investigation of psychiatric illness. Rehabilitation of disabled patients may be facilitated by the use of good aptitude tests.

An understanding of the essentials of personality testing as applied to her own selection for nursing should enable the nurse to apply this knowledge where it concerns other people.

5. LEARNING

Throughout training, the student nurse learns new skills, new facts, new attitudes. Some of the learning takes place without effort by doing the job; some of it is the result of her tutors' teaching, some the result of her own study. It is helpful to know something of the psychology of learning in order to make the best use of the available time for learning.

Learning is the acquisition of a new and better adapted pattern of response. Circumstances determine what is the correct behaviour. Changes in circumstances make old behaviour ill adapted, and new responses must be learnt. The home method of making beds or preparing meals is ill adapted to hospital use—new methods must be acquired. Old emotional responses to sickness are not helpful to the patient—a new approach to sick people is learnt. Old beliefs about illness prevent proper observation. New knowledge of physiology, psychology, pathology makes good observation and nursing possible.

The success of the new pattern of behaviour is the yardstick by which learning in nursing is measured. This is an important point. It is essential to *know* the result of learning: first, to know what kind of behaviour it is aimed to achieve; second, to know during learning what progress is being achieved.

Many experiments in learning have been carried out on animals. Rats have been observed learning a path through a maze or pressing levers in a cage. Cats have learnt to get out of puzzle boxes, monkeys have learnt to use tools. In each case the animal knows of his success because he is rewarded with food at the end of his trial. Human learning does not always lead to such clear-cut results. Learning how to nurse leads to the patient's comfort, to better observation of the patient's

symptoms, to skilful handling of equipment. It is not self-evident from the task itself when learning is completed. Outside information must be given; for example, the patient must say that he feels more comfortable, or his evident relaxation shows it, or the ward sister's approval indicates it. It is true that in a hospital opportunities for learning are so great that learning is almost inevitable. However, opportunities of acquiring wrong methods or attitudes are as numerous as opportunities of learning the right thing. To a very large extent, what determines success or failure is knowledge of results. No opportunity of informing students of their progress should be lost. This needs to be done personally. Published results of examinations are of doubtful value, especially to the less successful student. Knowledge of results fulfils two functions: it allows the establishment of a measure of learning, in other words, a criterion by which the outcome can be judged, and it serves as a reward. Because of our need for approval, we feel rewarded when someone praises our efforts.

In simple learning experiments, these two factors are separated. A rat's rate of learning can be measured by the use of a stop-watch, which shows how long a time is taken for each successive run through the maze. The reduction in time is a measure of learning, the final stage is reached when the rat is able to run through the maze without losing its way and in the shortest time permitted by its physiological limitations. The rat can be rewarded with food when he takes the right turn, punished with electric shocks at the wrong one. The effect of reward and punishment can be seen in the progress the rat makes. In human beings, praise is one of the few possible rewards; very few people other than small children will accept food or sweets as reward. Praise, approval, knowledge of results act at the same time as an incentive to learning and a measure of the success achieved.

There are some situations in which progress can be measured directly. When poetry is learned, for example, it is clear that learning has taken place when the poem can be recited without mistake. Mistakes are easily discovered, so that knowledge of results is inherent in the learning process. In learning to play tennis, some mistakes are self-evident and improvement occurs as these mistakes are corrected. Failures to hit the ball or to return it into the court are obvious mistakes. Other mistakes, however, cannot be noticed by the player, they must be corrected by an observer: posture, method of holding the racket, footwork, shoulder movements improve only as a result of favourable comment from a coach, particularly as every attempt to alter style for the better leads to a temporary setback in play.

Most learning in nursing is rather like this. Only few mistakes are glaringly obvious and can be corrected by the student herself. Improvement in approach to the patient, accuracy in reporting, gentleness in handling, are only possible if someone draws attention to these matters. Left to herself, the student may believe she is doing well. When her errors are corrected and made conscious to her, there is a temporary setback affecting speed and overall efficiency; the next stage is a higher level of performance. Knowledge of results and awareness of mistakes are so important to learning that they cannot be over-emphasized; yet, strange as it may seem, some nurses are reluctant to criticize and many other people forget to praise the work of others. Of the two, praise is probably the more important and effective.

Learning consists of making a new response to a stimulus to which it was not originally made. Rats, for example, know how to press a lever even before the learning experiment. They are learning if they manage to press the lever in response to a new situation. One experiment may consist of learning to press the lever when shown a circle, but omitting to do so

in response to a square. Human beings know how to walk or speak or lift up a bowl. The nurse has learnt something new when she walks to the patient in response to a groan that previously she would not have noticed; or when she speaks the right words to comfort the patient or to inform the doctor; or when she hands the doctor an instrument in response to a sign from the ward sister—a sign that previously she might not have understood.

There are basically three ways of learning to match new stimuli to old responses:

1. Conditioning.
2. Trial and error learning.
3. Learning by insight.

Conditioning

Conditioning was first described by the Russian psychologist Pavlov. He experimented on dogs. Dogs, like other animals, salivate when they eat or smell food. Pavlov rang a bell when food was offered to the dog, and before long he was able to show that it was possible to produce salivation by ringing a bell without giving any food at all. After a while of ringing the bell without offering food, the newly acquired pattern of salivation again stops. To maintain it, it is necessary to give food again at the sound of a bell from time to time. We say that the conditioned response has to be *reinforced*. It is possible to reverse the learning process by *deconditioning*; for example, by giving an electric shock with the ringing of a bell. The association will then be with pain rather than food.

Watson, a psychologist of the behaviourist school, showed that it is possible to condition children in the same way as dogs. He conditioned his own child to become afraid of furry animals by frightening him with a loud noise every time he played with a previously beloved furry toy.

Pavlov and the behaviourist psychologists have studied in detail how conditioning depends on the time interval between the unconditioned response and the new stimulus, and how conditioning is affected by reinforcement. Only a few conditioning experiments with human beings can be carried out in laboratories. It is possible to condition a blinking reflex to stimuli other than movement near the eye, and it can be shown that people differ in their responsiveness to conditioning. This represents one of the differences in personality. In everyday life it is probable that quite a lot of conditioning takes place. Some psychiatric symptoms may be the result of conditioning. Fears of open or confined spaces, of sharp objects, of blood, of carrying out certain treatments may have occurred as a result of conditioning without the person's knowledge.

Aldous Huxley describes in *Brave New World* how in his phantasy children could be conditioned against the use of books. His method is well described though not foolproof. It is possible that some isolated, strong dislikes or phobias have accidentally occurred by this process. A systematic attempt to decondition by making new associations with pleasurable stimuli may help to overcome the symptoms.

Trial and Error Learning

Trial and Error learning is best demonstrated by animal experiments. A cat which is shut in a cage can be observed to move about the cage apparently aimlessly. It touches and presses various parts of the cage; repeats, without any apparent pattern, some of the positions and actions already tried out; and eventually, apparently accidentally, hits on the right method of unfastening the door and getting out of the cage. The total time taken and the number of errors can be measured. If the cat is returned to the cage, the whole performance is repeated, but slightly shorter time is taken to

find the way out. Eventually, the correct move is made immediately.

In the course of learning, wrong moves far exceed correct moves in number, as they occur many times in each trial, while the correct move is made only once at each attempt. This shows that the frequency of carrying out an action is less important than the success of it. The wrong actions serve the purpose of encouraging further attempts. Adult human learning rarely appears to take place as aimlessly as trial and error learning in animals. When we try to solve wire puzzles, we come nearest to apparently aimless fiddling with the pieces until they suddenly come apart. In this manner, children learn to take things apart and to fit them together again.

Learning by Insight

When the period of aimless activity is reduced to a minimum we speak of *learning by insight*. Adults who try to take a piece of machinery apart look at it for a long time, note pattern, screws, holes, wires, and eventually when they begin the work they make the correct move at once and move the appropriate parts. They understand the task and know in advance which action is likely to lead to success. Even if a mistake is made it is not corrected by aimless activity but by renewed reflection until a new idea occurs.

The psychologist Kohler has demonstrated learning by insight in monkeys. The monkey in the cage was surrounded by boxes and sticks of various sizes. Bananas were placed somewhere just out of reach of the monkey. By use of boxes and sticks they could be fetched down. The monkey learnt to climb on a box to get the bananas from the roof, or to reach for them with a stick when they were outside the cage. There was often a period of unsuccessful reaching for bananas followed by a phase of apparently aimless play with boxes and

sticks. Then quite suddenly the monkey piled up the boxes in the correct manner and fetched bananas.

One monkey who had apparently given up his attempts to get bananas played with two sticks and apparently accidentally fitted them together to make a long stick. He immediately jumped up and tried to get the bananas. He had *insight* into the relationship between the newly learned skill of fitting sticks together and his previous attempt to obtain the bananas. Learning by insight is much more important to human beings than trial and error learning.

When general principles are used to solve specific problems, insight is necessary. In working out the area of a square, oblong or triangle, the general principle is learnt and applied to the different shapes. Those children, who fail to understand, attempt each new problem as if it were unconnected with anything that they have learnt before. Geometry to them becomes a great burden. Measurement of dosages of drugs, or dilutions of lotion are approached by some nurses in a trial and error manner causing great anxiety in the process. Insight into the problem means that the correct solution can be found in a flash. In applying knowledge of physiology to the understanding of diseases or knowledge of a familiar procedure to the attempting of a new one, insight learning takes place. It is possible that insight learning is similar to trial and error learning, except that errors are eliminated by thought rather than by action. Instead of actually walking through every blind alley in a maze, we can look at a map and think about walking through it. We can find the correct path before actually entering the maze. Similarly, we can see the correct solution of a puzzle by trying all other solutions in imagination. We can start spring cleaning in an orderly, planned way, having eliminated superfluous moves by thinking about them.

There is, however, a difference in the mechanism of various forms of learning. Some learning involves the formation of

some kind of link or connection between different ideas or actions. The order of movement in bedmaking needs to be established and followed precisely so that on every occasion the same sequence of movement is carried out. Connection between words and their equivalent in a foreign language must be learnt by forming appropriate links; multiplication tables are another example. In this kind of learning 'associations' must be formed.

Some people try to learn most things in the same manner, by deliberately forming associations between one bit of knowledge and the next. They try to find ways of memorizing by using mnemonics, rhymes, jokes, or attempts at remembering the initial letters are sometimes used. This type of learning is rather like learning by conditioning: new stimuli are connected with the responses to an old one. Experiments in trial and error learning or in 'rote' learning help to point to some rules of how associations are formed. Broadly speaking, 'frequency' and 'recency' of association help. An association which has occurred more recently is better remembered than an earlier one. The most important factors, however, are success and meaningfulness, and these are associated with insight.

Insight learning occurs suddenly. It consists of seeing how the various elements of the situation are related to each other. There is a mental reconstruction until it suddenly fits. Problem solving is an instantaneous activity. For a long time the student cannot see it, then suddenly it is perfectly clear. Everybody has undergone this experience but it is difficult to analyse because it is so sudden.

It might be argued that a problem does not really exist until the solution is at hand. If a small child finds himself among a lot of tools and electrical equipment, he has no problem because he does not know at all what the material is for. If he gets a chance, he plays separately with the wires, the screws and the

tools, but he does not appreciate their real function. An electrician confronted with the same amount of equipment has a problem. He sees the connection between the items and sees how an electric wiring can be fixed up. He mentally rearranges the heap of material until he suddenly sees the correct way of producing a meaningful pattern.

It is clear that in nursing the student becomes aware of more problems as she gains knowledge. Each problem exists only for those who make an attempt to solve it. To the junior nurse there are no problems of ward administration. She is concerned with her own work, and her problem consists in arranging her own actions or the equipment she herself uses in order to arrive at a satisfactory outcome. The ward sister sees the work of the ward as a whole. Her problem is related to her awareness of the work of all nurses and the needs of all patients.

The matron's problems refer to the interrelations between departments. She sees, organizes and reorganizes in her thoughts the demands of administrative staff, medical staff, domestic staff. She sees the work of various departments in relation to each other. She takes into account total man-power, money, time. What is a problem to her is no problem at all to the junior student because she cannot see what is involved. It is not that the matron's problems are more difficult to solve than those confronting students but rather than these are problems to the matron because she is already in the process of seeing their solution, whereas the student has not even become aware of such complexities.

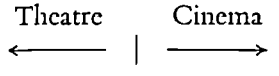
Political and social problems come into existence only when we already begin to see the way to solve them. While poverty is taken to be a necessary and inevitable state of affairs, it presents no social problem. When we see that it can be alleviated, we become aware of it as a social problem. To small children or unintelligent people, racial issues, armament,

refugees, religious intolerance present no problems. They are only seen as problems by those engaged in finding a solution.

The *Gestalt* School of Psychology is particularly interested in the way in which insightful learning and problem solving depend on the spontaneous awareness of the relationships of things. The German word *Gestalt* means 'form' or 'configuration'. Gestalt psychologists point out that awareness of form is an immediate experience. Perception of the total form occurs instantaneously. Learning consists in reconstructing the field until a configuration of the right sort is perceived. Gestalt psychologists stress that our behaviour is always determined by the way in which we see and understand things rather than by the objective reality of the situation. Our interpretation of environment depends on our attitude, our aim, our previous learning. We make the present fit in with our own frame of reference, and the situation becomes meaningful according to our own previous knowledge.

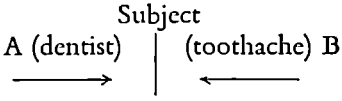
Gestalt psychologists describe this in a vocabulary borrowed from physics. They say that we move in a 'field' according to the forces which operate at a given time. Our action may be the 'resultant of a number of vectors' leading in different directions. Barriers, whether real or imaginary, cause change in the direction of activity. They may be so strong that they counteract movement, or they may result in detours or in changes of aim.

Conflict situations are described in the same graphic way: they are represented by vectors acting in opposite directions. There may be 'double approach', a conflict situation in which two alternatives appear equally desirable. This is easily solved if one force is slightly stronger than the other, or if conscious deliberation gives one alternative a little more force. The choice between attendance at a cinema or theatre is an example:



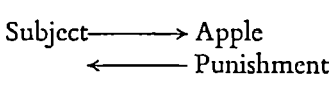
Desire to go to the cinema moves the subject towards it. Desire to go to the theatre moves him in the opposite direction. He will soon find a way of increasing one or the other force and make a decision.

Double avoidance is a state in which both alternative actions are equally distasteful:



The individual feels pushed towards one alternative, A; but the nearer he gets to it, the more he is repelled by it and pushed towards B which also repels with intensified force as this is approached. The toothache, A, pushes the individual towards the dentist, B, but the approach to the dentist makes him prefer the toothache and pushes him back again. Distaste for war may be as strong as fear of being a coward. The thought of fighting makes a man want to run away; the idea of running away is so repulsive that he feels compelled to stay.

'Approach avoidance' conflicts imply ambivalent feelings to the same situations. Desire for an apple from the larder and fear of punishment represent such a conflict. The wish to qualify as a nurse and to pass examinations may be counteracted by the fear that the examinations may be too difficult and failure may be humiliating.



Graphic representation of the conflicts helps a person to understand that there may be complete inactivity if the forces acting on him are equally matched. Vacillation may occur or complete avoidance of the conflict by indulging totally irrelevant action. People with hysterical illness solve their double avoidance conflict by 'forgetting'. A patient may

suffer from amnesia and cannot remember who he is, what he is doing, where he is going: 'he has left the field'. Whether he experiences the forces as equal or not depends on his own perception of himself and the external events; it is the result of previous learning.

When insight occurs, learning is sudden and apparently effortless. Students, however, are aware of the great effort involved in study which precedes the very rewarding experience of sudden insight. Many experiments have been carried out to investigate how learning takes place and how study can be effective. These experiments can be carried out only with carefully selected material lending itself to measurement and which is learnt sufficiently slowly to make observation of progress possible. The results obtained from learning experiments may, however, apply also to other forms of learning.

Learning of Skills

Experiments in learning skills have yielded some useful knowledge. Skills like typewriting, tracing patterns while looking into a mirror or fitting various parts of equipment together have been studied. These lend themselves to experimentation because learning is obvious. It can be measured by timing the total performance. A graph can be plotted showing how much more quickly each attempt was completed than the previous one. An alternative way of measuring learning is followed when a fixed amount of time is allowed and measurement made of how much of the task was completed: for example, how many words typed in a period of ten minutes. Another method is to count mistakes and observe their reduction in successive trials.

These experiments have shown that learning takes place fairly rapidly at first and that there follows a period in which apparently little progress is made; then, suddenly, rapid pro-

gress again occurs. There are characteristic learning curves: rapid rise followed by *plateau of learning*. Depending on the complexity of the task, there may be more than one plateau (see Fig. 4). One possible explanation of the plateau is that separately performed items of the skill are in the process of integration. During early learning, they are performed consciously. During the plateau, they become habitual and form an integrated high-order form of behaviour which later

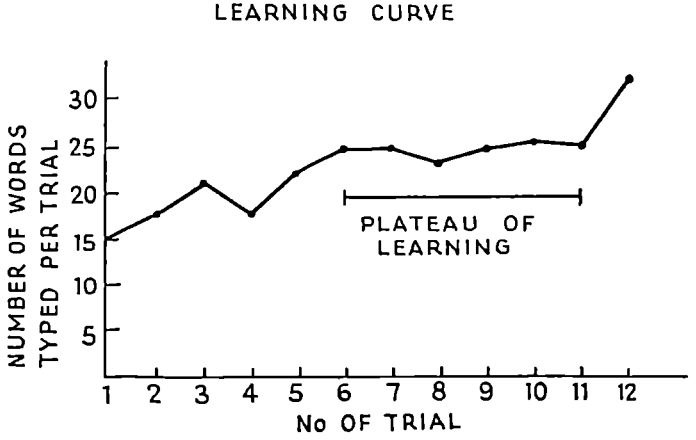


FIG. 4

allows for new skill to be attempted. Boredom or fatigue may be responsible for plateaux.

Learning to drive a car is a clear example of this happening. Rapid progress is made in the first few lessons in the use of gears, clutch and steering. Then for many weeks there seems to be a standstill. Suddenly the whole process of using controls becomes one: gears are changed correctly without the learner being aware of it; clutch, brake, accelerator are used without conscious awareness. The driver is now free to learn the more complicated manœuvres or to attend to traffic.

Learning to type begins with rapid increase in the skill of using the fingers and remembering where the letters are. Then there is a plateau followed by a phase of learning in which the student is no longer aware of looking for letters but instead thinks of groups of letters and words. After a further plateau, it becomes possible to think of the subject matter being typed and the typist is no longer conscious of the use of the keys.

Skills in nursing are probably learnt in the same way. The first blanket bath takes a very long time. Every action, every move is conscious. Skill in handling water, soap, flannel, rapidly increase; and after a plateau in learning, the procedure is carried out sufficiently automatically to enable all the attention to be devoted to the patient without the nurse having to think which way to wring out the flannel. It is important to practise nursing procedures sufficiently often to reach the stage in which the nurse becomes free to give full attention to the patient's comfort and need. Unfortunately, sometimes a student forgets that the purpose of learning a procedure is to be able to carry it out really well, and students sometimes feel that as soon as they have learnt a procedure it is beneath their dignity to perform it, it becomes the task of a more junior nurse. Patients often comment on the very different experience of having a bed made skilfully: pillows arranged, sheets smoothed, of being skilfully lifted, skilfully placed on a bedpan. They feel this is done very differently by the ward sister than by an inexperienced student.

Everyone knows the discouragement of being on a plateau of learning. No progress seems possible, the student feels that effort is futile. He often gives up the attempt to learn if there is no one to provide the necessary encouragement to overcome it. It may well be that some of the wastage in student nurses occurs at a time of plateau. The first plateau may be reached early in the first year of training, another one usually occurs

early in the second year. People often abandon their attempts to study a foreign language, or tennis or typing or pottery just after the first rapid progress, during the first period of standstill. Evening classes suffer a rapid reduction in numbers before Christmas, often when people feel they are making no progress and reach the conclusion that their effort is not worth while. It may be helpful at such times of discouragement to know that plateaux invariably occur and that this is not a reason for despair.

Very often a sudden increase in learning occurs just before the end of the practice period. When a learning experiment is carried out, warning is sometimes given that time is nearly up. 'Only two minutes to go.' This usually results in a sudden spurt of rapid progress. Before examinations, everyone is aware of the amount of learning which can be fitted into a very short space of time. There is usually some guilt feeling about doing so much in so short a time, having done so little before. This is not justified. In fact, the long period of apparent inactivity is probably necessary to make rapid progress possible in the end. Some people feel that cramming before examinations is not real learning. It is real in the sense that it marks a steep rise in the learning curve, but it needs consolidation in a plateau of learning later. To avoid discouragement it is well worth providing periodic goals in the form of test papers or end-of-term examinations. These have a value in terminating plateaux. Obviously they would lose in value if they occurred too frequently. The spacing of intermediate goals should depend on the age of the student and on the subject matter. (Children need them more frequently.) The degree to which morale is influenced by a feeling of despondency where no progress is made should also be taken into account.

Most learning is not a learning of skill, but of information and facts. This depends very largely on insight. To investigate learning more accurately, experiments have been carried out

in such a way that either they aim to measure the acquisition of insight—for example, experiments on concept formation—or that the material chosen for learning is such that it rules out insight learning.

The most comprehensive series of investigations was carried out by Ebbinghaus. He used nonsense syllables in his experiments. These are formed by picking out vowels and consonants and putting them together in such a way that the syllables have no meaning: GAB, DUN, SIL, KES, would be acceptable syllables; SUN, DOG, BUT, would be excluded because they have meaning. Nonsense syllables can be arranged to form lines and groups of lines to be learnt like poetry. They can be presented visually, given to the subject to read and study, or they can be projected on to a screen one at a time, or exposed in an apparatus for a measured length of time or read aloud to the subject. Ebbinghaus investigated the effectiveness of the various methods of presenting material in learning.

The first step in experiment consisted in deciding how to measure learning. It is possible again to measure how many syllables have been learnt in any given time. Another possibility is to measure the time taken until the subject is able to repeat the assignment correctly. Using this as a measure of learning, it is found that although the subject was able to repeat correctly immediately after learning, he quickly forgot. If asked an hour later, he could remember only very little of it, the next day hardly any at all. If the next day, however, he relearns the same material, he does it much more quickly than the first time showing that learning had not been completely wasted.

Measurement of forgetting and time saved in relearning is as useful as the observation of learning and of mistakes. Even if the subject remembers none of the material he learnt the previous day, he may be able to pick out of a number of sheets of paper

the one he had studied the day before; he recognizes what he has learnt. Recognition is an indication of learning. The only way the subject could manage still to remember his assignment the next day, would be to go on learning long after his first accurate reproduction. This is called *over-learning*. We do this with poetry or with parts in a play; we repeat them many times after we have first succeeded. Most other learning does not proceed to the point of over-learning because most people find it boring to go on with something they feel they know well. It follows that in order to know a subject well it must be relearnt after some forgetting has taken place, or so much more must be learnt in the first instance than is really necessary that there is still enough knowledge left after forgetting. Relearning is the usual practice in school and in nurse training. However well a student knows the subject at the time she learns it, she has to relearn before the P.T.S. examination and again before the preliminary examination.

She may feel disappointed when, at the end of a year, she feels that she knows less than she did at the end of the Preliminary Training School. But on relearning she finds it possible to reach her original level in a very much shorter time than it took her before. Even the vaguely familiar ring of some things apparently completely forgotten is a sign of learning and a help to relearning.

Textbooks and lecturers usually give much more information than the student needs, allowing for a good deal of forgetting. Some students find very condensed textbooks helpful, but for most students these are useful only for revision purposes. They cannot easily be used for study because there is nothing to spare for forgetting. Ebbinghaus tried various arrangements of nonsense syllables to see in what order people were able to memorize the material. He found that the beginning and the end were learnt most easily, and also any syllables that were markedly different from the rest; for example, if

any of them were presented in red, while the rest were black, these were remembered easily. If any of the syllables are accidentally meaningful, for example, if one of them belonged to the learner's own car number or telephone number, these too will be learnt quickly. Learning, then, spreads from these quickly learnt parts to the parts immediately in front and behind and so on, until it is complete.

Similar ways of learning are often observed in real situations. The first and last lectures of a course often stick out; so does any lecture given by a visiting lecturer or a substitute. If any lecture happens to be particularly relevant to the work the student is just doing in the ward, or to a patient she happens to be nursing, it is much better remembered.

In any one lecture the opening remarks and the summary at the end are the really important parts. Any anecdote told in the middle is also likely to be remembered because it stands out. Method of study was investigated by Ebbinghaus. He found that if a one-hour study period was divided into six ten-minute periods with intervals, much more learning took place than if the hour was undivided. He referred to this as 'distributive' learning. It is more effective than 'massed' learning. This applies to many other learning situations. At school, for example, four periods of mathematics per week are better than two double periods or one whole morning of mathematics. The time-table for student nurses is usually so arranged that each subject is taught on every school day, rather than whole days being devoted to different subjects. Some people believe that a course of lectures spread over perhaps twelve weeks is more useful than if all lectures are given in four weeks, and for that reason find study days more effective than study blocks. Private study should be distributed over several periods in preference to few long sessions. One hour's study every day is better than two days of staying up all night. It is more effective to study a little of each subject

every day, than to devote one evening to anatomy and physiology, another evening to public health, and yet another evening to psychology. There is of course an optimal study period for each type of subject matter. Where a large amount of preparation is necessary, for example, if apparatus has to be set up as in bacteriology or for physiological experiments, or in practical nursing, it becomes uneconomical to make the class too short. Lectures are better used if they are as short as possible. Each student must find his own best rhythm for study, but however convinced an individual may be that she studies best by sticking to one subject for many hours, it is at least worth trying to divide the total period up into several shorter ones and to distribute them more evenly over the weeks or years.

Ebbinghaus showed that there was a marked difference in the rate of learning according to the method by which the total amount was tackled. In some instances, his subjects were encouraged to learn a page of nonsense syllables by reading through the whole lot and learning the whole page. In other instances, the page was divided into several parts, each part being learnt separately. The former method is called 'global learning'; the latter, 'part learning'. Global learning is more effective than part learning. Although many subjects believed they could succeed better if they learnt a few lines at a time, they did in fact learn more easily when they treated the whole page as one. Global learning is generally more effective than part learning. In learning poetry, the method of learning one verse at a time leads to an association of the last line of the verse with the first line of the same verse instead of leading on to the next. The result is that the first verse is very well learnt, the rest much less so, and that there is danger of getting stuck and having to restart, instead of being able to carry on when prompted. It is particularly true that a meaningful whole is more easily learnt than separate parts which do not

appear to have any meaning in relation to each other. The whole poem, not its separate verses, has meaning. Even with nonsense material wholes are learnt better than parts; difficult parts need special practice later.

To apply the principle of global learning to the study of nursing, it is important to consider how big the 'whole' subject should be to make a suitable unit for learning. Lecture courses can be so arranged that the first lecture gives a survey of the total subject to be covered, and the last lecture gives a summary of the course. Any individual lecture can in the first few minutes give an outline of the subject as a whole. Textbooks are sometimes so arranged that the first chapter gives an indication of the total subject matter of the book. Each chapter has an introduction giving an outline of the whole chapter. In this way, each part is seen in relation to the whole. It is worth while beginning a new subject, anatomy and physiology for example, with a very simple outline of the total functioning of the body. Reading a very simple book like those written for children, which can be read through as a whole before detailed study of any part takes place, can be helpful. Most students have difficulty in learning any part of physiology when it is first attempted. After a study of the whole body, the study of any one part falls into place and becomes quite easy.

One of Ebbinghaus's most important findings relates to the contrast between active and passive methods of learning. He compared the results if the subject spent all his time reading the material to be learnt with the effect if he spent part of it reciting the material himself. Learning takes place much more rapidly if the subject attempts actively to recite after every reading. Many other learning experiments confirm this. If a person tries to learn vocabulary in a foreign language, it takes him much longer to go on reading the words and their translation than to try to think of the foreign word, then look

it up if he fails. The activity of searching for the answer helps him to remember it when it is supplied.

This principle too applies to nurse training. In the course of study, it is essential to do something actively about the information in the books or that derived from lectures. During a lecture, for example, it helps if the student listens actively and applies the information while it is being given. Some people write it down and feel that the activity of writing while listening makes them active. It would probably be more useful if they wrote only an occasional note because this might involve the greater activity of evaluating what is said, sorting it and selecting from it what appears worthy of a note. If the lecture refers to some patient whom the student has nursed, it is useful to think actively of the application of the subject to the work she has seen in the ward. Throughout a lecture she should listen critically. This does not necessarily mean looking for faults, though that can be a very useful activity. Critical approach may mean admiration of the skill with which the subject is treated, or comparison of the lecturer's methods with those of others. It involves a silent running commentary on what is said. Textbooks should be read with the same critical approach: as the student reads she can actively discuss with herself the meaning of the statement, the way of explanation and its application. Reading rapidly and actively summarizing is much more helpful than reading slowly and trying to remember.

Silent discussion with oneself is one way of learning actively. More useful still—whenever it can be done—is real discussion with others. Asking questions, explaining to others, giving a talk oneself, repeating to someone what the lecturer has said are the best ways of learning. Active methods of learning may involve trying to discover an answer to a problem oneself before the answer is in fact given by the teacher or by the book. This is why some teachers begin by asking questions

even though they know that the students probably do not know the answer. If they try to find out first, they are more likely to make full use of the explanation when it is given. Writing of papers is an essential tool in the clear formulation of thought. The most fruitful method of learning is an attempt to communicate to others what has been learnt. Reporting back, either by a straightforward summary, or by some more dramatic manner, such as enacting some point in a sketch or putting it into poetry helps in learning it.

All learning depends on motivation. Only if anyone wants to learn can learning take place. Human beings want to learn for a variety of reasons: in childhood, because they want to please someone; later, because self-respect is enhanced by success. Knowledge may seem worth possessing for its own sake. Children show immense curiosity and explore endlessly, repeating any action which gives unexpected and pleasurable results. They will, for example, switch lights on again and again once they have accidentally discovered how switches work, continue to pull the lavatory chain, or repeat words or syllables which sound pleasing to them. Many adults find success in learning sufficent motivation. Success in nursing patients well, in doing work well in the ward is sufficient motivation for those who want to nurse to make them persevere with the difficult and sometimes uninteresting parts of their study. Where additional motivation appears necessary, it is interesting to consider the effect of reward and punishment as incentives to learning.

Rewards can be tangible: sweets or presents can be given, but adults do not often need this. To most people, praise acts as a reward. Punishment can be physical, though this is hardly applicable to adults. It can consist in some enforced deprivation. For most adults, criticism and blame act as punishment.

Experiments have been carried out chiefly with animals where reward in form of food or water is not only an incentive

to learning but the end point of the learning experiment. Experiments with children are more relevant. In one of these experiments, groups of children were learning arithmetic; without actually checking on their results first, one group was left to carry on without any criticism or encouragement. Children in a second group were repeatedly told how good they were; those in a third group were told how stupid and lazy and incompetent they were. The results showed that the group who were given neither reward nor punishment progressed least of all. Both the rewarded and the punished children improved at first, but very soon there was a marked falling off in the group who were criticized and a steady improvement in the group who were praised. It is generally found that punishment has only a very transient effect, and that only if by improvement there is hope of earning praise. Constant punishment without rewards for effort has no beneficial effect. Encouragement and praise, on the other hand, are incentives to do well either in order to retain the good opinion of others or because of the pleasure obtained from work well done. Praise must be sincere to be effective in the long run; indiscriminate praise can be effective only in a short experiment.

Learning is made easier by working with other people. In some experiments, progress of several groups of children was compared. Some children worked by themselves, some worked in different rooms but knew that other children were working elsewhere, and some worked in direct competition with other children.

Those who competed did best, but even working in company with others or in awareness of others was better than working entirely alone. The usefulness of competition and rivalry is well known to students. Providing the members of the class are well matched and all have the opportunity to be successful, competition is encouraging. If students are of very

different ability, some are bound to be unsuccessful however hard they try, and for those students competition is discouraging. Their incentive for learning may have to come from competing against themselves, trying to improve on their own previous performance. The danger of failure in competition is largely eliminated at school by streaming classes and by the careful selection of children for secondary education. Within his own class, every child has the opportunity to succeed. The attempt to coach children for grammar school entrance at eleven is not usually to the ultimate advantage of the child, as he is likely to become discouraged in competition with children who are brighter. In nursing schools, the value of competition depends on the way in which students are originally selected.

6. REMEMBERING, FORGETTING, PERCEIVING

Success in learning depends, among other factors, on two important activities:

1. The way in which new material is first apprehended, that is, the process of perception.
2. The amount of forgetting which takes place.

Some forgetting is inevitable. It is most rapid at first and takes place more slowly as time goes on. Immediately after the first correct repetition of a poem or a series of nonsense syllables, forgetting begins. One hour later only a small amount will be recalled, two hours later there will be less recall still, four hours later even less, and by the next day there may be very little. The difference in the first few hours is very marked. It then becomes less noticeable and barely matters after several days. The amount recalled is illustrated in Fig. 5.

The amount of forgetting can be reduced by over-learning in the first instance; that is, continuing beyond the moment of first correct recall. Many lessons at school and in nurse training aim to do this by spending more time on every subject than appears at the time to be necessary. Forgetting is also allowed for by going more deeply into every subject than is really essential, ensuring that, even after forgetting a good deal, enough is still remembered.

Students often guard against forgetting by thinking about the material at intervals, in fact by relearning at odd moments. Forgetting is least marked if immediately after learning the student goes to sleep. The next best activities following learning are games, sports and relaxing at social activities. If it is necessary to learn several subjects, it is best to follow any

period of learning with one of a completely different nature. Forgetting is most marked if two subjects learnt in succession are very similar to each other. Experiments with nonsense syllables show that the worst possible results arise from learning several groups of nonsense syllables in succession. Syllables followed by groups of numbers produce much better results; shapes or drawings make a better contrast still, and relaxation or sleep after learning gives the best results of all. School

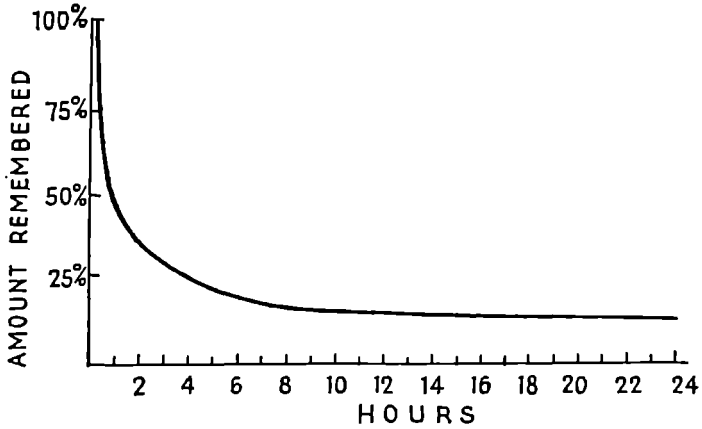


FIG. 5

time-tables are so arranged that a language lesson is followed by mathematics, not by another language; history is followed by physical training, not by geography or literature.

Variation of subjects is carefully arranged in nurse training schools, so that very dissimilar subjects follow each other; for example, practical nursing and anatomy. In her own study, the nurse can use her time in such a way that the greatest possible variation occurs. A period of reading may be followed by writing or discussion, the greatest possible variety of subjects being studied in succession.

Remembering depends not only on how well the material has been learnt, but also on the emotional state of the learner and on the extent to which remembering is useful. As soon as any knowledge becomes superfluous, it tends to be forgotten. If the student works for examinations only and cannot see the usefulness of her knowledge in her work, then most of what was learnt is forgotten immediately after the examination. Information about individual patients is remembered until it is used either for reporting or in treatment. It is forgotten as soon as use has been made of it. Remembering incomplete tasks and forgetting completed tasks results in great economy of effort and allows us to take in new information all the time, which would be impossible if every bit of information no longer needed were still retained. Student nurses can be helped to make the best use of their experience by being shown how each piece of knowledge forms part of a bigger whole and therefore continues to be of use. Anatomy and physiology for example are not subjects to be learnt and forgotten when no longer needed. They are learnt in order to make use of them later in the study of disease. Knowledge gained about one patient does not cease to be useful when the patient is discharged. It becomes useful when it is applied to the nursing of some other patient with a similar complaint or a similar personality, and when lectures about the patient's disease are attended or textbooks are consulted. Lectures can be so arranged that each subject remains open for the addition of more information and thus forgetting can be reduced. It is helpful to end a lesson knowing where the information leads, or aware that information so far obtained is incomplete. A lesson which leaves the student sufficiently unsatisfied to cause her to reach for a textbook in search of knowledge, or which has aroused sufficient interest to lead to discussion is much better remembered than a lesson which is well rounded off and complete in itself.

Forgetting is often associated with the learner's emotional state. Everybody tends to forget unpleasant, painful experiences. This process is called repression. This is not deliberate and is a great help in dealing with unpleasant experiences and with any less desirable personality characteristics. Not only the unpleasant experiences are forgotten but also the anger, sorrow, humiliation which accompanied the experience. If learning becomes an emotionally unpleasant activity, forgetting is much more pronounced. This may be why punishment is not in the long run effective in promoting learning. Experiments with incomplete tasks show the process of forgetting very clearly.

In one experiment, children were given a large number of tasks to do, each taking only a few minutes. They were allowed to complete some, and in others they were interrupted before completion; for example, there were a few lines to be copied, a few sums, some drawings to be copied, codes to be deciphered, and many other tasks. At the end, the children were asked if they could remember the things they had been asked to do. They remembered only some of the tasks; which ones, depended on the instructions they had received. Those who were told in advance that there would not be time to complete them all, remembered incompleted tasks and forgot the completed ones. Some had been told that the whole thing was very easy and had been made to feel stupid for not completing the tasks. They remembered only the completed ones and forgot the unfinished ones about which they felt uncomfortable.

A similar experiment was carried out with adults who were asked to do some puzzles. Some were told they were testing the puzzles in order to grade them according to difficulty. Others were told that all the puzzles were very easy and well within the capacity of small children. The subjects were prevented from completing some of the puzzles. Those who

thought they were testing the puzzles remembered clearly the unfinished ones. The others, who felt that they were stupid because they had not succeeded in all the puzzles, forgot the unfinished ones and remembered the completed ones.

The forgetting of unpleasant worrying events is sometimes evident when a history is taken from a patient. Some of the most significant events in the patient's life may be completely forgotten. A serious illness, a stay in hospital, or the cause of his parents' death may not be recalled by the patient. Even prompting by a relative may not lead to recall. Without knowledge about repression, it would be surprising that such important events should be forgotten.

Repressed material is not necessarily permanently forgotten; it may be inaccessible to conscious recall at one time and may be remembered quite spontaneously in a different context. In fact, conscious effort to remember may make it more difficult. Free association of ideas may suddenly lead to the recall of something which appeared to be completely forgotten and which when remembered arouses considerable emotion. Repressed material is recalled when current events and circumstances evoke a connection and when the emotional state makes it possible to remember. When anyone is depressed or hears depressing news, all past recollections suddenly assume a depressing nature. All kinds of examples of the sad things that have happened to the individual himself, to others, to the world, are suddenly remembered. When the mood is good, funny or amusing incidents, jokes and success stories are remembered. It is well known that visitors to patients sometimes indulge in recollections of all the sad and unfortunate experiences which they remember suddenly when the association with hospital, sickness and death brings those memories to the foreground. Patients do not find stories of other people's suffering, other people's operations, treatments and misfortunes at all comforting. Nurses may have to help visitors to

remember positive, encouraging, hopeful topics of conversation by their own cheerful optimistic attitude to visitors. The visitors in turn help the patient to think of cheerful events in response to the relatives' mood.

Repression of unpleasant, painful thoughts occurs not only about the past but also about the future. For many patients, the problems related to their return home, to assuming once more the role of the bread winner, to resuming the position in the family usurped by someone else during the patient's illness, are so difficult that they rarely emerge in consciousness.

The patient may appear to forget his family and his work and remember only events which occur in the hospital. His conversation is about the ward, the nurses, other patients, food he is served, the activities of doctors, matron and other staff. He appears to forget all he is told about his own home and family. Children in hospital show this to a very marked degree. They appear to forget their parents soon after arrival in hospital, do not talk at all about home and sometimes fail to recognize their mother when she visits. It is very obvious that the thought of home would be too painful and is therefore repressed. Rehabilitation is very difficult until the patient is able to think of his future life. It becomes possible to help patients once they consciously worry about specific problems or difficulties, but no help can be given while the patient has forgotten all about his troubles. Repression of painful material is a useful defence mechanism, allowing the patient peace of mind and relaxation. It is a solution of difficulties in so far as it makes the patient behave as if difficulties did not exist. To overcome difficulties, however, the patient has to be helped to face them. In the long run, protection from the recall of unpleasant thoughts is not in the patient's interest.

The activity of remembering is only possible if the brain is healthy and intact. When the brain is damaged by accident,

operation, drugs or toxins, remembering is impaired. The amount of forgetting is related to the extent of the brain damage. Because forgetting takes place most rapidly immediately after learning, and much more slowly later on, the material most recently learnt is most completely forgotten after head injury. Old knowledge remains intact. After accidents causing unconsciousness, there may be complete loss of memory for the events leading up to the accident. Patients who suffer from concussion may have forgotten what they were doing at the time of the accident. On recovery from electroconvulsive therapy, epileptic fits or an anæsthetic, the patient may forget where he placed his belongings, what was the last meal he ate, which part of the ward he is in.

Some forms of brain damage interfere not only with recall but also with the ability to understand and learn what is going on. Old patients, or patients who suffer from confusional state during heart failure or fever, appear to suffer from loss of memory for recent events, while retaining vivid and detailed memory of their distant past. Their inability to remember recent events is very largely due to their lack of attention and concentration and consequent failure to grasp and learn what is happening around them. Accuracy of remembering depends first and foremost on the accuracy of observation and on learning which take place in the first instance.

Some people have the ability to see every detail instantaneously. They succeed in taking in a complete picture at once as if they were storing a photograph somewhere inside them. Later, when trying to remember, it is as if they were looking at the photograph and reading off details they might not consciously have noted at all. This process is called 'eidetic imagery'. It is a rare ability, useful to anyone on whose accuracy of evidence one has to depend. It occurs more commonly in children and in some artistic people. Most people perceive only inaccurately what is happening, and their

ability to remember reflects faults in perception in an exaggerated way.

Perception is the interpretation of sensory stimuli which reach the sense organs and brain.

The eye is capable only of distinguishing shape, movement and colour. When we say that we can see a table, or Uncle Jack, or a boat on the horizon we make use of the sensations, remember other similar sensations and give a meaningful explanation of the sensations by referring to objects and people.

Perceiving is a learnt activity. To perceive, it is necessary to remember previous experience, to recognize the new sensory stimuli as identical or similar to stimuli previously experienced and named. When the infant first experiences the sensory stimulus which an orange, for instance, presents, a coloured round image appears on the retina. Similar images are produced by the moon or by a large ball or by a rattle. Later, the infant repeatedly has the same sensation but he learns to handle the orange, gets an idea of its size. He puts it into his mouth and learns about its texture, he smells it, bites it and learns about taste, throws it and learns what weight it has and how much damage it can do. Eventually, he hears the word orange frequently used in connection with the object and learns that it can be cut and produce a good drink, and that his mother dislikes him playing with it. When he then *perceives an orange* all his knowledge about oranges is used to interpret the visual impression.

The moon, which at first produced the same stimuli, has not given any new information. It cannot be reached, or played with, knowledge about it remains much more imperfect than knowledge about oranges. Perception of distance, however, has been learnt by the fact that the moon cannot be reached.

The ball and the rattle are recognized by the noise they make, the texture when they are pressed or sucked, their

hardness. Their size is known by handling them; and their distance, when they are first seen, by the effort required to reach them. Playing with them is approved and encouraged. By the time the infant can name the four different objects which produce the same orange, round, visual image, he is making use of a wealth of information without being conscious of it. Perception includes all this information.

All perception is learnt in the sense that we can name what we perceive only if similar perceptions have occurred before. The use of language is closely linked with perception.

When something entirely new appears we can only describe it as being '*like something else*', possibly like a composite picture of a number of previously known things. We can perceive the new thing only by comparing it with what is already known. There is, at the moment of perception, an effort to make the experience meaningful. This 'effort after meaning', as it is called by some psychologists, determines the way in which it is later remembered. If on first acquaintance a man looks like 'Uncle Jack', he is remembered to be like him. When asked for details later, the colour of his hair is dark like Uncle Jack's, he has a moustache like him, is about six feet tall, of medium build. His eyes, mouth, smile, movements are recalled as resembling those of Uncle Jack. In fact, the more the new acquaintance is considered, the more like Uncle Jack he appears to be. Often when the new acquaintance is seen again there is failure to recognize him because in reality he may be very little like Uncle Jack, while the memory of him has become more and more similar to Uncle Jack.

Perception depends always on the degree of understanding at the time. As everybody who perceives the same thing has different previous knowledge, different expectation and attitudes, different standards of comparison, no two people ever perceive the same event in precisely the same way. In remembering what was perceived, distortions occur according to the

importance that has been attached to the various parts of the perception in the first instance. In some way it is remembered as more conventional than it really was; in other respects, unusual details which had been noticed are exaggerated on recall. Different people's reproduction of the same situation in paint or drawing or in story form are totally different and become more different as time passes.

The psychologist, Sir Frederick Bartlett, of Cambridge, has demonstrated the process of perception and the distortion on remembering by a series of experiments. He drew a pattern, for example, which had certain features of a cat but otherwise was a very unusual design. The first person shown the picture was asked to draw it from memory and pass his drawing on to the next person who, in turn, drew it from memory. The features resembling a cat became more and more cat-like until in some series a completely conventional drawing of a cat was produced, often with cat-like details totally unwarranted by the original picture. Other reproductions stressed some of the unusual features of the design and these were accentuated until there was a cat, with patterns specifically noted to be unrelated to the cat. Both the familiar features and the unusual ones had become exaggerated.

Similar distortions occurred in the retelling of a rather involved illogical story. Familiar elements were retold in more and more familiar versions. The story became shorter, more logical and more commonplace. A few details noticed to be incongruous became more absurd and irrelevant.

It is very important to remember the distortions which occur in perception and in subsequent remembering when the reliability of evidence is considered. What is seen at the time depends on what the observer expects to see, on his attention and on the meaningfulness of what is perceived at the time. How much of it is remembered and how accurately, depends on the distortions which take place in the effort to understand.

It also depends on the emotional need to forget unpleasant aspects, particularly as they affect the person himself. It is very easy for him to accept suggestions as to what he has perceived and then to believe it to be perception. After showing someone a picture for a short period, the subject can be asked to describe what he has seen. When he has enumerated all he can remember, some of which is almost certainly wrong, he can be asked such questions as: 'Did the lady in the picture wear a hat?' or 'How many bottles did the milkman carry?' Even if there was no lady or milkman in the picture, many people are prepared to give the number of bottles and to swear that the lady did wear a hat. They later remember the lady and the milkman perfectly clearly. If they are shown the picture again, they are genuinely surprised to find how different it is from their recollection. It is well known that distortion occurs when people give evidence in court. Counsel for defence or prosecution make use of this knowledge when they wish to throw doubt on the reliability of evidence of a witness.

Nurses have to learn to perceive some situations accurately and guard against distortion in reporting. This can be done only by learning how to make observation of new facts meaningful and by writing down observations immediately. Signs and symptoms of the patient, his facial expression, posture, abnormal colour, or observation of pulse, of excretions or discharges cannot be accurately perceived by the new student because she does not know what to expect when she looks at the patient. When she knows something of the illness, she notices symptoms which she has learnt to look for. Her observations become meaningful. The more experienced and knowledgeable she is, the more detailed the perceptions become. Because observations become more meaningful they are better remembered and reported. Unusual or unforeseen events such as accidents or sudden changes in the patient are less well perceived because the necessary 'set' is lacking to make

perception meaningful. It is all the more important for the nurse to give a running commentary to herself at the time, making details of observation conscious and writing a statement immediately before distortions can occur. It is possible to train oneself to observe by noticing what belongs together, what is out of place, what changes are taking place and what explanation might be given to them.

Training to perceive details and remember accurately depends on knowing what is relevant. The new student cannot distinguish among a mass of details which are those relevant to the patient's illness. The more experienced nurse selects perceptions relevant to the patient's illness. There are obvious advantages in being able to select what is important, but also dangers in that knowing what to look for makes it possible to neglect observations which appear irrelevant yet may be significant. This is why a fresh look at the patient, the unbiased report of a new nurse, the observation of another doctor, the comments of visitors may bring to light some observation which had been overlooked. Sometimes the fact that the patient's illness has been 'diagnosed' interferes with observation. Only those things which are relevant to the named illness are noticed, other symptoms or complaints may be ignored and a better understanding of the patient's illness prevented. Transfer of the patient to another ward, or the introduction of new staff, may lead to a completely new way of looking at him. Publication of articles describing a new syndrome often leads to many observations of the condition because attention has been drawn to symptoms previously thought to be irrelevant. An attitude of optimism and hopefulness leads to observation of improvement which might go unnoticed in a more pessimistic setting.

Although perceiving is a learnt activity, there are certain stimuli to which we appear to respond more readily than to others. Some noises cannot be ignored, some patterns of sound

are noticed with more pleasure than others. Some visual stimuli tend to call for response more readily than others.

McDougall includes in his definition of instincts the tendency to pay attention to stimuli of a certain kind. He was considering the paying of attention to dangerous things, but in fact we do not know about danger until we have learnt about it. Animals certainly respond in a specific way to some selective stimuli. Birdsong, coloration of the male animal, certain movements of the body for example evoke sexual behaviour. Some objects, for example feathers, grit and straw, are perceived by birds and used for nest building. Birds respond to particular patterns on the mother's beak and peck at it. Certain specific patterns of stimuli are perceived as a whole and act as 'Innate Release Mechanisms' for the animal's instinctive behaviour. It is difficult to find similar specific patterns of stimuli in human beings. However, there is apparently a tendency to perceive some kinds of pattern with satisfaction while other stimuli appear to us defective and unsatisfactory.

We notice things which have a good form and have a tendency to fit perception in with our expectation of good form. Squares, circles, symmetry are perceived with satisfaction. Figures which are well rounded and closed are more pleasing than irregular shapes with parts missing. 'Gestalt' psychologists pay particular attention to the need for completeness, wholeness and closure. Our need to see figures as complete leads us to ignore faults at times. We see this shape

as a square and remember it as a square without paying attention to the missing line. When we do notice the piece missing, the gap is magnified in our perception and recollection because it is disturbing to feel that the figure is incomplete. When nurses observe symptoms, they tend to observe all the symptoms which should be there although some may be missing.

When observations do not fit into a good pattern, we have a tendency to make up a pattern. We remember numbers in groups, make up rhymes, make noises into tunes. Similarly, we try to classify observations. The greatest satisfaction is gained when everything is neatly organized and named. Our tendency to organize perception into a clear pattern is so great that we sometimes feel satisfied when order is established, without realizing that the organization into pattern stems from us not from the material we perceive. We feel satisfied when we know the name of a disease without realizing that the disease for which we have only one name may in fact have many causes, many different origins, many manifestations, that in fact there may be many conditions grouped together under one name. Nurses often believe that they know more about the patient when they know the diagnosis. In fact they have merely satisfied their need to categorize. In order to know more about the patient it may be necessary to forget the classification and look again at all the details which can be observed.

The need to classify, to see things as complete, to close the subject, is much greater in some people than in others. The activity of creating order from a wealth of apparently unrelated perceptions is a valuable step in acquiring scientific understanding. However, to see clear patterns where they do not really exist, to demand simple structure always, and to see things only in clear categories leads to excessively simplified perception of a complex situation; it prevents reassessment, regrouping of perceptions and causes a great deal of material to be ignored. Learning consists both of the activity of creating clear, classified patterns which serve as a framework for further perception and learning, and also consists of the process of reconstructing existing patterns, reassessing and breaking down established patterns to make integration into bigger wholes possible.

When we perceive the world around us, we always have to make some judgments on rather scanty evidence. Often we do not even know why we judged as we did. Size and distance of objects, for example, are related to each other. We know how big people are. When we see them as very small, we judge them to be a long way off; when they look big, we think they must be close by. We use a 'frame of reference' of well-known objects, and judge new impressions by comparison. We assume, for example, that the walls and window frames of a room are vertical and judge people's position in space by reference to the room. If the room is distorted, we tend to misjudge the size, distance and shape of objects and people in it. When we know the shape of an object, for example when we know the table top to be square, we continue to see it as square, whatever the position of the eye and therefore the image on the retina, in relation to the object. We tend to see colour as constant, even if the light changes.

There is always the possibility of error in perception. We usually compensate for errors by using several senses at the same time. We do not rely entirely on sight to judge size and distance, but also use touch and hearing. We verify the perceptual experience by handling the object and doing something with it. Very often, however, errors in perception do occur; these are called 'Illusions'. Some of them are universally experienced, some are personal errors, resulting from private expectations and attitudes. Some visual illusions can easily be demonstrated, examples of which may be seen on page 246. Perception of size is often determined by the importance which is attached to the person or object. Children nearly always see and remember their teacher as tall and big. An experiment with similar sized coins of different value showed that the coins of bigger value were seen to be bigger than the coins of smaller value. Villages, towns, places known

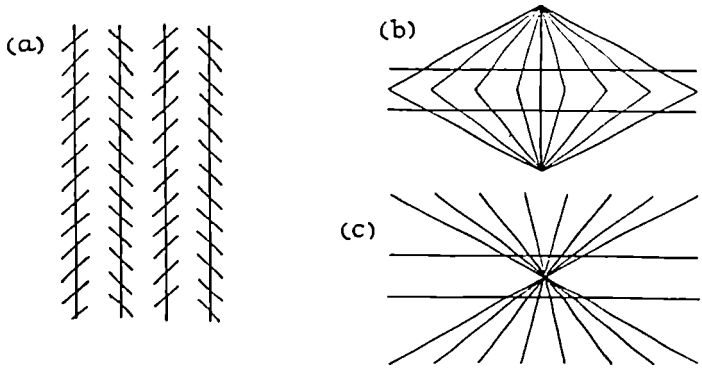


FIG. 6. Some examples of illusions

in childhood appear bigger in retrospect than they really are. Holidays appear longer than they really were.

Sometimes it is difficult to know how much error there is in perception, particularly if there is no means of checking by different approach. In familiar surroundings it may be easy to recognize shapes or noises. If the frame of reference is removed, it may be impossible to perceive accurately what is going on.

Many patients find it very difficult to distinguish clearly what they see and hear in hospital. Where everything is strange and new, there are no fixed impressions against which to measure the reality of perceived events. This is made worse by any defect in vision or hearing the patient may have. It is a terrifying experience to be unable to orientate oneself clearly. It cannot be stressed too much how important it is to help a patient to learn about his environment by making use of every possible sensory device. Showing, allowing the patient to touch, to handle and to use equipment. Explaining, talking about the tools used to carry out a procedure, confirming the patient's perceptions when he is right, correcting them when he is mistaken, are essential to good nursing. Particular attention must be given to a patient whose eyes are bandaged, who cannot hear clearly, who is only partially aware of his environment because of sedation or whose position in bed makes it difficult for him to observe what is going on.

Perception is the necessary raw material for thought. If a person is deprived of sensory stimuli, it becomes very difficult for him to think clearly. Images of previous perceptions become so important that it is hard to know for certain what is reality and how much comes from his own reconstruction of past perceptions. Normally we can clearly distinguish between images of our own and reality because images belong to one sense only. In the absence of sensory stimulation,

images become so powerful that they begin to be taken as perceptions.

There are some mentally ill patients whose own images are so powerful even when there are perceptions of reality, that they fail to distinguish between reality and images. The term 'hallucination' is used for perceptual experiences which do not arise from sensory stimulation. It is never possible to be sure whether a patient is misinterpreting a stimulus and has an illusion, or whether he experiences a perception for which there is no stimulus at all—an hallucination. Some patients are able to describe their hallucinations very clearly either in words or by drawing pictures of them.

We often manage to have fairly accurate perceptions even though the stimulus is very weak or present for only a very short time. We refer to the perceptual threshold when we try to measure how long an exposure is necessary before a picture or word is recognized; how bright the light has to be before we can see, how loud a noise must be to be heard. The threshold differs for different people. Activity of the sense organs plays a part. Apart from that the individual general state of readiness and awareness determines the threshold of perception. When anyone is tired or ill, the threshold may be high and many things he would normally notice remain unseen or unheard. Certain drugs, however, heighten perception. Aldous Huxley described the changes in perception which occurred when he had taken the drug Mescaline. Some people who have become addicted to drugs have perhaps done so because they enjoyed the greater awareness of stimuli under the influence of drugs. The threshold for hearing may be lower when other senses are not used. Blind people can learn to make use of auditory information which is not noticed at all by people with sight. It is possible that patients in stupor have a much lower auditory threshold than is realized.

The threshold differs for familiar and unfamiliar stimuli.

Those stimuli which cause emotional distress differ from those which are neutral. Nurses sometimes become unaware of noises which are clearly perceived by and very irritating to patients. The sounds of a trolley being set up, of keys rattling, may be very alarming to the patient and not observed at all by the staff. Conversation between nurses or between doctors is often heard by the patient to whom it refers, just as anyone may hear his own name mentioned against the general background of noise of undifferentiated talk. Patients always believe that preparation for treatment or discussion of prognosis or diagnosis refers to themselves and, therefore, hear and see clearly some things which in isolation give rise to misunderstanding and unnecessary anxiety.

Although conscious perception occurs only when sensory stimulation has reached the threshold of perception, a certain amount of information can be conveyed by noises or visual stimulation just below the threshold of the individual. This is referred to as 'Subliminal Perception'. It can be demonstrated that words of a given length and printed sufficiently clearly and largely can be read when they are flashed momentarily on a screen. At that point, words which have no particular emotional significance can be clearly recognized. If words which cause anxiety—referring to death, violence, suffering or sex—are interspersed with neutral words, it is found that they cannot be recognized at that level of exposure. The threshold of perception for these words is higher than for neutral words. Measurements of blood pressure, breathing, perspiration, however, show emotional response. This indicates that some perception must have taken place below the threshold. This can also be demonstrated if a person is asked to say the first thing that comes to his mind every time something is flashed on the screen. Even if he is not quite able to read the word on the screen, the association which comes to mind is usually relevant.

The fact that some perception occurs even below the threshold of conscious awareness has been used in advertising in some countries. If the name of some merchandise is flashed on the cinema or television screen so fast and so feebly that it is not consciously recognized, it is not possible deliberately to resist such advertising and therefore it may be more effective than more overt use of advertising. Most people consider 'subliminal' advertising to be immoral. The publication of results of subliminal advertising has caused a good deal of indignation. For practical purposes it is useful to remember that whispered words or a very brief glance at a chart or a textbook may leave patients with incompletely understood awareness which may nevertheless cause changes in their behaviour and emotional state.

The way in which people perceive the world around them is clearly dependent on themselves as much as on the sensory stimulation provided. Previous experiences, readiness to listen, attention, interest, physical health may make a lecture or demonstration perfectly clear to one student, while another student whose background, attention and interest differ may come away from the same lecture with a totally different impression of what has been said. Much of what is perceived in any given situation is in fact put into it by the perceiver. The external world is reconstructed and interpreted to fit in with the personality of the person who perceives. He is 'projecting' into the situation much of his own personality. Clearly, the more precise the external stimuli, the less room for projection; the more vague the external circumstances, the more projection can take place.

Projective tests can be used to give some indication of the personal element which enters into perception. Two of the most widely used tests are the Rorschach Test and the Thematic Apperception Tests described on page 205. Tests similar to the Thematic Apperception Test could be devised to find out a

nurse's attitudes to the various situations she is likely to meet. The way she approaches hopelessly ill patients, her reaction to death or to permanent disablement, to old people, also her way of looking at the structure of hospital administration, staff relationships, the way in which she sees her own position in the community could be elicited by use of projective tests.

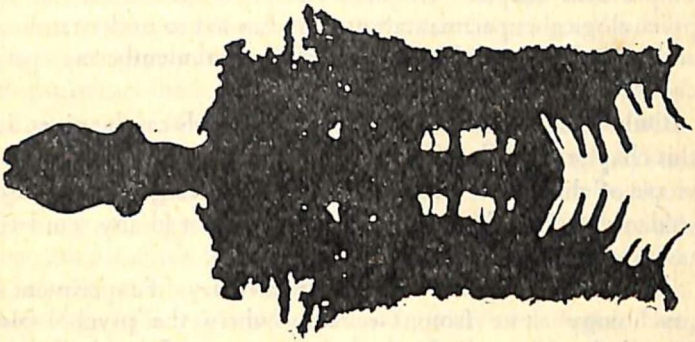


FIG. 7 An inkblot similar to those used in the Rorschach Test.

Projective tests cannot be very easily scored or standardized. The stories which are told by the subject must be interpreted by the psychologist who, in the process of interpretation, projects some of his own personality into the way he understands the stories. However, a much clearer picture of each student's individual understanding could be gained if her characteristic way of perceiving her work and her own personality could be known.

7. EXPERIMENTAL SCHOOLS OF PSYCHOLOGY

In previous chapters, frequent reference has been made to psychological experimentation. This has led to understanding and knowledge of the laws of learning, remembering, perception and behaviour.

Only a brief summary of the main schools can be given in this chapter. Details of the experiments would go beyond the scope of this book, but they make interesting reading, and students are urged to read more about them in any standard textbook of experimental psychology.

Wundt. The main influence in the early days of experimental psychology came from Germany where the psychologist Wundt began to study the measurement of psychological reaction in his laboratory. The general trend of measuring and then of expressing psychological laws in mathematical form originated from this work.

Ebbinghaus—Tichener. Some of the early work on learning was carried out in Germany by Ebbinghaus, and in England by Tichener. Their main contribution was the detailed description of the association of ideas. They expressed their findings in the form of laws of learning. Their method of approach is often referred to as the 'Associationist School' of psychology.

Thorndike arrived at similar conclusions from observing 'Trial and Error' learning in cats.

Pavlov. His experiments in the conditioning of dogs, and his interest in the physiological basis of behaviour led to the foundation of the 'Physiological School' of psychology, a school of very great importance. It has contributed to the

understanding of body-mind relationship; in other words, the psychosomatic approach to behaviour. It is possible to produce conditioned responses in human beings. Some psychologists attempt to treat certain symptoms by conditioning. Patients have been conditioned to vomit when they taste alcohol. In this way it may be possible to cure alcohol addiction.

The great school of 'Behaviourist Psychology' is to some extent a development arising from the conditioning or 'reflex' schools of psychology. Like the conditioning school, behaviourists are interested in the relationship between '*Stimulus* and *Response*'. They are, however, more concerned with *behaviour* and to a lesser extent with the underlying physiological processes. Behaviourists study only '*observable behaviour*'. They do not deny the existence of experience, but because experience cannot be verified by objective observers or by experimentation, they limit the subject matter of scientific psychology. They define behaviour in fairly wide terms. Not only the gross movement of the body but also the small amount of muscle contraction which is observable only with the aid of instruments is taken as behaviour. So are changes in glandular function, changes in perspiration, in diameter of capillaries, in blood pressure, pulse rate, respiration rate. These are referred to as 'Molecular Behaviour', while the total response of the organism is called 'Molar Behaviour'.

John B. Watson is considered to be the founder of the behaviourist school of psychology. He is said to have used his own child for some of his experiments and to have claimed that it should be possible to produce any desired form of behaviour by methods of conditioning. In his book, 'Behaviourism', he explains the main principles of the behaviourist method of study. Most of the behaviourists have confined their experiments to animals. Some of their findings are applicable to human beings; the laws of learning for example appear to be very similar in animals and men.

E. C. Tolman. Animal experiments are usually set up in such a way that the animal must learn the method of obtaining food or water. The food or water act not only as rewards but also as *goals* of learning, and Tolman makes this point very strongly in his book, *Purposive Behaviour in Animals and Men.* Like all behaviourist psychologists, he is interested in the ability to 'discriminate' between different stimuli. Behaviourists do not need to study experience; they do not want to know what the animal sees or how it feels. They simply observe whether it is able to discriminate between various shapes or various colours in learning to find the food.

An example of a learning experiment:

Rats are deprived of food for a known length of time. Eventually, they are placed on a platform in front of two movable doors; one door with an oblong drawn on it leads to food; the other door with a circle on it does not lead to food. After a few trials, the rats learn to jump through the door which leads to food. They clearly learn to discriminate between oblong and circle.

The stimulus for learning is 'food deprivation' which can be expressed accurately. The behaviour (jumping) is observable. Learning can be measured by the time it takes and the number of errors made. The animal's 'discrimination' of pattern can be deduced from its success in learning, and the 'reward' can be measured by the amount of food given.

Tolman made some observations about the incidental learning which takes place; that is visual or other clues which the animal apparently takes into account while learning the type of behaviour needed for getting the food.

Karl S. Lashley has contributed valuable information about the function of the brain cortex in learning. He has shown that earlier beliefs about localization of brain function were oversimplified.

B. F. Skinner has studied learning in animals in extensive experimentation. He became interested in the difference between 'Respondent' behaviour and 'Operant' behaviour. Respondent behaviour occurs when an external stimulus is presented; Operant behaviour results from food deprivation or other internal drives. Skinner used puzzle boxes in which the animal pressed a lever to obtain his reward, the animal procuring its own food when it behaved correctly. Skinner refers to this as '*Instrumental*' learning. The animal is instrumental in producing the effect.

Clark L. Hull has gone much further in expressing behaviourist psychology in mathematical form. There are many other prominent psychologists in the behaviourist schools.

The Gestalt School of Psychology in contrast to behaviourism is almost entirely concerned with 'Experience', particularly the experience of perception which, in the opinion of Gestalt psychologists, is immediate and primary. For many centuries arguments had been going on about the nature of perceptions: how do we know that what we see corresponds to the real thing? What is the relationship between the characteristics of the external world and our sense data or between sense data and perceptions?

Gestalt psychologists offer one solution; treating as real and important *only perceptions*, ignoring what lies behind them because it cannot be known. We behave according to our perceptions. Gestalt psychologists are also interested in the neurological events which accompany perceptions. Although there is no precise knowledge of this, Gestalt psychologists believe that there is a physiological event of comparable pattern to the perception, a 'trace' in the brain. This theory is referred to as 'Isomorphism'. The aspects of perception considered important by the Gestalt School are those which create patterns, order and meaning of the sensory impressions. We always experience things in a 'perceptual field'. This

means that everything we see is seen against a background. The background helps to determine the figure we see.

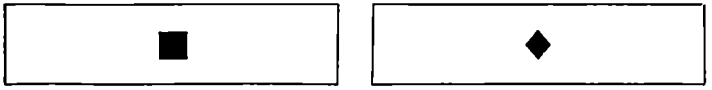


FIG. 8

The same object is seen as square or diamond according to its background; or, in the language of Gestalt psychologists, according to our perceptual field of it. (Fig. 8.)

If patterns do not exist, we tend to create them: we group objects, perceive notes in form of rhythm or tune. The entire pattern is seen as a complete whole and can be transposed on to different background or into different size, or in the case of music into different key. We feel more comfortable if a figure is a good one. Gestalt psychologists speak of 'good form' if it is complete, closed, rounded, symmetrical, full. Another word they use is 'pregnant' for a well rounded, complete figure. The most important psychologists of the Gestalt School are: *Wertheimer*, *Kohler* and *Koffka*.

Kurt Lewin developed the idea of 'field dynamics', transposing the idea of forces acting in a field according to definite laws, from physics to psychology. The field in which we operate is our own psychological field as we see it. Behaviour can be understood if it is known how people perceive the barriers and tensions in their own life. Lewin's method of representation is helpful in understanding the private world of the paranoid patient. He shows how the perception of danger depends on the individual's own field and how it affects behaviour. Failure or success depend entirely on his own levels of aspiration, his own field of action with its own barriers, limits and tensions rather than on objective difficulties. Other psychologists of the Gestalt School are working on

problems of human conflict. In Canada, the work of *Hebb* is throwing light on the physiological processes of learning. Experiments with machines which can learn have some bearing on Hebb's very complex theory.

H. J. Eysenck. In this country, Eysenck is systematically subjecting psychological research to statistical analysis and attempting to put much experimental work on a sound, scientific base.

SUGGESTIONS FOR FURTHER READING

There are many comprehensive textbooks of Personality. Students may find it helpful to read some chapters of these but most books on personality are too detailed to be read as a whole.

ALLPORT, G. W. *Personality.* (Constable.)
CATTELL, R. B. *Personality.* (Harrap.)
EYSENCK, H. J. *The Structure of Human Personality.* (Methuen.)

The biological basis of Personality is discussed in:

SCHEINFELD, A. *The New You and Heredity.* (Chatto & Windus.)

The following books describe some fascinating experiments:

EYSENCK, H. J. *Sense and Nonsense in Psychology.* (Pelican.)
EYSENCK, H. J. *Uses and Abuses of Psychology.* (Pelican.)
BARTLETT, F. C. *Remembering.*
KNIGHT, R. *Intelligence and Intelligence Tests.*
VERNON, P. *Personality Assessment.* (Methuen.)

All general textbooks have good chapters on learning and give explanations of Gestalt theory and Behaviourism.

PART III

Psychology and the Hospital

1. INTRODUCTION

In previous chapters, an attempt was made to describe how a knowledge of personality development and of personality characteristics helps nurses to understand patients and to understand themselves. Throughout these chapters, however, the assumption was made that behaviour could be explained if there was available sufficient knowledge about the individual's uniquely characteristic personality.

This assumption is not entirely justified. Behaviour is not only determined by the individual's own personality, but also by the standards and expectations of the society in which he lives. There is as much variation between people of different cultures as there is between different people in the same society. Whether a patient complains noisily or suffers in silence is only partly determined by his own personality. Partly he follows the standards of behaviour of his own group. In some countries, people who cannot control their emotions and who give way to tears are thought childish. Those who hide their feelings are admired. In other countries, it is not only proper to display feelings but if the patient does not complain his suffering may not be understood.

People of different cultural background have different feelings about privacy. To some people it may be perfectly natural to undress in public, to submit to nursing care in an open ward, to be examined in the presence of a group of students. Other people value privacy and modesty to such an extent that they become acutely distressed in many situations which occur in hospital. To be seen naked even by one nurse may cause them great anxiety, and physical examination by a doctor of opposite sex or before onlookers may be quite unbearable.

In some societies, it is customary for the whole family to visit the patient frequently, to crowd around the sickbed, and either to try to interest the patient in family affairs or to try to share his suffering with him. In other societies, it is more usual to expect that the patient needs peace and quiet. Visitors try not to burden the patient with their affairs, and they do not expect the patient to include them in his private world of suffering.

People differ greatly in their eating habits. Each nation has its own favourite foods, its own way of preparing and cooking food, and its own rules about the number of meals eaten per day. It is necessary only to remember what a cup of tea means to the English to realize that some attitudes are shared by people of similar cultural background, in little things as well as in big issues.

Not only national and racial culture, but also social class determines behaviour. The middle classes, from which many nurses are recruited, share a liking for order and cleanliness which may be strange to some patients. There are differences in moral values between members of different social classes. The middle class, for example, may feel more disapproving of premature sexual relationships than either the upper or the lower classes. Attitudes to divorce or to illegitimate motherhood may vary between members of different social class.

Student nurses may find it profitable to read some of the very interesting books on sociology and social anthropology. These describe widely divergent patterns of culture. The behaviour of many patients, and the attitude of some of their colleagues may be more understandable in the light of such reading. In the next few chapters, attention will be focussed on the influence of the hospital culture on the behaviour of patients and personnel.

Social psychology is the study of the individual in relation to his society. It is well known that the same person may

behave very differently when he is at home or at work or at his club, or a patient in hospital. The social setting, the presence of other people determine which kind of behaviour is appropriate.

Social psychologists have studied behaviour in many different situations. Only a few studies have been carried out in hospitals. Much more is known about schools, universities, factories and small social groups, such as family or club. An attempt will be made to examine the kind of psychological problems which are studied by social psychologists. The question whether the findings are applicable to the special problems of the hospital will be left open until more research can answer it.

2. ROLE, STATUS, STEREOTYPES

People often say that they would recognize a nurse anywhere they met her. There is a belief that membership of the nursing profession causes the individual concerned to behave differently from other people. In some instances there is truth in the statement that nurses behave in a special way; in other respects, it is probably a fallacy. When reference is made to *role determined* behaviour, it is implied that certain jobs or certain positions in life are associated with predetermined behaviour patterns. When, on the other hand, there is a generalized discussion about people, ascribing characteristics to the entire group as if everyone belonging to it were alike, use is being made of a *stereotype* which rarely has any valid justification.

Stereotypes are over-simplifications and generalizations about national, racial or religious groups as well as social and professional groups. Many people believe that the Germans are all alike, or that there are typical Chinese or Arabs or Jews. People of the upper class, or of the working class are described in stereotypes. Nursing or teaching are professions about which stereotypes exist. When the stereotype consists of many unfavourable characteristics, it is often associated with prejudice. People build an idea for themselves of the typical Jew, or the typical Negro and then behave to all Jews and Negroes not according to their real personality but according to their own idea. Often people are surprised when they find that the real people they meet are quite different from their preconceived idea. They tend then to call their new acquaintance atypical but to keep their idea of the stereotype intact rather than modify it in the light of experience. When the stereotype formed about a group contains fewer unfavourable charac-

teristics, it may give rise to humorous descriptions and characterizations or to unjustified admiration. There are many jokes about the British army officer or about the city financier, or the foreign diplomat. Some of the more eccentric aspects as well as some of the more likeable personality characteristics enter into these stereotypes. When the Germans are described as thorough, reliable, hardworking; or the Japanese as good businessmen; the Americans as efficient and forceful; the French as amorous and emotional, use is being made of national stereotypes.

The danger of forming judgments about whole groups of people on the basis of stereotype lies in the difficulty this creates in communication and understanding. It is much more difficult to get to know an individual person really well if he is approached with a ready formed opinion. Anyone who dislikes all Jews and has a stereotype of Jews as mean, grasping or dishonest people is unlikely to be friendly, sympathetic and sincerely interested when he makes the acquaintance of a Jew. His relationship with the Jewish person is likely to become strained as a result of his own first approach, and he will consequently reinforce his unfavourable opinion and his stereotype idea of the Jews.

Stereotypes about nursing are very commonly formed in the popular mind. They do not give rise to prejudice but they hinder clear thinking and communication about nursing. The greatest difficulty arises from the indefinite nature of the concept of 'nurse' which enters into the stereotype. For most people it embodies the person who actively cares for the helpless sick, soothes the feverish brow, fights for the life of a sick child or watches over the delirious mutterings of a wounded soldier. It is not at all clear in this picture of the nurse what precise knowledge or skill she requires for her activities, or indeed what are the activities involved in fighting for someone's life. The detailed professional requirements are

not included in the stereotype. Nor are the many activities of the nursing administrator, the nurse in public health, the nurse in many specialized fields of work. The stereotype of the nurse includes only the bedside nurse; not her skills, but only her personality. She is a person who is good, kind, patient, wise, alert, selfless, devoted—in some way, a superior being. Sometimes, the stereotype of the nurse is an exaggeration of all the positive and favourable personality characteristics people would like to find in their nurse. Often, however, some of the less likeable characteristics are added. Nurses are seen to be hyper-efficient, cold, hard-hearted disciplinarian, authoritarian people. It seems possible to combine the most contradictory characteristics in the stereotype of the nurse.

Patients often enter hospital with a stereotype of a nurse in mind. Their idealized picture of the nurse helps them to gain confidence at a time when they most need to trust the hospital. On the other hand, they may fear the nurse and react with unreasonable apprehension to the hospital. Nurses would do well to remember that every patient has a preconceived idea of what nurses are like. It is a difficult task to break down the patient's stereotype and show him that nurses are real people.

Nurses, themselves, have stereotypes in mind when they decide to enter the profession. In some way, these stereotypes act as a model for the new student. There are numbers of possible dangers. The model may be so unreal and idealistic that there is no hope of ever achieving any resemblance to it. If the student retains the idealized stereotype of the nurse, she will think of herself as a failure and become discouraged in her work. It is also possible for her to think of herself as prematurely approaching the stereotyped image. Some nurses have phantasies as soon as they put on a uniform, in which they imagine themselves to be the perfect nurse they have in mind. They believe that they really are always kind, patient, helpful

and knowledgeable. To have such a view of herself interferes with the examination and critical assessment of her own personality, which is a necessary part of professional growth.

To have a stereotype of a nurse in mind sometimes makes it difficult to understand the tremendous differences between the requirements in various branches of nursing. The hospital nurse may more or less fit the stereotype; the health visitor almost certainly does not fit it. Nurses in mental hospital work or in mental deficiency do not resemble the stereotype at all. The question—what is *real* nursing?—reveals the difficulties which arise from having a stereotype of one particular kind. It may be very difficult for a nurse to adapt herself to a new experience in nursing if she has not learnt to modify her stereotype of a nurse.

A nurse's behaviour is strongly determined by the way she sees her *role* and the way other people in the team understand it. Every job carries with it certain expectations of the person who fills it. Appropriate behaviour and attitudes are prescribed. In some fields of work, there are clear, written rules about the kind of behaviour which is obligatory and the kind of behaviour which is prohibited. In the army, it is impossible to be in doubt about the appropriate behaviour for every occasion and for every rank. For nurses, the rules are unwritten, not always clearly laid down, somewhat flexible. It is sometimes difficult even for nurses to discover what behaviour is expected of them, and a great deal of anxiety arises because of the fact that an unwritten code of role behaviour has to be learnt.

When the psychologist speaks of role, he does not mean to define what part of the total work should be done by any particular individual; nurses sometimes refer to roles in that sense. They speak, for example, of the nurse's role in relation to the team, meaning to define which jobs precisely should be

carried out by the nurse, which jobs by the doctor, the social worker, the occupational therapist. Or they speak of the role of the nurse in health education, trying to define for themselves what special contribution the nurse can make. Psychologists are not concerned with the definition of the scope of the work. When they speak of 'role' they wish to determine what kind of behaviour has to go with the job which has been decided upon.

With each role, there are some patterns of behaviour which are essential. Others, however, appear less directly related to the work, yet they are equally carefully regulated. It is, for example, essential to nursing that the nurse should be willing to preserve life, that she should have an interest in the weak, the sick, the helpless. It seems essential that she should obey orders in an emergency, that she should be willing to work at week-ends or nights at least sometimes, that she does not go off-duty in the middle of an operation. All these ways of behaving are inherently related to the nature of the work.

It is much less clear why a nurse should never go off duty early even when she is not busy, or why she should never smoke in uniform, or why she should completely accept irregular duty hours, or why she should wear uniform at all. There may be very good reasons for each of these things, but they are less clearly related to the requirements of the work itself. It may be of interest to examine in detail all the rules about behaviour to see how far they belong to the necessary role pattern and how far they are related to role, but constitute permitted, not obligatory, behaviour. In the details of nursing procedures, some actions are essential, others appear to be unrelated to the task.

Other workers do not always agree with nurses about the nature of role determined behaviour. They may, for example, find it difficult to understand the rules about smoking, or the

way in which nurses defer to each other in discussions. On the other hand, they may expect the nurse to perform tasks she is unable or unwilling to perform, or may take upon themselves tasks which the nurse sees as related to her role. The doctor may require the nurse to carry messages for him or to remind him of his engagements. The nurse may not see this as related to her task. She may feel that she should give more help to the doctor during an operation; he may not see this as part of her function. The fact that no role is entirely defined leaves room for each to create his image of his own and other people's roles. There is often considerable misunderstanding and friction until open discussion clarifies the issue. As with stereotypes, the title 'nurse' is understood differently by various members of the team. For most people, all nurses have the same kind of role. The bedside nurse is the person that patients and doctors tend to think about. Within the nursing profession, the role of each individual is totally different from that of any other nurse.

Student nurses, staff nurses, ward sisters have different behaviour prescribed for them; nurses outside the ward team behave differently again. Patients are often vaguely aware of these complications. They may find difficulties in understanding and often express their concern. They may become very anxious if they call a nurse 'sister' or the sister 'nurse'. They are afraid to ask the wrong person for a glass of water or a bedpan, and they worry because they do not know who to ask for information. Nurses, themselves, may know that their role does not prohibit giving bedpans or giving whatever attention the patient needs, but the patient may not understand this. It is essential to help the patient to understand the issues clearly and to reassure him about the fact that his care is the business of every nurse whatever her role.

When the difference in behaviour expected of nurses of various ranks are examined, reference is made not only to role

expectation but also to *status*. Status is the position each occupies in her relationship to other people. In every group an order of importance and esteem inevitably develops. Colleagues give each nurse a certain status at work. At home in the family she occupies a different status position. Everyone has some status in his club, in the classroom or in the community. Status may be high in one social group and low in another. A father may have a high status in the family; at work he may occupy a position of low status. A child may consider his family position one low in status, but his performance at school may give him a high one there. He may have a higher status on the playing field than in the classroom. It is important to most people to feel that their status is high at least somewhere in their life. Most people are happier at work if they are satisfied with their status there.

To understand how status affects nurses' behaviour, it is necessary to examine the status of nursing in relation to other jobs, and to examine the status associated with various positions in nursing. The status of nursing as a profession is frequently discussed. Many nurses feel strongly that the status is not high enough. Yet at the time of choosing their career, they must have regarded it favourably. No one is likely to choose a career which he believes to have low status. Some opinion surveys of the status of nursing have been carried out. Nurses themselves have been asked what occupation they would have chosen in preference to nursing, and which occupation would have been their next best choice had they been prevented from nursing. This reveals where the nurses see their profession in the status ladder. It appears from studies that nurses vary in their views in different hospitals. Some compare nursing with other professional work, such as medicine or teaching. Others compare it with such jobs as secretarial or salesman's work. Men look upon it differently from women. The status which school teachers give to nursing determines to some

extent which of the children are encouraged to think of nursing as a career.

Some people feel that monetary reward determines the status of work, or at least reflects its status. Others feel that money is unimportant in determining it, that the intrinsic value of the work itself is the essential factor. On the basis of the argument that the intrinsic value of work is important, people responsible for the administration of the health services seek to raise the self-esteem of every group of workers by stressing their special contribution to the welfare of patients. This does not, however, entirely prevent the attempt of each group to raise its own status.

Status within any one group may become all the more important if the profession as a whole is uncertain of its position. In nursing, much of the traditional behaviour of juniors towards seniors, and seniors towards juniors, is related to status difficulties. People are uncertain whether they can retain their status in a more informal atmosphere. The whole system of hospital etiquette is designed to strengthen and clarify the status system and to make it more dependent on the job each individual holds and less on personal characteristics.

Some people find a sudden change in status very uncomfortable and distressing. Having held a responsible job before entering nursing, new students may have difficulties in adjusting to student status. Each move between wards may necessitate adjustment to a new status. Work in a new special field of nursing may make the nurse feel insecure and doubtful of her status.

Change in status may be very important to patients and determine their attitude to sickness. Theoretically, the patient enjoys the highest status of all people in hospital. In practice, patients may feel very lost because of the sudden loss of all their status positions at work, in the family and in their social setting. In hospital, the patient may feel that he is unimportant.

His attempts to seek attention, or his behaviour towards other patients, may represent his attempt to regain a more satisfying position. When people feel comfortable and satisfied with their status, and when they understand clearly their own and other people's roles, *morale* at work tends to be high. Morale will be discussed in the next chapter.

3. MORALE

When people are observed at work, it can readily be seen that an atmosphere exists between people which affects their happiness, the quality of their work, their attitude to the place of employment, their work satisfaction, indeed every aspect of their working life. The word *morale* is often used for this all pervading aspect of human relationship. When morale is high, everything at work goes well. When morale is low, there are many indications of disturbance. Morale cannot be directly described or measured. Instead, many different aspects of work are used separately as indices of morale.

Although there is no way of demonstrating morale, its influence is felt by all members of the group. Each person is aware that his or her own attitude and behaviour are part of the characteristics of the group as a whole. Each is aware that some factors outside his own personality are affecting him. Morale is influenced by the extent to which people in the group are able to solve their problems of status and role definition. These are only a small part, however, of the total picture.

General Job Satisfaction

Job satisfaction makes for good morale and is greater when morale is high. It occurs when the work meets the needs of the people who perform it. It is not always easy to identify the needs of all the people who work together; and usually, although all have chosen the same job, they have done so for very different reasons.

People enter nursing with all kinds of preconceived ideas about the work. Often their idea of the real nature of the work

has little correspondence with reality. There may have been no opportunity to find out in detail what kind of work nurses perform, what skills or knowledge are required, how much study is needed, how much money is earned; working conditions may not have been investigated and possibilities for promotion or for specialization may never have been discussed. The nursing stereotype may be all that had guided the choice of a career. The new recruit may have matched this stereotype against her own idea about herself. Her daydreams about her own future may also have lacked factual basis for action. When the work is thus chosen without adequate knowledge about her own ability or the nature of the work, job satisfaction is unlikely to occur.

The motives for choosing nursing may be consciously expressed. Some women hope to satisfy their need to give freely of their maternal feelings. Some need to have recognition and esteem, some need scope for their creative abilities and their thirst for knowledge; some seek companionship and friendship from their fellow workers; some need to feel big and powerful and hope to be able to achieve this as a result of their mastery over sickness and adversity. The need to gain independence from home may be very important. Often these needs are unconscious but may nevertheless enter into the choice of the career. Nursing can satisfy many of these needs, and this is why so many people derive tremendous satisfaction from their work. Not all needs, however, can be met all the time. When the individual becomes conscious of them, he is better able to plan his career or to continue to gain satisfaction from the work though he may have to rely partly on other activities for his emotional gratification.

If the future nurse needs to be protective and motherly, for example, she may be happier nursing severely sick people and would not choose to work in a convalescent or rehabilitation ward. If she needs to feel challenged, she might choose a

situation in which frequent emergencies arise rather than work with chronically ill patients. Some fields of nursing make more demands on the intellectual ability of the nurse, others on her emotional adjustment. Success in each case satisfies different needs. Promotion to administrative posts often means reduced contact with patients and therefore less opportunity to satisfy some of the emotional needs.

There are so many different aspects of nursing that it should be possible for everyone to find satisfaction. The new student may have to be helped to see how different her experiences are in each of her successive ward assignments. While she is unaware of her own motivation, she may find it hard to see beyond the current experience if her needs are not satisfied. Job satisfaction not only depends on the fulfilment of emotional needs but also on the extent to which the work measures up to expectations. The term 'Level of Aspiration' is used when inquiry is made as to what aims people set for themselves.

Most people have a fairly realistic idea of their own abilities. They seek work which is difficult enough to provide continued stimulation and yet is not so difficult that it cannot be accomplished. As each experiences success or failure, he adjusts his level of aspiration. Some people's personality is such that their level of aspiration is unrealistic. Their anxiety may be so great that they always set their level of aspiration much too high, or they may have learnt, by setting it much too low, never to risk failure. People like this find it difficult to be happy and content in their work. But people who are able to set their level of aspiration realistically, may also be disappointed in nursing. Some feel that there is insufficient scope for them. Circumstances may prevent them from aiming high enough, or from progressing fast enough. People in senior positions sometimes discourage what they consider too rapid progress.

In order to work to full capacity, it is necessary to have an opportunity for experiment with new ideas. There is need to try new skills and risk making mistakes. In nursing, mistakes may, however, prove dangerous to patients, and so elaborate safeguards against them may limit the progress the student is able to make. Most nurses enjoy the challenge of emergency situations although they may be worried by the amount of responsibility they may have to take when they feel inadequately prepared. On the whole, it is a more satisfying experience to perform a task which stretches the nurse's ability to its limit than to work comfortably within her previous competence. Some nurses, either because they are more timid or less able, fail to gain job satisfaction because they dare not set their levels of aspiration high enough; or because however low they are set, the reward of success never comes.

When students enter nursing, their level of aspiration usually reaches into the range of responsibilities concerned with bedside nursing. In order to attract enough students of superior ability, it may be advisable to draw attention at the earliest opportunity to the limitless career value of nursing in its various branches and to help to raise the level of aspiration of the most adventurous students. Job satisfaction is often related to the social structure of the place of work. More will be said about this aspect of work later.

When morale is not good, every aspect of work is affected. Where productivity can be measured, reduced output is one indicator of lowered morale. In hospital, work is difficult to measure. Work quality suffers, but again in nursing it is not easy to observe this. The sensation of fatigue reported by personnel is one sign that work appears to be less enjoyable than formerly. Among the most common results of low morale are: *rapid turnover* in personnel, *absenteeism* and *accident proneness.*

Turnover

There are many good reasons for anyone to change his job. In the early years of working life, it is common to make several changes before settling down to the chosen career. Once a career has been selected, changes in work are usually related to advancement and promotion. Some personal decisions may also indicate making a change. Marriage, or the fact that the family has moved to a new address, may necessitate change. On the whole though, if anyone is happy in his place of work and his choice of career, he does not make too many changes.

If in any organization staff turnover increases very much, it is worth while to investigate morale. People who wish to change do not often refer to their dissatisfactions. They tend to find sound reasons why a change has become necessary. It almost appears as if rationalization is prevalent in such conditions. Investigation of job satisfaction, however, often shows that people who have failed to find congenial friends, who are on bad terms with their fellow workers, who criticize management and leadership are those who soon after leave their work. The people who are most settled are the ones who mention the pleasure they derive from good companionship, who have made close friends among co-workers and who find their superiors at work competent and fair.

Absenteeism

People who feel that morale is poor may not actually leave. They may express their dissatisfaction by frequent absenteeism. They often awake in the morning feeling unwell and rather low, and they decide to take time off. This is by no means a deliberate and conscious form of malingering. On the contrary, the people concerned would feel very hurt if it were

suggested that they were ill because they did not look forward to their day's work.

Genuine illness becomes much more frequent in those who are unhappy. Feelings of malaise become more troublesome. When anyone feels psychologically troubled, he develops many organic symptoms which become sufficiently disabling to warrant staying away from work. When the individual feels happy in his work, conscious of his responsibility and needed by his fellow workers, he often ignores minor ailments because work is important. When the worker is not too sure whether his work is worth while, or when he does not feel personally wanted, it is easy to give in to minor illness.

Accidents

It may seem surprising that accidents may have psychological significance. By definition, an accident appears to be an event which happens fortuitously with no known antecedents. Yet a study of the circumstances in which accidents occur often shows that considerable psychological stress precedes the accident. People who worry suffer from lack of concentration, and so, cause accidents. Their anxiety may make them clumsy, and worry may be responsible for slower reaction time and therefore accidents are less easily warded off. Loss of sleep and fatigue may have something to do with accidents. When people are mentally unwell they may resort to taking drugs or alcohol which in turn increase the risk of accidents.

When morale is low, the accident rate generally rises and increased damage results to property and persons. Some people are much more prone than others to have accidents when they are under stress. In any community a few people between them have most of the accidents, while a large

number of people never have accidents at all. People who repeatedly have accidents are said to be 'accident prone'.

Some psychologists look for a more specific connection between psychological troubles and accident proneness. They feel that certain people behave as if they were punishing themselves by being hurt. In extreme cases, people who are totally oblivious of danger or who enjoy taking risks are people who do not find life worth while. Any sudden increase in accident rate or any serious accident proneness by certain members of staff should lead to investigation of morale.

4. WORKING WITH OTHER PEOPLE

Very few activities in nursing are carried out in isolation. Most of her working life, the nurse works with others or at least in the presence of other people. There is much evidence that behaviour changes in the presence of other people. The term *Group Dynamics* is used in the attempt to explain the effect of the group on the individuals who compose it.

A group, in psychological terminology, consists of a number of people who have a common interest, goal or common purpose and who form some kind of association with each other because of their common business. If a number of people happen to find themselves at the same place without the bond of common purpose this constitutes a *crowd*. The people travelling in the underground train at the same time, or queuing for tickets for a cricket match, or present at the scene at the time of a road accident have similar interests or aims, but they have not assembled for the purpose of interacting with each other, they form crowds. In a crowd, an individual may behave in a markedly different way from his usual standards. Examples have been described of the mass excitement of crowds during political unrest, at Negro lynchings, antisemitic outrages. The individuals concerned would not, singly, have behaved the way they did; in fact, often they felt ashamed of their actions. In a crowd, they appeared to be less conscious of the controlling influence of their own moral standards and seemed to lose the sense of responsibility for their own actions. Similarly, as one of a crowd, the individual can get more excited and exhilarated by such events as peace celebrations, parades, elections. Even the enjoyment of a good concert can be heightened by the

presence of an excited audience. Crowd behaviour does not concern us directly in considering the work of the nurse.

The effect of a group on the functioning of the nurse and on the behaviour of patients is, however, very important. The first group in human life is the family group, and we have already shown how experiences in that setting may affect attitudes later in life.

Adults belong to a large number of groups simultaneously, some of these being called *Face to Face Groups*. These groups form when a small number of people meet for the purpose of discussing a problem or carrying out jointly some work project or to enjoy a game, a meal or some conversation. In a face to face group, people are affected by the physical presence of others. Face to face groups are sometimes referred to as 'Primary Groups'.

An individual may belong to many groups without actually meeting their other members. In hospitals, the nursing staff forms one group of whom only few ever meet face to face at any one time. The nursing staff forms a separate group from the medical staff or the domestic staff or the maintenance staff who have their own groups. The hospital staff as a whole, however, also forms a group with interests and activities concerning all. Nurses may, at the same time, belong to a professional organization, such as the Royal College of Nursing or the Student Nurses Association. They may also be members of their church, of a political party, perhaps a trade union. These larger groups are referred to as 'secondary' or official groups. In each group, different demands may be made upon the nurse; sometimes these are conflicting and create anxiety until the difficulties are resolved.

A sense of belonging appears to be very important to all human beings. More satisfaction may be derived from membership of some groups than from others. In some groups there is a secure feeling of attachment, although a member

may sometimes have difficulty in belonging wholeheartedly and may then feel that she is only a 'fringe' member. Sometimes it becomes necessary to deal with people to whom the individual may not feel drawn at all, or may even feel hostile. There may exist a sensation that certain groups of people exclude a would-be member from close membership. Psychologists speak of '*Ingroups*' to describe the nucleus of people most closely concerned with membership, and of '*Outgroups*' to describe those who fail to be integrated into the group or against whom a group appears to operate.

Each group develops its own standards of values, its own rules about behaviour, its own attitudes to which members are expected to conform. When individuals fail to conform, the group as a whole exerts pressure to bring the members' behaviour within the range of acceptable behaviour, or else takes action to expel the offender from membership. Groups differ in the degree of variation from the norm that they are able to tolerate and also in the type of sanctions they use against offenders.

Anyone who seeks membership in a group is usually attracted by at least part of the group's programme. One joins a sports club, for example, because he likes its range of sports activities or its facilities, its geographical location, or some of the people in it. Another joins a political party because he agrees with its overall outlook. A third joins a particular hospital because he believes it to provide good medical and nursing care.

Once anyone has become a group member, he discovers aspects of which he was not previously aware, and which may not be entirely acceptable. The sports club, for example, may have some members whose political opinions the new member does not share; the political party may consist of some individuals whose views on health matters are contrary to what has been expected; the hospital may have developed

staff social activities which do not appeal. In order to remain a member of the group, the individual must make some compromise and behave in such a way that he does not offend the existing members.

Groups appear to have some kind of independent life of their own. They evolve in an almost predictable manner. During their existence, they go through phases of development which are reminiscent of the developmental stages of man. There are early difficulties of group formation and establishment of group norms which resemble childhood and adolescent troubles. They have a period of adult maturity and may finally develop the sluggishness of old age and the degenerative processes of senility. This description refers to the function of the group as a whole, not to the characteristics of any of its individual members. Group standards are formed by the interaction of the members. Once standards are formed, individual members are affected by them. Some interesting experiments have thrown light on some details of group interaction.

A classical experiment is that of Muzaper Sherif. If a small ray of light shines on to a screen in a completely dark room, everybody who watches the screen has the impression that the point of light moves. This is a universal optical illusion. If people are asked to say how far they think the light has moved, they are willing to give an approximate measure. Some people say they saw it move a few inches, others saw it move several feet. When, after individual judgment, people discuss their impressions, they change their view and gradually come to an agreement which appears to be a compromise between the different impressions. When the experiment is later repeated, each individual's judgment is much nearer the mean than their original estimate. This very simple experiment may appear irrelevant, but it has served as standard for other experimental work, and it is clear that many judgments are

formed by groups of people in the same sort of way. If people are asked to judge the beauty of paintings or the literary value of poetry, agreement is reached in similar way.

Decisions about group actions or about group acceptance or rejection of particular points of view are made by a similar process. Some people in the group appear to have greater influence than others in determining the outcome of discussion. People with great influence are said to have a high prestige in the group. The merits of individual members' remarks are not always examined critically or logically. The higher the prestige of a member, the less careful is the examination of his views before they are accepted or incorporated in group decisions. If any particular person's membership is valued by the others, he will find his views to be more influential than if his continued membership were of no concern to the group. Group attitudes and group standards are therefore much more likely to be changed from within than by any attempt to modify them from outside.

Within a group, there can be vigorous argument and violent disagreement without damage to group feeling. The purpose of this is to effect change. If a group is criticized or attacked by an outsider, it reacts as a rule by closing its ranks and protecting itself. No modification of views is likely to occur as a result of outside pressure; on the contrary, opinions tend to harden, and the group tends to become more rigid in its standards when it is attacked. This process can be seen in action in political parties where vigorous disagreement can occur between people of the same persuasion. The party, however, tends to show a united front to its opponents.

In hospitals where the morale is good, there can be very outspoken criticism from within, while all group members have the same purpose to improve existing practices. As soon as an outsider criticizes, all the staff is united in their defence. In joint consultation, staff and management always meet each

other after their disagreements have been settled from within and when they can present a unanimous decision to each other.

It has been shown that groups are more efficient in solving problems than are the individual members. Small groups have been experimentally engaged in solving puzzles or mathematical problems. It was shown that while within a given time no single person solved the problems, groups were successful in providing the correct answers. This, of course, happened only when every member of the group concentrated on the problems and was actively trying to co-operate. The hope that committees might be more competent than individuals in solving the complex problems of a hospital, is based on the assumption that they are all motivated by the same aim.

When a group is engaged in solving a common problem, the more active and also the more silent members are serving a useful function. Often the silent members are the ones who are able to assess all the contributions of the more vocal members. When perhaps in the end the silent member speaks, his contribution may be of utmost importance. During the discussion, he may nod approval or disapproval, look interested or bored, smile encouragingly or frown in disbelief. The non-verbal participation of a silent group member may make a great deal of difference to the success of a group. In discussion groups or committees, it is of interest to see how important are the contributions of each member. Sometimes, personal feelings between some of the members may enter into the outcome of the discussion. There may be a tendency for one person always to contradict another, or for the group always to accept or veto the suggestions of certain people.

When a decision has been made by a whole group, the members feel much more bound by the decision than if it had been imposed on the group by one person. This was shown, for example, when a group of women, after dis-

cussion, decided to give some practical help in a volunteer programme to hospitals. When they themselves had made the decision after discussion, they acted on it. When they had been persuaded to do so they had said yes, but had done nothing. In making any attempts to help young mothers to change the way of feeding their infants, discussion groups are more effective than advice by the health visitor. Decisions about nursing procedures are more likely to be carried out if they are made by the ward sisters themselves.

In every group, individual people develop friendships with each other, find that they like some members better than others, benefit more from their association with some, less with others. Individual relationships within the group have an effect on group morale as a whole. The psychologist, Moreno, has developed a technique of measuring social distance between people which he calls the 'sociometric' technique. Either by observing people's interaction with each other or by asking questions about it, a picture is formed of the choices people make within the group. Someone can be asked who is his best friend; if everyone has one choice only, it is soon discovered how often mutual choices occur, how often there are chains of choices: A choosing B, who chooses C, who chooses D. Triangles may form: A choosing B, who chooses C, who chooses A. By allowing more than one choice to each person, it is possible to get a clearer picture of the likes and dislikes, and particularly to discover who is the most popular in the group, and who is isolated. Other observations may show which members of the group are the most active; which the least active; who initiates action; who agrees; and who opposes. Various questions about other people may give an indication of the role each member assumes in the group. Who do you like best? may reveal the most popular group member. Whose opinion would you ask? might show up the person with most prestige. Who do you think would be most

useful in an emergency? might indicate the leader of the group. From the number of mutual choices in the group, the way in which people are connected with others, some valid conclusions can be drawn about the morale of the group.

When group morale is high, the group tends to be active and productive. It concerns itself with its main purpose. Group rules are generally accepted and there are few problems of rule enforcement.

When a group's morale is low, the group as a whole behaves in a very similar way to that in which some neurotically ill people behave. The group resorts to a variety of defence mechanisms which may be successful in keeping it intact but interfere with the productive functioning of the group. In an attempt to increase cohesion between members, the group often behaves as if it were attacked by an outside enemy. It feels under attack and reacts by finding a scapegoat. This may be one of the members who is gradually made to leave the group, or more often the group unites in some warfare against another group. Preoccupation with enforcement of rules and preservation of group standards makes it very difficult for change to take place. The normal process of internal argument is suspended, and consequently the group becomes resistant to change. Misunderstandings often occur where members of the group are uneasy with each other. This makes the group wide open to rumours. Members of the group believe rumours about each other and about people outside the group, and in turn contribute to the spread of rumours.

Within the group, there is often avoidance of discussion. People feel uneasy with each other. They cannot safely reveal their feelings and consequently hide them and avoid all topics which might arouse strong emotion. The result often is that the group is unable to deal with its business. Instead it chooses

neutral topics, resorts to lengthy small talk or explores important topics by indirect reference. This is sometimes seen in meetings in hospital where the most important item on the agenda is never discussed at all or dealt with very briefly while some unimportant point is dealt with at length. Some committees spend an excessive amount of time in discussing food problems. This serves the purpose of testing out the feeling among the members and making it possible to reach agreement on a neutral topic rather than risk disagreement. It is interesting to note how a group settles on some apparently irrelevant topic of discussion and uses it to examine feelings within the group. Someone may, for example, relate the difficulties of a friend of hers in another hospital. The whole group may show great interest and concern and explore at length relationships at that other hospital. All the arguments and anxieties which are relevant to their own group are used, but in reference to the other situation.

Very little attempt has so far been made to study in detail the group dynamics of hospitals. Most of the knowledge about groups is derived either from the therapeutic groups with mentally ill patients or from detailed study of industrial relations. Some applications to hospital are obvious. Further investigation of hospital problems should prove interesting and profitable.

5. LEADERSHIP

Whenever a group of people embark on a joint project some form of leadership is required. Even in groups which meet without any specific purpose other than perhaps to play or to converse, it soon becomes evident that one person assumes leadership. Sometimes a leader is specifically appointed. Discussion groups, for example, may have a leader appointed for them before the meeting is convened. Football teams or cricket teams have a leader before the team is selected. Appointment to the position of ward sister in hospital or to the matron's job is an appointment to leadership. Officers in the forces are chosen to lead. In industry, the foreman, the shop steward, the directors, all have positions of leadership, each of a different kind. The question arises whether certain people have special personality characteristics which give them the ability to lead.

It is well known that some animals adopt a hierarchical order within the herd or flock. Experiments with chickens have shown that the more dominant animals peck the more submissive ones until a definite pecking order emerges. The term 'pecking order' is at times jocularly applied to relationships in human society.

It would appear that leadership qualities do exist in human beings, and that suitable education can help people to acquire skills in leadership. To a large extent, however, the characteristics of the group determine the kind of leadership which is required. Every group arranges itself into leaders and followers and adopts the leaders who serve its purpose best. In industry, foremen are often chosen because of their superior skill and knowledge relating to production. The men so chosen have

proved their ability to understand the goal of the management and are able to make a substantial personal contribution. It is assumed that their greater skill gives them the necessary prestige and enables them to lead the workers. This often proves to be a fallacy. If the workers were all primarily concerned with the goal of the organization, the foremen so chosen would have greater success. Very frequently, however, the individuals and the various subgroups of individuals have objectives and goals far removed from the overall purpose of the industry. A successful leader takes the changing needs of the small groups into account and aims to make the small groups integrated parts of the entire organization.

In hospitals, ideally, all employees should be working for the same goal. However, there are many problems specific to small subsections of personnel. Student nurses have problems of their own not shared by trained staff. Nurses have problems and needs which are special to their work and different from the problems of doctors. Electricians in hospital have special concerns of their own, kitchen staff meet difficulties that other groups fail to notice or understand. Each of these groups and all other subgroups within a hospital require leaders who understand the effect they have on each other. Excellence in nursing or electrical engineering or cooking is not sufficient to make them acceptable to the group.

In different situations, people may require different leaders. A particular person may satisfy the group while they are all engaged on learning a new technique in their job. His knowledge and teaching skills may render him particularly suitable for leadership. If a fire broke out, an entirely different member of the group might take the initiative to lead people to safety and to avoid panic. If the group decided to form a dramatic society, another member would emerge as leader; if they decided to form a cricket team, yet another man would be appointed. Where the organization is sufficiently flexible to

allow different people to adopt new roles as the need arises, leadership is usually determined by the group itself.

In most situations, leaders have to be chosen, trained and appointed although this does not have to preclude emergence of spontaneous leaders. Ward sisters must be chosen; it cannot be left to the group to select someone to lead a nursing team. A good ward sister makes it possible to allow individual nurses to assume leadership for a special purpose; for example in planning a particular nursing project or in organizing the Christmas activities. The matron of a hospital is the appointed leader for the entire nursing staff. Good leadership on her part entails discovering the people who can take the initiative in leadership in a large variety of nursing activities. Delegation of responsibility which is part of good leadership is the ability to utilize leadership qualities wherever they are found and to give those who are able to take responsibility the greatest possible scope for independent action and decisions on behalf of their group.

People appointed to leadership positions can use them in a variety of ways. These have been described as Autocratic, Democratic and Laissez-faire. The word democratic is not used in a political sense. Broadly speaking, autocratic leadership has all authority vested in the leader himself. In democratic leadership, responsibility is delegated. In laissez-faire leadership, channels of authority and the areas of responsibility are not clearly defined.

An investigation of different types of leadership in youth groups was carried out in America by Lippitt and White. Each group in turn was organized under each of the three forms of leadership. It was found that under laissez-faire leadership, there was the smallest amount of constructive or enjoyable activity. Under autocratic leadership, the young people functioned well while the leader was there, but all activity ceased when the leader left the room. In the absence

of the leader the group became totally disorganized. With democratic leadership, the group was most productive, morale was highest and activity continued in the absence of the leader.

Democratic leadership seems to be most desirable to some psychologists, although in some organizations, it may be less appropriate. The army, for example, functions well on an autocratic organization. Many investigations show that industry may do better with democratic leadership, and hospitals may be very similar to industry. In small groups, democratic leadership often produces best results though some people feel safer with a more authoritarian approach. Leadership depends for its success on the channels of communication which are available.

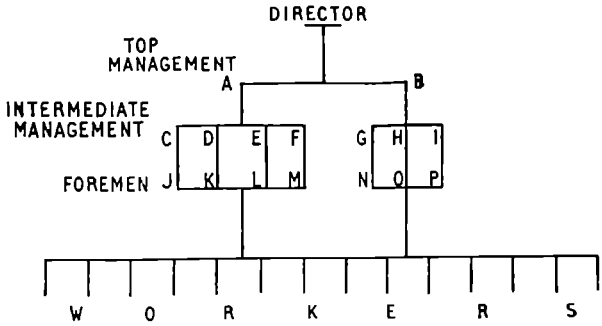


FIG. 9. Downward direction of communication from director to workers.

In some autocratic organizations, communication is clearly channelled, but mostly takes place in a downward direction. The directors give instruction to top management. The top management passes it on to intermediate management which in turn passes it on to the foremen who instruct the workers. There is no official opportunity for people at the same level

to discuss with each other or to make their views known to people above them.

In democratic leadership there is provision for communication between people at each level and for 'feed back'. Each group informs the person who has given the instructions of the outcome of discussions. Difficulties that are anticipated or have occurred as a result of new instructions are discussed, and the management is informed of the way in which their plans are received. Upward communication also makes it possible for workers to make suggestions and to take an active part in initiating change.

Some organizations have the necessary machinery for democratic functioning, but it is used in an autocratic manner. There may be meetings of workers, but these are used only for grumbles about unimportant matters. Meetings between workers and management are called but abandoned for want of agenda. Suggestion boxes are available but not used. In such organizations it appears that people in leadership positions are unable to try a democratic organization. Their reluctance may be due to the fact that a change from autocratic to democratic leadership is often accompanied by a period of relative disorganization. The belief that democratic leadership in schools is desirable has been gaining ground. In the classroom, it can be shown very clearly that sudden removal of autocratic leadership creates tremendous anxiety. The transition to democratic organization takes a little time and does not immediately appear to be successful. If a change from autocratic to democratic leadership is to be tried out in industry or in hospital it may be necessary to prepare for a period of difficulty. It may take a few weeks before meetings and other channels of communication can be used constructively and everybody can be convinced that it is safe to speak.

In small groups, the various forms of leadership can be most clearly observed. Many nurses have had experience of

participating at meetings or conferences, for example where different group leaders have adopted different techniques. Some group leaders act as chairmen in such a way that the members of the group feel free to discuss anything they like. The chairman merely summarizes, clarifies or helps the group to return to an important point without too many side issues being pursued. The chairman is interested in the contributions of each member and makes it easier for shy and retiring people to speak. He allows silence to take place while people are thinking or trying to cope with their feelings. Most of the discussion takes place between members of the group. The chairman's remarks are addressed to the group as a whole; the members' remarks are addressed to each other.

CHANNELS OF COMMUNICATION

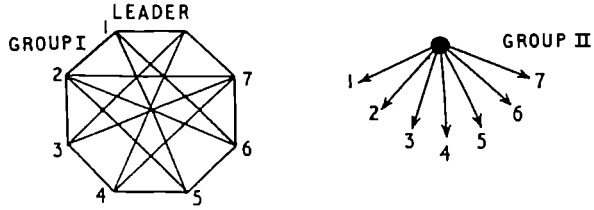


FIG. 10

Another group leader may take a much more active part. He decides on the choice of the subject, decides what is and what is not relevant. He addresses people individually, calling on them to speak. All remarks are addressed to him.

It is interesting to note the effect of seating on the type of leadership. Some leaders feel that they need a table in front of them or that they like to be seated in a raised position. This clearly marks them off from the group. A barrier is set up between the leader and the group which is symbolic of the relationship he wishes to create for successful performance of his role. Where the leader wishes to be a member of the

group, a barrier would be an obstacle to his function. The kind of group in which members communicate with each other is more successful, where the room is small, seating informal, preferably in armchairs, where ashtrays are provided and smoking accepted.

There are advantages and disadvantages in both types of leadership. Most committee procedure is formal, all remarks addressed to the chair. Committees are meant to settle issues efficiently and fairly rapidly after preliminary discussion has already taken place. Preliminary discussion where all issues should be raised and where it is not yet clear who has the greatest contribution to make, may be more productive in a more informal setting. Hospitals with their large staffs and complex problems may need both types of leadership on different occasions. Both need practice for successful use.

6. THE PATIENT'S COMMUNITY

The effect patients have on each other has received relatively little attention. In the days when people paid for hospitalization, those who could afford it chose to have single rooms. Only those who had to accept beds in an open ward did so. Even now, many patients regret that private rooms are not available to everybody, and many people still choose to pay for the amenities of a private room. The conveniences of receiving visitors in private and of sleeping in a room alone without disturbance are obvious; but apart from this it is not so certain that it is beneficial for a patient to be alone.

Nurses and doctors often talk and behave as if each patient were being treated as an isolated, separate individual. They ignore the effects of patients on each other, yet these effects may be harmful or most beneficial. Talk about nursing the 'whole patient' refers to the patient's body and mind, his physical and emotional difficulties. The patient's own social background, his family, commitments, his anxieties about wife and children may be remembered, but his new social attachments to patients in the ward may be overlooked.

Patients are often frightened on arrival. Although nurses do everything in their power to reassure the patient, there are long periods when he is left alone with his thoughts and with nothing to do but observe other patients. Patients in neighbouring beds are much better able to help than anyone else. If they can confirm that the hospital is good, that nurses are competent and considerate, if they can speak from their own experience, the new patient will find comfort much more rapidly than if they increase his fears by tales of terrible happenings. Patients gain confidence by observing the treatment given to other patients quite as much as by their own

experience of it. Patients who are ambulant are often able to give assistance or call for help. They are nearly always responsible for the provision of company for one another during the long idle hours of hospital life, especially when the most acute phase of the illness is over.

Many patients feel upset about some patients who are in great pain or who are dying. While there is certainly a need to perform many treatments in private in order to spare sensitive patients the distress of watching and being observed, very often the knowledge that other patients are worse off is a source of comfort rather than of distress to many patients. Wherever possible, arrangements should be made for removing a dying patient to a private room for his own sake and for his relatives' sake. The other patients in the ward are naturally distressed by death, but it has to be faced and it is not necessarily harmful for patients to share in grief. Patients who are in private rooms and not aware of what is going on in the ward may find it much harder to understand the mood of the wards. They may feel neglected when they are kept waiting while nurses are busy, without being able to derive comfort from seeing someone else well nursed. Even in a private room they would feel the depressing effect which death has on the ward and the nurses, and they may find it more difficult to deal with their troubled feelings all alone.

It is well known that different wards have entirely different atmospheres. Partly, the nursing staff creates the feeling of strain or relaxation, of pessimism or optimism. Partly, however, it is created by the patients themselves. Orthopædic wards and wards for plastic surgery are sometimes among the most cheerful with the highest morale in spite of the serious condition of some patients. The atmosphere almost certainly helps many patients to accept their disability more readily. Gynæcological wards have an atmosphere quite unlike that found elsewhere. The fact that all patients have important

psychological problems in common creates a special kind of bond. The nature of their illness results in a certain amount of secrecy, a characteristic way of joking and talking in a peculiar mixture of lightheartedness and seriousness.

In recent years, the atmosphere in children's wards and in geriatric wards has received much attention. The pathetic loneliness of the aged when they are sick in bed is a serious handicap to recovery. Early ambulation and determined attempts not to allow old people to become bedridden have helped to keep patients in touch with each other. In wheelchairs, elderly patients are able to sit around a fire, see each other, talk to each other and take interest in each other. Deafness, shortsightedness and inhibited movement make it too difficult to bridge the conventional distance of beds.

Children's wards have recently become lively, happy, active places. The effect children have on each other is obvious. Serious problems arise when isolation of a child is absolutely necessary, because a sick child cannot easily overcome loneliness. Widespread use of cubicles without imperative reasons is now no longer practised in children's wards. In playrooms and during school, every possible attempt is made to encourage interaction and use it for each child's advantage.

In mental hospitals, the therapeutic effect of the community has been recognized much longer, though only recently have systematic attempts been made to study the social aspects of mental hospitals and to make active use of patients' ability to help each other. The atmosphere of the hospital as a whole and of each ward is known to be important. Many patients derive personal benefit from feeling useful to the hospital community. Ward meetings of all kinds are commonly held in mental hospitals. Patients actively participate in discussions, elect their own committee and many take office in patients' organizations. Group psychotherapy offers opportunity for a special kind of participation in mutual help.

A very strong sense of belonging is one of the beneficial factors of this form of therapy. In some mental disorders, the patient's own efforts at active participation in therapy are even more important than in others. Psychopathic patients, for example, or alcoholic patients have for so long shown their inability to accept help from others that traditional relationships between nurse or doctor and patient are almost doomed to failure. Where patients begin to feel responsible for their own therapy and become active in helping each other, their outlook sometimes changes. They can accept help from each other with less resentment than from staff.

The term 'therapeutic community' was originally coined to describe how, in a particular hospital for psychopathic patients, a community spirit developed which helped many patients to gain self-respect, to cultivate their assets to the fullest degree and to gain control over their antisocial and aggressive tendencies. The need to run such a ward democratically was discussed very fully. It was difficult for the staff to give up their position of superiority, and to merge completely with the patient community. In the community, the staff had equal rights and obligations, but not superior positions. They constituted the more stable and well adjusted section of the community, but with the patients experienced all the trials and tribulations of communal living and of slowly developing culture patterns.

Not all patients would benefit from this extreme form of self-government or need to be included in such self-directing community. For some patients, more maternal or paternal attitude of staff may be indicated. The benefit of active participation in therapy and in the formation of the hospital community is, however, usually a desirable state of affairs.

Much remains to be done to explore the application of the knowledge gained from social psychology to the treatment of patients and the conduct of hospital affairs. The psychologists

whose work has been concerned with the investigation of social interaction have not formed psychological schools the way other psychologists have done.

Many psychologists in Great Britain and in America are engaged in the educational or industrial applications of social psychology.

SUGGESTIONS FOR FURTHER READING

There are many good books on social psychology. These describe behaviour in groups and the effects of society on the individual. Few books however deal specifically with the hospital.

NEWCOMB, T. M. *Social Psychology.* (N.Y. Dryden Press.)
MAIER, N. R. F. *Principles of Human Relations: Applications to Management.* (Wiley.)
BROWN, J. A. C. *Social Psychology of Industry.* (Pelican.)
JONES, M. *Social Psychiatry.* (Tavistock.)
STANTON, A. H. and SCHWARTZ, M. S. *The Mental Hospital.* (Tavistock.)

The last two books study the interaction of staff and patients in psychiatric hospitals.

EPILOGUE

In the preface to this book it was stated that a knowledge of psychology is necessary for an understanding of the nurse's work. The student who has reached the end of this book will be convinced that a knowledge of nursing is necessary to the understanding of psychology. It is the same with all basic subjects. They appear difficult until they are applied. Then the interest deepens and everything seems easy and obvious. It is often said that physiology must be learnt before one can study pathology. In reality, physiology acquires meaning only when one is confronted with disorders of function. Just so with psychology. Normal, healthy behaviour does not appear worthy of study until one meets examples of emotional disturbance.

Having studied this book early in training, it is hoped that the student will feel the urge to read it again as and when practical experience in nursing makes manifest a need for deeper understanding. Not only this book, but some of those mentioned in the text and many others on the library shelves should be consulted. Appetite for psychology grows with every book one reads. As the reader's nursing experience widens, she herself will find examples to illustrate her reading and she will discover the need for more theory to illuminate her practice.

For the expert nurse and the expert psychologist much work remains to be done. As I compiled lists of books for further reading I became aware of the paucity of experimental work carried out in nursing. In the last section of the book it was necessary to take all examples from industry, because too few studies of hospitals have been carried out. Will any reader be inspired to remedy this defect and provide, for inclusion in future editions, new information about psychology in nursing?

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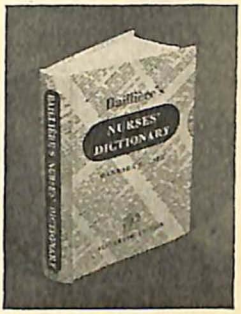

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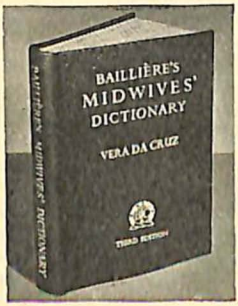

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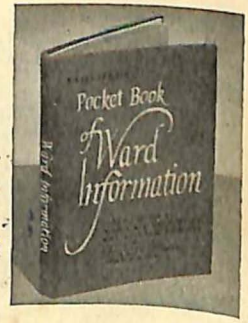

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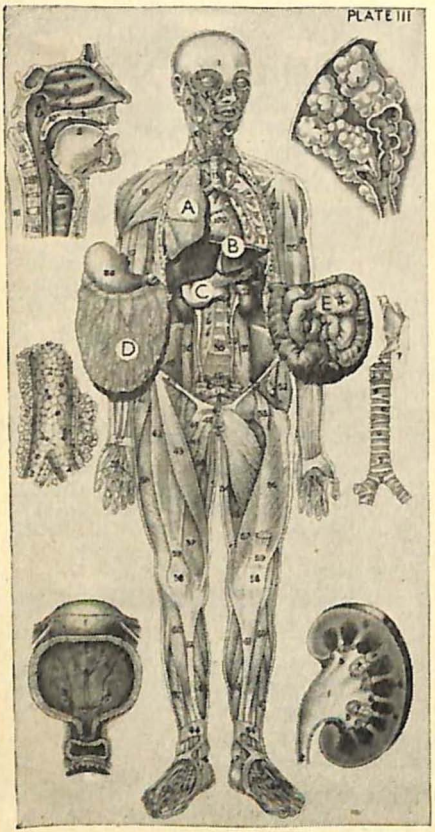

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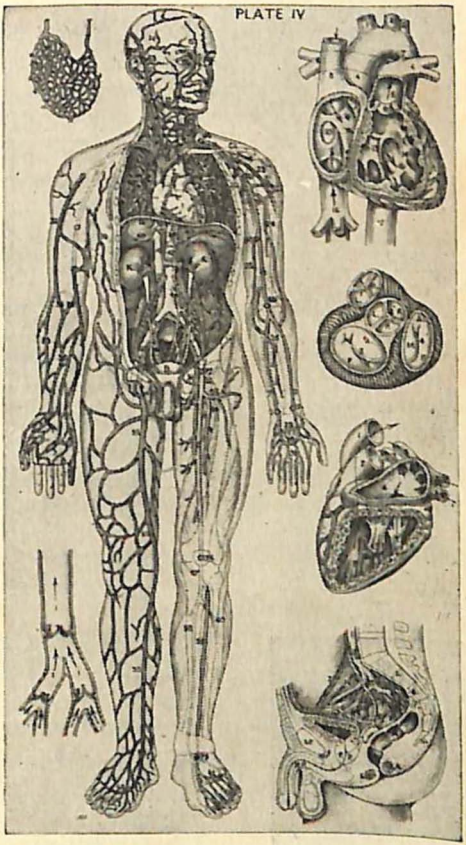

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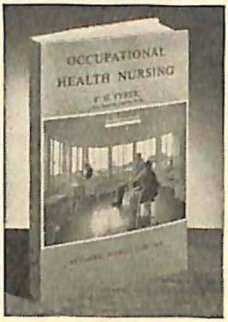

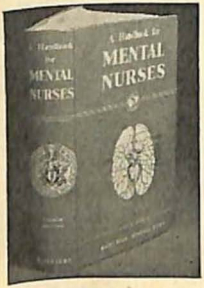

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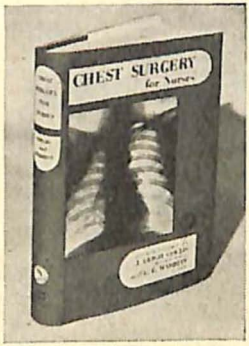

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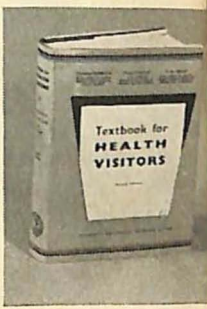

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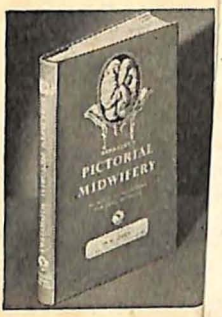

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