

THE NEGOTIATION OF PSYCHIATRIC REFORM

THE NEGOTIATION OF PSYCHIATRIC REFORM:
SABOTAGE IN A THERAPEUTIC MILIEU

By

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ABSTRACT:

The transition from one form of psychiatric treatment towards another demands reform in the social milieu presently existing in the ward. The discussion presented here is a descriptive analysis of everyday life in a psychiatric ward undergoing an officially ascribed transition from custodial to therapeutic patient care. The theoretical perspective used in approaching the analysis of the data is one broadly conceived within the framework of symbolic interactionism. The analysis is derived on the basis of a modification of the process of inductive theory construction as conceptualized by Glaser and Strauss. A focus upon staffs' definitions of their participation in the ward and their interpretations of the ongoing social reality therein constitutes the basis upon which the study is formulated. The findings illustrate the highly problematic nature of the transition towards the construction of a therapeutic milieu and the variety of interpretations applied to this conceptualization of psychiatric treatment. An analysis of negotiation and bargaining among people indicates that the degree of difficulty in coping with this situation becomes so great that the transition process appears to subside in this mutual agreement of the staffs': above all else the need to demonstrate orderly social interaction is of paramount importance if some degree of social order is to be salvaged in the ward. A significant disparity still exists among people with regard to treatment orientations and the dichotomy of individual systems of meaning remains firmly polarized along a custodial, therapeutic spectrum. This convergence must therefore be understood as deriving out of people's interpretation of their vested interests on one hand, and on the other, their recognition of the need to survive in a social system highly conducive to hostility among staff. Finally I conclude that the outcome of negotiation is a working consensus among people that can best be understood within a framework of pragmatic compatibility.

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CHAPTER ONE

Introduction

A. The Problem in Historical Perspective

This thesis is an account of everyday life in a psychiatric treatment ward for children. The ward in which fieldwork was conducted (called herein "Dixon") included thirty-five residents. This population varied according to age from three to fourteen years, and a variety of psychiatric diagnoses were attached to these children: there were six children with behavior problems, three diagnosed mentally retarded, seven labelled autistic, three monogoloids, one hyper-active child and nine children diagnosed as childhood schizophrenics. Six children were present for a period of observation and as yet had not been diagnosed.

When the ward first opened in the mid-sixties, it operated under the general mandate of providing for the total needs of the residents. The psychiatrist presently employed in the ward prefaced an explanation of this mandate with a brief description of people working in the ward at that time. It appears that the ward was primarily staffed by psychiatric nursing assistants, with a part-time psychiatrist and chief-of-service and a social worker and occupational therapist shared by all wards in children's service. From here the psychiatrist continued,

...as the ward was predominately staffed by nursing assistants it gradually came to reflect a treatment orientation that was fundamentally grounded in the experiences and understanding these people possessed regarding psychiatric treatment. In short, treatment evolved from a custodial frame of

reference and total patient care came to embody an emphasis upon the physical well-being of the child. (1, Psychiatrist)

This situation has since been altered to include a full-time psychiatrist, social worker, occupational therapist, and two child care workers (see chart one). As Chart One illustrates, subjects of this study include a variety of staff members who have worked in the ward for varying lengths of time. With the exception of six people (one social worker, one occupational therapist, two child care workers and two psychiatric nursing assistants), a majority of the present staff had operated within the framework briefly described by the psychiatrist above. As a greater time period passed between the initial opening of the ward and the redefinition of treatment goals, uncertainty increased with regard to the nature of the treatment setting people were expected to be working towards.

This interpretation of the situation was particularly apparent among people who had worked in the ward prior to the present psychiatrist's arrival (see chart one). The following statements refer to the ward as a workplace before and after the present psychiatrist's arrival.

...something seemed to be happening to the ward, there was always so much confusion, so many new meetings to attend and just too much talk about problems the ward was supposed to be experiencing. Most times I tried to ignore the situation and just continue to do my job as always.
(8, Sr. NA)

...its difficult to say what happened in the ward, there seemed to be a lot of tension

DISTRIBUTION OF STAFF IN THE WARD

CHART ONE

PART A

<u>Code Name</u>	<u>Job Title</u>	<u>Sex</u>	<u>Age</u>	<u>Certification</u>	<u>Place of Training</u>
1	Psychiatrist and Chief-of-Service	F	36	M.D., F.R.C.P.	University and General Hospital
2	Occupational Therapist	F	26	Licensed Graduate	University
3	Head Nurse	F	30	Registered Nurse	General Hospital
4	Social Worker	F	26	B.A. (psychology)	University
5	Child Care Worker	F	24	B.A. (social sciences)	University
6	Child Care Worker	F	24	B.A. (social sciences)	University
7	Senior Psychiatric Nursing Assistant	F	29	Diploma Course	Present Hospital
8	Senior Psychiatric Nursing Assistant	M	31	Diploma Course	Present Hospital
9	Senior Psychiatric Nursing Assistant	F	25	Diploma Course	Present Hospital
10	Psychiatric Nursing Assistant	F	26	Diploma Course	Present Hospital
11	Psychiatric Nursing Assistant	M	25	Diploma Course	Present Hospital
12	Psychiatric Nursing Assistant	F	24	Diploma Course	Present Hospital
13	Psychiatric Nursing Assistant	F	23	Diploma Course	Present Hospital
14	Psychiatric Nursing Assistant	F	23	Diploma Course	Present Hospital
15	Psychiatric Nursing Assistant	M	24	Diploma Course	Present Hospital
16	Psychiatric Nursing Assistant	F	24	Diploma Course	Present Hospital
17	Psychiatric Nursing Assistant	F	23	Diploma Course	Present Hospital
18	Psychiatric Nursing Assistant	F	23	Diploma Course	Present Hospital
19	Psychiatric Nursing Assistant	F	23	Diploma Course	Present Hospital

In the above table, code numbers one through four represent staff labelled professionals in Dixon and numbers seven through nineteen represent non-professionals. In the study I refer to those people indicated by code numbers five through nineteen as paramedicals.

DISTRIBUTION OF STAFF IN THE WARD

CHART ONE

PART B

Years of Training	Years in Present Hospital After Training	Years in Dixon	Length of Stay in Relation to the Initiation at the Ascribed Label		Code Name
			<u>Before</u>	<u>After</u>	
11	2 yr. 6 mo.	2 yr. 6 mo.	22 mo.	8 mo.	1
4	8 mo.	8 mo.	NIL	8 mo.	2
3	1 yr. 4 mo.	1 yr. 4 mo.	8 mo.	8 mo.	3
4	8 mo.	8 mo.	NIL	8 mo.	4
4	8 mo.	8 mo.	NIL	8 mo.	5
4	8 mo.	8 mo.	NIL	8 mo.	6
1 yr. 6 mo.	8 yr.	3 yr.	28 mo.	8 mo.	7
1 yr. 6 mo.	8 yr.	3 yr.	28 mo.	8 mo.	8
1 yr. 6 mo.	5 yr.	3 yr. 6 mo.	34 mo.	8 mo.	9
1	5 yr.	5 yr.	52 mo.	8 mo.	10
1	2 yr. 6 mo.	2 yr. 6 mo.	22 mo.	8 mo.	11
1	2 yr.	2 mo.	NIL	2 mo.	12
1	3 yr.	2 yr.	16 mo.	8 mo.	13
1	2 yr.	2 yr.	16 mo.	8 mo.	14
1	2 yr.	2 mo.	NIL	2 mo.	15
1	2 yr.	2 yr.	16 mo.	8 mo.	16
1	1 yr.	10 mo.	2 mo.	8 mo.	17
1	1 yr.	11 mo.	4 mo.	8 mo.	18
1	1 yr.	1 yr. 14 mo.	6 mo.	8 mo.	19

among staff and nobody seemed to know quite what to do anymore. Since then I almost always have the feeling that my training just hasn't prepared me to deal with this kind of situation. (10, PNA)

...I'm just not sure what the doctor was trying to get at in terms of treatment goals for the patients. I didn't used to have this problem but Dr. _____ seemed to talk a different language that was just too complicated for me. (9, Sr. NA)

When Dr. _____ first arrived she didn't seem very certain about what she was doing in the ward or the kinds of procedures she wanted us to follow. This uncertainty seemed to cause a lot of tension among staff when they came to perform their duties (7, Sr. NA)

This view of the situation, although recalled in retrospect by these people, will prove very important to our understanding of how people grapple with everyday life in the ward. Note, for example, that three of the respondents were senior psychiatric nursing assistants. The likelihood of their point of view affecting other nursing assistants was considerably high since they were,

...supposed to act as a go-between, between the psychiatrist and head nurse and the nursing assistants in order to keep personnel informed about what is happening in the ward in terms of administrative decisions and treatment programs. (7, Sr. NA)

The data confirms the presence of this chain of events and therefore a strong conviction among nurses, that the psychiatrist was uncertain about her primary treatment goals. This situation in turn influenced others' understanding of the treatment setting.

The Doctor simply didn't know what she was really trying to do in the

ward. How could we be expected to participate in a program that
(a) didn't appear to exist and
(b) isn't explained to us in a concrete way. (14, PNA)

I came here immediately following training and I just wasn't prepared to deal with an atmosphere which I found to be totally confusing. There didn't appear to be any concrete routine that I could fit my job into. It would have helped if either the senior or the head nurse had provided some specific advice regarding the treatment routine in the ward.
(17, Sr. NA)

Over time the psychiatrist became aware of the growing uncertainty experienced by members of the staff,

...not because they informed me directly but simply because the atmosphere became so tense and tempers so visible that it was no longer a disputable argument but rather a fact-- some kind of specific treatment program would have to be constructed and issued to staff. (1, Psychiatrist)

It was also becoming increasingly apparent to the psychiatrist that a definite treatment orientation would have to be defined in the ward, in order to clarify work procedures for staff. Hence, the initiation of a new treatment program was born out of a reaction to the existing situation in the ward. According to the psychiatrist, this new treatment mandate could be conceptualized as one evolving through a therapeutic treatment milieu. As noted above, the psychiatrist defined the previous treatment mandate as one primarily based on custodial patient care. This new approach would therefore require the reconstruction of treatment

procedures in the ward. Accordingly, with the ascription of this new treatment label, many changes would have to follow.

This transition from custodial patient care towards the construction of a therapeutic milieu constitutes the focus of this thesis. An analytic description of everyday life will be presented in order to provide an understanding of how people coped with this new definition of treatment procedures in Dixon. This was considered an interesting goal, in that the new program was defined in reaction to a situation of growing uncertainty and ambiguity, with regard to job performance and also because it was ascribed "onto" the existing social milieu rather than developed through the ranks. As the analysis unfolds, the reader will become aware of growing discontent among members of the staff, since the new treatment mandate was not interpreted as one clarifying their purpose in the ward. Instead, everyday life became increasingly problematic for them as they attempted to make sense out of their immediate social world. This thesis is an examination of this process experienced by people, and the outcome of the analysis illustrates the way in which they operated so as to construct some degree of order in their social environment.

B. Theoretical Perspective

The following is a brief discussion of the theoretical perspective used in approaching the analysis of the data. As the following discussion will indicate, this approach is one broadly conceived within the framework of symbolic interactionism. To begin with the organisation of the hospital ward is simply viewed as

...the framework inside of which
social action takes place...
(it)...is not the determinant of
that action... (Blumer, 1962: 189).

This organisation and changes in it are viewed as

...the product of the activity of acting
units and not of 'forces' which leave
such acting units out of account. (Blumer,
1962: 189)

It is people who act toward and interpret their formal and informal
associations such that streams of new situations arise and old situations
become unstable. The creation and re-creation of meanings and expectations
take on a processual character such that norms may be found to be
operating, but they are "creatively" reaffirmed from day to day in the
social interaction of the participants. (Shibutani, 1962: 143)

Human society exists in social action and must be examined in
terms of this action. As it is my goal in this empirical study to
understand human group life, my analytic scheme must begin with people
engaging in action or the ongoing process of fitting together self
and others' activities. (Blumer, 1969: 6-7) In this sense then social
interaction is not simply a medium through which psychological and
sociological determinants pass to create certain kinds of human behavior.
Interaction, therefore, is something that occurs between two or more
people and not an interaction process between two or more societal
elements that are forwarded as causative influences on human behavior.
(Blumer, 1969: 6-7) I assume that social interaction between human
beings is an interpretive process whereby self and others' behavior
is accounted for, thus indicating that behavior is not simply released

through interaction but is constructed through this process. Individuals are compelled to create their own situations in relation to the accounts they have of others' conduct and upon this basis make decisions regarding their own behavior.

Within this framework, the conceptualization of social organization as evolving through people's involvement in a negotiated order is based on the assumption that the distribution of labour cannot be legislated but must be grappled with in each social encounter. Life in the ward is therefore examined as an emergent process rather than one determined on the basis of an officially ascribed social structure.

Fundamental to our analysis of social organisation is the conceptual area of roles. I believe that by viewing role-taking as a process, roles can be shown to be more than just an extension of normative or cultural deterministic theory¹ and that a dynamic view of role maintains a consistent approach with the theoretical concerns of symbolic interactionism.

The key to understanding human behavior from the standpoint of the role-taking process can be found within an action framework. Therefore, the meaning underlying human conduct can be determined within the range of the contemporarily operating interrelations among components of the social system. Role-taking is a process that designates a kind of relationship that is experienced in the present toward a significant

1

For example, Linton's (1936: 113) concept of role and his use of a model of role functioning is viewed as gravely over simplified for this reason.

other participating in an ongoing social act. Accordingly, an individual is experiencing role-taking whenever his conception of his own role is altered by modifying his construction of the role of a significant other. (Turner, 1956: 325)

Ralph Turner defines role-taking in its most general form as,

...a process of looking at or anticipating another's behavior by viewing it in the context of a role imputed to that other.
(Turner, 1956: 316)

In this way, role-taking is more than just a reaction to another's behavior, in terms of arbitrarily understood symbols, it is a means of inferring the feelings, or motivations behind another's action and anticipating the subsequent behavior of this significant other. Another central feature of role-taking is "...the process of discovering and creating 'consistent' roles out of behavior," of "devising a pattern" that will both cope effectively with various types of relevant others and meet some recognizable criteria of consistency. (Turner, 1962: 126)

Instead of positing the distinct existence of identifiable roles, Turner discusses a tendency to create and modify conceptions of self- and other-roles as an interactive orienting process, making "...the process...not only role-taking but role-making." (Turner, 1962:

22) Turner also maintains that actors behave "as if" there were roles - although roles exist only in varying degrees of definitiveness and consistency. Throughout social interaction actors attempt to define roles and make them explicit, thereby in effect creating and modifying them as they proceed.

"Roles 'exist' in varying degrees of concreteness and consistency, while the individual confidently frames his behavior as if they had unequivocal existence and clarity." (Turner, 1962: 22)

The moving force behind the process of role-taking is the interacting individual's capacity to mold the phenomenal world into roles, that is, to relate to others as if a role were being enacted. In fact a role can only be considered to exist if actors continue to react in this reciprocal manner.

Turner also argues that formal organisational role prescriptions restrict the natural process of role-taking and that this set of regulations should not be accepted as the prototype but rather as a "distorted instance" of the more general phenomena of role-taking. For this reason, formal roles can be considered at best a skeleton of rules which may evoke and set into motion the process of role-taking and hence role creation. Role prescriptions cannot provide a "bell jar" around role behavior for this is the reflection of dynamic social interaction and will remain "fixed" only as long as human conduct undergoes cumulative revision in the role-taking process of accommodation to and compromise with the demands made by organisational conformity. It is precisely the role-taking and role-making processes that are viewed as problematic in this thesis as social interaction and the negotiated order are examined within the context of an ongoing social system.

I assume a fully interactive conception of role whereby people may seek some degree of predictability in self - other relationships and

confirm this throughout social interaction in order to cope with patterns of role relations in everyday life. As such, roles operate in terms of roughly conceived frameworks for behavior. Or for example, as Sarbin states in his analysis, roles "...involve the person as an organisation of acts..." as the self and others attempt to establish an adjusted pattern of social interaction.

A role is a patterned sequence of learned actions or deeds performed by a person in an interaction situation. The organising of the individual actions is a product of the perceptual and cognitive behavior of person A upon observing person B. B. performs one or a number of discrete acts which A observes and organizes into a concept, a role. ...once having located or named the position of the other, A performs certain acts which have been learned as belonging to the reciprocal position; these actions are conceptualized as A's role.

(Sarbin, 1954: 225)

The actions of persons are interwoven through the course of social interaction against a cognitive background of role expectations, such that "role-enactment" evolves as an actor performs actions appropriate to his location of the positions of self and significant others.

The concept of stock of knowledge is considered in this thesis in terms of the background information about social reality that an individual brings with him to the negotiating process. According to Berger and Luckman,

Since everyday life is dominated by the pragmatic motive, recipe knowledge, that is, knowledge limited to pragmatic competence in routine performances, occupies a prominent place in the social stock of knowledge. (Berger and Luckman, 1966: 42)

In this study, the accumulation of this knowledge is selective and taken to be derived from two sources: On the one hand people's formal training provides them with an understanding of how things should be done in the ward and on the other, people's informal socialization experiences determine the way in which they operate during the course of everyday life.

In this thesis concern is with the kind of collective action people perceived themselves to be a part of in a psychiatric treatment unit. For this reason I rely to a great extent upon verbatim accounts of what people say they are doing, how they feel about their action and why they are acting in such a manner. I shall try, therefore, to examine people's views of their own experience within the framework of "... a dense network of social relationships, institutional demands and constraints, and temporally connected contingencies." (Becker, 1970: 2)

Within the symbolic interactionist tradition, the concept of perspective is used to analyze the collective action of relatively homogeneous groups. For example, Becker defines the concept of perspective as follows:

... a coordinated set of ideas and actions
a person uses in dealing with some problematic
situation... a person's ordinary way of thinking

and feeling about and acting in such a situation. These thoughts and actions are coordinated in the sense that the actions flow reasonably, from the actor's perspective, from the ideas contained in the perspective. Similarly, the ideas can be seen by an observer to be one of the possible sets of ideas which might form the underlying rationale for the person's actions and are seen by the actor as providing a justification for acting as he does. (Becker et al., 1961:34)

As the analysis of everyday life in the ward unfolds people's definitions of the situation clearly evolve in relation to their collective perspectives or modes of action in the psychiatric ward.

It follows from this discussion that there may be more than one perspective dominating the social scene. In fact the use of the concept definition of the situation (as it is discussed in the latter chapters of the thesis) implies that there is "... no one-to-one correspondence between an objectively real world and people's perspective of that world." (McHugh, 1968:8) Instead something intervenes when events and people come together, an intervention that makes possible the variety of interpretations which Schutz calls "multiple realities". (Schutz, 1962: 207-259) For this reason the same events or objects may have different meanings for different people, to the point

where the degree of difference may produce comparable differences in behavior. As the analysis develops the variety of definitions of the situation, with regard to treatment programs, will be illustrated as well as the way in which people eventually develop a definition of the situation within a perspective of pragmatic compatibility.

C. Outline and Summary of the Thesis

We turn now to a discussion concerning the organization of the thesis and a brief outline of the content and hence findings of each chapter. The chapters are presented as follows in order to relate an ongoing description of everyday life in the ward. In Chapter Two we begin with the research methodology. Here I discuss the selection of the research site and entry into the hospital ward, with a brief presentation of a pilot study also conducted in Dixon. Participant observation is discussed as the most viable research method for approaching this study. A very important section of this chapter includes an examination of how a modification of the process of deriving grounded is used in the analysis of the data.

The analysis of the data actually begins with Chapter Three. This chapter introduces the concept of a therapeutic milieu in order to illustrate the treatment model that the Chief-of-Service hoped to introduce in Dixon. Contrary to the fundamental premises of a therapeutic milieu treatment program, the official change in orientations did not evolve democratically through the ranks, nor were members of the staff supplied with a set of conceptual definitions concerning participation in such a

system. A discussion concerning the relationship between what did occur and the ideal conceptualization of a therapeutic milieu follows. A major contrast between orientations results from the retention of the traditional classification system of staff. With this system the dichotomy between professional and non-professional people remained intact. This situation provides staff with contradictory cues concerning their job performance. On one hand, people were to participate in a democratic social system with a sharing of responsibility; on the other, people saw all about them aspects of a traditional social organisation.

I decided to examine people's educational backgrounds in order to see whether or not their individual systems of meaning, as derived through formal training, might determine how they would interpret this predicament and eventually act upon it. This focus on the origins of people's stock of knowledge indicates the range of divergent paths followed prior to entry into the ward. Furthermore, people's formal socialization did in fact provide the kinds of resources they utilized in interpreting and defining everyday life in the ward.

From here the discussion turns to an analysis of the problematic nature of the transition towards the operationalization of the concept of a therapeutic milieu. This discussion indicates that nurses' training experiences derive from a custodial orientation towards treatment. For this reason their training emphasizes the preservation of orderly routine and the physical care of patients. The analysis continues by showing that nurses experience difficulty coming to grips with the new treatment program. They feel that their training does not provide them with

information concerning this type of program and also that the mandate itself is poorly defined. By contrast, child care worker's university training prepares them for involvement with the interpersonal development of the institutionalized child. They feel that they understand the principles underlying the new treatment goal and consequently they are prepared to work towards the development of a therapeutic milieu. With this chapter a distinction begins to emerge between child care workers, who eagerly accept the new treatment mandate, and nurses who, from the initial stages of the redefinition, express critical feelings.

Chapter three continues with an analysis of professionals' training experiences. To begin with this discussion shows that the psychiatrist's present perspective towards treatment varies from the one studied during her training. In fact, the redefinition of the treatment program and the necessary changes therein are based on this altered conceptualization of mental illness. The ascription of a therapeutic milieu label is an attempt, by the psychiatrist, to comply with the organisational demands of this new approach. Therefore, as an analysis of the initial stages of research indicate, the psychiatrist remains strongly committed to this new treatment mandate.

Both the social worker and occupational therapist interpret their training as preparing them for work in this kind of treatment setting. Only the head nurse's training creates difficulty with regard to the reconstruction of the social milieu. Her training prepares her for work within a traditional hospital environment and it is with considerable caution that she approaches the new treatment mandate.

Chapter Four begins to examine how people cope with this new mandate during the course of everyday life in the ward. As this discussion continues, with an analysis of people's accumulating stock of knowledge, we turn to an examination of job titles and the division of labour. Within this framework, a focus upon people's feelings of ambiguity and uncertainty illustrates their definition of the ongoing social system.

This analysis opens with an examination of paramedicals' perceptions of the sources of their feelings of ambiguity and uncertainty. The primary source of their feelings appears to be defined as professionals' expectations of their job performance. Professionals also define their perceptions of ambiguity and uncertainty as evolving through others' expectations of their jobs. This analysis indicates that the head nurse interprets the psychiatrist's job performance as increasing the ambiguous nature of her job, since the kind of information deemed necessary for the performance of her job is not provided by the psychiatrist. The psychiatrist feels that the very nature of her job is jeopardized by the head nurse's lack of understanding about the therapeutic needs of patients. Both the occupational therapist and social worker feel that they understand the professional requirements of their job. However, both view others' expectations as placing ambiguous demands on them. The situation becomes increasingly difficult for them as they must rely on nurses' job performances in order to fulfill their own job priorities.

In the following section I discuss how people define the parameters of their job, since the official ascription of the new treatment mandate. This includes an in-depth analysis of informal socialization experiences

in the ward. I conclude that nurses continue to define the parameters of their job in relation to the traditional way in which their job performance had always been done. With this treatment orientation in mind, nurses interpret many of the expectations held by others who support the new treatment mandate as illegitimate claims on their time. Nurses feel that an acceptance of a therapeutic orientation would force them to relinquish much of their control previously exercised over patients. Their feelings of ambiguity and uncertainty about their participation in the ward increase with their fear that the traditional technology used in their job was growing obsolete. Seniors' interpret the psychiatrist's efforts to democratize the social structure as an attempt to exclude them from participation in ward management. In contrast to this position, child care workers interpret as inappropriate any demands that jeopardize their fundamental concerns with active patient care, especially as they tend to come from custodially oriented staff.

The discussion shows that among paramedicals themselves there are contrary interpretations of others' job performances. Child care workers attempt to encourage nurses to adopt a positive attitude towards the evolution of a therapeutic milieu. Nurses, however, cling to the traditional job titles still existing in the ward to define their occupational duties in accordance with their stock of knowledge accumulated during training. This chapter confirms the disparity among these people that was initially suggested in Chapter Three. On one hand nurses interpret their informal socialization in the ward as sustaining their traditional occupational duties; on the other, child care

workers continue to react against any attempts by nurses to inhibit their own plans to conform to the new treatment mandate. This chapter concludes that the nature of this disparity evolves through people's allegiances toward treatment frameworks, that is, between custodial and therapeutic orientations.

The final sections in the chapter include a discussion of the analysis briefly outlined above. The findings illustrate that at this stage of the research, nurses' define the relationship between the officially ascribed treatment mandate and the occupational structure traditionally accepted by them in highly problematic terms. Professionals also attribute others' expectations of their job as placing them in an ambiguous position in the ward. With the exception of the head nurse, who includes other professionals in this category, their primary difficulties lie with nurses' interpretations of their job. This situation derives from nurses ongoing interpretation of their own and others' role enactment within the framework of a traditional occupational hierarchy. This chapter concludes that in order for people to interact they must grapple with the content of self and others' stock of knowledge, the reciprocal influence self and others exert in terms of role enactment processes and people's general interpretation of their social milieu. What becomes increasingly problematic for people is the "shape" of their interaction with others, that is, the relationship between their self-expectations and others expectations of them in relation to their job performance.

The findings demonstrate that there are two systems of meaning to

be taken into account as people attempt to come to terms with their own and others' definitions of the situation. There is a system of meaning employed by nurses which encompasses a custodial orientation toward treatment procedures and social action in general. In contrast to this definition of the situation is the system of meaning sustained by professionals and child care workers representing a therapeutic milieu orientation toward treatment.

Chapters Five and Six examine how people formulate a working consensus in order to achieve some degree of social order in the ward. Chapter Five begins with a discussion of the ongoing processes of negotiation that people enter into in order to attempt to validate their job performance in view of their interpretations of everyday life in the ward.

Whereas Chapter Four illustrates the problematic nature of creating a working consensus among staff, Chapter Five is an attempt to analyze how people get things done in the ward. This includes an analysis of people's participation in their evolving social milieu. A conceptual framework is provided in order to explain the direction and pattern of the negotiating process among staff. This interactionist framework also includes an examination of the nature of human interaction and the articulation of joint action. My task in this chapter and the one following is to present a descriptive analysis of people's explicit distinction between orderly social interaction and their interpretation of the need to demonstrate or produce the appearance of this kind of order. This is handled through an examination of an evolving pattern of social

interaction and communication networks in various settings in the ward.

The analysis begins with a discussion of the psychiatrist's approach to redefining the treatment mandate. This includes the democratization of the social structure, a sharing of responsibility among staff for patients' daily therapeutic experiences and the development of a team approach to the construction of an active therapeutic milieu. This discussion indicates a problematic situation that is twofold: people are provided with a mandate that may or may not be acceptable, first, on ideological grounds and second, because of the way the mandate is imposed.

From here the discussion examines the psychiatrist's attempts to continually engage in interaction with others that would convince them of the validity of operating within a therapeutic milieu framework. Nurses respond by attempting to legitimate their action in terms of the importance of their job as agents of patient management and orderly routine in the ward. Nurses experience considerable difficulty comprehending what for them appears to be a highly theoretical solution to the problems of patient care. In fact, they express a high degree of hostility toward this concept. Rather than accepting teamwork as the context within which a therapeutic milieu could evolve, nurses continue to try to indicate the the validity of the traditional approach to patient management. Fundamental to interaction initiated by the psychiatrist is her over-riding concern with the transition from this kind of custodial orientation toward therapeutic treatment. According to the psychiatrist, this can only occur if staff agree to work within the context of a psychiatric team.

Nurses feel ill-prepared to work in such a set-up and furthermore they experience difficulty understanding the cues issued by the psychiatrist as team leader. Nurses find themselves in a situation that requires them to translate psychiatric jargon into operational concepts that they can use during the course of everyday action in the ward. Also contributing to their skepticism is their interpretation of their disparity between professionals, who continue to initiate policy and hence daily tasks, and themselves as being responsible for the operation of these demands on a day to day basis in the ward.

In the next section of this chapter I discuss a pattern of social interaction as it evolves in the context of negotiating order in the ward. This pattern is illustrated through an examination of the network of communication (see Charts Three to Ten) sustained among people in the ward. Through an analysis based upon the premises inherent in an interactionist perspective, I conclude that the bond between nurses and the head nurse is far more apparent than between these people and those who openly support the therapeutic mandate (child care workers, occupational therapist and social worker). In fact, over time the degree of social interaction between these people decreases substantially.

Next I focused upon people's interpretations of their function within the context of a psychiatric team. This analysis shows that while child care workers and other professionals expressed open support for a new visiting session scheme, nurses offered very few opinions during policy meetings. However, nurses did have very strong feelings about the application of the concept of teamwork to the visiting routine in the ward.

This is confirmed through my observations of an active network of informal social interaction among paramedicals. Nurses not only acknowledge shared membership in cliques but indicate that these cliques serve as support groups with regard to people's interpretations of how they should be operating in a psychiatric treatment ward. Within the framework of these groups nurses speak openly about their feelings of ambiguity concerning the newly ascribed treatment mandate. Furthermore, these kinds of opinions formulated during public policy meetings are conveyed to absent clique members as a way of sustaining clique solidarity on policy issues. This discussion also concludes that there are contrasting positions adopted by paramedicals on the issue of visiting routines which can be generalized to include most policy issues in the ward. This dichotomy develops on the basis of a polarization between people's systems of meaning. These systems of meaning in turn determine who supports the new treatment mandate (therapeutic patient care) and who continues to resist commitment.

In the next section of this chapter I focus upon how people operate under the therapeutic milieu mandate, while attempting to incorporate their individual and in some instances shared view of social reality. Underlying paramedicals' action there exists a degree of uniformity based on shared membership in a clique. The discussion concludes that people rely to a large extent on small groups consensus in order to create a base upon which their definitions of social reality evolve. The findings in this chapter also show that people are prepared to at least demonstrate the appearance of orderly social interaction among

cliques as a way of sustaining social order in the ward. The pattern of demonstrating orderly social interaction evolves over time and also contributes to the nature of the definition of the treatment setting.

I conclude that paramedicals refer to an unwritten agreement which encourages them to create the appearance of orderly social interaction. This kind of action occurs when they are visible to those defined as authority figures. Nurses are also prepared to feign an active interest in the new treatment mandate although they make every effort to avoid situations where such action is necessary. In response to this kind of action, child care workers are prepared to turn a blind eye to nurses' job performances in order to allieviate informal pressure put on them by others to revert to a custodial treatment orientation. Paramedicals make a conscious decision to work in an environment conducive to the pragmatic development of a working compatibility in order to avoid a setting too prone to crisis upon crisis.

Professionals appear well aware of this process of negotiation among paramedicals. Over time their contact with nurses becomes restrained and limited to communication defined by them as necessary for the fulfillment of their own job. Eventually they retreat from contact as much as possible. The avoidance of overt conflict is the legitimation given for such action, as professionals now feel they are free to adopt a position whereby others' role enactment need not interfere with their own concern with keeping the ward running as a treatment setting. We can conclude that the actual transition towards a therapeutic milieu appears to be subsiding in people's mutual agreement that above all else

the need to demonstrate orderly social interaction is of paramount importance if some degree of social order is to be salvaged in the ward.

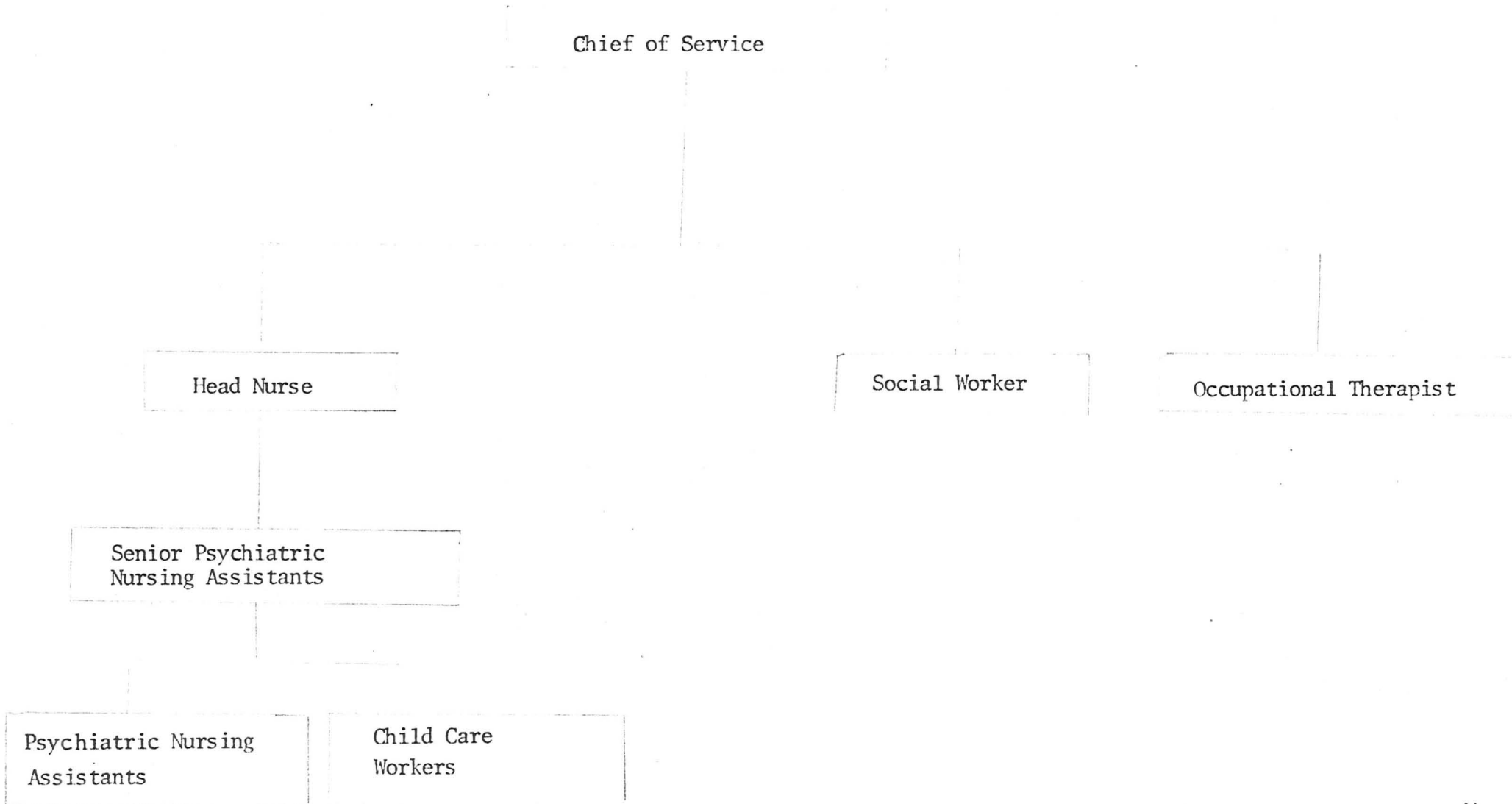
Chapter Six is the result of a chronological analysis of data collected throughout the course of the study. The focus is upon decision making processes in the ward as a way of illustrating people's converging definitions of social reality.

The regularity with which a pattern of decision-making emerges in the ward confirms earlier findings (described in chapter five), concerning the determination to demonstrate orderly social interaction whenever they feel such action is to their mutual advantage. At other times people simply learn to avoid confrontation with others. This relative isolationism provides them with an opportunity to exert their energy according to their individual definition of the work situation and their job performance within this framework. A significant disparity still exists among people with regard to treatment orientations and the dichotomy of individual systems of meaning remains firmly polarized along a custodial therapeutic spectrum. This convergence must therefore be understood as deriving out of people's interpretation of their vested interests on one hand, and on the other, their recognition of the need to survive in a social system highly conducive to hostility among staff. Finally, I conclude that the outcome of negotiation is a working consensus among people that can be best understood within a framework of pragmatic compatibility.

A brief note on terminology will be included here in order to clarify future references to members of the staff (see Chart Two for an

CHART TWO

FORMAL SOCIAL STRUCTURE PRIOR TO THE TRANSITION IN TREATMENT LABELS



outline of the formal social structure in the ward). The term professionals is used to refer to the psychiatrist, head nurse, social worker and occupational therapist, while the term paramedical includes senior psychiatric nursing assistants, psychiatric nursing assistants, and child care workers. Frequently the word nurses appears on its own and refers to seniors and nursing assistants. Abbreviations are used after quotations selected from the fieldnotes in order to indicate the Occupational category of the speaker. The following list illustrates these abbreviations:

Psychiatrist	Psychiatrist
Occupational Therapist	O.T.
Social Worker	S.W.
Head Nurse	H.N.
Senior Psychiatric Nursing Assistant	Sr. N.A.
Psychiatric Nursing Assistant	P.N.A.
Child Care Worker	C.C.W.

CHAPTER TWO

Research Methodology

A. Selection of Site

The site chosen for this research study was a large, urban psychiatric hospital. In particular, one ward was selected from among those composing the children's services of this hospital and a formal investigation concerning everyday life in this ward began. This site was of special interest as the traditional treatment set-up was undergoing a formally ascribed transition towards a therapeutic treatment milieu. The thesis accepts as problematic this official redefinition of the treatment program and therefore also takes as problematic the need to understand the nature of people's social interaction and interpretations of everyday life in this ward. This site was selected, since it invites a focus upon staffs' participation in the ongoing negotiation of social order, while permitting an interpretation of the real world from the perspective of the subjects under investigation.

B. Entry into the Site

A letter was sent to the Director of Children's Services requesting permission to conduct a research project in one of the psychiatric wards under his charge. A very brief outline was presented in this letter, simply as a way of indicating a serious intent to study the ongoing routine in the ward and to show that such a study would be used only for personal academic purposes. From here an appointment was set up for a meeting with the Director. During this interview, permission was granted on the basis that approval also be given by the Chief-of-Service in the ward and that a high degree of discretion be exercised on my part

concerning the confidential nature of the project. Next, I had a meeting with the Chief-of-Service, briefly expressing my wish to observe everyday life in the ward and also to conduct interviews with members of the staff. The psychiatrist appeared very enthusiastic about my request and stated her willingness to cooperate, provided the remaining staff shared her opinion. The psychiatrist then invited me to attend a policy meeting and to speak to people concerning my project. During the discussion that followed, staff appeared to express their joint approval regarding my task, with only one nursing assistant questioning who would have access to the results of the study. The opportunity was taken at this point to clearly reiterate the confidential nature of the project and that no one connected with the hospital would be permitted to read the final paper. People appeared to be satisfied with this response and it was decided, by those present, that my project should continue.

The decision to withhold this paper from members of the hospital staff was considered necessary in order to encourage people's confidence and also to insure, in this my first major fieldwork project, that the data collected did not result in any kind of repercussions for those participating in the ward at that time. It must also be noted here, that this was not my first contact with people in the ward, as I had previously been employed by the hospital as an activity worker in Dixon. Furthermore, it seems quite likely that my former contact with staff, in the sense that I shared a working environment with them, contributed to their willingness to cooperate with this project. In fact, very shortly after my arrival in the ward as researcher, people appeared not only to accept my presence but also to look forward to conversations with me. As one nursing

assistant commented, "It's so good to have someone around just to talk to and to know at the same time that I can trust you."

This kind of response to my presence in the ward gradually helped to "shape" the way in which I was to conduct myself, throughout the course of the study. While a member of the staff, my position was somewhat different from others as I was, at the same time, a full-time university student. As my work in the ward appeared to be an "extra-curricular interest" to most staff, they interpreted my concern regarding psychiatric treatment in a positive way. For example, one nurse stated "You must really care about these kids to spend so much time here." Therefore it appeared, that as I was not a permanent member of the medical team and as I was considered to be working in the ward by choice, I was not perceived as a threat by these people. In fact, they would frequently offer me friendly advice and at times ask my opinion about routine issues. When I arrived in the ward, to request entrance as a research student, it appeared that this same kind of interpretation was placed on me, that is, I was viewed as a concerned person and not someone who was present to take over another person's job or to offer criticism about others' action. For these reasons then, staff continued to take me into their confidence often explaining at great length their interpretation of the ongoing situation. The major difficulty in transferring from employee to researcher developed when people expected me to reply directly to their inquiries concerning the operationalization of treatment procedures in the ward.

On one hand, I did not want to exert any kind of social pressure that might influence staffs' participation in their evolving social milieu, while on the other hand, as participant observer, I

hoped to remain sensitive to the tradition of verstehen or understanding that recognizes two fundamental kinds of human behavior.¹ One aspect of this tradition conceptualizes an inner perspective of human behavior which assumes that understanding can only be achieved by actively participating in the life of those people being observed, thus encouraging insight by means of introspection. Accordingly, there is an outer perspective of human behavior that assumes that the study of man's behavior is adequate to produce knowledge about social life.² The former perspective enables the researcher to perceive and interpret human behavior at a greater depth since an emphasis is placed on man's ability to know himself and thus to know and understand others through "sympathetic introspection" and "imaginative reconstructions" of "definitions of the situation". As Filstead concludes, this approach emphasizes a basic assumption underlying human behavior,

...that man, being a symbol manipulator, is only "understandable" through the perception and understanding of those symbols that are being manipulated. Through median social psychology, sociologists can role take the part of those under investigation, thereby understanding the meaning of human behavior. (Filstead, 1970: 6)

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For a discussion of the philosophical and sociological aspects of this approach please see the following; Max Weber, Theory of Social and Economic Organization, translated: Talcott Parsons, New York: Oxford Press (1947); G.H. Mead, Mind, Self and Society Chicago: University of Chicago Press (1934); W.I. Thomas and Florian Znaniecki, The Polish Peasant in Europe and America, 5 vols., Chicago: University of Chicago Press (1918-1920); Alfred Schutz, Collected Papers, 3 vols., The Hague: Nijhoff Press (1964); Edward A. Shils and Henry A. Finch eds., Objectivity in the Social Science, Glencoe Ill., Free Press (1949).

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A further discussion of this distinction can be found in the following: Severyn Bruyn, The Methodology of Participant Observation, Human Organization 21; 224-235, (1962).

Briefly this means that objects can be studied and hence understood purely from the point of view of observation whereas mental and social processes can be known only from the inside, that is, through the shared meanings and interpretations we give to objects.

Hence, insight may be regarded as the core of social knowledge. It is arrived at by being on the inside of the phenomena to be observed.... It is participation in an activity that generates interest, purpose, point of view, value, meaning and intelligibility, as well as bias. (Wirth, 1949: xx)

As my position as researcher was evolving and as people's expectations of my function in the ward continued to include some kind of verbal contribution to the issues at hand, I attempted at all times to consider the nature and content of my social interaction in relation to the flow of communication evolving among staff in the ward. This mode of action is legitimated in view of the following qualitative methodological perspective to the research situation at hand.

...with respect to things human, it is not disinterest that makes knowledge possible but the opposite; without the factor of interest in the primary sense of concern or care, there can be no recognition of the subject matter in its distinctive human character and hence no real awareness of its situation and no understanding of behavior. (Matson, 1964: 242-243)

While I am not denying the potential ability a researcher may have in terms of being scientific in the collection of data, the point to be emphasized here concerns my attempt to picture the empirical social world as it is actually defined and interpreted by those people under investigation. This then is assumed to be a primary goal of the research project and one that is crucial for the validity and hence reliability of the data under discussion.

Once my presence in the ward had been established and I appeared to begin my participant observation, I found it necessary to provide members of the staff with an explanation about why I wanted to do research in Dixon. As I was already familiar with people in the ward and was aware of their apprehension with regard to "...fancy explanations and big abstract phrases.", I decided to avoid a long detailed description of my research design. Instead I simply stated that I was very interested in learning about everyday life in the ward and that I was writing a paper as one of my university requirements. This appeared to satisfy people and in fact, they often made reference to how they were indirectly helping me earn a degree. To a certain extent, I think this interpretation of the situation encouraged them to be very cooperative with me, as I was "...just trying to get by in life like everybody else". (19, PNA)

As chapter five will illustrate, a strong informal network of social interaction existed in the ward. It became my goal to avoid creating the appearance that I was taking sides with any particular clique in the ward. Since I hoped to achieve maximum cooperation from staff, their opinions about me, especially in terms of my personal integrity, were very important. I made a point of repeatedly assuring staff about the confidential nature of the study and I did not discuss others' direct responses with people. In order to do this, it was sometimes necessary for me to avoid questioning staff too closely in the presence of others.

Over time my personal position also became important. As I became aware of the division among staff, I frequently found myself lending a sympathetic ear to others' definition of the situation. I attempted to avoid direct responses to questions concerning my opinion of the treatment

setting, by turning the discussion back to the person who had addressed me. I did not want to become known as highly opinionated, with regard to the ongoing struggle between treatment perspectives, rather it was my intention to be viewed as an interested and sympathetic recorder of events by all people concerned.

C. Preliminary Pilot Study

When the original proposal was drawn up for this study, it included three major research techniques to be used with equal weight in the final analysis of the empirical world. These techniques were to include a structured, open-ended interview (see Appendix A) with each member of the staff, a pre-coded questionnaire (see Appendix B) to be distributed among staff and participant observation to be conducted at length and to include a representative sample of various time periods during the course of a day's routine.³

Formal interviews were frequently conducted with people during the evening shift (usually after eight o'clock) in order to comply with the rigorous schedule of duties to be performed by them during the earlier hours of the day. The exception here included professionals, who were interviewed in the privacy of their own office at their convenience. The average duration of these interviews was between 1 1/2 and 2 1/2 hours with the exception of the psychiatrist whose interview lasted

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A selection of data derived from the interview schedule were used in chapter four and five, when I thought the material illustrated the topic under discussion particularly well. Whenever such data were used, however, the text indicates that this is the case.

three hours. The interview schedule was used in each case as a means of collecting a similar range of responses from each person, although a considerable amount of probing was initiated in order to encourage an individual to elaborate his position. Also, where it was considered necessary, the order of the schedule was shifted in order to make it more appropriate to the particular interview at hand.

Following the interview, staff were asked to complete the questionnaire. This procedure was used in order to prevent interrupting their action in the ward at a future date and also to ensure a complete response rate. While the questions included were pre-coded, the questionnaire was introduced to staff in such a way, that they were encouraged to write comments wherever they felt their opinion needed to be elaborated.

As the interviews and hence the distribution of questionnaires continued I gradually became more involved in participant observation in the ward. Not only did my time as observer increase but the quality of people's verbal participation with me increased in relation to the amount of time I devoted to observation. It was during this stage of the research project that a decision was made to utilize the data collected through formal interviews and the questionnaire as a preliminary pilot study which I proceeded to document in the usual manner. From the analysis of this data and my increasing involvement in the present social milieu I decided to formulate a research design that would permit an in depth analysis of staffs' participation in the interpretation of

everyday life in a psychiatric ward. In this sense, then, it is possible to say that the participant observation that developed was "grounded" in the analysis of the data previously set aside as a pilot study.

D. The Present Research Study

In the following discussion I shall outline briefly the methodological meaning underlying participant observation and indicate why this particular research technique was selected as the major source of data for this thesis. From here, a presentation of grounded theory, that is inductive theory construction, will be developed in order to indicate how an adaptation of this research perspective provided the fundamental methodological premises upon which this thesis was based.

1. Participant observation as a method

Prior to selecting a particular research technique, certain methodological assumptions must be dealt with first. For example, assumptions must be indicated concerning the nature of man, the process of knowing research data in the mind of the observer and assumptions about the method of verification. The concept of the nature of man is very closely related to the concept of meaning, which the observer seeks to discover and explain, in the context of the shared human reality of the subjects under investigation. As I attempt, in this thesis to understand the meaning derived by people in a psychiatric ward, from the interactive world they share with others, I am seeking to explain the common-sense realities of these people. This is so, as it is only at this point that I can construct meaning on the basis of these already organised realities. The methodological importance of participant observation in gathering this kind of data is expressed by G.H. Mead's

conception of what constitutes the nature of meaning.

There are two characters which belong to that which we term 'meaning'; one is participation and the other is communicability. Meaning can arise only insofar as some phase of the act which the individual is arousing in the other can be aroused in himself. There is always to this extent participation. And the result of this participation is communicability, that is, the individual can indicate to himself what he indicates to others. (Strauss, 1956: 183)

In participant observation we can assume that an individual can communicate a message to an other and have it understood as he can arouse in himself. Hence, on the basis that meaning can be functional, the observer can act methodologically. Participant observation as one form of qualitative methodology encourages the researcher to obtain firsthand knowledge about the empirical social world under investigation. To understand the meaning people attach to this reality, participant observation allows the researcher to derive the analytical, conceptual, and categorical components of explanation from the data itself. In this particular case, the pilot study also aided the development of relationships between concepts that were pursued in depth through participant observation. Putting aside a pre-coded questionnaire and an interview schedule, that also proved somewhat restricting, aided the transition away from highly quantified techniques that tended to utilize preconceived, rigidly structured categories of analysis as well as operational definitions constructed by me as research observer.

2. A modification of the process of grounded theory, as originally proposed by Glaser and Strauss

The decision to concentrate upon the data derived through participant observation was made in order to emphasize one of the

major goals of this thesis, that is, a direct examination of the empirical social world of a psychiatric milieu and hence a comprehensive descriptive analysis of the data therein. This decision was also made in view of the problem of verification in the study of the empirical social world. Rather than accepting a priori assumptions and artificial models of explanation, participant observation encourages verifiable knowledge about the empirical world, since this technique requires the researcher to interpret the world from the perspective of the subjects under investigation.

To try and catch the interpretative process by remaining aloof as a so-called 'objective' observer and refusing to take the role of the acting unit is to risk the worst kind of subjectivism, the objective observer is likely to fill in the process of interpretations with his own surmises in place of catching the process as it occurs in the experience of the acting unit which uses it. (Blumer, 1962: 188)

Participant observation was conducted in such a way as to incorporate a modified version of inductive grounded theory, as proposed by Glaser and Strauss in their work concerning the generation of substantive theory.⁴ To begin with the analysis of the data collected will not be used to derive a completed theory regarding everyday life in a psychiatric treatment milieu, but rather this thesis is an attempt to remain sensitive

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Reference is made here to the following works: B. Glaser and A. Strauss, Discovery of Substantive Theory: A Basic Strategy Underlying Qualitative Research, in W.J. Filstead ed., Qualitative Methodology: Firsthand Involvement With the Social World, Chicago, Ill., Markham Pub. Co. (1970); B. Glaser, The Constant Comparative Method, Social Problems 12; 436-445, (1965); B. Glaser and A. Strauss, The Discovery of Grounded Theory: Strategies for Qualitative Research, Chicago, Aldine Pub. Co. (1967).

to the fundamental premises of Glaser's and Strauss' conceptualization of the discovery of grounded theory. It is hoped that in this way the thesis will provide a meaningful descriptive analysis of people's interpretations of everyday life in a psychiatric ward undergoing a formally ascribed transition from custodial to therapeutic treatment procedures. As this thesis is concerned with a descriptive analysis of everyday life in a psychiatric ward, an attempt will be made to generate sociologically significant relationships that both derive from and can be illustrated by data collected through participant observation.

According to Glaser and Strauss grounded theory, in its final presentation can be documented as a codified set of propositions or as a continuing theoretical discussion using conceptual categories and their properties.⁵ While the presentation of data analysis in this thesis is theoretically formulated along the lines of this organisational formula, the outcome reflects a modified version of the constant comparative method of generating grounded theory. This means that while the methodological process adhered to in this thesis was one that reflected the theoretical and philosophical goals of Glaser and Strauss' phenomenologically oriented inductive method of theory construction, the outcome is a descriptive analysis of people's involvement in everyday life, rather than the generation in total of a theory of social action in a psychiatric treatment ward.

Also, a very important modification in the methodological approach

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For a detailed discussion concerning these processes please see Glaser and Strauss, The Discovery of Grounded Theory: Strategies for Qualitative Research, Chicago, Aldine Pub. Co. (1967), pp. 31-33.

outlined by Glaser and Strauss derives from the fact that the constant comparative approach was applied to the fieldnotes in an analytic process after the data had been collected. The fieldnotes utilized in this thesis were separated from the interview schedule and questionnaire, in order to free the analysis from as much external pressure as possible, with regard to deductive theory formation. It was at this point that the process of generating conceptual categories and their properties began to be derived in the sense proposed by Glaser and Strauss and an attempt to determine sociologically significant relationships grounded in the data commenced.

From here the constant comparative method was applied in order to emphasize the many similarities and differences between the occupational groups being studied. In this way categories and their properties emerged from the data, indicating variables that will clearly be important to a theory explaining the kind of behavior under observation. This process is believed to be an appropriate goal in itself since the descriptive analysis of people's involvement in everyday life in the ward, will it is hoped prove fruitful in uncovering important emergent categories, that may in the future be useful in the construction of a theory of social action in a psychiatric ward.

According to Glaser and Strauss, the discovery of grounded theory should be a joint collection, coding and analysis of fieldnotes. As indicated above, owing to a modification in this process, the thesis fulfills the latter two requirements only. Thus as the process of generating emergent relationships evolves, a theory in itself can not be

constructed, given the modifications discussed above and still remain faithful to the total range of principles inherent in Glaser and Strauss' formulations concerning inductive theory construction. However, the thesis presents an analysis according to the coding procedures emphasized in this methodology. For example, when coding procedures were initiated, the categories were derived from the fieldnotes and as such the analysis can be viewed as one emerging through the perspective of the subjects under investigation. The coding procedure evolved through peoples comments concerning particular issues in the ward. In fact the coding and hence discussion of the data represents staffs' presentation of everyday life in a psychiatric ward as they define and interpret the ongoing situation. Throughout the thesis people's comments are included at length to illustrate particular relationships that they see existing in the ward. These comments were recorded at the time of participant observation and indicate staffs' responses not only to myself as researcher but also in dialogue with other members of the staff.

Chapter Three

Pathways Leading to Employment in a Psychiatric Ward

A Introduction

This chapter begins with an examination of the way in which the new treatment label was inaugurated in the ward. This discussion is followed by a presentation of the concept of a therapeutic milieu as it is found in the literature. From here a contrast is drawn between the traditional hospital setting and the social and therapeutic milieu envisioned within the model of a therapeutic treatment program. The transition towards this treatment setting is a highly problematic one for those involved. This is owing, partly, to the way in which the new program was introduced, to the kind of preparation people experienced prior to their employment in the ward, and finally to their participation in the ward itself. The last two aspects of this statement will be expanded upon in chapter four; however, here people's early socialization is discussed and the origins of their stock of knowledge introduced.

This chapter is important as a means of introducing the variety of occupations present in the ward and the divergent paths followed prior to entry into this setting. This information will provide the reader with a basic understanding of the resources staff draw on to interpret what is going on in the ward and in particular, their perspective towards

treatment procedures.

The recently ascribed treatment program demanded major alterations in the operating technology utilized in the ward. These demands were dictated by the Director of Children's Services and the Chief-of-Services for this ward. As will become increasingly apparent throughout the study, people within this social system were not clearly informed about the philosophical framework within which this new program must operate. For example, members of the staff were not provided with a set of conceptual definitions regarding participation in a democratically evolving therapeutic treatment program. This neglect in itself is not only contrary to the fundamental premises of a therapeutic milieu treatment program (Caudill, 1958, Jones, 1953, Cooper, 1967, Colarelli and Siegal, 1966, Stanton and Schwartz, 1954, Greenblatt, York and Brown, 1955), but also contributes to the reinforcement of the traditional ideological perspective already present in nurses' stock of knowledge.

1. The therapeutic milieu as a treatment program

We may conveniently preface this analysis with a brief overview of the theoretical constructs utilized by Maxwell Jones and other early researchers in this field. According to Jones, psychiatry has for too long,

...paid far too much attention to the model (of mental illness) created by general medicine. This is inevitable so long as doctors, nurses, and other professionals associated with psychiatry

take their undergraduate training in general hospitals, whose social organisation is geared more to the needs of surgery than of psychiatry. (Jones, 1968: 126, brackets added).

The results of this can be seen in traditional psychiatric settings where the expertise of the medical leader goes unchallenged, with the absence of two-way communication and the maintenance of rigidly defined status differentiation. For example, as the major forms of treatment derived from somatic, insulin, drug or individual psychotherapy, it is understandable that psychiatrists came to view the medical profession as "...the exclusive purveyors of therapy" (Greenblatt, York and Brown. 1955: 5). With this kind of treatment perspective, psychiatrists failed to acknowledge the potential usefulness of other members of the hospital staff with regard to treatment procedures. In particular, the interpersonal relationships between patients and staff that are a part of the everyday treatment setting were not taken into account as a viable aspect of the treatment process. Equally important, according to Greenblatt, York and Brown (1955: 5), however, is the psychiatrist's failure to comprehend and prepare for another set of responsibilities, that of leader of a therapeutic team involving all members of a hospital ward.

In response to this kind of situation, the concept of a therapeutic milieu was developed as a way of establishing a more fruitful form of psychiatric treatment. Treatment was

to evolve beyond the restrictions created by individual psychotherapy, insulin, drug and somatic treatment. Instead of leaving therapy totally in the hands of the psychiatrist, all members of the staff were encouraged to accept responsibility for providing active therapy for the patient. This responsibility was to include the development of positive interpersonal relationships between staff and patients and an earnest attempt to provide a social environment conducive to therapy on a twenty-four hour basis. In this kind of setting the manner in which tasks are performed becomes very significant, as the evolving social milieu is considered a viable therapeutic influence.

This calls for a radical reconstruction of the ideological perspective guiding the allocation and distribution of labour within the therapeutic community. To illustrate the potential value of such a treatment set-up, Jones (1953) created a rigorous program of in-service training in order to demonstrate that attendants could be trained to participate as therapists rather than remaining as custodial officers and housekeepers. In this particular community, an emphasis was placed on processes of social interaction between attendant and patient in such a way that custodial functions were minimized, and even the performance of housekeeping chores was utilized as a therapeutic device. There are also several other cases presented in the literature (Cooper, 1967, Greenblatt, York and Brown, 1955, Stanton and Schwartz, 1954,

Zander, Cohen and Storland, 1957, Colarelli and Siegal, 1966, and Jones, 1968), stressing the need for informal but continuous training among all levels of staff, in order to,

...remake the hospital as a social institution: to replace autocratic administration, inflexible departmentalism, and reliance upon considerations of status, salary and power by more democratic procedures, greater general permissiveness and delegation of responsibility, reduction of departmental and status barriers, greater encouragement of initiative and utilization of the concept of the therapeutic team.
(Greenblatt York and Brown, 1955: 17).

In accordance with this increase in responsibility (particularly for nursing assistants), support must be given by administrative officers and supervision must be redefined as a counselling mechanism rather than as a way of checking up on staff or "handing down orders" (Jones, 1968: 23-29). Within this democratically oriented therapeutic milieu, social interaction is encouraged in order to create a pleasant working atmosphere and so provide the patient with a friendly and efficient environment.

2. The social milieu in relation to this program

The re-definition of the treatment program was an attempt to incorporate the ideological and organizational principles outlined above. However, while the ascription of a therapeutic milieu label was attached to the treatment program, there remained an official classification system dividing people into a professional, paramedical dichotomy. This classification system was defined by the central

administrative board of the hospital. Included as professional personnel were the psychiatrist and chief-of-services, the head nurse, the occupational therapist, and the social worker. Senior psychiatric nursing assistants and psychiatric nursing assistants were classified as non-professional or paramedical personnel. Although the occupational category of child care worker existed on this ward, the two people involved were not classified according to this scheme. According to the chief-of-services, this was so because the category was specific to this ward and had existed only since the period of reconstruction.

A brief discussion will follow concerning this dichotomy in order to introduce the relationship between the premises underlying the concept of a therapeutic milieu and the reality of the situation at hand. When discussing the professional or non-professional aspects of an occupation, two questions must be considered. Firstly, does the occupant of the position have autonomy and secondly, who controls the content of knowledge he or she is to learn? Nurses, for example, are in a position of officially ascribed powerlessness, not only in terms of their practical lack of autonomy but also in terms of their training. On the other hand, the head nurse's occupation was not so clearly defined. Although she was officially classified as a professional, her job often included the performance of tasks and the involvement in relationships, in ways similar to those of

paramedical people.

According to Freidson, paramedical occupations tend to be based upon the technological knowledge of the physician in such a way that the tasks performed by these personnel must be approved by the physician. The kinds of tasks performed by paramedical personnel support the focal tasks of the physician; that is, diagnosis and treatment, and usually express a subordinate position. That is, work is done on the request or order of the physician. The division of labour that follows is controlled by a dominant profession and is,

...constructed on the basis of a stratified system of labour in which the occupants possess varying degrees of integration around the work of the physician.
(Freidson, 1970: 52)

As Freidson discovered in his research, the data collected in this study illustrated that a hierarchy of prestige and authority evolved among paramedical personnel. For example, in the case under study, the head nurse experienced greater prestige and authority than the attendants, owing partially to her professional classification in the ward, and the longer and more formal period of training she had experienced. Yet as the head nurse stated.

I find myself in the ambiguous position of taking orders from the nursing supervisor, the psychiatrist, the occupational therapist, and the social worker while being responsible for communicating ward policy to the nursing attendants who in turn must perform the required tasks. However, while I am responsible for the smooth operation of the ward I don't really have any power to alter the program

established by the other professionals on the ward even if it causes conflicts for me. (3,HN)

The question of commitment to work also serves as a useful index of professionalism. The following statements will indicate that with three exceptions only (one nursing assistant (17) and two child care workers (5 and 6)), a marked identification of oneself through one's career was found only among those labelled professionals in the ward. For example, the psychiatrist expressed a commitment to her job in terms of a life long goal to provide services for children and especially those children with some kind of mental illness,

...even prior to university and medical school the course of my education was planned carefully so as to prepare me for medicine and eventually psychiatry as a lifelong career.(1, Psychiatrist)

The social worker also undertook her university training with a general goal of "eventually working with people", which over time became focused in terms of psychiatric social worker within a hospital setting.

...for as long as I can remember working with people has been important to me and while I was sometimes uncertain about how I was to fulfill this goal I never doubted my commitment to serve people as a career. (4, S.W.)

In contrast to this kind of occupational goal found among those labelled professional in the ward was the position expressed by members of the paramedical staff. The decision to undertake training was made by these people for a variety

of reasons. For example, some wished to leave high school and their parent's home in order to be self-sufficient adults.

I wasn't much interested in finishing high school and my parents couldn't afford to keep me much longer so I first thought I'd leave the Maritimes and head west to find a job (15, P.N.A.)

If the respondent was a high school drop-out then the hospital provided what he considered to be a "respectable way of earning a living". The emphasis in these kinds of responses was placed on financial security and the achievement of respect from the community at large.

I knew that I didn't have enough education to be a proper nurse but I figured that this would be a respectable job that I could be proud doing (10, P.N.A.)

For some, training was undertaken strictly for economic gain (this included seven members of the staff: 3, 11, 12, 13, 14, 19),

I didn't have any plans when I left school except to find a job and get some money. This place seemed like a good idea especially as I wouldn't have no worry about room and board and I'd receive a diploma which could be used in other hospitals too (8, Sr. N.A.)

We can see another interesting contrast in backgrounds between professional and paramedical staff. The former category of staff were born in large urban Canadian centers and received their education and training in their place of birth. Paramedical staff, on the other hand, all came to the

training school from geographically smaller and less populated areas. For example, four (7, 8, 15, 18) personnel originated from the Maritimes and from small towns whose population is under 5,000 persons, two (9,10) members of the staff came from rural areas in the Barbados, four (11, 16, 14, 19) came from small rural towns in Quebec and two personnel (13, 17) came from Ontario towns whose population was under 10,000. This diversification in backgrounds between people will be examined as a possible source of conflict regarding the evolution of a definition of the work situation. In a later chapter, particular attention will be given to an analysis of communication and decision-making processes involved in the evolution of such a definition.

B. Education: Origins of a Stock of Knowledge

The hospital in which the unit under study is located trains psychiatric nursing assistants. This course extends over a period of one year and is largely composed of practical ward experience, with approximately three months of classroom training to initiate the program. Certification results in the confirmation of a diploma which is recognized as the equivalent of a practical nursing diploma except that ward duty occurred in a psychiatric hospital. The basic one year course can be supplemented with a six month training period in the administration of a psychiatric ward after which an examination can be written and, if successfully passed, nursing

assistants become senior psychiatric nursing assistants.

On the ward studied there were three senior psychiatric nursing assistants and ten personnel in the psychiatric nursing category. With the exception of one psychiatric nursing assistant, all the above nurses were trained at this hospital. As Chart I indicates, the length of stay in the ward varies with each staff member; however, only one psychiatric nursing assistant has remained for a longer duration than the senior nurses. More interesting however, is the length of stay on the ward in relation to the initiation of a therapeutic treatment label. Again, with the same one exception, senior members of the nursing staff worked in the ward for a considerable length of time while it served as a custodial treatment setting. It is also worthwhile to note here that only two psychiatric nursing assistants have come to the ward since the inauguration of a therapeutic milieu while three members of the staff worked in the ward for a period of six months or less. While it might be expected that the transition towards a new kind of treatment program might be less disturbing for nurses who had experienced the ward as a work setting for a shorter period of time, it should be remembered that with one exception only, training occurred in the nursing school within this hospital.

Although training took place over a range of years, with two seniors completing their training eight years prior to the commencement of this study, there appeared to be

considerable consensus regarding the content of the training program. For example, while textbook titles altered over the years, the fundamental orientation towards training remained little changed. Nursing assistants were of the opinion that the subject matter included three major areas, routine bedside care, drug control and distribution of information about the administrative tasks performed by various members of the hospital staff. When the subject of bedside care was pursued nursing assistants were in total agreement that such training was of little value to them now as people active in a therapeutic unit for children. In fact, each nursing assistant at this level of training reiterated several times that "...people around here learn from experience..." or "...to get things done in this ward you have to do it on your own the hard way, until you gradually pick up the routine". During informal discussions with nursing assistants (fifteen members of the staff) a total of 47 responses recorded within the first two months of study illustrated this kind of opinion.

1. Nurses' training experiences

The following description of the certification program is based on nurses' verbalizations of their experiences in training and their opinions of the success of the program in preparing them for work in a psychiatric treatment ward. A majority of classroom hours were allocated to routine bedside care, with four of the nine months spent in practical on-the-

job training in the medical and surgical wards of the hospital. These wards were occupied by patients already institutionalized in the hospital community and in need of medical treatment.

In preparation for these duties lecturers informed trainees about rudimentary nursing practices and at the same time indicated to them some aspects of the patient-nurse relationship. Information was also given to students at this time concerning the control and distribution of drugs, and textbooks provided the rationales for the particular distribution of the various kinds of drugs to patients. As students, psychiatric nursing assistants were prepared to complete doctors' medication orders and to keep reports on patients' consumption, however, on duty they were not permitted to directly provide a patient with his medication. This experience as will be shown in a later section of this thesis was a source of considerable dissatisfaction among nursing assistants, particularly as they were called upon to fulfill this task when the head nurse was otherwise occupied in the ward.

i) The preservation of orderly routine. When discussing the nature of their training, nurses generally referred to the tasks they were required to learn in caring for the physical needs of the patient. In fact, a great majority of responses describing the training program were made about this aspect of patient treatment. For example, the following is representative of this pattern:

We spent hours making beds, emptying bedpans, washing medication cups, bathing patients, changing patients' bedclothes... (12, P.N.A)

Somehow we always seemed to spend so much time on mundane tasks like making beds and tidying up the wards and serving in the cafeteria, we never had a chance to think about their (the patients) illnesses (17, P.N.A.)

Everything they told us seemed to me to be common-sense; what I wanted to know was what we were doing for the patients' mental problems (18, P.N.A.)

This kind of pattern indicated training staffs' concern with fundamental routine tasks and the development of order in the nursing assistant's method of handling his duties and responsibilities. On the other hand, nursing assistants expressed feelings of apprehension that even as students they wondered how they were going to cope with, as one person stated, "...the bizarre quirks patients seem to have...". These feelings of uncertainty will be discussed in greater detail as they become important to our understanding of peoples' interpretation and definition of the social system as a viable work environment.

The third period of training began with brief training sessions in various psychiatric wards. At this time, learning to control patients' outbursts of anger or expressions of severe depression was stressed by nursing supervisors. As students, it gradually became apparent to nursing assistants that they were responsible for controlling any experience that might disrupt everyday hospital routine. In retrospect, nurses recognized a definite emphasis on routine, stability,

control and order, or as one staff member succinctly put it,

...we were taught that everything had to appear as if it were happening like it was supposed to... (19 P.N.A.)

This concern with ward routine was emphasized by each nursing assistant during informal discussions in the ward. As the analysis of the data unfolds, this aspect of students' socialization will be shown to maintain a firm grip on the actions of nursing assistants as they participate with others during the course of every day life in the ward.

ii) An emphasis on physical care. As students, nursing assistants were also informed through experience in a variety of wards, how to write daily reports in the Medical Log Book. This experience varied according to the routine established on the ward, however, in general, students were expected to state briefly their observations about the patients they had worked with during the day. There were certain kinds of behavior that had to be reported according to hospital regulation: physical injuries acquired by patients through the day; incontinent patients; aggressive behavior; social problems that might be observed between patients or any behavior pattern that was unusual for a particular patient and might have some repercussion on the general behavior of all patients. In summary, nursing assistants' noted that as students they were instructed primarily to observe the,

...medical side of a patient's problem (that is) to deal with his physical needs and to control his behavior problems. (17, P.N.A.)

This emphasis in turn moulded the kind of documentation nursing assistants included in the log book concerning patients,

...as this kind of information on the physical well being of the patient seemed to be what everyone was so worried about (19, P.N.A)

It appears from many discussions with nursing assistants that the vast bureaucratic structure of the hospital was viewed as creating a somewhat formidable experience for them. Frequently conversation illustrated the lack of formal information provided students as they were confronted with larger numbers of personnel, various disciplines and departments and jobs that were observed to be a part of the treatment program, but whose function remained unexplained. According to nursing assistants, they were left to discover for themselves what was really going on in the hospital. This process created a great deal of confusion for them as they felt ill-prepared to cope with the wide variety of experiences that confronted them each day. As one person remarked:

"...how the administrators ever got this hospital operating in the first place, never mind how they keep the whole thing together, still confuses me." (18, P.N.A.)

After several months students began to understand the hierarchy of supervisors and the relationship that must be maintained between themselves and their immediate supervisors. It is doubtful however, whether students were actually aware of their multiple subordination situation. In fact, we may well question whether or not students were informed about the complex nature of the relationship between medical and

nursing personnel or, for that matter, any kind of interdisciplinary understanding of mental illness and a patient's everyday behavior. As will be elaborated later, we suspect that as the nursing assistants received very little information about other staff members' jobs and the potential each has in a treatment environment, he must come to terms with this situation in a way most suitable for his own ends during the enactment of his own constructed role in a treatment ward.

iii) Formal training in relation to the constructs of a therapeutic milieu. From the brief discussion above concerning training, it is apparent that as yet there has been no direct mention of the philosophical orientation underlying the program. Concern with this aspect of nurses' training will involve an examination of their accumulated stock of knowledge. This will include an examination of how nurses' conceptualized supervisors demands regarding the treatment of patients, and in general, how others' attitudes were interpreted in view of the ongoing social setting in which this treatment was to occur. This discussion will follow in a later section of this thesis; here we are simply interested in possible background experiences that contribute to the formulations of this knowledge.

a) A contradiction in emphases. Nurses were questioned about the treatment goal that was presented to them while training at the hospital. In each case, the following reply appeared ready at hand,

Nursing assistants in this hospital are expected to care for the total needs of the sick patients (14, P.N.A.)

When nurses were invited to continue, this kind of response was most frequently followed by a statement of routine housekeeping chores or tasks, such as caring for minor injuries, preparing medication and assisting the patient with his or her personal hygiene. In fact, while discussions and observations were being conducted regarding this aspect of nurses' training, fifty-three responses were made in terms of the completion of everyday routine tasks and twenty-six responses were addressed to the problem of taking care of the physical needs of the patients.

Nursing assistants in this hospital are expected to care for the total needs of the sick patient (14, P.N.A.)

Only direct references issued by the nursing population (ten nursing assistants and three senior nursing assistants) concerning treatment goals were recorded here. As each person responded towards both aspects of training, it is significant to note, not only the high degree of consensus present, but also the fact that nurses reiterated these goals, in different ways, several times during informal conversations. Only two psychiatric nursing assistants described the emotional needs of the patient as a major treatment goal and only one of these assistants was trained in this hospital. In summary, nursing assistants appeared to agree that their training program expounded the treatment goal of the hospital in terms of a

smooth-flowing and routinized treatment environment and patients' apparent physical needs.

It is within the context of this previous training that nurses' evolving stock of knowledge must be understood. Particular attention will be given in the remaining discussion to their original interpretation of the goal situation and the relationship here to the newly ascribed treatment orientation. Nurses' interpretation of this relationship will be clearly illustrated in the following chapter. Suffice is to reiterate here nurses' familiarity with a traditional bureaucratic form of organization and a custodial approach to treatment procedures. In general, the social structure into which nurses were trained was composed of a rigidly ascribed hierarchy which established formal lines of authority, communication and decision-making. Nurses were expected to provide custody and control over the patient and to operate and sustain an orderly working environment for medical staff, who, in turn provided the patient with psychiatric treatment in the form of drug therapy, electro-convulsive shock therapy or perhaps some kind of individual psycho-therapy.¹ This kind of orientation to the treatment of psychiatrically defined mentally ill patients, plays an important part in shaping the

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As in the example of custodial treatment provided by Erving Goffman(1961), nurses were taught early in their careers to control patients' aggressive expressions in order to mold them into a uniform mass and thereby succeed in shaping them to fit the cast of resident in an efficient orderly bureaucratic structure.

phenomenal world of the student nursing assistant. Early in their training nurses learned to conform to the prevailing psychiatric ideology that provided for a custodial orientation to treatment. Once this pattern became firmly embedded within their practices, new demands evoked a highly problematic situation for nurses.

b) Supplementary training for seniors. Senior psychiatric nursing assistants experienced a further period of training in the hospital. This training was primarily concerned with the administrative requirements of a psychiatric ward. On the average, seniors were older than other nursing assistants, and with the exception of one nursing assistant, they had been working in the ward for a longer period of time prior to the ascription of the therapeutic label than any other member of the staff.

Seniors agreed that the aim of their supplementary training was,

...to provide us with information so that we could take over the administrative responsibilities of the ward during shifts when the head nurse wasn't on duty and also to learn how to be a liaison between nursing assistants and the head nurse
(7, SR. N.A.)

According to one senior, however, the details involved in fulfilling these administrative tasks were not very clearly explained.

...paperwork seemed to be the only thing we learned to deal with. They (training staff) certainly made sure that we knew which forms to fill out every possible routine procedures, (8, SR. N.A.)

It appears, therefore, that seniors' supplementary training served to reinforce the necessity of maintaining an uninterrupted routine in the ward. To sustain this ordered atmosphere the emphasis in training was placed on task oriented aspects of administration rather than, for example, on learning how to participate in the development of compatible working relations among people. This observation was supported by many responses seniors made in terms of their feelings of uncertainty, about the preparation they received in the course, for their function as liaison between head nurse and nursing assistants. For example, one senior stated quite frankly that,

...the course failed to provide me with a better understanding of how people should work together and how I could contribute to such a situation (7, SR. N.A.)

2. Child care workers: Training for involvement with the interpersonal development of the resident

Child care workers were specifically recruited to fill a new occupational category that was created immediately following the official redefinition of the treatment program. Both held university degrees in the social sciences and accordingly felt they were trained to promote the kind of positive interpersonal relations between staff and residents, necessary for the maintenance of a therapeutic milieu. Upon accepting the job, they received a few hours briefing from the psychiatrist concerning the orientation of treatment procedures. As one child care worker stated, this brief discussion

...was our only means of learning about the very complex nature of the ward and the essential aspects of our duties within this milieu ... (5, C.C.W.)

The manner in which the psychiatrist stated the treatment goals for the children and the child care workers' responsibilities in fulfilling these goals provides some information concerning their evolving stock of knowledge. According to these people, their university training was also a major factor influencing their ideological perspective towards treatment procedures, the social structure in a therapeutic milieu and their attitudes toward mental illness. Specifically, this training included instruction in child psychology, the sociology of the family, the sociology of group behavior, practices in clinical psychology and general social psychology. As one worker remarked,

...I have been preparing to work with clinically diagnosed, mentally ill children for several years and selected my university courses to prepare me for work in an active therapy unit (6, C.C.W.)

Both workers acknowledged that after their initial conversation with the chief-of-service, they were somewhat apprehensive about what kinds of specific responsibilities they would share. According to one child care worker,

Our conversation with Dr. _____ revolved around the treatment philosophy now being used by personnel in the ward. The psychiatrist was extremely anxious that we accept the concept of a therapeutic milieu and be prepared to participate with the children in a total active treatment process... (6 C.C.W.)

The information presented to these two workers were centered primarily upon the concept of therapeutic milieu.

We were encouraged by the psychiatrist to consider the child's interpersonal behavior situation and to realize the tremendous importance in the relationship between a child's social and physical environment and the development of his self-concept and his interaction with others in this milieu (5, C.C.W.)

The information presented above illustrated a fundamental contrast to the early background experiences of nurses and child care workers. On the one hand, nurses were socialized into a career that emphasized routinized procedures, control and custody of the "...mentally sick patient", while child care workers were initially indoctrinated with a philosophical approach to treatment procedures. This orientation relied heavily upon the interpersonal development of the patient and also emphasized what is considered, in the literature, to be a social model of mental illness.⁽¹⁾ It follows therefore, that the emphasis found in the course of training offered by this hospital, provided nurses with a strong custodial orientation towards treatment. The origins of child care workers' stock

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The most systematic approach to the conceptualization of a social model of mental illness can be found in T.J. Scheff (1966). Here, mental illness is examined from within the framework of the labelling process and in turn as a societal reaction to deviance. For an adaptation of this approach the reader may turn to Szasz' work (1962, 1963, 1970, and 1972), where the following perspective is explored at great length "Both psychiatry and law are concerned with defining which roles are socially legitimate and which are not, and with forcing conformity to prescribed roles. Institutional psychiatry enforces role conformity by defining role deviance as mental illness punishable by commitment" (Szasz, 1970: 102).

of knowledge, however, lay in their university training and the briefing given to them by the psychiatrist which stressed the philosophical goals of a therapeutic milieu as a treatment procedure. This distinction will be shown to have a significant influence upon almost every aspect of the social system and in particular the negotiating processes between members of the social structure.

3. Professional members' training experiences

The four remaining members of the staff to be discussed include professionals working in the ward. As Chart I indicates, the length of stay varies among members of this group, with the psychiatrist working for the longest period of time, a total of twenty-two months prior to the introduction of a therapeutic treatment program. Next comes the head nurse who began work here eight months prior to the alteration in treatment labels and finally, we can see that both the occupational therapist and the social worker have worked for a considerably shorter length of time and only since the redefinition of the treatment setting.

In each case initial training was experienced outside the present hospital setting and for the social worker and the occupational therapist there was no previous hospital experience. For these people university instruction prepared them for careers which they chose to establish within a hospital environment. The head nurse, on the other hand, received her training and registration through a general hospital and

participation in a psychiatric treatment environment for a period of four weeks during her three year training course. The psychiatrist's educational background includes a total of eleven years spent in both a university and hospital setting, with several of these years given to the study of psychiatry. The following discussion will outline these people's orientation to their jobs prior to their actual participation in the ward. This information is relevant as it will introduce the context through which members' social interaction can be understood.

1) Head nurse. In my initial discussion with the head nurse, conversation focused upon the training she experienced as a student, and particularly, as this training helped develop a professional relationship with patients and other members of the hospital treatment team. It was made very clear by the head nurse that as a student she was informed that nurses were in a subordinate position to members of the medical staff and that they must always be prepared to follow the instructions of this "line of authority". On the other hand, the student was also made aware of the "...very rigidly organized nursing hierarchy in the general hospital..." that must be adhered to during the fulfillment of everyday nursing procedures and care of the patient. As the head nurse frequently reiterated, these "...two distinct lines of authority..." continually confused the student nurses' working situation. As we shall see in a later section of this thesis the development

of lines of communication between medical (in this case the psychiatrist) and nursing personnel frequently appeared problematic to members of the psychiatric team. While the head nurse recognized this problematic situation, her learning experiences as a student have prompted her to suggest a seemingly simplistic solution,

...once a formal hierarchy of communications has been established, then the tenuous link between medical and nursing personnel will be strengthened. (3, H.N.)

When asked to comment on the general philosophy underlying the development of her relationship with patients the head nurse responded in terms of caring for the physical needs of the patient and providing a routinized, orderly environment for the patient's recovery.

As a nurse you quickly realize the importance of minute detail, the necessity for discipline and the maintenance of orderly routine in the sick ward...(3, H.N.)

The head nurse did not make a single comment regarding the emotional needs of the physically ill patient. When asked to elaborate upon her experiences during the four week training period in a psychiatric treatment hospital, the head nurse's primary emphasis remained on the physical comfort of her patients. This kind of training will be shown to contribute to the head nurse's difficulty in coping with the newly ascribed treatment orientation. Also, this aspect of the head nurse's stock of knowledge, that is, concern with the orderly

functioning of ward routine, will be shown as influencing the patterning of everyday social action in the ward and social interaction between members of the staff.

ii) Psychiatrist. According to the psychiatrist and chief-of-service, mental illness is not "...simply like any other physical problem, and requires for this reasons, a very different kind of social environment". It is this basic perspective that appears to provide an understanding of the psychiatrist's stock of knowledge and hence orientation towards both the composition of the social structure in a treatment environment and treatment procedures conducted by staff. Upon further questioning, the psychiatrist stated that her initial medical training provided a rigid model of mental illness. Within this model, mental illness was interpreted as a disease originating primarily in the neurological and genetic make-up of the patient;⁽¹⁾ however, after internship and a further period of specialization in psychiatry, this conceptualization of mental illness began to alter:

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The field of psychiatry, was for many years, dominated by models of personality that supposedly articulated any emotional or psychiatric abnormality as evolving within the individual himself. These disease models emphasized the individual's particular problems, in dealing with interpersonal relationships, as deriving from some physiological imbalance within the human body. In this sense, then, mental illness was viewed as similar to physical disorders and hence calling for physical care within the custody of a psychiatric institution. The following authors examine the concepts and practices inherent in this model: D. Cooper, (1970), R. Leifer, (1970), P.D. Laing (1965), E. Becker, (1964) and after (19) T. Szasz (1962, 1963, 1970, 1972), for references see footnote page of this chapter.

There is a whole spectrum of behavior that cannot be understood simply on the basis of the physical make-up of an individual. Rather there is the whole realm of social processes that the individual is involved in that must be accounted for if this behavior is to be comprehended. (1, Psychiatrist)

To coincide with a social model of mental illness the psychiatrist developed a strong orientation toward the concept of a therapeutic treatment milieu as the most effective means of operationalizing her stock of knowledge and eventually her treatment goals. The following includes a brief description of this set-up as it was ideally conceptualized by the chief-of-service and the general administrative body of the hospital. One of the fundamental premises included in the approach states that people should operate as a team,

...equally contributing to the mental and physical well-being of the patient (and furthermore), that this should be done in the spirit of co-operation and on the basis of mutual understanding of the goals each member of the staff expresses regarding treatment procedures (1, Psychiatrist)

It follows from this, that a democratic rather than authoritarian position be adopted in the processes involving decision-making in the ward and that open lines of communication be available to everyone. According to the psychiatrist, this situation calls for a loosening of the bureaucratic links found in the traditional hospital setting, with a marked emphasis upon active participation with patients, and less concern with the routine physical needs of the patients. This

then, is a brief outline of the psychiatrist's understanding of how her ideological perspective could be operationalized in a psychiatric treatment setting. As the thesis will indicate later, the stock of knowledge which formulates the basis of this orientation becomes increasingly problematic for the chief-of-service.

iii) Social worker. The social worker in the ward under study received a university degree in psychology and had no specific training in social work practice prior to taking up employment in Dixon. Her work began three months after the introduction of the therapeutic milieu treatment label. It is difficult to evaluate the social worker's background information in terms of a developing stock of knowledge, in relation to psychiatric treatment processes, as I was told several times that "...it was simply a spontaneous decision to work with the people" that brought the social worker to Dixon. University instruction provided some background in terms of a clinical approach to the study of psychological factors and human behavior however, specific preparation for a social work career was not planned. There was however a series of interviews with the chief-of-service and also the Director of Social Service during which time the social worker was informed about the conceptualization of a therapeutic milieu as a treatment environment. Employment was conditional upon the social worker's acceptance of this kind of treatment and also on her ability to integrate this

program into a workable frame of reference within the social work practice. As the observer was told,

I was given a clear rein to establish my responsibilities and specific program for daily action with the perspective of a therapeutic community (4, S.W.)

Not only did the social worker express an immediate understanding of the philosophical premises underlying the concept therapeutic milieu, she was also willing to operate within this framework and to,

...recognize the value of regarding the total range of emotional and physical needs of the patients as a primary treatment goal. (4, S.W.)

iv) Occupational therapist. The occupational therapist is the final member of the staff to be included in this initial introduction to the background experiences of personnel in Dixon. Specific university training was experienced by the occupational therapist, followed by the confirmation of a professional license. The occupational therapist accepted employment of the ward two months after the official alteration of the treatment program, and like the social worker "...the terms of employment clearly indicated that I must be prepared to operate with an active therapeutic milieu". As with the social worker then, the occupational therapist understood and accepted the social model of mental illness and the psychiatrist's attempted redefinition of the treatment setting; that is, the occupational therapist was prepared to develop a

a stock of knowledge conducive to the concept of an active therapeutic milieu.

The analysis presented above begins to illustrate the relationships between the ideal constructs of a therapeutic milieu and the reality of the situation in the ward. Although the official label designating the treatment orientation was altered, a serious discrepancy remained concerning the retention of a professional/non-professional occupational dichotomy.

As the discussion indicated, the origins of nurses' stock of knowledge derived from a custodial treatment perspective. In fact, the presence of this dichotomy served to legitimate nurses' action as if the treatment orientation had remained unchanged. As the following analysis will continue to show, the transition towards a new operating technology resulted in a highly problematic situation for nurses. As one nurse candidly remarked,

...things really aren't any different around here. Since a few new phrases are floating around about treatment programs but basically its the same old story. Everybody still knows who the professionals are and who does the important jobs around here (14, P.N.A.)

On the other hand, the transition was not as problematic for professional staff. For one thing, the psychiatrist played an important part in the re-labelling process and for another, the occupational therapist and social worker were beginning work in a hospital setting for the first time. These people's

early training was also open to the kinds of innovations required within a therapeutic milieu. Child care workers were also prepared to work within a therapeutic milieu and readily accepted the principle requirements underlying this treatment.

In order to understand social action, it is first necessary to understand this action in the context of meaning people attach to the situation in which they interact (Schutz : 1967, pp. 126-132). With this goal in mind, the origins of members' stock of knowledge was introduced in this chapter, in order to prepare the way for an analysis of people's interpretation of every day life in a psychiatric ward.

Chapter Four

The Social Construction of Everyday Life in the Ward: The Nature of Ambiguity and Uncertainty

A Introduction to Members' Conceptualization of Ambiguity and Uncertainty

The most commonly noted description of the ward setting discussed by members was one of overwhelming ambiguity and uncertainty. Statements expressing ambiguity and uncertainty evolved in terms of 1) self's officially expected job performance, 2) others' expectations of self's job performance, 3) self's expectations of other members' job performance and finally in very general terms 4) the primary treatment orientation expected in relation to the official redefinition of treatment procedures, that is, the formal definition of social reality.

Expressions of these kinds of impressions were most out-spoken immediately following the official reconstruction of the treatment paradigm. As time passed, this ambiguity and uncertainty was handled by members with less vocal hostility as they came to terms with their work environment. As one nursing assistant succinctly stated,

...for months people around here were shouting about the confusing situation we were forced to work in hoping, I guess, that things would change. Now people mostly turn to their own little clique to complain about things and gossip. They don't seem to care so much anymore...
(17, P.N.A.)

With a focus upon people's feelings of ambiguity and uncertainty, we can see how their definition of the ongoing social system evolved. From an examination of this kind of interpretation of the situation, I will show that through these conceptualizations of ambiguity and uncertainty people construct, not only a definition of social reality, but also one that they can "handle" and by so doing demonstrate some measure of social order. In this chapter I will focus on the nature of job titles and the incumbent division of labour in order to examine people's accumulating stock of knowledge, and at the same time, their definition of the situation.

The following series of comments indicate people's conceptualizations of the prevailing atmosphere felt to exist in the ward. For example, as one nursing assistant remarked,

Something else seems to be expected of us although I can't say exactly just what I mean by this; I do know that it makes me feel uneasy... (10, P.N.A.)

Or for example, as the following members' commented,

One of the biggest problems on this ward is knowing whether or not you're allowed to do what you think is best for your group of kids. It's difficult to get a straight answer out of the psychiatrist... (15, P.N.A.)

I am perfectly aware that some of the things I do are, in a sense, illegal in this ward... On the other hand, I could wait around forever if I expected ward policy to spelled out and my duties outlined. (13, P.N.A.)

Oh sure we know that we can't beat the kids and give unofficial injections, but many times I'm in an ambiguous position since I'm only a nursing assistant and often feel unsure of myself and the kinds of decisions I should be making for my group. I need more advice from the psychiatrist and especially the head nurse.
(16 P.N.A.)

When things come up in a meeting, we discuss them for a while but instead of things being cleared up, we're (nursing assistant) usually more confused than when we started. There are lots of big words and big ideas thrown around but nobody talks about how we can get them done.
(11, P.N.A.)

These comments express some degree of perceived ambiguity or uncertainty concerning nursing assistants' general occupational functions.⁽¹⁾ However, in many instances, nursing assistants and child care workers directed their feelings of hostility towards professional people in the ward. In fact, taking into account only those statements recorded in interviews, these people (a total of fifteen) issued eighty-two responses illustrating feelings of ambiguity and uncertainty in this way.

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Fox (1957), examined a similar situation in her study concerning medical students. As in the case under study, the individual is confronted with a situation only "...hazily defined for him". As the following discussion will illustrate, the uncertainty becomes increasingly problematic for the person as he or she attempts to know how he ought to perform in the ward and relate to others.

1. Nurses' and child care workers' perceived sources of ambiguity or uncertainty

The following responses illustrate the point noted above:

The feeling of tension among staff is very high in this ward. If the psychiatrist and head nurse would settle once and for all the primary treatment pattern, maybe we could all get down to the business of working with the children. The head nurse wants order and routine patient control, whereas the psychiatrist seems to be telling us to be flexible with the children and to relate to them on a personal level, to talk to them and to participate with them in their play activities. It is extremely frustrating trying to serve a dual function especially as one goal seems too formalized and the other practically inoperable in this ward. (5, C.C.W.)

How can they (the head nurse and psychiatrist) expect us to provide patient care when half the time they don't even seem to know what they want us to do with the children when it comes right down to daily activities. (14, P.N.A.)

I often get the feeling that Miss _____ (the head nurse) tells us one thing while half hoping we'll do something else. By this I mean that she doesn't always seem very pleased by Dr. (the psychiatrist) suggestions even though she will publically support the Doctor during ward meetings and at report time. I say this because Miss _____ (the head nurse) seems very forgetful when it comes to informing absent staff about policy or by setting aside enough time for us to do as the Doctor suggests. This often leaves so many things up in the air... (6, C.C.W.)

I'm not sure how much more I can take working on this ward. I have the feeling we're supposed to be doing great things for these kids when all we really get a chance to do is clean up after them. I have tried to talk to the O.T. about her activity program but she never seems to have the time... . Most things she wants us to do we just don't have the time for... . Anyway I'm not here to sit on the floor playing silly games with the children I'm supposed to be doing nursing duties, or so I thought anyway. (12, P.N.A.)

I figure I'm with my group of kids more than the Doctor or head nurse, yet they never seem to accept my suggestions seriously even though this is supposedly the point of having staff policy meetings. I thought this was part of my job, to observe the children during the day and report about them in the log book. Yet, I often wonder if this isn't just a waste of time... (18, P.N.A.)

It's really useless to try and do anything around here. If you take one approach with the kids you can be sure somebody is bound to shout... . In such a situation how can we be expected to have confidence in our work with the children when even the head nurse is so ambiguous about what we're supposed to be doing with this new program. (8, SR. N.A.)

I really wish we could just sit down and hash out what's really going on around here. The head nurse makes constant reference to my new position in the ward, now that we have a new to the kids' treatment. But I'm damned if I can figure out either what she means by my new position or for that matter what this new approach really means in terms of everyday ward routine. (7, SR. N.A.)

It is interesting to note that the last two statements were issued by senior psychiatric nursing assistants who have each worked at the hospital for a period of eight years with the last three in Dixon. Given that seniors include as one of their duties that of liaison between the psychiatrist, head nurse and nursing assistant, the likelihood of them transmitting their feelings of ambiguity and uncertainty appears significant and will be discussed again in a later section of the thesis.

2. Professionals' perceived sources of ambiguity or uncertainty in relation to others' action in the ward

i) Head nurse. The statements issued above represent the position of paramedical staff. Such conceptualizations, however, were also prevalent among statements issued by professional people in the ward and in several instances with equal hostility. For example, the head nurse made several references to the lack of co-operation granted her by the psychiatrist, especially as this co-operation was deemed necessary in order for her to function satisfactorily as head nurse by providing nursing assistants with relevant information about ward policy and treatment procedures. Reference was also made by the head nurse to the difficult and often abstract manner in which the psychiatrist outlined her suggestions regarding ward policy. However, the concern here was not so much with patients' treatment as with the fact that "...this makes life very confusing for me..." and similarly, "...half the time I don't know whether I'm coming or going, I seem to get only half the necessary information from the Doctor that I need to function properly". Thus, in terms of how she is expected to operate as a head nurse, the degree of perceived ambiguity regarding her job performance is severe. Throughout an interview with the head nurse she reiterated many times how unfair she felt this situation to be, that in fact she felt "...like a scapegoat for the Doctor's inability to communicate" but again the direction of this ambiguity is

significant for its lack of concern with patient care and primarily for the head nurse's concern with her own performance as ward manager. As the head nurse candidly remarked,

How the psychiatrist expects me to run this ward is beyond me. Her explanation of tasks is confusing to me and extremely vague and impractical... (3, H.N.)

ii) Psychiatrist. This general interpretation, however, appeared to be far from one-sided. For example, in an interview with the psychiatrist, several inferences were made in terms of her job performance being constantly jeopardized by the head nurse's "...apparent lack of deep concern with the individual needs of the residents in the ward". The psychiatrist continued along these lines noting that much of her time had to be given to overseeing the daily administration of the ward while,

...this shouldn't be a major aspect of my job. Developing an over-all perspective to serve as a guideline for daily action is part of my job, however, as soon as I remove myself from a routine manager position there appears to be considerable hostility on the part of the head nurse. I see myself in one kind of position, that of team leader of this new program, however, I often feel somewhat ambiguous about my actions as the others don't seem to accept this aspect of my job. Perhaps I should alter my principle understanding of the role of a psychiatrist. (1, Psychiatrist)

The psychiatrist also mentioned that her interaction with nursing assistants was very limited. She attributed this to their desire to avoid any kind of confrontation with her, regarding either the way in which they were performing or

even more significantly, "...they seem to want to ignore my explanations of what I am trying to do". Thus, "... I can never be certain whether they understand why certain things should be done as I request and therefore when I'm not around I can never be certain as to whether I'm having any meaningful effect in the children's treatment program".

iii) Occupational therapist. The social worker and the occupational therapist expressed less ambiguity in their individual understanding of the composition of their job. However, both emphasized the constant lack of certainty they felt regarding the daily operational aspects of their jobs. The occupational therapist felt that while her professional training had provided her with a sound knowledge of the technical details of occupational therapy,

...there seems to be a lack of understanding among the nursing assistants about the functions of an O.T. They frequently expect me to perform routine ward chores at the expense of my activity program. They are, I believe unhappy with what they interpret to be snobbery on my part and possibly that is why I suspect much of my activity program is poorly conducted. For this reason I often feel at a tremendous loss as to what I should do or how I can get around this problem. (2, O.T.)

iv) Social worker. As was the case with the occupational therapist, so too was the social worker in "...a very awkward predicament" (4, S.W.). She appeared to be quite certain about what a professional social worker should be doing in a psychiatric ward, however, she too must rely upon the cooperation of others for the performance of her job. The

following statement indicates the social worker's feelings on this subject.

I am frequently at odds with the nursing staff, just when I think I've explained some form of therapy to them, or how a certain child's parents should be handled on visiting night, bang, they do something completely contrary to my suggestions. I feel constantly ill at ease, trying to put into action certain goals that seem to be failing. Do I change my ideas or fight to change the system in which I must function? (4, S.W.)

B Informal Socialization Processes

In chapter three I discussed the various kinds of formal training experienced by members of the staff and the perceived relationship between this training and the work situation. Now the focus is on how these people learned to perform their job on a daily basis in the ward. The data discussed here concerns the informal socialization process people experienced as they interacted with others during the ongoing process of everyday life in the ward.

1. Paramedicals' interpretation of the parameters of their job

i) Introduction to the ward. Members of the staff were asked the following question in an interview, "Do you think your introduction to the ward was effective in helping you learn your job?" There were no positive responses to this question, with seventeen negative replies and two respondents (the head nurse and psychiatrist) omitting any kind of direct answer. The range of negative responses on the part of nursing

assistants included statements such as the following:

I arrived in the ward at 9:00 A.M. and was introduced to the head nurse by the nursing supervisor. The head nurse indicated to me my shift hours for the next week, pointed out which group of kids I was to work with and that's about it. No introduction to other staff, no explanation about the goals of treatment in the ward. To say the least, I was rather lost... (18, P.N.A.)

It seems when I joined the staff, Dixon was very short staffed and aside from being introduced to Miss _____ (the head nurse) there never seemed to be any time for a more formal orientation (16, P.N.A.)

After a week in the ward of stumbling around looking for the report book and even medical charts I got fed up and asked Miss _____ (the head nurse) for information about how the ward was run and where things are generally kept. I think she spent five minutes with me. A great help that was! (11, P.N.A.)

I realized the general set-up would be similar to the adults' section of the hospital, however each head nurse has her own way of doing things. This is especially true in this ward, a fact that I found out the hard way. Nobody seemed very helpful in the beginning, not that things have improved very much... (14, P.N.A.)

While the responses included above were directed toward the head nurse, it must be noted that this particular nurse no longer worked in the ward. However, nursing assistants who received their initial introduction to the ward from the present head nurse responded in a similar way. (1) In fact, as

1 This includes five nursing assistants (12, 15, 17, 18), two of whom (12, 15) arrived in the ward after the official ascription of the new treatment label.

the following examples illustrate, these people indicated that the information contained in the head nurse's introduction failed to provide them with a clear understanding of their job in relation to general treatment procedures.

The head nurse informed me that the routine in the ward was pretty complex and the best thing to do was to try and pick things up as I went along. Needless to say my impressions of the head nurse were not very positive. (15, P.N.A.)

The head nurse appeared unconcerned with my feelings as a new member of the staff. How she expects us to fit in properly with the rest of the staff and ward routine is incredible. Somehow I get the feeling that she doesn't interpret this responsibility as part of her job. (18, P.N.A.)

In summary, most nursing assistants considered that their introduction to the ward was not only shallow and somewhat unfriendly, but more important that it was not conducive to a ready understanding of the routine at hand. While the potential extrinsic value of work in this ward was stressed in terms relating to shift schedules, pay cheque schedules and the distribution of lunch hours and coffee breaks, little emphasis was placed on the possible intrinsic rewards to be found working in a therapeutic milieu. Since nurses' formal introduction failed to provide them with an adequate orientation towards work, the question remains concerning how their learning experiences contribute to their accumulating stock of knowledge and their interpretation of everyday life in the ward.

ii) Traditional job titles. In the absence of any alternative way of establishing a pattern of action, nurses resorted to the traditional distribution of job titles still existing in the ward. Nurses extracted basic cues regarding the nature and allocation of work from these titles, thereby interpreting their participation in the ongoing social system within this formalized hierarchy of occupations. How then does this already-at-hand distribution of labour become internalized as the way in which work must be sustained in the ward?

The formal period of training provided nurses with considerable indoctrination regarding the hierarchy of nursing personnel in a hospital setting. As one attendant stated,

...they (nursing teaching staff) make very sure that you understand that you are at the very bottom rung of the ladder and that you learn to show respect to those nurses in command. (11, P.N.A.)

Or as another attendant phrased it,

It isn't very long until you know your place in the ward as the word assistant seems to follow you around like the plague. (18, P.N.A.)

Nurses clearly recognized the officially ascribed subordinate nature of their job title and hence others' expectations of their performance. As one attendant succinctly stated, "We're definitely second class people where the nursing profession is concerned" (15, P.N.A.). This was further elaborated when this nurse expressed some uncertainty about where this placed him in relation to the total staff but that, "No matter

how you look at it we're bottom of the barrel, good enough to be with kids all day, but bottom of the barrel." (15, P.N.A.)

There were several instances where others' formal job titles confronted nursing assistants as they participated in the ward. According to official regulation, members of the staff were required to wear a label designating, not only their name, but their occupation, as well. Thus even in informal conversation with , for instance, one of the professional members in the ward, nursing assistants were constantly reminded of their subordinate position. This kind of interpretation of the situation evolved from the information supplied by each nursing assistant, with the following remark perhaps best representing the meaning this has for them.

I often get the feeling that we're supposed to pretend this guy (reference was made here to the social worker) is really something big. After all, like her badge says, she's not only a professional social worker, but a college graduate as well. (8, SR. N.A.)

Further differentiation between professional and paramedical members can be seen in the many references nurses made concerning "...the locked office doors which protect them (professional members), from the chaos in this ward" (19, P.N.A.). Professional staff each had a private office within the boundaries of the ward and as I observed, the letter heading on each door defined the professional association of each member, with the individual's job title printed in block letters. Considering nurses' interpretation of their job title as one subordinate to these people it is not surprising

that only eleven visits (during the period of observation) were made to these offices by nurses who had not previously been summoned to attend. On pointing out this observation to members, the range of responses received is shown in the following:

Just seeing the Doctor's name on the door and the string of letters after it makes me stop and wonder if maybe I'm not bothering her with something unimportant. Anyway, I usually talk myself out of knocking.... (10, P.N.A.)

I think the title on that door has gone to her head. (reference was made here to the head nurse). Who does she think she is anyway. sitting behind that big desk with her so-called important papers and her two phones.... I really can't be bothered facing her abrupt "Yes, and why have you come to the office", routine. Like the print says this is her sacred territory. (14, P.N.A.)

Give Mrs. _____ (reference was made here to the occupational therapist) an office with fancy words on the door and right away you'd think she was the most important person in the ward. Well I'm no fool, I know she thinks we're (reference was made here to nursing assistants) all stupid so I don't waste my time knocking on that door. (3, Sr. P.N.A.)

There are many similar kinds of remarks to be found in the fieldnotes, in fact, including child care workers and nursing assistants, each member directed at least one and in most cases several responses, towards each of the four office holders, that can be viewed within a frame of reference similar to those included above. In general, the content of a negative statement made reference to their interpretation of their experiences as either intimidating or humiliating while including the office as some kind of symbolic representation

evoking these negative responses. The constant visual reminder of job titles was also experienced by nurses as they read the weekly schedule of shifts. For example, starting at the top of the list is the psychiatrist followed by the social worker, the occupational therapist, the head nurse, senior psychiatric nursing assistants and lastly the nursing assistants, with each surname followed by members' credentials and job title in the ward. As nurses read this list of shift hours it is visually apparent to them that the professional members in the ward work straight hours, that is, 9:00 A.M. to 5:00 P.M. with every week-end free. The names located down the list however, represent those people whose working hours are controlled by professional members of the staff. As one nursing assistant astutely remarked,

They (reference was made to administrative policy makers in the hospital) sure don't hesitate to spell things out. Even our pay sheet tells us that we're non-professional workers, the lowest of the low you might say. (13, P.N.A.)

A final example of the visibility of job titles can be seen at mealtimes in the staff cafeteria. Paramedical staff are faced with staggered hours ranging from 11:30 A.M. to 1:30 P.M., while professional members throughout the hospital break for lunch at 12:00 noon. More significant however, is the eating arrangement observed. As one child care worker candidly remarked during an interview,

...the seat one occupies for dinner tells the tale of just who you are and what your business is in this excessively traditional institution. (5, C.C.W.)

Once again members are confronted with the social value attached to their officially created job title and never once was the unspoken rule of who sits where violated during the months of participant observation.

How well our labels serve the job of keeping personnel apart and preserving the illusions of expert and worker. (6, C.C.W.)

It can be inferred from the information supplied by nurses and child care workers that job titles and the traditional division of labour which they implied are of great significance to our understanding of the social order. In fact, nurses and child care workers define the social order in terms of the expectations that these job titles implied for them. These interpreted expectations are particularly important as they relate to the nature of social interaction between paramedical and professional people. Although the social milieu is supposed to reflect the recently ascribed treatment label, nurses and child care workers know and understand the subordinate nature of their labour. This situation becomes increasingly problematic for them when they begin to internalize and act upon these traditional job titles as a vital aspect of their stock of knowledge and as if this is the way things should be. Not only does this increase the ambiguity and uncertainty of many situations for these

people, this evolving stock of knowledge (as will be shown below and in the following chapters) does not clarify their job requirements as perceived by others in the ward.

iii) Self-expectations of the job. Each member of the staff was asked the following question: "What do you think you should be expected to do in the ward?" Two kinds of information resulted from this question. Firstly, the data include many examples of members' self-expectations regarding the nature of their labour in a psychiatric ward for children. Secondly, members also considered the kinds of expectations and demands they felt others could and could not legitimately place on them as participants in a treatment milieu.

a) Nursing assistants. The most frequent response in terms of nurses' self-expectations included the phrase "providing for the total needs of the patient". In fact, this statement began verbatim the comments directed toward this question by the total senior and nursing assistant population. During the interview with these people, I noted the apparent difficulty several nurses had in terms of specifying what they interpreted this general mandate to mean in relation to their everyday action in the ward. What followed in most cases was a description of how members expected to perform tasks in the ward that would sustain an orderly, routine atmosphere and provide for well behaving, clean children. With minor variations the following statement

appeared during each interview: "It is our job to make sure everything looks O.K. for the Doctor's rounds in the ward" (14, P.N.A.).

The kinds of routine tasks nurses expected to do ranged from "...making beds and tidying the dormitories" (12, P.N.A.), to "...preparing the children for meals, supervising meals, watching the children in the dayroom, supervising bath schedules, and tidying dayrooms..." (10, P.N.A.) Nursing assistants expected to perform supervisory tasks that they interpreted as "...necessary for the management and control of an orderly ward routine" (13, P.N.A.). They expected to perform tasks that would sustain a smooth-flowing routine in the ward, as established in the section concerning nurses' stock of knowledge. For this reason they expressed their expectations in terms of task oriented duties rather than concern with the psychological and emotional aspects of patient care.

Job expectations expressed by senior psychiatric nursing assistants indicated an even more direct emphasis upon such notions as order, routine, management, almost entirely omitting any mention of the relationship between themselves and the residents in the ward. As one senior explained

My major job expectation is to help the head nurse run a smooth ward. This means that filing must be kept up to date, the log book in order, daily reports written and signed, work schedules

made up, drugs must be ordered and general ward supplies too. I guess these are the sorts of things I expected to occupy myself with when I started working here as a senior. (7, SR. N.A.)

With some additions and variations in emphasis, the above list of expectations is also representative of the kinds of comments issued by the other two seniors in the ward. Management, that is, the performance of daily routine administrative tasks, constituted the greater part of the senior nursing assistants expectations for their job.

Over time nurses began to legitimate their job expectations on the basis of their earlier training, even though treatment orientations had officially altered. They believed that their training had provided them with

...very reliable assumptions of what we should be expected to do in the ward. (16, P.N.A.)

Furthermore, with the retention of the traditional job title scheme, these people continued to rely on this plan as a guideline for action.

After all, we were trained to be N.A.'s, we are called N.A.'s and we are definitely still treated like second class, non-professional staff in the ward. (13, P.N.A.)

Nursing assistants were not very flexible in terms of permitting their range of self-expectations to increase in order to accommodate the wide variety of interpretations placed on them as nursing staff since the ascription of the new treatment label. The consensus of opinion among this group indicated that those who had defined the newly created treatment

program and more specifically, those professional people who presently attempted to enforce this program, had far surpassed the acceptable range of occupational demands that could be expected of nurses. For this group there resulted an increased feeling of ambiguity and uncertainty as to their major purpose in the ward,

I'm pretty certain of one thing and that is that we're (nursing assistants) supposed to be performing our job differently. I think this is very unfair to Dr. _____ to expect this since we haven't been trained to meet these new demands. Besides I'm a nurse, not an activity worker... . (19, P.N.A.)

Or as another nursing assistant candidly remarked,

I resent having been trained to do one kind of job and then to be told by the occupational therapist that according to this new treatment program we're supposed to spend as much of our time as possible doing structured play activities with the kids... (13, P.N.A.)

The following statements were recorded during interviews and represent a sample of comments issued by nursing assistants indicating in each case a negative reaction to the interpreted increase in demands placed on them by the various professionals in the ward.

I resent the occupational therapist telling us that we are responsible to her for our actions during daily activity programs. To me this upsets the whole way things should be done, I'm a nurse and the head nurse should be my boss... (1)
(16, P.N.A.)

1 The activity program referred to here was created as one way of involving all members of the staff in active therapy with the children. The program was initiated by the occupational therapist under the direction of the psychiatrist and was to include several hours of activities daily. This program will be discussed at length in a later section of the thesis, suffice is to suggest here that it created a considerable amount of ambiguity for paramedical members, who were responsible for the day to day functioning of the program.

I came here expecting to take my orders from a head nurse. Now I get the feeling that everybody (reference was made here to professional members in the ward) is our boss and somehow we're supposed to get things done like they say... . If that's what they want I can play the game too... (11, P.N.A.)

b) Child care workers. According to the data collected from interviews with child care workers it appeared that their primary expectations were derived from philosophical and ideological concerns with mental illness and the problematic nature of sustaining a meaningful relationship with those who have been medically defined as mentally ill. Child care workers expected,

...to be able to devote all my time to participating with the children in their daily activities, to teach them how to become as self-sufficient as possible and somehow to help them develop as human beings with recognized social rights in this residence. (5, C.C.W.)

Neither child care worker expected to have to perform the kinds of routine tasks that to a large extent composed the goals of nurses in the ward. As one worker explained,

We expected to work with children not to have to maintain the basic physical requirements of a hospital ward... (6, C.C.W)

2. Paramedicals' interpretation of the concept of teamwork:
An increase in feelings of ambiguity and uncertainty

With the initial definition of the treatment program as an active therapeutic milieu, nurses were informed, according to the psychiatrist, that everybody would now be

working as a team and as such everybody would be responsible to every other member of the staff. Accordingly, "...the ward was to be organized with everybody participating as equal partners in a psychiatric team." (1, Psychiatrist). As the discussion above indicated, nursing assistants did not interpret the distribution of labour in this way. Furthermore, as another attendant stated.

I feel pretty bitter about this whole thing, suddenly my job is changed, with a new focus that seems very unclear. We're not equal to anybody except now we have new bosses to take orders from...(references was made here to the social worker and occupational therapist)
(12, P.N.A.)

A considerable degree of hostility and resentment developed as nurses felt their competency in several areas, once supported by the treatment mandate, questioned by professionals in the ward. With the alterations in treatment orientations the duties they expected to perform were seriously threatened by the very nature of the new perspective.

Nurses expected to work primarily in a managerial capacity in the ward; however, with the advent of the new treatment orientation this focus appeared to them to be in jeopardy. While nurses could not articulate the exact requirements of their "...new job in the ward..." (9, SR. N.A.), it was clear to them that "...professional staff no longer viewed(them)to be competent in handling this aspect of ward routine " (9, SR. N.A.) (reference was made here to managment tasks). According to one senior,

We were supposed to act as liaison between nursing assistants and the head nurse and psychiatrist, as one of the major functions of our job... (8, SR. N.A.)

However, consensus among seniors indicated that,

...this very important function were no longer to be one of our major tasks, instead we're supposed to work with children in activity groups and somehow manage to fit in our paperwork duties as well. (7, SR. N.A.)

This demand that seniors actively participate in play therapy was established by the psychiatrist "...in order to flatten the nursing hierarchy in the ward and distribute the responsibility of active therapy onto each member" (1, Psychiatrist). However, the data collected from seniors indicated that their interpretation of the situation was quite different; in fact, this demand regarding an equal distribution of labour appeared to erase what to them represented a legitimate claim to participation in management, that is, some degree of control over the psychiatric nursing assistant.

For this reason, seniors interpreted this aspect of others' expectations as illegitimate, or as one senior stated, "...not playing the game fairly" (8, SR. N.A.). Thus, the demand that they participate in play therapy as a primary function of their job was only grudgingly accepted,

...since there doesn't appear to be anything else we can do unless we want to lose our jobs. However, the fact that we're still supposed

to help run an orderly ward and do all our old chores as well seems dammed unfair (7, SR.N.A.).

Even more open resentment towards "...this ridiculous extra burden..." can be seen in the following remark.

If I don't feel like going off to do activities I pretend I'm very busy doing something very necessary, like charting drugs or writing out pay schedules. When anyone complains I just say that I'm doing my job, what more can they expect. At least this way something worthwhile will come from my time...(8, SR. N.A.).

The child care workers interpreted the situation in a very different way. When they accepted the job it was with the understanding that they would be actively involved with the children for their entire day.

We expected to have time to develop intimate relationships with the children, to be totally submerged in their daily routine (5, C.C.W.).

However, it soon became apparent to them that the head nurse, for example, expected them to "...participate in routine chores like babysitting during ward meetings, cleaning dayrooms, working evening shifts even though the children were ordered to bed at 7:00 P.M., to mention only a few of the boring tasks" (5, C.C.W.). What became even more upsetting for child care workers was the fact that there were chores to be done that could serve as a useful training session for the children,

...such as bed-making, tidying the dorms and even dressing the children, but always there is tremendous pressure just to get things done so that the ward looks like its well organized and efficient. (6, C.C.W)

This method of achieving order was completely contrary to these members' interpretation of the philosophical assumptions underlying action in a therapeutic treatment milieu. Each felt she was hired to fulfill some kind of the individual therapy with the residents, thus for them any demands that were placed on them that continually monopolized their time and energy for other purposes was considered unfair.

I expected support from the psychiatrist in order to organize my work, especially as the job category was new in the ward, and I wanted to fit in with other staff. While I expected our jobs to compliment each other I must admit that I didn't think I would have to compromise my ideals so as to maintain this all important aura of order. (6, C.C.W.)

The following discussion is a brief summary of the analysis presented so far in this chapter. Nurses and child care workers interpreted their everyday work experience to include others' expectations that they considered to be illegitimate demands on their job performance. On the part of the nurses, these demands were interpreted in relation to the traditional way in which their job performance had always been done. That is, in accepting others' expectations they felt that they would be required to relinquish some of the control they had previously held in the ward. With their rising fear that the traditional technology used in the performance of their job was growing obsolete, there was a marked increase in nurses' feelings of ambiguity and uncertainty about their participation in the ward. The

seniors interpreted others' demands as falling outside a range of acceptability, when expectations evolved that threatened the position traditionally occupied by them in the nursing hierarchy. For example, seniors interpreted the psychiatrist's efforts to democratize the social structure as an attempt to exclude them from participation in ward management, while still demanding that they fulfill routine paperwork chores as well as participate in activity programs. In contrast to this position, the child care workers interpreted as inappropriate any demands that jeopardized their fundamental concerns with active patient care in order to sustain the exterior appearance of a calm, orderly treatment milieu.

So far we have considered these members in relation to the demands placed on them by professional people in the ward. While this is definitely the most frequently discussed relationship in terms of paramedical staffs' self-expectations and others' demands, the following will present a brief discussion of the kinds of demands considered legitimate and/or illegitimate in view of members' peer group associations. Here again, a fundamental clash in the underlying philosophical direction towards treatment became apparent. There appeared to be a continual battle of words between nursing assistants (excluding members 17 and 18) and child care workers in this ward. Child care workers had only commenced work in the ward since the initiation of the new program, whereas the former group of staff represented in several instances (particularly the

seniors who had been working in the hospital for several years) the traditionally oriented custodial worker. Basically nurses considered the child care worker to be,

... extremely unpractical and abstract, especially when they toss around big words. How can they expect us to do as they do when what they appear to be doing has so few concrete results? In fact they seem to create more confusion than anybody else in the ward. (14, P.N.A.)

Or as another nursing member stated,

...all this philosophical stuff doesn't get the ward cleaned up for rounds, or the children dressed, or the meals supervised. We need more concrete ideas to work with and less of these foolish expectations of the job. (16, P.N.A.)

Child care workers on the other hand, expressed how important it was for members to have a philosophical goal underlying all treatment procedures in order to present the children with a consistent treatment program.

Only after this is done will the ward truly operate smoothly and democratically with everybody aware of what purpose he is supposed to fulfill in the ward. (6, C.C.W.)

Concern with mundane chores is therefore a waste of effort, according to child care workers, until a goal has been established to direct members' actions. While child care workers accepted the conceptualization of a therapeutic milieu to be such a goal, their attempts to encourage the adoption of this perspective among nurses met with considerable tolerance (as the above examples emphasize). Nurses disputed the value of this kind of goal as it was considered to be

...too vague and abstract to be put into operation on a ward that has managed quite well until now. (11, P.N.A.)

Instead, these members appeared to rely on the officially ascribed job title deriving their interpretation of their own and others' occupational duties and responsibilities on the basis of this title and their stock of knowledge accumulated during formal training and reinforced under the previous treatment program. According to nurses, if other members of the staff would adhere to the formal categorization of staff and issue appropriate expectations, some degree of social order could be sustained. As one attendant stated,

As far as I'm concerned a spade is a spade, and a nurse is a nurse. If only other staff would realize this and let us get on with our job this would be a much more efficient place to work in... . (10, P.N.A.)

C Professionals' Interpretation of the Parameters of Their Job

1. Head nurse

In response to questions concerning her interpretation of the kinds of expectations others could legitimately place of her job performance, considerable hesitation occurred on the part of the head nurse. This deliberation was accounted for by the head nurse in terms that indicated considerable uncertainty regarding others' claims since,

...the content of my job is continually undergoing change in order to bring it into line with the demands of the new treatment program. (3, H.N.)

When questioned further, the head nurse defined her occupation into two major areas, one concerning "administration and patient care" and another in terms of "supervision, supporting and teaching". It was also difficult for the head nurse to specify her actions within each of these areas, however, as she explained,

I am totally responsible for the operation of this ward and must therefore co-ordinate all activity within this ward and between Dixon and the rest of the hospital, (3, H.N.)

From here the head nurse continued by stating that she expected other members of the staff to support her in this task and that she in turn would provide nursing assistants and child care workers with support in their job performance. The head nurse also expected others to view her as a supervisor in the ward and to recognize the disciplinary nature of her job as well.

I expect others to take my advice not only because I am the nursing supervisor on the ward but also because it is my duty to serve in a teaching capacity in Dixon. (3, H.N.)

The lack of clarity regarding her specific function in the ward explains the series of negative responses issued regarding the head nurse's job performance. For example, during the interviews with nurses and child care workers (a total of fifteen people), a total of fifty-eight responses expressed their interpretation of the head nurse's role enactment as

inconsistent with the action they defined as being appropriate to the occupational category.¹ An examination of the data collected from an interview with the head nurse indicated that she was aware that others' expectations of her job performance were often unfulfilled; however, she felt that members of both the paramedical and professional staff frequently made illegitimate claims on her activity. The nursing assistants "...expect me to spoon feed them and make all the necessary plans and arrangements for thier shift" (3, H.N.), thus demanding maximum attention in terms of the head nurse's responsibilities regarding "supervision and support". On the other hand, the psychiatrist demanded that "...an emphasis be placed on my administration functions hence minimizing the amount of time I can spend working directly with the nursing staff" (3, H.N.). Several examples of this nature were express during an interview with the head nurse. On the one hand, she felt professional members of the staff expected her to allocate most of her time to her administrative functions whereas nurses demanded her time in a supportative manner. This polarization of claims placed on the head nurse contributed to the difficulty she expressed in terms of creating and articulating the nature of her job and therefore her own job expectations. Furthermore, this situation reinforced

¹ This figure was determined through an analysis of paramedical members direct responses concerning their expectations of the head nurse's job performance. As the number of responses far exceeds the number of people involved, it should be apparent that many examples were included in the data, specifically outlining the areas in which their expectations failed.

nurses' feelings of ambiguity concerning how they should relate to the head nurse and more specifically, considering the redefinition of the treatment program, the very basis upon which nurses could evolve expectations of this occupational category.

2. Psychiatrist

According to the psychiatrist, there existed among other members of the staff a variety of expectations, each claiming a major portion of her time and energy. Unlike the head nurse however, the psychiatrist wrote a job description fully explaining her expectations of the job as chief-of-services in a therapeutic treatment milieu. For this reason the psychiatrist, while recognizing the basic nature of her job, was better able to specify others' interpretations of her actions and others' expectations in terms of legitimate and illegitimate claims, than the head nurse. For example, the psychiatrist expected to allocate three-quarters of her time to "patient care and ward administration" with the other quarter given over to her function as "team leader in a therapeutic milieu". The primary difficulty experienced by the psychiatrist was one of explaining her occupation to other members. While nurses expected the doctor to "...be in command of ward policy, diagnostic treatment, the distribution of drugs and a hoard of other trivial administrative tasks" (1, Psychiatrist), it became very difficult for her when she attempted, as team leader, to encourage members to "...speak out and participate in

decision-making and ward policy" (1, Psychiatrist).

The concept of team leader was, according to the psychiatrist, very difficult for nursing members to grasp. While the psychiatrist expected nurses to eagerly participate in everyday ward routine as "...a team of equal partners...", she discovered that members interpreted this as an excuse on her part to "...opt out of my real job, which according to them seems to be that of an autocratic ruler " (1, Psychiatrist). Instead of accepting the psychiatrist as a member of the team with whom one participates in active patient care, members "...expected the total responsibility of patient care to be placed with me." (1, Psychiatrist). According to the psychiatrist, this must change under the new treatment mandate and others' expectations must be brought more in line with her expectations of her job performance. Fundamental to the concept of a therapeutic milieu is the notion that the actions of all members within the patients' environment serve as a positive catalyst in the process of rehabilitation. This can only be operationalized if members recognize the psychiatrist as a member of a team which shares in an equal distribution of power and policy decision-making. However, as the psychiatrist explained,

...the nursing members of this ward refuse to accept this kind of responsibility and therefore maintain false expectations of my role in the treatment program. I refuse to be regarded as an authoritarian figure although I must admit this seems to be the primary expectations others have of me.
(1, Psychiatrist)

According to the psychiatrist this interpretation of her job provided members with a scapegoat, that is, they refused to accept an equal share in the responsibility inherent in the children's activity/therapy program in order to be in a position to point the blame for the ineffectiveness of the program towards the psychiatrist.

...because of their large numbers it is possible for nursing assistants and seniors to sabotage my program. In fact, I am well aware that this occurs. Furthermore, in order for them to cover these kinds of actions they complain bitterly that I haven't provided them with a fixed set of rules and regulations regarding their interaction with the residents (1, Psychiatrist).

With the official redefinition of the treatment mandate the psychiatrist attempted to inaugurate an egalitarian social system; that is, all members would be encouraged to participate in active patient care and decision-making concerning ward policy. However, the co-operation necessary to sustain such a goal was not forthcoming from nurses. According to the psychiatrist's interpretation of the situation, nurses "...unfairly expected me to organize treatment and provide all therapy with the patients" (1, Psychiatrist), while they continued to view their own job as maintaining a routine, orderly environment for this treatment to take place in. Unlike child care workers, nurses did not conceptualize their job in terms of providing active patient treatment and in fact this was one of the major reasons, according to the psychiatrist, for their continued misinterpretation of her job in the ward.

The psychiatrist's self-expectations regarding her job received considerable more support from other professional members in the ward, with the exception of the head nurse. The reason given for this situation illustrated that members who are relatively unclear about the far-reaching developments involved in the principles used to reconstruct the treatment program tend to expect a more traditional job performance from the psychiatrist. The head nurse for example, frequently complained to the psychiatrist that too many policy decisions were left for her to make and that the demand for nurses participation in policy making in general detracted considerably from their other duties in the ward. As the psychiatrist remarked,

...the head nurse is really saying that in the long run she wants me to accept ultimate responsibility for all that happens in the ward. This understanding of the situation tends to undermine not only my interpretation of my job but more important, the fundamental legitimacy of the new treatment set-up (1, Psychiatrist).

3. Occupational therapist

With the redefinition of the treatment program in Dixon, a new occupational therapist began work in the ward. Her primary responsibility as she interpreted it was to "...work out the activity schedule for each group of children and to make sure nursing staff follow it through as efficiently as possible" (2, O.T.). According to data collected during an interview with the occupational therapist, she expected nurses

and child care workers to operate in completing the daily activity program, recognizing that they were responsible to her and must answer to her if tasks were not satisfactorily completed. However, while this expectation was held regarding others' understanding of her job, it was also apparent that others did not fully share this definition of the working situation. In fact, as the occupational therapist remarked, this was the most difficult aspect of her job, that is,

...trying to encourage nursing assistants to differentiate between their responsibilities to the head nurse, in terms of nursing chores and their responsibilities to the activity program and therefore to me as the staff in charge (2, O.T.).

Owing to the confusion surrounding the focus of their own responsibilities, nurses and child care workers expected, according to the occupational therapist, that she participate in,

...mundane everyday chores in the ward. For example, my time was often taken up with nursing staffs' requests for assistance regarding preparing the children for activity groups and after activities were over I was expected to clean up after the children and collect the equipment (2, O.T.).

According to the occupational therapist these expectations represented illegitimate claims, by other members of the staff, on the way in which she had conceptualized her anticipated job performance. This variation in job expectations created considerable frustration for her and also represented several hours of poorly utilized activity time, since nurses often refused to co-operate by co-ordinating their general ward

duties with the demands of the active therapy program.

The head nurse's expectations of the occupational therapist's job performance were also viewed as problematic. For example, the occupational therapist was very aware that she was expected to post-pone an activity session when "the head nurse thought there were more important things to be done in the ward" (2, O.T.). The occupational therapist continued here by listing several routine chores that seniors and even nursing assistants could use as "scapegoat issues" in order to forego participation in the program. It was made very clear to the occupational therapist that orderly routine, and hence traditional chores, must take priority over the daily activity sessions. For the occupational therapist these kinds of illegitimate claims jeopardized the very aspects of the job that she had defined as crucial in order for her to actively participate in a treatment environment that was supposed to operate under the definition of a therapeutic milieu.

4. Social worker

The social worker also began work in Dixon just after the official ascription of the therapeutic milieu mandate. She discovered, early in her career in the ward, that paramedical members had very few concrete expectations of her job performance. However, she also became aware of a considerable amount of criticism that they were directing towards her actions and furthermore, that these criticisms clashed with the way in which she had conceptualized her new job. For example, she

stated that nurses,

...frequently give me the impression that they don't think I'm doing any work at all. What they fail to see is that much of my work is administrative in nature and must therefore be done in my office (4, S.W.).

The social worker spoke openly about her,

...feelings that the rest of the staff expect me to join in with the everyday routine functioning of the ward, however, when I try to spend time in this way I find that I get behind in my responsibilities that relate more directly to social work (4, S.W.).

While the social worker referred primarily to nurses and child care workers, she also remarked that the head nurse very likely shared this kind of expectation. The social worker's position was very similar to the occupational therapist's in that the expectations imposed by others "onto" their jobs represented illegitimate claims on their time especially as these expectations thwarted what they considered to be the underlying purpose for their presence in a therapeutic milieu.

D A Brief Discussion of the Analysis Concerning People's Conceptualization of Ambiguity and Uncertainty

The following discussion will provide a brief summary and interpretation of this chapter in order to relate this data to the fundamental theoretical concerns of the thesis. The relationship members' interpreted as existing between the officially ascribed treatment program and the occupational structure traditionally accepted by members of the staff

was clearly outlined above. This relationship was defined by nurses in terms considerably more problematic than other people who experienced this official definition of the situation in an indirect way. For example, nurses had to deal directly with an activity program that for them lacked clarity of purpose and at the same time appeared to demand a new kind of technological knowledge on their part in order for them to fulfill others' expectations of their job. Professionals, however, had to deal with this interpretation of the situation constructed by nurses in order to fulfill their individual job expectations in relation to their interpretation of the therapeutic treatment mandate in the ward.

Everyday reality evolved on the basis of people's participation in social interaction. In order to interact, people had to take into account the content of self and others' stock of knowledge, the reciprocal influence self and others exert in terms of role enactment processes and finally, people's ongoing interpretation of their social milieu. What became increasingly problematic for all members of the staff was the "shape" of their interaction with others, that is, the relationship between their self-expectations and others' expectations of them in relation to their job performance.

From the analysis presented in the chapter, it is apparent that there were two kinds of systems of meaning ⁽¹⁾

1

According to Weinstein (1969:753), an actor's system of meaning is derived from the internalized network of categories that serve as an individual's central mediating function. In this way, the interpenetration of current and past experience is taken into account as part of the process utilized in investing stimuli with meaning.

to be taken into account, in order for people to understand their own and others' definition of the situation. On the one hand, there was the system of meaning employed by nurses, encompassing a custodial orientation towards treatment procedures and social action in general. In response to this definition of the situation was one maintained by professionals and child care workers representing a therapeutic milieu orientation towards treatment.

The problem now for members was the establishment of a working consensus, that is, "...a tacit agreement as to whose claims to what issues will be temporarily honoured" (Goffman: 1959, p.9). This would involve a way of changing the boundaries of the definition of the work situation as well as the kinds of tasks and the various lines of action possible during the course of social interaction in the ward (Weinstein in Goslin: 1969, p.757). Although people were aware of the official alteration in treatment orientations, they were uncertain about the exact changes this should have on their job performance. This was especially noticeable among nurses as they struggled to utilize the technology they had ready at hand. They had firmly internalized this custodial orientation during their training and had at one time been positively sanctioned for performing according to its principles. In social interaction nurses attempted to legitimate their job performance within this framework, thereby calling attention to aspects of their work that served to reaffirm their identity as ward custodian. In this way, nurses attempted to compel others' expectations

of what should constitute their job as a psychiatric nursing assistant (Weinstein, 1969: 757).

Professionals responded to this definition by reaffirming their demands that nurses adopt a therapeutic perspective towards treatment. It was also their wish that nurses should accept responsibility in the activity program as it constituted the major form of active therapy in the ward. Recalling that this program was designed by the psychiatrist and occupational therapist, in order to conform to their ideas concerning the formation of a therapeutic milieu, it becomes apparent that they were attempting to cast nurses into therapeutic roles that would be complementary to their own (Weinstein, 1969: 757).

In order to understand how a working consensus was achieved and some degree of social order sustained in the ward, the negotiation process will be examined in the next chapter. Prior to this discussion, however, I will consider another aspect of the negotiating process that came to light in this chapter. This will include a brief interpretation of the verification process and the nature of social interaction.

Turner's work (1962: 20 - 40) suggests that the purposes and sentiments of actors constitute a unifying element in role genesis and maintenance. There must be, for the actor, criteria by which he can verify that what he has in mind is in fact a consistent role. Internal and external validation provide the major sources of verification for the

actor participating in an ongoing social system. Internal validation is experienced by the actor, during the course of interaction, enabling him to successfully anticipate relevant other behavior and make some kind of judgment whereby others' behavior is interpreted as creating a consistent role (Turner, 1962: 29).

During external validation the self makes a decision that his behavior constitutes a role from the perspective of others who are considered to be in a position of legitimacy. As the interactionist perspective would confirm, the likelihood of discrepancies arising from the dual operation of external normative criteria (formal, institutional rules and roles) and internal interactive ones (such as goals, sentiments and selective interpretations), is considerably high. In fact, these kinds of discrepancies sustain roles within "...a hazily conceived framework for behavior rather than as an unequivocal set of formulas " (Turner in Rose: 1962, p. 32). The degree of internal and external validation necessary for the maintenance of some kind of consistent framework for action in this ward was very low, both in terms of one's definition of his job and the relationship between this job and others' general interpretation of the treatment program. Given that these validation processes were in constant jeopardy, the tenuous nature of social interaction among members of the staff was very apparent.

To begin with, we must recall that this treatment mandate did not evolve on the basis of a grass-roots decision, rather it was imposed on staff and new patterns of interaction were officially expected to develop in order to satisfy these new treatment demands, thereby providing a means by which people could participate in the distribution of labour in the ward. However, this situation became problematic for members and social interaction failed to provide adequate cues upon which they could validate their interpretations of their job performance. The role-taking and role-making processes therein appeared to inhibit the actual development of members' role enactment. What did evolve, according to their interpretations of the situation, were various kinds of exigencies that can be understood in terms of their role enactment in the ward. This included inconsistencies between self-expectations and others' expectations, role ambiguity and uncertainty and eventually people's experiences in terms of role stress and strain. The most suitable example of lack of satisfaction regarding the transition from custodial patient care to active therapy with patients can be seen in the pattern of interaction that evolved in terms of patient therapy, management of the ward and control of the residents. The pattern of interaction that evolved can be viewed in terms of the two major treatment frameworks within which members operated and derived a definition of self and others' role enactment.

Interaction between nurses and others involved the transference of role enactment expectations, such that illegitimate claims were being offered in terms of others' jobs, and in turn these others interpreted these claims as inhibiting their defined job performance.¹

The following chapter will examine the ongoing processes of negotiation that people enter into in order to attempt to validate their job performance in relation to their interpretation of everyday life in the ward.

1

This situation presents an excellent example of Weinstein's conceptualization of altercasting (1969: 756-7). Nurses continued to expect the demands of the professionals to subside, in order that they might continue to perform in the way that they best understood. Also, "...a return to the good old days..." (9, Sr. N.A.) would assure nurses of some degree of power in the ward by once more acknowledging their right to the control and management of the patient. This also represented a determined effort on the part of nurses to prevent professionals from interfering with their independence and at the same time maintain control over their own destiny (Crozier, 1964: 185). From the professionals point of view it was imperative that nurses accept the perspective of a therapeutic milieu and the fact that they must perform therapy in the context of the activity program. Any other behavior on the part of nurses was interpreted as uncooperative and an attempt to personally sabotage the direct actions and goals of the professionals.

CHAPTER FIVE

An Examination of Negotiation and the Evolution of Everyday Life in the Ward

A. Introduction and Conceptual Discussion of the Negotiated Order

This chapter will discuss people's participation in the evolving social milieu and their definition of the situation at hand, that is, how they interpreted daily action in the ward. In order to do this, a conceptual framework is needed that would explain the direction and pattern of the negotiating process among members of the staff. This will include a brief examination of the nature of human interaction, the articulation of joint action, and the nature of the negotiating process itself.

What then is the nature of human action? As indications are made to the self the individual is forced to confront the world - he must interpret and define his situation in relation to this world of objects in order to act. In fact, as Blumer recognizes in his essay on Society As Symbolic Interaction (Blumer, 1962: 180), action is derived from the account that man takes of the variety of objects and interpretations he gives these objects concerning their relevance to his immediate plans. Behavior therefore is not a result of environmental factors, stimuli, motives or attitudes but is constructed on the basis of how individuals interpret and designate these things in the action they are constructing. (Blumer, 1962:183) It is fundamental to the

interactionist perspective that the concept of self-indication exists in its own right and that through this process human beings construct their conscious acts.

This is vitally important, as I am interested in the activity of a group of human beings and how they create, adjust and re-create the flow of situations in which they act and upon which their actions are constructed; the formal and spontaneous division of labour; cooperative and conflicting actions and finally; the guidelines people establish for their actions. This is a matter of how actors take into account various factors such as motives, dispositions, role requirements and social expectations, in the expression of their actions.

The interactionist view of human action is also relevant to the study of collective action in that the interpretative process can be accounted for among participants in a group as they make indications to each other and not merely to themselves. Collective action, is in fact, the outcome of just such an interpretative process. As collective action requires a fitting together of a variety of individual lines of action, joint action must evolve out of many diverse components that formulate these lines of action. According to the interactionist perspective this organization of diverse lines of action has a distinctive character in its own right and it is inherent in the "articulation or linkage" of the joint action itself.

As the individual lines of action undergo continual formulation through designation and interpretation, so too does the process of joint action. Even in the case of repetitive joint action, such as in

the psychiatric ward under study, the meaning generated in order to fulfill, for example, existing rules, must be taken as problematic and resulting from an ongoing interpretative process (Blumer, 1969: 18). Joint action must be recognized as a reflection of the variety of background "worlds", systems of meanings and interpretative schemes of the individuals that come together in social interaction.

The previous two chapters presented the reader with the history underlying an individual's participation in joint social interaction. The next two chapters represent an attempt to understand how people "get things done" in the ward, since (as chapter four illustrated), the process of establishing a working consensus proved highly problematic for staff. The nature of this process will be examined here, through an analysis of members' participation in negotiation. Ultimately these final chapters will illustrate how some degree of social order was sustained among people in the ward.

Within the negotiating process there must be working agreements, that not only include cooperative action but also take into account the violations of rules. (Strauss et al., 1964: 14) Furthermore, these kinds of agreements emphasize a continual negotiative activity that includes processes of vital importance to the "shape" of everyday life in the ward. For example, as well as invoking or avoiding formal rules, these tacit understandings between people generate activity such as "politicking", "persuading," and "bargaining". (Simon and March, 1958: 128-30) These activities are necessary in the ward since "...commitment to the hospital may be less than total because of commitments toward groups within

the hospital." (Strauss et al., 1964 : 15) Allegiances to these groups or cliques will bear upon negotiations and therefore, we must assume that a variety of agreements and disagreements will exist, with different frequencies, among different categories of personnel. (Strauss et al., 1964 : 15)

The conceptualization of social organization as evolving through people's involvement in a negotiated order was based on the assumption that the distribution of labour cannot be legislated but must be grappled with in each kind of social setting. It must also be assumed, within this framework, that people's particular interpretations of the ongoing social situation inevitably give rise to unforeseen consequences. This will be illustrated as life in the ward is examined as an emergent process rather than one determined on the basis of an officially ascribed social structure. For example, as was shown in the previous chapters, the accumulated stock of knowledge attributed to professionals and paramedicals becomes strengthened, muted or transformed as the individual underwent changes in his occupational and personal identities.

My task in the following two chapters will be to present a descriptive analysis of people's explicit distinction between orderly social interaction and their interpretation of the need to demonstrate or produce the appearance of this kind of order. This will be done through an analysis of the evolving pattern of social interaction and communication networks, in various settings such as activity sessions, ward policy meetings, report meetings and informal gatherings.

B. Teamwork: An Instrument of Therapeutic Treatment

1. The psychiatrist's interpretations of the components of a therapeutic milieu.

This discussion begins with an examination of the psychiatrist's attempts to institute the recently ascribed treatment program in the ward. This action began with the psychiatrist informing people during a ward policy meeting that the social milieu within the ward was to be officially redefined in terms implying democratic teamwork and a sharing of responsibility among members for patients' daily therapeutic experiences. Treatment was to be conceptualized as a shared experience between patients and all members of the staff on a twenty-four hour basis. Rather than providing for the patients' needs in the custodial tradition, staff, as a team, were to be encouraged to develop therapeutic contact with the patient and to utilize even the simplest tasks as a therapeutic experience for the patient. Essential to this team effort was nurses' acceptance of an active part in therapy and an understanding of a team approach to the development of an active therapeutic milieu for patients. Within this framework staff were expected to adjust to "...a flattening of the traditional social structure so often found in psychiatric hospitals."

(1, Psychiatrist)

The psychiatrist was asked to explain the implications of this redefinition of the social structure. It was the psychiatrist's opinion that there was a growing body of literature in clinical psychiatry indicating the democratization of the social structure as the first major renovation necessary in order to initiate the transition from patient custody to active therapy. In order to utilize this goal,

I felt that members of the staff must be equally involved in the establishment of ward policy as this would compel them to accept responsibility

for their individual actions in the ward. With this being the case, staff would not be able to shift the blame onto others when programs failed or things went wrong in the ward. Everyone would share in our failures and successes as equal partners involved in a team effort. (1, Psychiatrist)

Ideally this "...flattening of the social structure..." (1, Psychiatrist) would imply people's shared concern with patients' welfare over and above their individual functions as members of various occupational groups. This being the case, it would, according to the psychiatrist, be easier for staff to make the transition towards teamwork since members would not feel their individual "...roles threatened by others if they were primarily concerned with the welfare of the patients and if this was simultaneously experienced by every member of the staff." (1, Psychiatrist)

The psychiatrist hoped her job would be viewed by others as providing teaching resources and support for them, as they gradually accepted responsibility for the active planning and operating of therapeutic treatment policy within the ward. This sharing of responsibility called for maximum cooperation among staff,

...and a real desire to accept others' advice and to participate in treatment programs as an individual learning experience. (1, Psychiatrist)

Therefore staff were expected to interact in a manner conducive to open communication and the provision of,

...a warm friendly atmosphere in which patients could participate in therapeutic experiences with them. (1, Psychiatrist)

As the introduction to this chapter illustrated, social systems evolve through the interaction and negotiations of members, suggesting the likelihood that the ascription of a treatment label would prove highly

problematic for people. Our problem therefore becomes twofold: Firstly, people are provided with a treatment mandate that may or may not be acceptable to their individual ideological persuasion and secondly, people may or may not support the way in which the program was officially issued and hence the immediate reconstruction of the custodial treatment framework. How then do staff come to terms with this situation? How do they interact with others in the ongoing processes and negotiations that come to construct everyday life in a psychiatric ward? What does it mean to be a member of a psychiatric team and to operate within a framework conducive to active therapy? What, for staff, is the outcome of their labour and interaction within their social milieu in relation to the newly ascribed treatment mandate? These and several other questions will be commented upon in the following discussion.

(i) Therapeutic contact and the negotiation of teamwork

How then do people interpret the actual operation of the psychiatric team in Dixon? In order to handle this kind of question, I will first examine general conceptualizations of a teamwork approach to the treatment of patients, in a hospital setting. The psychiatrist, for example, felt that in order to contribute to the daily functioning of the team as a therapeutic instrument in patient care, it was necessary to continually engage in interaction with others that would convince them of the validity of operating within a therapeutic milieu framework. During various kinds of ward meetings, the flow of interaction between nurses and the psychiatrist almost always, implicitly or explicitly, made reference to the two major treatment ideologies underlying the operational base of these people's action. As the psychiatrist continued to explain future

action in the ward in terms of nurses' participation as active therapists rather than as custodians, they reacted with comments that attempted to legitimate the importance of their job as the agents of patient management and orderly social action. Documentation representing this kind of interaction was collected during the various meetings observed in the ward. The following series of quotes can be viewed in light of this framework:

- Psychiatrist:
(1) Children who are being verbally reprimanded for their behavior must be spoken to in a quiet, calm and reassuring voice. Staff must make it very clear to them that they do not disapprove of the whole child because of their behavior...
- Senior Psychiatric
Nursing Assistant:
(7) This is all very well but it takes up a lot of time, especially during the busy hours of the day when things are likely to be at their most hectic and the kids are most likely to get into fights with each other...
- Psychiatrists:
(1) Still if the nurse removes the child from the crisis scene and tries to talk to him about the causes of his behavior there can be positive results...
- Senior Psychiatric
Nursing Assistant:
(7) It is very difficult for one or even two nurses to separate the boys when they are really set on a fight. Besides there is so much yelling and screaming going on most times that nothing gets across when you do try to talk to them.
- Nursing Assistant:
(19) I agree we don't get a chance to talk to the child when he is becoming more and more upset its all we can do just to get hold of him and try and keep him away from the others.
- Psychiatrist:
(1) But surely at this point the child has become calm enough to be talked to rather than restrained.

Nursing Assistant: If you let the kid go most times he'll try to get
(19) right back into the fight, I think its best just to put him in the "quiet room" and let him cool off and come to his senses himself.

Senior Psychiatric
Nursing Assistant: I agree. If the child is not put into the "quiet
(7) room" before you know it the whole ward is in a turmoil and likely to stay that way for the rest of the shift. If you remove the problem child then the rest of the ward will calm down and settle back into routine.

The term "quiet room" used by people above referred to a small chamber that was to be utilized by staff, as a way of isolating patients who were creating a disturbance in the ward. According to the psychiatrist it had been explained to staff a number of times that children were to be placed in this room for a period not exceeding twenty minutes and that a member of the staff should be present at all times. However, I observed children being placed in this room thirty-four times during the period of study with a member of the staff present on four occasions only (each of these occasions involved child care workers). The suggestion that members discuss with the child the problem he is experiencing in his life in the ward was clearly not one put into frequent operation by nurses. In fact on several occasions I witnessed a child being physically dragged to the isolation room and locked inside without any further explanation on the part of the nurse.

It became apparent that while the psychiatrist frequently verbalized her treatment goals, for example, a sharing of therapeutic contact between staff and children, she did not provide a practical solution as to how members were actually to operate in this way. The psychiatrist felt that if,

...members of the staff would only accept the goals established by the newly ascribed treatment

mandate then putting specific principles into practice needn't be so problematic. (1, Psychiatrist)

However, this kind of suggestion frequently issued by the psychiatrist in meetings appeared to create hostile interpretations of the concept of teamwork among nurses as the following statement implies.

Sure its alright for her to sit there and tell us we should cooperate as members of a team in developing contact with the patients since she already thinks we have all the time in the world to play mother to these kids. I'd like to see her sit and talk to a child who's having a temper tantrum. But then like the others (reference was made here to the head nurse, social worker and occupational therapist), she's never around when these things go on. Somehow she must be very busy... (11, PNA)

It was the psychiatrist's goal that people act as a unit and hence provide a constant therapeutic experience for patients. As such she expected the concept of psychiatric team to encourage them to participate in creating a ward environment conducive to this ongoing experience. The implications of this interpretation have far-reaching effects in terms of how members are expected to conduct themselves with the children during the course of everyday life in the ward. Again people interpreted the psychiatrist's explanation of ongoing active therapy as highly theoretical and in need of concrete substantiation. One set of reactions in light of this argument can be seen in the following dialogue observed during a ward policy meeting.

Psychiatrist: We must realize that every one of our actions
(1) has repercussions on the patients in the ward.
For this reason we need to cooperate with each other in trying to make even the simplest experience a worthwhile one for the patient.

- Nursing
Assistant:
(13) Can you give us an example of what you mean by our actions affecting what is good therapy or bad therapy?
- Psychiatrist:
(1) Well for example, if staff cooperate in maintaining a calm, orderly atmosphere in the cafeteria at lunch-time then the patients will be in a happier frame of mind for their afternoon nap and this in turn will have a positive effect on the afternoon's activity session.
- Nursing
Assistant:
(13) But I always find that the only way I can keep control in the ward is to try and squelch problems before they grow. So I believe in preventing trouble by ruling with an iron hand in the old fashioned way.
- Child Care
Worker:
(5) That's not a fair attitude to take because you're expecting trouble before it even develops. I think we should try and appear happy among ourselves so some of this rubs off on the kids and therefore we stay calmer and so do they.
- Psychiatrist:
(1) Precisely. The children can only experience contentment in an atmosphere of warmth....
- Nursing
Assistant:
(19) This is all very well but I don't always have the time to explain something ten times only to have the kids ignore me anyway. I think if we disciplined the kids more often then they would respond to us better and we wouldn't have to control them so much.
- Psychiatrist:
(1) But controlling patients' behavior isn't providing therapy for them. We have to understand that it is natural for them to act out their frustrations and we should be around to help them understand why they are behaving this way.
- Nursing
Assistant:
(19) Well I'm not sure this is a very realistic way to look at things. In fact the kids would try to get away with murder if we'd let them...

During this meeting, in which the concept of daily therapeutic contact was discussed, only two (19,13) of the seven nurses present (19,13,17,11,18,8,10) expressed their opinion, whereas every other person in attendance (head nurse, social worker, occupational therapist and psychiatrist) contributed several times to the conversation. Interaction patterns very similar to this evolved in each of the ward policy meetings attended (a total of fourteen meetings over a period of seven months). For example, one or two nurses would act as spokesmen for the nursing staff, both child care workers frequently expressed their opinions and offered suggestions, while professionals most often initiated interaction among people, hence determining the kind of issues to be discussed. I will continue with an examination of this particular ward policy session in order to clarify people's interpretations of the psychiatrist's conceptualization of teamwork in a psychiatric ward.

(ii) Paramedicals' hostile response

We can see from this dialogue that some uncertainty was expressed by the two nursing assistants who spoke up regarding the psychiatrist's notion of creating an ongoing atmosphere of calm and order. However, after the session ended and members broke off into small groups I observed the outcome of interaction among nurses to be primarily one of open hostility and criticism towards the psychiatrist's,

...attitude that everything would be just fine if we would only learn to be a team and work together, she forgets to add, in her way of course. (19, PNA)

With the exception of two nurses (17,18) and one senior nursing assistant (8) who remained silent throughout, I noted that the consensus of opinion

among the others (19,13,11,10) was that team really referred to nursing assistants and that in fact they were always to blame when disorder evolved in the ward. For this reason the two spokesmen among the nurses interpreted the psychiatrist's references to "orderly calm" and "an atmosphere of warmth" from within another system of meaning. For these nurses, order and calm were viewed as components reflecting the management of the ward (with the words "orderly routine" occurring nine times during the course of this six minute informal interaction session) and the control of the patient. It appeared that their interpretations of the meeting removed the notion of what constituted treatment, from the realm of therapy into the hands of "iron discipline". Further examples of this interpretation of the situation can be seen in the following comments issued by others, who had by now joined the informal gathering.

This stuff about talking to the kid when he's having a tantrum is a waste of time. Its much easier to keep control of the situation by holding him down or removing him from the ward. (11, PNA)

With a little old fashioned discipline this ward would soon take shape.... These kids are perfectly capable of learning how to behave. Anyway I believe actions speak louder than words. (10, PNA)

If I tried to reason with these kids every time I wanted something done in this ward, I'd wait forever. I think we just have to tell these kids in no uncertain terms that they are not expected to cause trouble in the ward and that if they do upset the apple cart they must be punished. (19, PNA)

These statements clearly indicated that these people hoped to maintain order in the ward by actively disciplining the patients, rather than providing the kind of therapeutic contact envisioned by the psychiatrist as a means of ongoing treatment. Rather than accepting the concept of

teamwork as providing the context within which a therapeutic milieu could evolve, the following will indicate peoples' interpretations of this approach to the distribution of labour. For example, after this particular session I observed a pattern that was to be noticed on each occasion following policy meetings, that is, nurses open expression of their opinions regarding the issues discussed during the meeting. At the same time, however, the pattern of interaction that evolved divided people among several small groups, with almost no information passing between groups at this time. As noted on the above occasion four members issued a stream of negative thoughts about the new program, with each person contributing at least two examples of why "...it could never work anyway" (13), with the most severe responses considering the psychiatrist's determination to compel people to understand their action in terms of therapeutic teamwork, "...as a real farce. Does she honestly believe I'm going to change from a nurse to playmate overnight?" (10) Three other nurses separated from this group and after a time, I joined the two nursing assistants to inquire about their ideas about what happened in the meeting. Both nursing assistants appeared to be somewhat uncertain about the meaning underlying the psychiatrist's statements, particularly with reference to their own job performance. As one nursing assistant commented,

I really can't say I have any opinion on the notion of a psychiatric team. It just seems like a big word to me since I've never been trained to do therapy or even to do activities with children.
(18, PNA)

Or for example as the other nursing assistant continued,

I believe in being as kind as possible to these children, since they're deprived and so I like

to do things for them to save them from so many frustrations. But it seems this isn't right either...
(17, PNA)

These two members while not openly hostile towards the psychiatrist's determination to implement a therapeutic treatment program appeared to be somewhat at a loss with regards to how this should be done. The senior psychiatric nursing assistant (8) on the other hand, indicated that he was fully aware of what was really going on,

As I see it this whole thing about teamwork is an excuse on the part of the psychiatrist for her taking an even more invisible position in the ward. She's trying to get us to do her work — she's the boss and she's supposed to do therapy.
(8, Sr. NA)

Like the two members discussed immediately above, this senior also felt that there was not much purpose in complaining about the situation, "...since we could never get everybody to agree on any kind of solution anyway".

(8, Sr. NA) While the former group were expressing considerable hostility towards the notion of therapeutic teamwork, a degree of consensus was also shared among them (17,18,8) although it indicated a somewhat different interpretation of the situation in the ward. The following statement is representative of this kind of perspective.

Nobody around here really cares enough to try and change things. So the way I look at the ward is simple, I don't waste my time complaining and I don't expect great things to happen. (8, Sr. NA)

The discussion noted above indicated the psychiatrist's presentation of her interpretation of teamwork as an instrument of therapeutic treatment for the patient in a psychiatric ward. Fundamental to interaction initiated by the psychiatrist, for example during the ward policy meetings, was the

required transition from a custodial treatment to one that emphasized people's social interaction as a valuable factor in the formation of a total therapeutic experience for the institutionalized patient. It is this goal that the psychiatrist brings to the negotiating process as it evolves among members in the ward through the course of everyday life.

2. Paramedicals' conceptualization of teamwork

For nurses, the notion of a psychiatric team implied a new operating technology and a new treatment ideology for which they felt ill-prepared to cope with in terms of their past training and also from within the custodial framework which formulated the basis of their accumulated stock of knowledge. Furthermore, there is substantial evidence in the data indicating that nurses experienced considerable difficulty in accepting the cues issued by the psychiatrist and team leader, in terms of the request for a democratic involvement of all members, in policy formation and the sharing of responsibility regarding active patient therapy. For example, the psychiatrist's explanation of the components of this democratic philosophy tended to be interpreted by nurses in such a way as to express their suspicion and distrust of the actual operational value their verbal output may have during the course of ward meetings. On one level, nurses interpreted this situation as others attempting to enforce demands on their job performance, in terms of conforming to the treatment principles inherent in the concept of an active therapeutic milieu setting. On the other hand, nurses found themselves in a situation that required them to translate psychiatric jargon into operational concepts that they could use during the course of everyday action in the ward. That is, in order to cope with

much of the information communicated to them by professionals, nurses had to deal with an explanation of treatment goals that they interpreted as being highly abstract and theoretical. A further situation contributing to their skepticism can be seen in their interpretations of the negotiating process ensuing from formal and informal gatherings in the ward.

Substantial agreement was issued by nurses, in terms of their observation of marked differentiation between those people who primarily initiated policy issues and therefore daily tasks and those people whose responsibility it was to operationalize these demands on a day to day basis in the ward.

As stated above, the researcher frequently observed a similar pattern of social interaction during the course of ward policy meetings. The following discussion will attempt to clarify this pattern in order to examine how members negotiate the everyday distribution of labour in the ward. The emphasis will first be placed on responses issued by paramedical members regarding their interpretation of their function within the context of a psychiatric team, and secondly upon professional members reactions to this definition of the situation.

C. Negotiating Order in a Psychiatric Milieu: An Examination of the Pattern of Social Interaction

1. Participation in a network of communication

Professionals contributed substantially to each of the ward policy meetings, although it must be noted that the psychiatrist far surpassed the level of verbal output achieved by the others. This ranking of output was followed by the social worker, occupational therapist and head nurse. The majority of comments issued by the psychiatrist were directed towards nurses, in a kind of lecturing framework rather than in the form of questions

and answers. As Chart Three illustrates, this form of communication occupied anywhere between twenty-five and forty-five minutes of the one hour policy meeting (see Chart 3). These comments provided explanatory information for nurses regarding the newly ascribed treatment scheme. This information was intended to convince nurses of the value of creating a therapeutic treatment milieu and the importance of their job performance in implementing a plan. As Chart Four shows, specific directives concerning policy were also given to nurses (see Chart 4). These statements included requests by the psychiatrist for alterations in treatment routine and in particular, the redistribution of labour in the ward.

This level of output was sharply contrasted by the flow of communication initiated by nurses and directed towards the psychiatrist (see Chart 4). This contrast would appear to reaffirm the existence of a traditional hospital hierarchy, as viewed through the eyes of the nurses in the ward. Nurses appeared to participate in the network of communication as though they were still a part of the traditional authority structure that was, by definition, obsolete in this ward.

By comparison with the number of directives issued towards nurses, the psychiatrist spoke much less frequently to the head nurse, social worker and child care workers (see Chart 5). With very few exceptions, the content of these comments represented the psychiatrist's attempts to solicit support from these people. The direction of this support was twofold; first, the psychiatrist hoped to confirm the advantages of a therapeutic milieu program and second, she hoped to gain support from these people regarding the content of her communications to nurses.

CHART THREE

Psychiatrist's Communications Directed
Towards Nurses: In Terms of Lecture Time

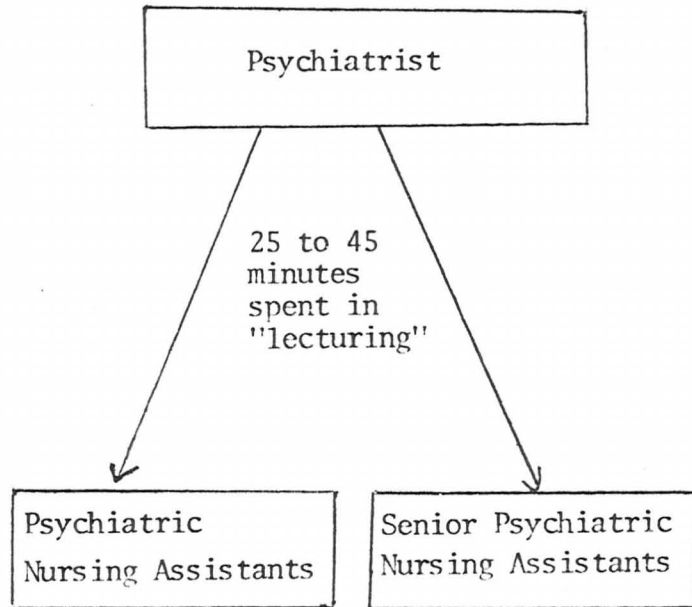


CHART FOUR

Psychiatrist's Communications Directed
Towards Nurses

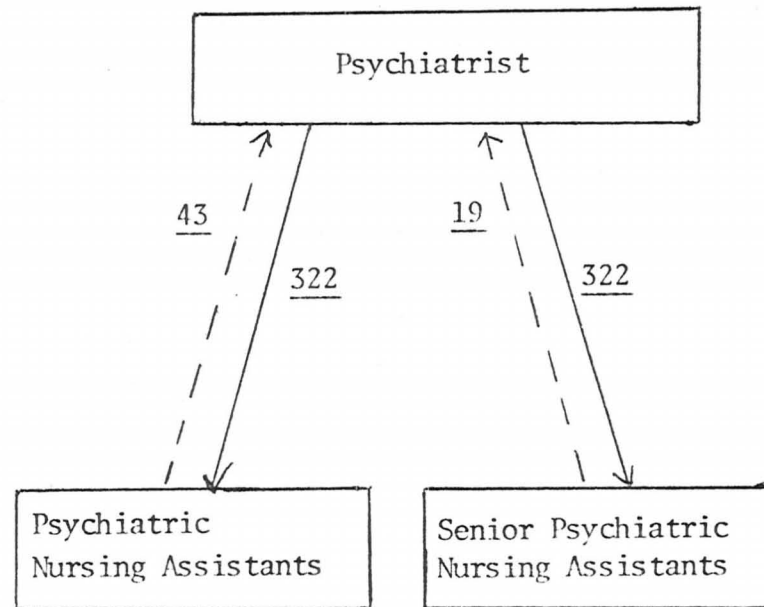


CHART FIVE

Psychiatrist's Communications Directed Towards
the Head Nurse, Social Worker, Occupational Therapist
and Child Care Workers

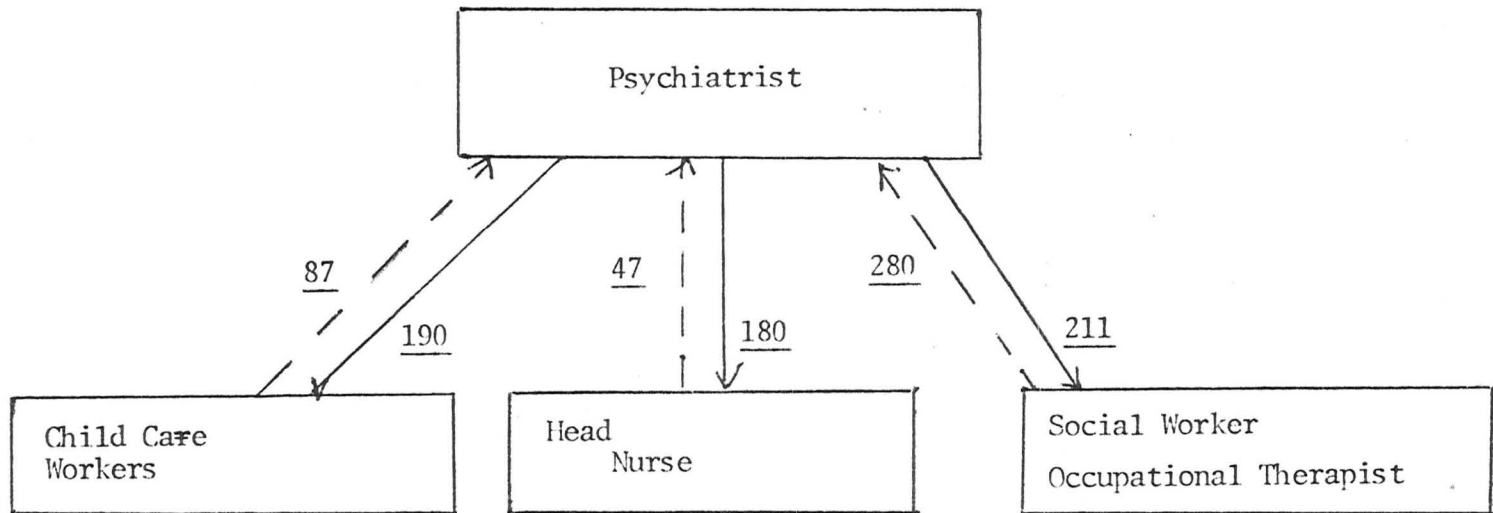


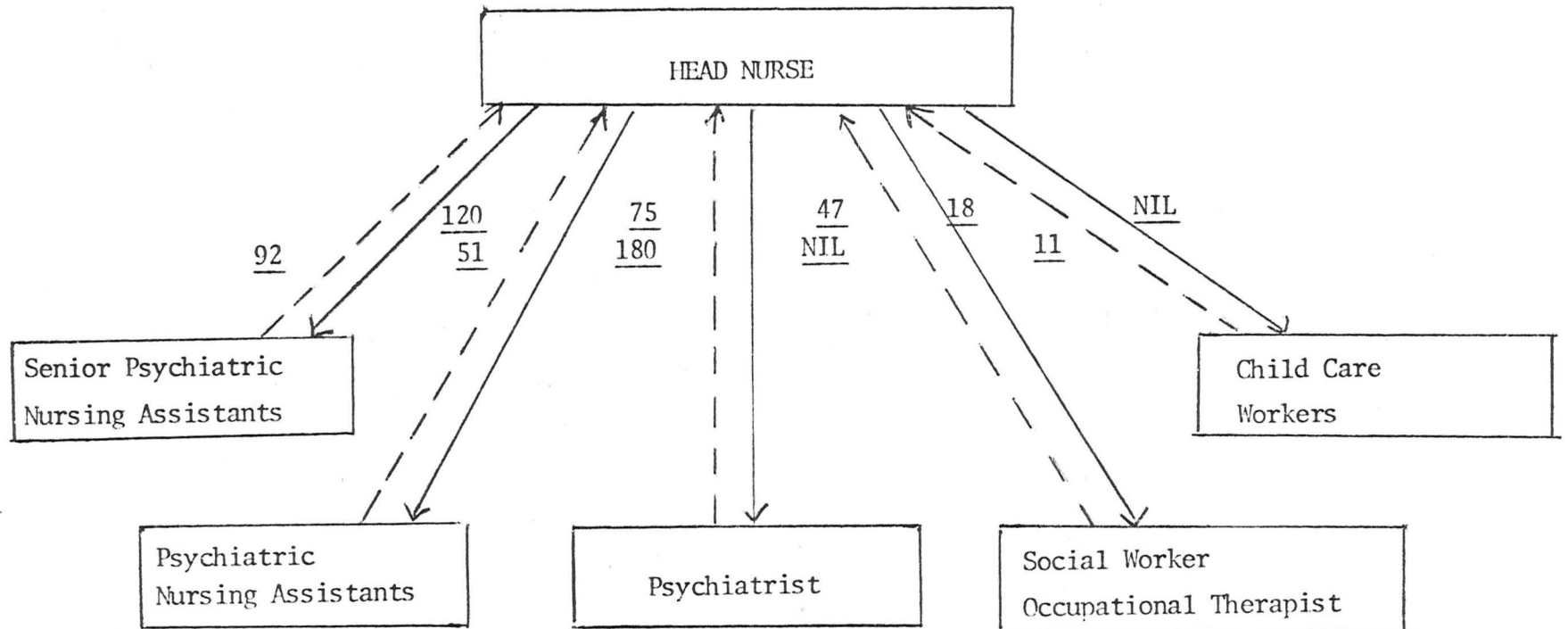
Chart Five illustrates the communication pattern that evolved on the basis of communications sent to the psychiatrist by the head nurse, social worker, occupational therapist and child care workers. The content of these comments, with the exception of those issued by the head nurse, supplied a significant degree of support for the psychiatrist. For example, the two-hundred eighty comments directed by the social worker and occupational therapist were attempts to initiate discussion about the organization of ward routine under the new treatment mandate. Child care workers' comments included supportive statements concerning the distribution of labour under the new mandate and the orientation of the mandate itself. The head nurses' statements, however, indicated uncertainty about whether or not nurses would be able to implement the program and how quickly ward routine should be altered to fit this new program.

The head nurse primarily addressed herself to senior psychiatric assistants and secondly towards nurses in general. As Chart Six illustrates, this pattern represented one-hundred ninety-five directives out of a total of two-hundred sixty statements (see Chart 6).

This suggests that the relationship between the head nurse and nurses followed the traditional line of hospital authority. In this respect, it is important to observe the lack of communication directed towards child care workers and the very small number of statements issued towards the social worker and occupational therapist. The head nurses' communications primarily included those members of the staff who did not openly support the psychiatrist's line of action in the ward. The head

CHART SIX

Head Nurse's Communication Directed Towards Nurses,
 Child Care Workers, Psychiatrist,
 Social Worker and Occupational Therapist



nurse felt that it was her responsibility to encourage cooperation between these people. In particular, her statements directed towards seniors solicited their help in organizing ward routine, in accordance with the psychiatrist's demands for a therapeutic milieu. Comments made by the head nurse towards nursing assistants repeatedly requested them to cooperate by performing their duties in conjunction with this evolving routine. Essentially, the head nurse was requesting cooperation from nurses in order to illustrate the success of her own job as supervisor and teacher.

The direction and content of nurses' comments further confirmed that they continued to interpret their relationship to others within the context of a traditional authority structure. To begin with, these people contributed the least to the ongoing network of communication in policy meetings (see Charts 7 and 8).

Unlike the social worker, occupational therapist and child care worker, nurses offered very few opinions or suggestions to others during the course of these meetings. In fact, nursing assistants issued one-hundred sixty-two comments, with a majority (one-hundred twelve) directed towards inquiries made by professionals. Most of these statements were directed towards the head nurse, again illustrating a stronger bond here than elsewhere in the communication network. As Chart Seven shows there were no comments directed towards child care workers and only eighteen directed towards the social worker and occupational therapist.

The dichotomy evolving throughout policy meetings, between staff who arrived with the redefinition of the treatment mandate and those

CHART SEVEN

Psychiatric Nursing Assistants' Communications Directed Towards
Senior Psychiatric Nursing Assistants, Child Care Workers,
Head Nurse, Psychiatrist, Social Worker and
Occupational Therapist

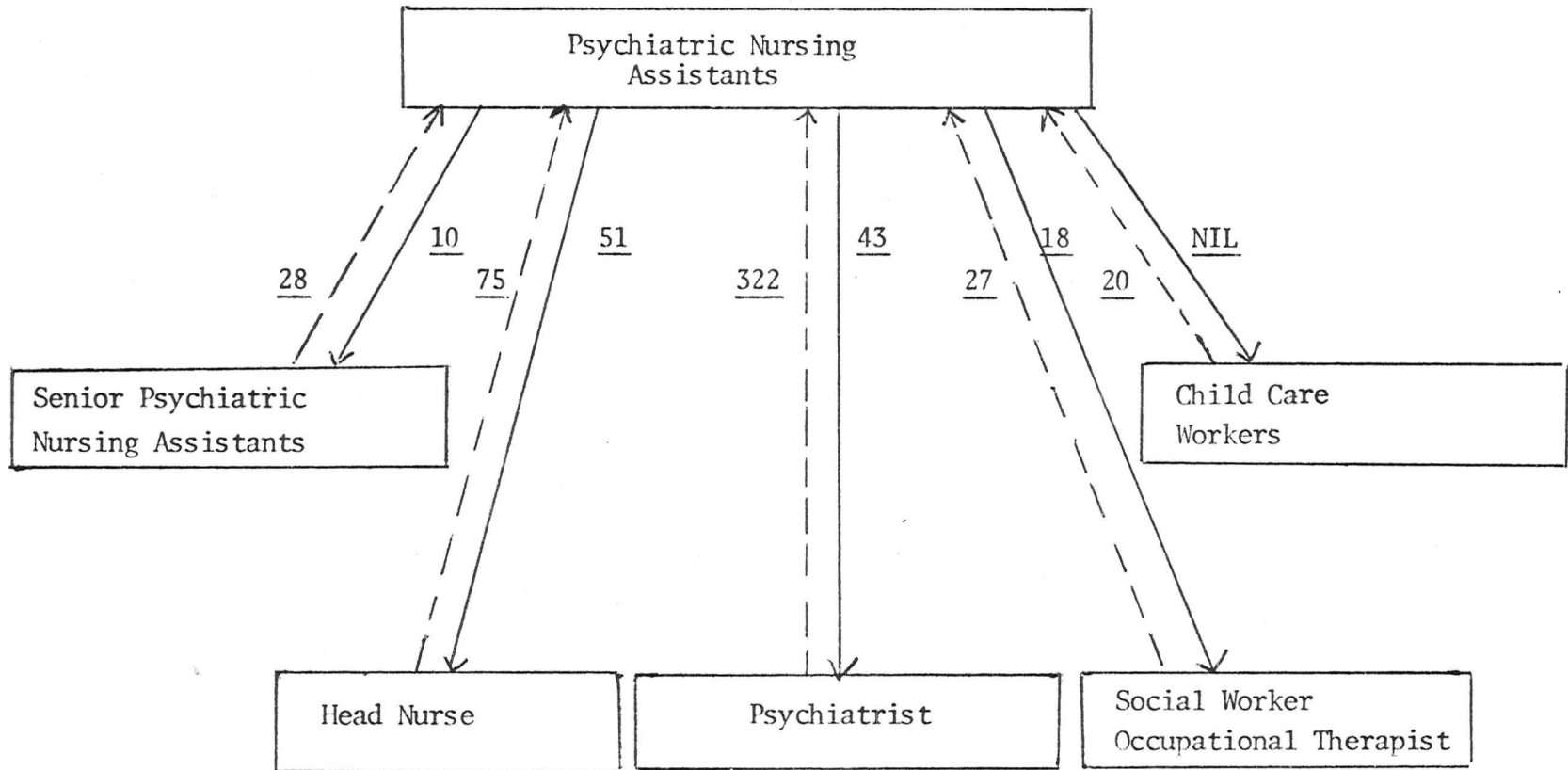
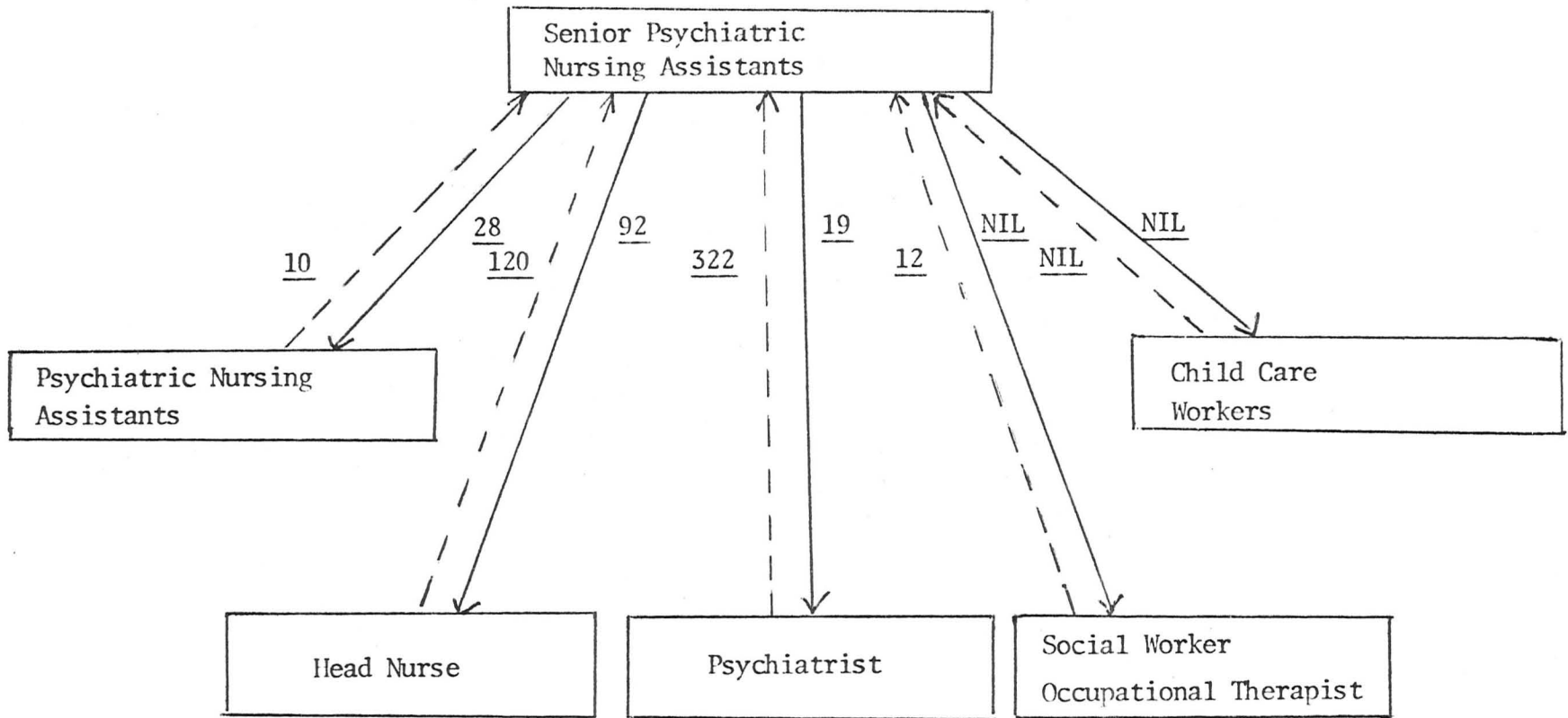


CHART EIGHT

Senior Psychiatric Nursing Assistants' Communications Directed Towards
Psychiatric Nursing Assistants, Child Care Workers,
Head Nurse, Psychiatrist, Social Worker and
Occupational Therapist



people active in the ward prior to this change is clearly evident in this chart. This pattern is illustrated by the low degree of communication between nursing assistants and those members of the staff who supported the psychiatrist's line of action. The tendency, therefore, is towards minimum communication between those who openly support therapeutic-patient care and those people who are not firmly committed to this mandate.

Senior psychiatric nursing assistants directed almost all of their statements toward the head nurse. In fact, of the one-hundred thirty-nine comments made by seniors concerning ward policy, ninety-two involved dialogue with the head nurse. With the exception of a few statements directed towards the psychiatrist, a majority of the remaining comments were directed towards nursing assistants, in an effort to find support for their criticisms of ward policy.

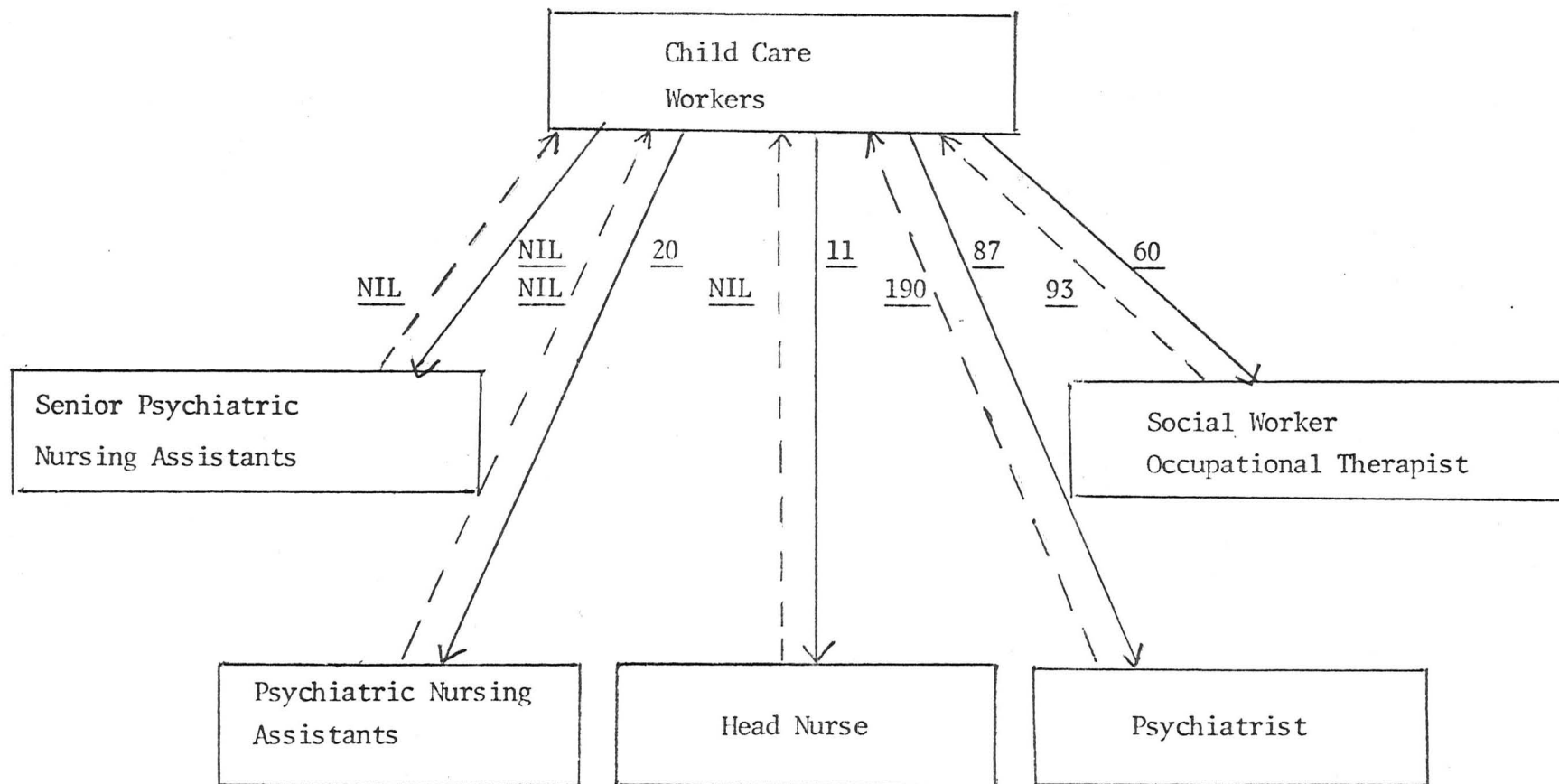
The flow of comments issued by child care workers, with the exception of some exclamatory remarks directing their disagreement or hostility towards nursing assistants (twenty statements), were directed towards professionals in the ward (see Chart 9).

Chart Nine illustrates, most of these comments were directed towards the psychiatrist. These statements were issued in support of the psychiatrist's suggested line of action towards the distribution of labour in the ward and the treatment mandate in general. Unlike the other paramedicals in the ward, the child care workers expressed their opinion about ward policy several times, in dialogue with the psychiatrist.

The social worker and occupational therapist directed two-hundred

CHART NINE

Child Care Workers' Communications Directed Towards
Nurses, Head Nurse, Psychiatrist,
Social Worker and
Occupational Therapist



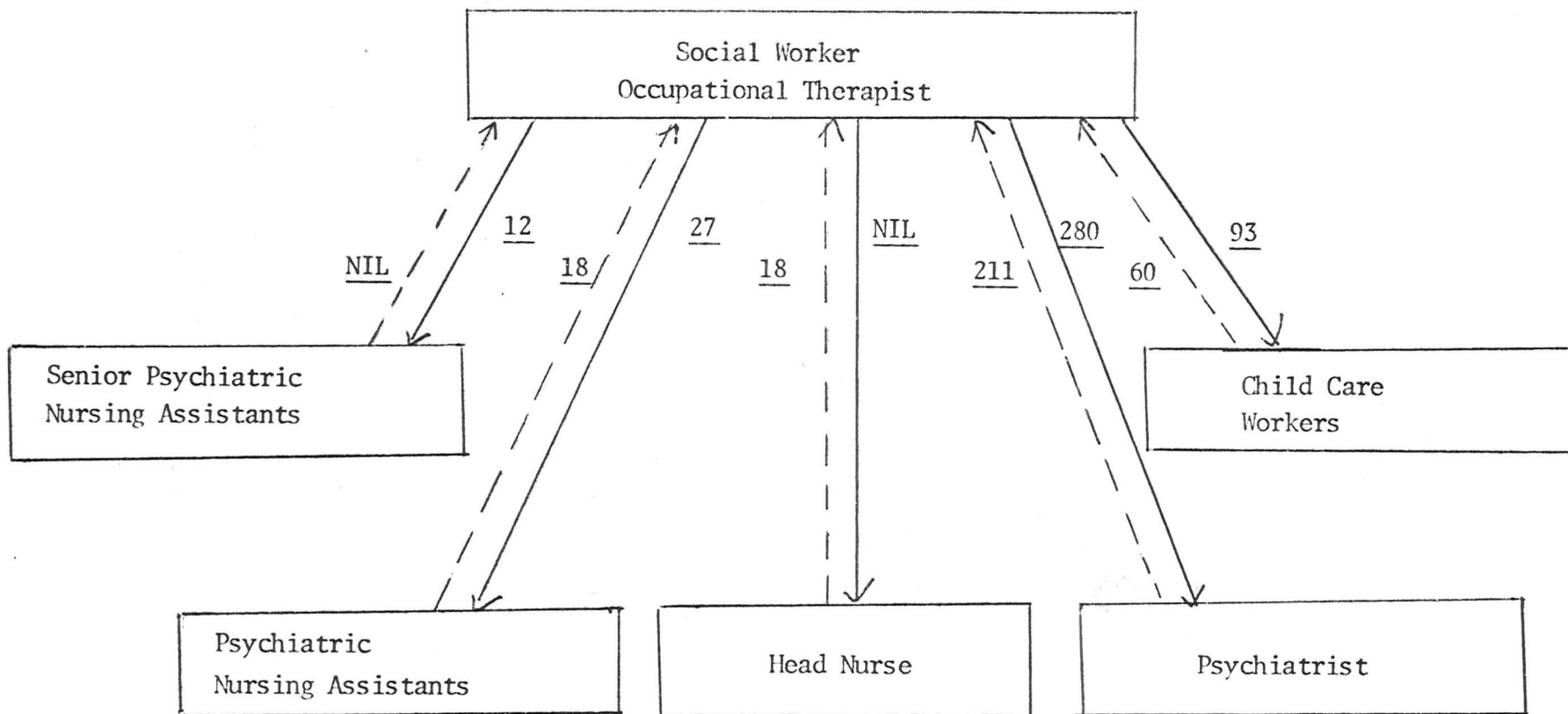
eighty comments (out of a total of four-hundred twelve) towards the psychiatrist, ninety-three towards the child care workers and none towards the head nurse (see Chart 10).

The social worker's and occupational therapist's statements supported issues that would contribute to the goal of creating a therapeutic milieu in the ward. The very small number of comments directed towards nurses and the fact that none were spoken to the head nurse, illustrated a constant theme in these meetings. This pattern of social interaction (also present, with minor variations in the direction of child care workers' comments), shows a significant division between custodial and therapeutically oriented staff. Furthermore, this flow of communication and particularly the low level of interaction between these people will continue to reflect upon the pattern of negotiation in this ward.

The analysis of the data presented in Charts Three to Ten illustrates the flow of communication among members of the staff. This network of communication clearly indicates the pattern of social interaction that evolved during fourteen ward policy meetings. For example, the bond between nurses and head nurse is far more apparent than between these people and the child care workers, social worker and occupational therapist. The data also suggested that nurses responded towards the head nurse and psychiatrist in terms of the traditional authority hierarchy that they had previously experienced in the ward. Unlike child care workers, social worker and occupational therapist, these people spoke primarily when addressed by others and they did not issue strong supportive comments to the psychiatrist. The dichotomy between staff who openly supported the

CHART TEN

The Social Worker's and Occupational Therapist's
Communications Directed Towards Nurses,
Head Nurse, Psychiatrist and
Child Care Workers



psychiatrist's therapeutically oriented line of action and those who were not firmly committed to this approach was also apparent in this analysis. The degree of social interaction between these people was very low and as the following discussion will show, the network of communication proved highly problematic for members of the staff.

2. Ward policy meetings: an example of patterned social interaction

The impact of the pattern of social interaction described above will be considered, as the substantive content of this interaction is examined. At this point, we are ready to come to terms with a major focus of this chapter, that is, an analysis of people's interpretation of their function within the context of a psychiatric team and in particular their participation in the ongoing negotiating process. An analysis of their definition of everyday life in a psychiatric treatment setting will be presented in this way.

The following excerpt from the second ward policy meeting presents a frequently repeated pattern of interaction, although of course the specific content of the discussion varies with the issues under discussion. The discussion opened with the psychiatrist explaining various procedures for people to follow during visiting hours in the ward, as there were, according to the psychiatrist, several changes to be made in line with the new teamwork policy. For example, under the previous set-up in the ward, visiting hours were organized and supervised by the social worker, psychiatrist and head nurse. This however was to change in order to involve everyone in the ward with patients' families so that,

...you too (reference was made here to paramedical members) can have the opportunity of observing the

child in relation to his family. This experience should provide you with valuable information that should help you understand some of the reasons why the patient behaves as he does. (1, Psychiatrist)

The psychiatrist paused at this point and possibly since there were no comments she decided to continue to elaborate the merits of such an alteration in routine and to explain some of the incidents and behavioral sequences staff should "...be on the look-out for..." (1, Psychiatrist), during these visits. There were a few mumbled comments among paramedicals, however, after one or two minutes the psychiatrist asked for their opinions regarding this new plan. As opinions were not forthcoming the psychiatrist added that,

It would be a great help if everyone would discuss this matter openly and some kind of decision could be reached in terms of when and how this new plan might be put into action. (1, Psychiatrist)

This request initiated a brief dialogue between child care workers and the psychiatrist with the former expressing their support for this plan and also suggesting that perhaps some kind of rotation system might be worked out among staff so that everyone would have this opportunity as often as possible. As one child care worker added,

This will give us an excellent chance to view the child within the context of his family relationships and possibly will provide further valuable clues about the sources of the patients' illness. (5, CCW)

Still, no comments were issued by the largest body of staff to be affected by this change. After another two or three minutes of silence the psychiatrist referred by name to several nursing assistants with the following results.

I don't really mind one way or the other.... (12, PNA)

It seems O.K. to me.... (18, PNA)

I guess its alright.... (11, PNA)

One person did however elaborate her position in the following way.

To some extent I think this is going to cause a great deal of confusion all way round. For one thing, we don't know the kids parents and for another what are we supposed to say when they start asking a lot of technical questions about their kids. (After a brief pause, this member added the following) Besides who's going to take care of our other routine chores in the ward while we're with the visitors? (12, PNA)

One of the senior psychiatric nursing assistants added a brief comment directed towards the head nurse, to the effect that this would require changes in work schedules and would also place an extra responsibility

...on the shoulders of nurses who it seems to me already have their hands full with the kids never mind having to deal with the parents as well. (7, PNA)

As was frequently the case during ward policy meetings, I observed an almost constant low-key conversation going on between clusters of staff seated around the meeting table. There was one noticeable difference regarding this observation between nurses, child care workers and professionals. The latter two occupational categories eventually verbalized the results of their interaction, whereas nurses did not appear prepared to do so. As this pattern was particularly apparent during the course of the meeting described above and since the main issue under discussion called for nurses' acceptance of the concept of teamwork as a therapeutic instrument, I decided to construct a follow-up investigation of their interpretations of the actual outcome of this meeting.

3. Sharing clique membership: an informal network of social interaction.

Before continuing with the discussion concerning visiting hours in the ward, a brief digression will be necessary in order to place the analysis into perspective. This will include a description of clique formation in the ward. During the course of formal interviews with nurses I noted that, with two exceptions, one senior (9) and one nursing assistant (16), people divided personnel into several small groups (see Chart 11), as one person stated,

This ward is divided into several cliques with almost no communication between members who don't belong to your clique (14, PNA)

It was also noted that the pattern created by people in their description of the groups was very similar and in each case three members were described as not being a part of any of these small groups (9,10,16). It soon became apparent that members' interpretation of the concept of teamwork was closely related to those people who shared membership in the same clique. This membership provided an individual with support and was also attributed by staff to be a resource for picking up cues regarding their interaction with others in their social milieu. This kind of experience will be taken into account in the following discussions concerning people's construction of social reality and hence the process of defining everyday life in a psychiatric setting.

A general over-view of the data concerning clique membership indicated that there were one or two outspoken members, who appeared to express an opinion on almost every topic discussed during ward policy meetings. This included in Group A, nurses 19 and 13, in Group B, child

CHART ELEVEN

Formation of Cliques

CLIQUE A

Psychiatric Nursing Assistant	15
Psychiatric Nursing Assistant	14
Psychiatric Nursing Assistant	13
Psychiatric Nursing Assistant	19
Psychiatric Nursing Assistant	12

CLIQUE B

Child Care Worker	5
Child Care Worker	6
Psychiatric Nursing Assistant	17
Psychiatric Nursing Assistant	18

CLIQUE C

Senior Psychiatric Nursing Assistant	8
Senior Psychiatric Nursing Assistant	7
Psychiatric Nursing Assistant	11

CLIQUE D

Psychiatrist
Head Nurse
Social Worker
Occupational Therapist

ISOLATES

Senior Nursing Assistant	9
Psychiatric Nursing Assistant	10
Psychiatric Nursing Assistant	16

care workers, 5 and 6 and in Group C nurse 7 was the most frequently outspoken person. Group D provided somewhat of a variation to this pattern in that its membership was composed of professional personnel, whose contributions to the ongoing social interaction in the meetings was fairly evenly distributed among the head nurse, social worker and occupational therapist with the exception of the psychiatrist whose verbal communications far out-numbered the others in the group.

After the ward policy session described above I discussed its outcome with each person in attendance and also with those people, who owing to shift schedules, were absent from the meeting. Beginning with this latter group I became aware of the full impact of the previously defined clique formation in the ward, particularly, in terms of how the informal network of social interaction provided these people with information about the content and outcome of the issues discussed during the meeting. As the follow-up extended to include those nurses who had attended the meeting it was apparent that absent nurses utilized cues offered them by those who shared membership in the same clique. In this way, the data provided further evidence regarding people's recognition of self and others' membership in cliques. The following analysis will illustrate the content of people's evolving social interaction within cliques as a means of grappling with the concept of a psychiatric team and hence nurses' interpretations of everyday life in the ward. For example, in terms of outcomes, two fundamentally contrasting positions were viewed by absent staff as having evolved through the course of the meeting. One nursing assistant explained that she had received reliable information from a friend that,

We're going to get an equal chance to share an active role in the patients' therapy by visiting with the

children's parents and talking to them about their relationship with their child. (17, PNA)

When asked whether or not this task offering (Strauss et al: 1964, p. 142) was a good idea this person replied that she was "...very proud to be given the opportunity of participating in the ward on an equal level with the social worker and psychiatrist." (17, PNA) She added hastily however, that this "...would likely cause a lot of trouble in the ward..." (17, PNA), as there were certain staff whom she named that probably would not go along with this new aspect of the job. When asked to explain why she thought these others might object to this kind of team approach to handling visiting hours with parents she replied as follows.

There are always some people who like to cause trouble and who seem to be against things just for the sake of being difficult. For myself I like to at least try and go along with things so it at least looks as if everything is going on as its supposed to. (17, PNA)

As with the discussion recorded above, the following conversation with a senior took place several hours after the meeting under study and after shift changes had occurred in the ward. When asked whether or not he had been informed about what had been discussed during the ward policy meeting, an interesting aspect of the patterning of interaction in the ward became apparent. This person, like all those also absent from the meeting, did not turn to the report written by the psychiatrist in order to determine the events of the meeting.¹ Instead, as the following examples

1

Following each ward policy meeting the psychiatrist wrote a report summarizing the issues discussed and the final outcome of the meeting. Strong consensus existed among nurses that these reports were "...almost useless, since you need a dictionary to read them." (11, PNA). Or as another person elaborated, "the report simply includes the psychiatrist's opinion about what happened. For example, the way she wants us to think about certain things is the way she writes up the report." (19, PNA) It appeared, therefore, that a majority of nurses found the content of these reports to be of little value during the course of daily action in the ward.

will confirm, nurses relied upon their "friends" or "other people who share my way of looking at things" to provide them with information necessary, firstly, for their understanding of the course of events and secondly, for the construction of a judgement regarding the meaningfulness of these issues in relation to their job performance.

According to this senior it is often difficult for nurses who work the evening shift to be well informed about many kinds of activities that occurred during the day.

Its useless to try the report book since its written by the Doctor and almost impossible to read, never mind understand. (8, Sr. NA)

I then asked if he had been informed by anyone about the content of the discussion that had taken place earlier that day. The reply indicated that such information, although it should have been offered by the head nurse, had eventually been supplied by a fellow senior who "...clued me in as she was rushing around trying to get ready to go off duty."

(8, Sr.NA) The content of this meeting was interpreted in the following way.

Its the same old story. We get this lecture about sharing responsibility and acting like a team but what is really happening is that we get the work piled on us while the Doctor and the others (reference was made here to professional members) sit back and talk about how things should be done.... (8, Sr. NA)

When asked what he intended to do if their participation became mandatory this senior replied that he would accept this,

I'm not going to worry about it since there isn't anything I can do about it. Anyway I suppose when the time comes I can always go through the

motions like the others or try to find something else to keep me busy during visiting hours. (8, Sr. NA)

Contrasting the position expressed above, by the senior, is the following one illustrating nursing assistants strong opinions regarding the perceived imposition on their already heavy task load.

At first I couldn't believe it when (member 12, PNA) told me about this new scheme. As if we don't have enough to cope with already, we'll have to face parents now too. I'm certain its just an excuse for the Doctor to pass the buck onto us and to get out of some work at the same time. (13, PNA)

It really burns me up hearing about this new plan. Its just one more way the Doctor has of pushing her tasks onto us. Everybody knows she doesn't like to be bothered with parents anyway. (15, PNA)

I wasn't all that surprised when (member 19, PNA) told me about what happened in the meeting. This kind of thing is always going on around here. Passing the buck seems to be the psychiatrist's favourite pastime -- we get more work and those in power sit back and waste time observing what's going on. (14, PNA)

In order to show the growing consensus among nurses with regard to visiting hours and the more general concept of teamwork, I would like to return briefly to the psychiatrist's referral to nurses (11,12,18), during the meeting in which visiting hours were discussed. These nurses were requested to express their opinion of the new visiting scheme and in return replied with brief one-sentence remarks. While these comments appeared to reflect a fairly positive interpretation of the scheme, it seems more likely, when the following quotes are considered, that nurses replied as they felt the psychiatrist wished them to. When each person was questioned privately the following day, the results indicated that in

two cases these public remarks were substantially altered.

I'm sick and tired of having the high and mighty (reference was made here to professional members in the ward) pass their tasks onto us and calling it sharing responsibility. They should remember how we were trained and why we were hired in the first place. (12, PNA)

Sure I think its unfair especially since all we end up with is more work. In any other normal ward I've worked in, visiting hours have always been taken care of by the Doctor and Social Worker. (11, PNA)

When the researcher reminded each of these members that their present position was somewhat different from the one they had expressed during the meeting their responses were fairly similar as the following indicates.

For one thing, I've learned that it does very little good to express my real opinions as there seems to be little willingness on the part of the psychiatrist or head nurse to accept any of my suggestions. On the other hand they might think I'm incompetent. In either case, its to my advantage to go along with the game.... (12, PNA)

If we disagreed it would only result in more useless discussions since things inevitably work out the way the psychiatrist and head nurse want it. Frankly, I just can't be bothered, its less trouble this way and I can't lose my job. (11, PNA)

Like the nursing assistant (19, PNA) who expressed her opinion (although this was stated in a fairly cautious manner as will be indicated below) during the meeting, the people above made specific reference to this increase in job tasks as a means of 'passing the buck' on the part of the professionals. This increase in their task requirements created hostility among nurses, since they felt that this demand was illegitimately conceived on the basis of the psychiatrist's catch-all statement,

...in order to exist fruitfully within the context of a therapeutic milieu members must join together as a psychiatric team and learn to share equally in the responsibility involved in treatment. (1, Psychiatrist)

Similarly, during a private interview with this nurse (19, PNA), it became apparent that her opinion also evolved from a more hostile interpretation of the situation. The depth of hostility felt by this nurse was masked in the public meeting for fear of reprisals, not only from therapeutically oriented staff but also out of fear of "...being ridiculed by members of the other cliques in the ward." (18, PNA) Certainly the increase in tasks was viewed as an imposition and while this member did not wish others to view her as "...an incompetent nursing assistant", she also admitted that,

You can't be too careful around here if you want to keep your job.... This fact is always on my mind when I do speak out during meetings so I tend to avoid most of my real feelings.... (19, PNA)

As noted earlier, there were three paramedicals who not only excluded themselves from clique membership but who were also viewed by others as "...not belonging to any particular group in the ward." (17, PNA) These nurses were each approached within the next three days (the three day delay in contacting one nurse (9) was caused by illness on the part of this person), in order to determine how they were informed about the issues discussed during the ward policy meeting and their interpretation of the psychiatrist's determination to alter routine visiting hours procedures. The two nursing assistants involved had received very little information concerning this new ward policy. In fact they both indicated that if their days off duty coincided with policy

meetings it was very unlikely that anyone would take the time to provide information regarding alterations in ward routine. One nurse stated that since she refused to take sides in debates between the various cliques in the ward, she was usually excluded from informal conversation,

...however, I get along pretty well with the others.
I just do my job and mind my own business. This way
I don't get involved in any big squabbles and the
others don't bother me too much. (16, PNA)

This interpretation of the situation was similarly shared by the other nursing assistant, who felt that while she did not always hear the latest news, she eventually picked things up and by,

...not getting involved in the ward I manage
to keep on fairly friendly terms with everyone
and stay out of trouble with the psychiatrist
and head nurse at the same time. (10, PNA)

Considering the specific issue at hand both nurses were aware that they would now be expected to interact with parents and children during visiting hours and both appeared to accept the situation as "...just one more task to be done" (10, PNA) and "...not worth complaining about since we wouldn't get anywhere anyway." (16, PNA)

The senior nursing assistant commented that in general the situation was very difficult, since she felt that she was often in charge of the ward, while not always fully informed about new policies that were to be put into practice or old tasks that were to be discarded.

Even though as senior I'll be in charge of the
ward during visiting hours the head nurse never
bothered to fill me in.... I just happened to
hear the gossip by accident. (9, Sr. NA)

When asked to express an opinion on this situation the senior appeared to hesitate and finally stated that while the psychiatrist might think

its a good idea "...I think that its just an excuse to place more duties with nursing staff." (9, Sr. NA) However she continued by stating that she would do her part in the new scheme "...because its so much easier and more practical than starting trouble." (9, Sr. NA)

The pattern of social interaction examined above was apparent, with only minor variations, owing to shift schedules, on each occasion following ward policy meetings. The data indicate that staff relied to a large extent on their informal contacts in the ward in order to collect information about what happened during their absence from a particular meeting. At the same time, members internalized cues through this network of communication, that provided a basis from which to construct a working definition of action during the course of everyday life in the ward. The descriptive analysis presented above also elaborated the processes of role-taking (Turner, 1956: 316) and role-making (Turner, 1962: 22) that people experienced in social interaction. This discussion also indicated the interrelation between people's interpretations of the psychiatrist's attempts to initiate several changes regarding their job performance and significant others who are defined as sharing clique membership.

D. People's Attempts To Demonstrate the Existence of Orderly Social Interaction: An Evolving Definition of the Situation

The following discussion will illustrate how people operate under the formal auspices of a therapeutic milieu mandate, while attempting to incorporate their individual and in some instances shared view of social reality. In order to do this, visiting sessions will be considered once

more, as well as other examples, with regards to the pattern of social interaction among members of the staff.

Before presenting specific examples from the data, the following will briefly outline some general trends found in the fieldnotes. Possibly the most noticeable characteristic appeared once more in terms of people's shared participation within the framework of their small group membership. For example, underlying paramedical's actions there existed a degree of uniformity recognized by the members themselves as evolving on the basis of shared membership in the same clique. That is, individual interpretations of various kinds of formal policy remain uniform within the boundaries of each of the cliques. As a majority of social interaction occurred among members of the same clique, it follows that they relied to a great extent on small group consensus in order to create a base upon which their interpretations of social reality might evolve. For example, the processes of role taking and role-making that people experienced in interaction with their significant others provided a framework within which their role enactment (Sarbin, 1954: 225) could be derived. In this way the data will indicate that staff utilize mechanisms of consensus and support from within their small social network as a way of sustaining some kind of uniform interpretation of the hospital ward, as treatment setting and work milieu. In this way they view the ongoing social interaction between people in other cliques from within a relatively cohesive framework that continually reaffirms their interpretation and definition of everyday life. The data will show that with the support of one's network of shared social interaction, people appeared prepared to

at least create the pretense of orderly social interaction among the membership of the various cliques in the ward. In fact, their attempts to demonstrate the existence of orderly social interaction was an evolutionary process and over time, one that contributed to people's definition of the situation at hand, both in terms of the nature of treatment offered residents and their interpretation of the milieu as a work environment. In this way the data will show that some degree of social order was sustained among people in the ward, although as indicated throughout the thesis, the relationship here to the officially ascribed social order was indeed a precarious one.

1. Visiting sessions: paramedicals' attempts to operationalize a major task offering

The discussion concerning staffs' participation in the ward during visiting sessions will be prefaced by a brief explanation of the outcome of the meeting in which this new scheme was proposed. As the ward policy meeting was coming to a close, I noted that no formal count was taken of people's opinions, nor was it made very clear that the proposed alterations would hence forth constitute new ward policy. After an informal conversation with the psychiatrist and separately with the head nurse, it became apparent that they expected the new policy to begin immediately. In fact, the head nurse had already requested one of the seniors to re-write the work schedule for the following week-end incorporating paramedicals in the list of staff to be present during visiting sessions.

In order to illustrate how staff interpreted and operationalized their participation in visiting sessions I observed thirty-five, one hour

sessions, with the following results. During visiting hours, which consisted of one hour Saturday and Sunday afternoon and one hour Wednesday night, paramedicals always represented a majority of personnel present and on nineteen occasions professionals were absent from these sessions. As the following chart illustrates professionals attendance was clustered primarily at the beginning of the period of observation and gradually diminished such that the final ten sessions were attended only by paramedicals. (see Chart 12) Consistent with this observation the data illustrated paramedicals increasing hostility (directed particularly towards the psychiatrist and secondly generalized to include the therapeutic treatment mandate), towards the demand for their compulsory participation in visiting sessions. Observations drawn regarding their expressions of hostility were almost always accompanied by statements indicating their decisions that,

...nothing can be done to change things so I try to do things my way and when I can't get away with it I usually pretend to do what I think others expect me to. (15, PNA)

During the sessions where no professional people were present paramedicals frequently ushered the children and their visitors into the ward cafeteria or one of the dayrooms, locked the doors behind themselves and retreated to the nursing station. In fact, other than very brief introductory comments between these people and relatives (with the exception of child care workers and two psychiatric nursing assistants), only forty-one incidents occurred which resulted in dialogue between nurses and relatives. It was also noted that on eleven occasions nurses initiated interaction in order to determine information regarding residents'

CHART TWELVE
 PROFESSIONALS' ATTENDANCE DURING
 VISITING SESSIONS IN THE WARD

Visiting Sessions	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35		
Head Nurse				X	X				X	X																											
Psychiatrist	X							X						X						X					X												
Occupational Therapist	X	X										X	X	X											X												
Social Worker	X				X	X	X	X		X	X						X				X				X												

clothing or when the child would be going on an outing with parents. There appeared to be little attempt made, on the part of these staff, to engage relatives in interaction which might provide them with further information concerning the residents' social history. On the other hand, regardless of who else might be present, the four members excluded from the above observations (4,5,18,17) initiated interaction with the visitors, "...in order to act in a manner conducive to open communication between parents and staff." (5, CCW) For these people the opportunity to interact with visitors was utilized as a means of collecting information "...that might help me understand why a patient is here and at the same time give me some idea about how to fulfill his emotional and physical needs." (17, PNA) Unlike a majority of nurses who retired to the nursing station while on duty during visiting hours, these people remained visible to the visitors and appeared to interact with them as frequently as possible.

(i) A contrast in interpretation between nurses and child care workers

The following represents a series of statements issued by paramedical members within the first six sessions observed and is included here to indicate their interpretation of their recently acquired duties regarding visiting sessions, and also to show the contrast in interpretations among the membership of the various cliques in the ward.

When I'm in charge of the ward I don't mind what goes on or doesn't go on between staff and parents just as long as the staff cooperate when the psychiatrist is on duty so everyday looks O.K. (7, Sr. NA)

I don't plan to get tough with the staff. They already have too many tasks to perform as it is. What is important to me is that everything looks

good when the visitors arrive or the psychiatrist and head nurse are around. (8, Sr. NA)

Both nurses referred to above recognized the psychiatrist's intention regarding participation between personnel and visitors as an opportunity for learning more about the resident; however, as the statements indicate they are not prepared to enforce this demand as long as,

...nursing staff behave as they're supposed to when somebody important comes around to see the ward and how it is operating. (Reference was made here to the psychiatrist and head nurse) (7, Sr. NA)

During the first six sessions observed, nurses expressed a considerable amount of uncertainty regarding how they should act in the ward. However, as the following will illustrate, they described their situation as "...a very unsatisfactory predicament to be in." (15, PNA)

...I'm not sure how we can get around this situation as yet but you can be sure that I'm not going to automatically accept this added burden just because the psychiatrist thinks it might be a useful exercise. (14, NA)

Like so many new tasks these days this one was dumped on us so quickly we didn't really get a fair say in the matter. I guess we'll just have to play this one by ear for a while until we can work out some kind of plan.... (19, PNA)

I'm not exactly sure what to do right now but I do know that we'll probably work out some plan eventually.... (13, PNA)

As with the illustrations noted above, the fieldnotes collected during these sessions indicated nurses' uncertainty concerning the kind of action appropriate in this situation. However, as the fieldnotes also indicated nurses gradually turned to others "...who usually share my outlook on things in the ward" (12, PNA), in order to find support for their

dissatisfaction. This kind of awareness developed on the basis of informal conversation and represented, once more, people's reliance on others whom they defined as sharing their view of social reality. Eventually, as the fieldnotes collected throughout the remaining sessions indicated, consensus regarding appropriate forms of behavior evolved along two major lines. The following will outline nurses' decisions regarding action, and in response to this situation, Clique B's (5,6,17,18) definition of the situation,

As soon as I realized there were others who shared my feelings on the subject I decided to talk things over with them. Now we've more or less worked things out so we don't take this new job too seriously. Still, things run pretty smoothly when necessary. (11, PNA)

The respondent was asked to elaborate this point with the following result,

I mean even though people have different opinions about things when we have to get along in order to put up a good front for the psychiatrist or head nurse, staff seem willing to cooperate at least on the surface. (11, PNA)

This observation was inferred by a majority of nurses and represents their decisions to cooperate, at least to the point where they are prepared to demonstrate some degree of orderly social interaction, in order to accomodate, in this case, the psychiatrist's concern with their participation in visiting procedures. As one nurse candidly stated,

The best way to survive in this ward is to turn a blind eye on other staffs' action and not make too many complaints. This way others will side with you and if necessary cover for you if something goes wrong when the psychiatrist or head nurse is around. (14, PNA)

There were several incidents of this kind observed during visiting sessions, indicating a high degree of informal support among nurses. For example,

they were always ready with a quick excuse in support of a fellow clique member, should the psychiatrist or social worker appear unexpectedly in the ward.

This network of informal social interaction, as it evoked support among nurses, excluded two nursing assistants who shared clique membership with the two child care workers in the ward. There was very little visible social interaction between these people and those discussed above, and as in many other situations demanding an understanding of the basic premises underlying a therapeutic treatment mandate, other cliques appeared to avoid contact with this one whenever possible. For example, nurses stated openly that they preferred to work with their group of children away from "...the hawkish eyes of the child care workers..." (11, PNA), or "outside the range of the child care workers' disapproving glances." (13, PNA) During the first six sessions observed, child care workers expressed a high degree of dissatisfaction concerning nurses' "...lack of meaningful interaction with visitors." (6, CCW) In fact one child care worker went so far as to state that the presence of nurses in the ward was probably "...detrimental to the whole notion of therapeutic treatment" (5, CCW), since they refused to cooperate with the psychiatrist's request "...to mingle with parents and to involve parents and children in interaction conducive to therapeutic treatment." (5, CCW) As noted above, these people altered their behavior very little in relation to the presence or absence of professionals; however, a noticeable change did occur regarding their interpretation of nurses' action as they continued to experience visiting sessions in the ward. Whereas the range of comments issued in the first few sessions tended to

express hostility towards nurses' action in the ward this focus gradually altered as the following remarks illustrate.

I've got to the point now where I don't really care what the others do in the ward, I feel we can do very little to change their basic custodial orientation towards the patients so I'm prepared to try and ignore them as much as possible....
(5, CCW)

The way I look at it, life in the ward must go on, so if this means ignoring others behavior with patients instead of getting into an argument that might develop into some kind of crisis I'm prepared to do it. (6, CCW)

What goes on during visiting sessions is typical of the whole attitude nursing staff have towards patients. I just try to avoid the other nurses as much as possible and hope that they won't interfere with the way I want to do my work.
(17, PNA)

Further evidence of this shift in focus can be seen in terms of the following kinds of observations. Several attempts were made by these people (17,18,5,6), to encourage nurses to actively participate with visitors and on several occasions during the first few sessions, child care workers offered verbal suggestions to others regarding their action with relatives. This kind of action, however, did not envoke lengthy social interaction between paramedicals and it soon became apparent to people in Clique B that this was not, according to nursing assistants, an acceptable form of behavior on their part. In response to this situation, child care workers and the nursing assistants involved in this small group gradually began to avoid contact with others while on duty. Although this kind of avoidance was noticeable throughout the course of everyday life in the ward, visiting sessions provided an interesting example of the lack of

reciprocal support between members of the various cliques. During these sessions nurses would put off informing child care workers that a particular resident's parents had arrived or that the psychiatrist or social worker wished to see them about one of the residents and his family. Also, nurses frequently created embarrassing situations for these people, such as sending one of the children from their group on an outing when the visiting list indicated that his parents would be arriving that afternoon. Another example of this kind often occurred during a Wednesday evening session, when nurses would send children to bed, even though they were supposedly under the supervision of one of these people, so that when his parents arrived apologies had to be made for the child's absence and the child care worker had to leave the room to redress the child and bring him downstairs once more. While these incidents occurred with frequent regularity, that is, at least once during each session in which this group was participating, child care workers gradually evolved a way of coping with unexpected difficulties.

As these members of Clique B defined particular areas, such as those mentioned directly above, as problematic, they reacted by turning to others within their group for support concerning the way in which they attempted to interact with visitors and also as a means of reaffirming their fundamental interpretation of the nature of a therapeutic treatment mandate. At the same time there was a marked decrease in the flow of advice from these people to other nursing assistants in the ward as the following representative statements indicate.

I've given up trying to change things around here. Now I rely on my small group of friends

for support and ignore the others as much as possible. Really, this is the only way any kind of treatment will get done.... (5, CCW)

I'm through worrying about all the problems in this ward and that includes trying to give hints to other nursing assistants as well. I've come to the conclusion that as long as we stick together and support each other then we can get on with the work at hand and ignore the others as much as possible.
(18, PNA)

Gradually they began to concentrate their efforts more firmly on the notion of providing a therapeutic experience for the group of children under their supervision, rather than trying to convince others of the validity of their actions and the newly ascribed treatment program in general. This shift in focus can be seen in the following comment issued by one of the child care workers in the ward.

Over the last few weeks an unwritten agreement seems to be developing, they (Reference was made here to members in Cliques A and C) ignore our attempts at providing a therapeutic experience for patients and we avoid their negative influence in the ward as much as possible. (6, CCW)

When asked to elaborate upon the nature of this unwritten agreement, this person continued by referring to the situation as one where most people recognized the division in the ward along the lines of those who supported traditional treatment methods and those who appeared to accept a more therapeutic orientation towards treatment. With this being the situation, this person concluded that,

...most staff in the ward would now go to great lengths to avoid any kind of contact with members of opposing cliques. (6, CCW)

- (ii) Orderly social interaction: the nature of an unwritten agreement

The field observations collected during the latter half of the visiting sessions attended substantiated this interpretation of the situation, that is, very little social interaction occurred between people from Clique A and C and those operating within Clique B. There was almost no contact observed between these cliques in terms of actually cooperating in group therapy with children and relatives. In fact, nurses continued to retire to the nursing station while the people in the latter group tried to cope with these sessions on their own. A pattern very clearly evolved during visiting sessions, to the point where stages can be drawn regarding the network of social interaction that developed through the course of observation. For example, the initial decision to relate the concept of teamwork to the visiting scheme created a high degree of hostility among certain nurses in the ward. This in turn was countered by members in Clique B when they expressed their acceptance, in principle, of this formal elaboration of the concept of psychiatric teamwork. In fact, they were prepared to go to considerable lengths to "...win over the other nursing staff...." (5, CCW), and to legitimate their own actions by attempting to convert "...those members of the staff who maintained a more traditional attitude towards the dichotomy between professionals and non-professionals in a hospital setting." (6, CCW) This approach to the situation altered as they gradually came to view their efforts as a waste of valuable time and also as one nursing assistant remarked,

We stopped worrying about their activities with the children and concentrated our efforts within our own group, with the hope that they too would adopt a more live and let live attitude towards our interpretation of teamwork. (17, PNA)

This notion of laissez-faire was apparent not only among these people (Clique B) but was also reciprocated on the part of other nurses whenever possible. Again utilizing visiting sessions as an example, the number of encounters between people substantially decreased, including the number of events defined by those in Clique B, as others' efforts to sabotage their attempts to participate in therapy sessions with the residents and their visitors.

The observations recorded at this time suggest that this particular pattern of social interaction evolved on the basis of paramedicals' interpretations of the need to demonstrate some kind of orderly participation in the ward, especially when they were visible to those defined as authority figures, that is, professional staff. In order to comply with this evaluation of the situation, nurses candidly acknowledged that if they believed their jobs could be firmly secured by their efforts, then they would be willing to go through "...the motions required to create a peaceful front...". (19, PNA) At the same time if people believe it to be to their advantage to seemingly cooperate with those in Clique B, since it was recognized that this latter group was "...somehow more in line with the psychiatrist's ideas about treatment or at least they pretended very effectively to be so..." (8, Sr. NA), then this kind of interaction would be consciously developed. Paramedicals' decision to demonstrate orderly social interaction, while on duty in the ward, had multiple repercussions. For example, nurses would feign an active interest in the new treatment mandate, when they felt the situation called for this kind of action, that is when the head nurse or psychiatrist was present in the ward. At the same time they would make every effort to avoid

the psychiatrist, in order to continue doing the kind of things they defined as their occupational function regarding the residents' treatment. The consensus of nurses' opinion on this point indicated their concern with sustaining, whenever possible, their fundamental ideological perspective regarding treatment procedures. In this case, this included a passive, custodial orientation to treatment. In this way they hoped to maintain, some aspects at least, of the traditional medical hierarchy and hence the distribution of responsibility for treatment among staff. In order to have the opportunity to perform as they wished nurses appeared willing to negotiate a compromise with the people in Clique B. To a large extent this was based on staffs' mutual decision to live in an environment conducive to the pragmatic development of a working compatibility (Goffman, 1959 : 9) among people, that would in turn legitimate the lack of social interaction between certain cliques. This was particularly apparent in terms of their day to day performance with the children where staff expected, in return for their cooperation, reciprocal responses from others, especially in the presence of the psychiatrist or head nurse. With this being the case a situation gradually evolved,

...in which our jobs are secured and child care workers and their supporters can go on working like crazy trying to cure the kids and impress the psychiatrist. (7, Sr. NA)

In this way some semblance of orderly social interaction was sustained in the ward while at the same time people continued to negotiate a situation in which they could avoid an existence too prone to crisis upon crisis. Also, for nurses the practical advantages included an opportunity to avoid

prolonged contact with the psychiatrist in terms of receiving lengthy lectures concerning therapeutic practice in a psychiatric ward. At the same time, nurses learned to avoid situations that would result in advice offering by people in Clique B.

There were several situations which involved a confrontation between staff regarding some activity with the children, or some alteration in the daily routine. In fact, in eleven out of thirty-five visiting sessions attended, observations were made to this effect. There were of course a variety of other occasions in the ward in which such situations could also be viewed. Usually when people became involved in a heated discussion there developed a point beyond negotiation, at which time their action indicated an abrupt retreat from participation in the ongoing dialogue and hence an end to social interaction. On almost every occasion observed the situation resolved itself when individuals retreated to the confines of their support group. As stated previously, these small groups not only provided support for people's accumulated stock of knowledge regarding treatment procedures, but as illustrated above, they served as a useful social outlet for the release of tension and frustration with others in the ward. Through this process of external validation (Turner in Rose: 1962, p. 31) people's definition of the ward setting was sustained.

2. Activity program: A contrast in interpretation
between nurses and child care workers

In order to comply with the basic premises underlying the recently ascribed treatment mandate, staff were divided into small groups by the psychiatrist and placed in charge of anywhere between four and six children.

These small groups were created with the intention that they provide an opportunity for staff and residents to participate in a variety of daily experiences conducive to active therapy. Paramedicals were also responsible for the participation of their group of children in the routine activity program scheduled by the occupational therapist as a means of achieving one of the major components of active treatment in the ward. The network of social interaction among paramedicals observed during the preliminary organization of these daily sessions and within the sessions themselves evolved in a very similar pattern to the one analyzed above.

(i) Nurses

In the early days of the activity program nurses very candidly expressed their dissatisfaction with the formal organization of this program and more importantly with the notion that they were compelled,

...to take orders from the occupational therapist
in order to fulfill the psychiatrist's new ideas
about treatment through teamwork and the use of
small groups. (12, PNA)

As might be expected, senior psychiatric nursing assistants expressed even more hostility towards this new program than other nurses, since it involved four of their labour hours each day and lessened their opportunity for contact with the head nurse and hence allowed them less time to be involved in administrative duties in the ward. This proved increasingly problematic for these nurses as there were certain administrative tasks that still remained within their range of occupational chores. Now, however, they felt that they were in the awkward position of trying to fulfill two major functions in the ward. For example, the head nurse continued to expect seniors to complete basic paperwork tasks and daily

reports, that had at one time occupied a major portion of their day.

The psychiatrist, on the other hand, continued to demand full participation in the activity program, as seniors contribution to therapy.

The following statements were issued by nurses within the first two months of observation in the ward and are included here to illustrate their initial misgivings regarding this program and also to indicate the direction of these comments, that is, their interpretation of the source of their dissatisfaction.

The only thing this new program seems to be doing is adding a lot of confusion to the ward. First we're supposed to be nurses and as such responsible to the head nurse. Now however, it seems as though most of our day is going to be taken up with these boring activities. I also don't think the occupational therapist has any right to tell us what to do, that should be the head nurse's job. (10, PNA)

For one thing, it seems strange to me that we should be expected to perform activities with the children without any training. For another, it doesn't seem right to me that we should be responsible to the occupational therapist. After all, we are supposed to be nurses. (13, PNA)

The activity program is just another way of giving us more work to do. Now we have to worry about equipment and the fact that we must be in certain places at a certain time in order to participate in activities. If this is the psychiatrist's idea about how teamwork should function then something need to be changed drastically. (8, Sr. NA)

In general the fieldnotes indicated that nurses were concerned with the fact that the psychiatrist's interpretation of teamwork not only demanded an increase in tasks, but also that it upset the traditional organization of the ward. Nurses were now expected to spend a considerable

portion of the day involved in conducting activities with the children, at which time they were responsible to the occupational therapist rather than the head nurse. They not only indicated that they felt ill-prepared to cope with the instruction of many of the activities (that is, a majority of them did not understand how the activities they were performing constituted therapy), but also that the program demanded action that was not interpreted as part of their traditional occupational duties. For example, they were now compelled to recognize their responsibility to occupational therapist, rather than the head nurse, for their work in the activity program.

(ii) Child Care Workers

Child care workers on the other hand expressed almost immediate approval regarding the idea of an officially constructed activity program. Play therapy was a form of treatment readily understandable to them and encouraged the kind of action that they interpreted as an integral part of their job. Unlike nurses who gradually began to express concern over the number of hours they were expected to work intimately with the children during these sessions, child care workers felt that this was one of the most important aspects of the therapeutic mandate, as this time represented the only formal treatment offered and residents. Only two other paramedicals (17,18) supported this position since they too defined ward policy as offering very little in the way of actual psychiatric treatment with the exception of these activity sessions. For these people, the activity program represented a practical way of keeping the children busy "...and out of trouble in the ward" (17, PNA), while also making their own job more interesting "...and peaceful, since we can take our group of

kids off to an activity room and ignore the other members in the ward, especially those who think we're wasting our time." (18, PNA) While child care workers expressed the nature of their work in theoretical terms such as "...activities that would enhance the therapeutic relationship between staff and children" (6, CCW), the two nursing assistants mentioned above were concerned with "teaching the kids how to get along with others, how to use the toys, how to share equipment...". (17, PNA) However, when it came down to actually working with the residents, the field observations indicated that all four cooperated as supervisors of the same group of children (this number of staff members being necessary to cover the various shifts in the ward schedule) and in fact, fulfilled their tasks in very similar ways. They appeared to agree on the notion of maintaining the activity program and expressed their support regarding the psychiatrist's plan to do so.

As the period of transition continued and as the field observations were recorded, it became apparent once more that a polarization evolved among staff as they gradually came to grips with a definition of the ward, in terms of their relationship to treatment procedures and as a workplace in general. Over time nurses' hostility towards their compulsory participation in the activity program increased, although they did not verbalize this discontentment during ward meetings or personally to any of the professionals involved in the formulation of the program. A majority of the examples concerning this situation indicated that they preferred to discuss their dissatisfaction with others whom they felt shared their perspective on the developing situation and hence would be

more sympathetic with their problems. This kind of action often occurred when nurses removed their groups from the ward on the pretense of doing some activity and instead the children were left on their own to run about, while they discussed the situation at hand. The consensus of opinion regarding positive aspects of the activity program concerned nurses acceptance of the sessions as an opportunity to get off the ward, or at least to remove one's group from the visual range of the psychiatrist and head nurse, thus enabling them to do very much as they wished with the children.

While this lack of concern regarding the activity schedule created several problems between nurses and child care workers (especially as the latter group, including members 18 and 17, supported in principle these sessions as a form of therapy), there was a noticeable decline in social interaction and hence verbal disputes among cliques as the study continued. Here again, people referred to the notion of an unwritten rule guiding their behavior. This included the idea that if nurses avoided contact with those who disapproved of their interpretation of how they should perform in the ward, then they could perhaps safeguard their job, while at the same time perform as they wished providing they did not disturb others in their job performance. With the shared consensus of people's support group, staff appeared willing to "...turn a blind eye where others' job performance was concerned" (6, CCW), in order to alleviate at least some of the informal pressure to conform to the demands inherent in the new treatment mandate.

3. Professionals respond to this ongoing process of negotiation

To some extent professionals in the ward were well aware of this

ongoing process of negotiation among paramedicals in the ward, and as I observed, frequently took part in this process in so far as it was necessary for them to take into account this interaction, while performing their job in the ward. Their contact with paramedicals was restrained and limited to communication defined by them as necessary for the fulfillment of their own job. As the following analysis will indicate they expressed a high degree of concern regarding, "...the constant state of flux and instability among staff in the ward." (2, OT) At the same time, concern seemed to be directed primarily towards that aspect of paramedicals' duties that most reflected their own job performance (for example, as teacher) and in turn was most relied on by them in order to complete their own tasks. Ultimately, however professionals indicated during formal interviews that,

...its up to nursing staff to learn how to cope with their problems and to eventually work them through to a satisfactory conclusion.
(1, Psychiatrist)

In evolving this position they frequently attempted a variety of tactics in order to encourage paramedicals to conform, at least to some degree with the new treatment mandate. Eventually, however, (with the possible exception of the psychiatrist) professionals adopted the idea that if contact with paramedicals could be avoided as much as possible, then they would be free to adopt a position whereby others' role enactment need not interfere with their own job performance. During the final month in which the research was conducted the social worker summarized her relationship with paramedicals as follows,

Just so long as the way in which nursing staff conduct their tasks and the kind of relationships they form with patients is not taken as a reflection

of the manner in which I perform these functions I've come to the point where I don't really care anymore what they do. I feel that in the past I have encouraged these people to develop some kind of sensitivity toward therapeutic treatment therefore I'm not prepared to be held responsible for their actions, especially since I can not force them to conform anyway. (4, SW)

The kind of isolation that they interpreted as being essential in order to participate as professionals in the ward indicates their determination to be absolved from formal responsible for the actions of others. At the same time, however, they (including the psychiatrist) acknowledged their "...total reliance upon non-professional staff in the ward for the operation of the daily treatment routine." (3, HN)

Professionals most often presented the activity program as an example of this kind of reliance. The psychiatrist acknowledged this program as generally providing the only formal treatment offered the children, while the occupational therapist adopted this view even more emphatically, as it represented the major source of legitimation for her existence as a member of the staff. The head nurse also made several references to the fact that "...in a way I'm responsible for the smooth operation of the activity program since it is conducted by nurses and they come under my jurisdiction." (3, HN) The social worker also made several references to her reliance upon paramedicals to contribute to the improvement of,

...the physical and emotional skills of the children through the activity program so that I can report this progress to the parents and the psychiatrist, since these are important indicators of the child's social development. (4, SW)

An examination of the responses issued by professionals, concerning

the relationship between their job performance and the activity program, indicated a strong reliance upon paramedicals. They relied upon paramedicals to operationalize the philosophical goals concerning psychiatric treatment, while at the same time creating an over-all atmosphere conducive to therapy. For example, considering the twenty-seven comments issued by them directly relating their own job to the activity program, twenty-three described this relationship as existing on the bases of paramedicals' satisfactory job performance in this area. This represents a clear majority of each person's responses and as the statements presented above indicate, the breakdown of the comments followed two major lines; firstly, concern with the legitimacy of one's own job performance and secondly; in relation to this, concern about others' opinions of one's job performance.

How then do professionals participate in the ongoing network of social interaction and what is their contribution to the "shape" of the treatment setting as a negotiated order among people? In order to respond to these questions it was necessary to observe a situation in which there was at least some degree of contact between paramedical and professional staff in the ward. The activity program and ward meetings pertaining to this program provided a major source of information. For example, each professional issued several statements regarding their relationship to this program, with reference to teaching and supervisory duties, as the major way in which they were involved with the program and therefore concerned with paramedicals' participation. At the same time, each professional expressed his motive for participating in the ward, in these capacities, as a way of contributing to the creation of a therapeutic treatment milieu.

The following statements issued by them describe the nature of this participation, while also indicating the kind of difficulty they have in terms of operationalizing their basic theoretical goals concerning psychiatric treatment.

I feel that it is my duty to serve as a kind of teacher in the ward. For example, I think it necessary that nursing staff be shown how to conduct the schedule of activities in a manner conducive to therapeutic rehabilitation. Also, for this reason I try to visit each activity group in a supervisory capacity in order to insure that some kind of therapy is in progress. (At a later point in this same discussion this member presented the following information.) While I must admit that my knowledge is pretty academic, I have never been very certain about the practical angles of establishing a therapeutic milieu - except of course writing up the activity schedule. (2, OT)

As head nurse my job is basically one of supervision however, I like to think of myself as a teacher in so far as this allows me to transfer my knowledge to nursing staff. Actually, in this way I can fulfill my responsibility to the team efforts at work in the ward and also contribute to the kind of treatment patients eventually receive. Sometimes I worry about my part in the ward as everything seems so settled on paper, that is, the way I'm supposed to be a liaison between the psychiatrist and staff. However, when it comes down to my day to day work things don't appear so organized. (3, HN)

The social worker defined her relationship to this program as an indirect one, since she did not actively perform a set of tasks within this framework. She was, however, concerned with the way in which paramedicals related to residents, and in turn their reports regarding the social development of the children in these groups. The social worker expected paramedicals to cooperate with her, by volunteering this information; however, she gradually came to accept the fact that this

cooperation would not be forthcoming.

I find it increasingly necessary to patrol the activity groups and at least appear to nursing staff as if I'm supervising their job performance. Otherwise I find them unwilling to cooperate with me which in turn leaves me in the very awkward position of trying to make a transition between my goals regarding therapeutic treatment and the way in which nursing staff conduct these groups. (4, SW)

During a formal interview with the psychiatrist, she expressed a serious concern over the fact that,

I'm really quite powerless in the ward when it comes to making certain that staff do their best to contribute to the setting as a therapeutic milieu. While I may be team leader I am only too well aware on nursing assistants efforts to sabotage my goals regarding treatment. For this reason I feel as though I must continually bargain with them in order to ensure that some meaning derives from my teaching and some kind of devision of labour developes regarding treatment procedures. (1, Psychiatrist)

As the statement above illustrates, the psychiatrist was concerned over the results of her interaction with paramedicals in terms not only concerned with how this will reflect upon her job performance as a teacher but also with the maintainence of a therapeutic milieu, and as will be indicated below, the eventual "shape" of everyday life in the ward.

4. Social interaction between professionals and paramedicals: an attempt to avoid an overt conflict of interest

We turn now to data collected during the final four weeks of the study in the ward. If we consider the pattern of social interaction between professionals and paramedicals during this period, the data clearly indicate a gradual shift regarding the distribution of responsibility for treatment in the ward. As discussed in an earlier chapter, the decision to

organize the ward on the basis of the psychiatrist's conceptualization of how a medical team should function in a therapeutic milieu created a situation defined as problematic by paramedicals. For example, they expressed considerable ambiguity and uncertainty in terms of the impact this new treatment emphasis would have on their traditional job performance, while at the same time indicating the difficulty they interpreted as evolving on the basis of putting this approach into operation. As the discussion above illustrated, the outcome of this situation on the part of paramedicals was primarily concerned with this period of data collection in order to secure information about professionals' participation in this ongoing process of negotiation and its relationship to social order. An overview of this data indicated that professionals appeared to opt out of any kind of ultimate responsibility for the day to day operation of treatment procedures, while presenting the concept of teamwork as a rationale for this action. Eventually they appeared to acknowledge, certainly within the boundaries of their own clique membership, "...the strength in numbers indicated by nursing assistants." (1, Psychiatrist)

In fact, the observations that composed this data suggested that at this stage in the project a situation was developing in which professionals evolved a shared definition of the situation which converged upon grounds common also to paramedicals. Rather than emphasizing the theoretical content of their stock of knowledge and the relationship here to their orientation towards treatment procedures (and hence one of the basic forces underlying their participation in the ward), this convergence involved a pragmatic decision to deal with what might be viewed as the

operational level of people's social interaction in the ward. As indicated throughout the thesis, people's reasons for accomodating this kind of action within their own and others' frameworks of behavior represented a wide variety of underlying motivations. However, as was the case among paramedicals, professional personnel began to formulate a consensus of opinion whereby they appeared willing to adopt the idea that if,

...undue contact was avoided at all costs between professional and non-professional staff then verbal confrontations be avoided. This way everybody would be able to go about their own jobs and there wouldn't be so many feelings of hostility among staff.
(3, HN)

The data collected during interviews with professionals indicated that they interpreted their decision to more or less privatize their experiences in the ward as a way of sustaining social order. As the social worker remarked,

Without this silent decision to live and let live, life would be unbearable not only for staff but the patients too. You might say that this pretense of order and peace is probably the only way we keep our sanity around here. (4, SW)

Professionals accepted as the most viable alternative to what they interpreted as a constant threat to the ward itself, that is, inter-and intra-staff conflict, the conscious avoidance wherever possible of others who not only do not share their view of social reality, but who may at any time oppose their conceptualizations during their daily performance and thereby create a series of unwanted crises.

CHAPTER SIX

Demonstrating Orderly Social Interaction: A Converging Definition Of Social Reality

A. Paramedicals' participation in decision-making

In order to elaborate the pattern developed in the previous chapter, that is, the notion of people's converging definitions of social reality, we will now turn to a discussion of the decision-making processes in the ward. This chapter is concerned with people's attempts to present their everyday action within a framework of orderly social interaction. This examination will be conducted on the basis of a chronological analysis of the data collected throughout the course of the study and includes people's comments concerning their participation in decision-making. While some of the information presented here will be drawn directly from decision making meetings, most of the discussion that follows will include statements recorded during informal participant observation.

1. Nursing assistants' interpretation of their powerlessness

A preliminary overview of this data indicated that almost all nursing assistants had, at one time or another, considered their participation in decision-making to be a worthwhile aspect of their job. This period occurred primarily before the ascription of the new treatment label and was understood as evolving on the basis of the traditional social structure that existed under the custodial treatment mandate. For example, almost all of these people (with the exception of two nursing

assistants) used the expression "chain of decision-making" when referring to the primary way in which they participated in decision-making in the ward. In relation to this kind of participation, they interpreted the traditional hierarchy as the most effective way in which they could voice an opinion regarding some action that was about to take place in the ward. The following series of quotations is representative of nursing assistants feelings on this matter (with the exception of members 17 and 18), and is taken from the fieldnotes that were collected between the seventh and eighth week of the research project.

I used to have the feeling that I could go to the head nurse with my ideas on things happening in the ward... and at least feel as though I counted a little. Now I often feel uncertain about what is expected of me and that there isn't much use in my expressing an opinion. Anyway the end result is that I feel excluded from decision-making in the ward. (10, PNA)

Things seem so cloudy now... its difficult to determine who makes the decisions around here although I know it isn't me. I used to think that the head nurse was interested in my opinions but now with the emphasis on teamwork there seems to be so much confusion in the daily meetings that the psychiatrist probably ends up by making most of the real decisions. (14, PNA)

I think I'm gradually getting the picture about this new treatment program. The psychiatrist and head nurse do so much talking about abstract notions concerning treatment in the daily meeting that we never get a chance to express our opinion before the time is up. Consequently the psychiatrist and head nurse appear to have all the power to make decisions. It didn't seem so bad before when we could at least talk to the head nurse privately. (19, PNA)

A majority of observations made at this time suggested that although they did not have a great deal of decision-making power prior to the redefinition of the treatment program, nursing assistants felt that they were

in an even more vulnerable position now, since they had less opportunity to actively negotiate with professionals privately or during ward meetings. This interpretation of the situation, coupled with their job performance, created a situation in which they gradually adopted a hostile attitude towards people whom they interpreted as being responsible for this shift in their relationship to decision-making as well as those whom they felt supported, in principle, the concept of teamwork. In addition, they conceptualized teamwork as a deliberate effort on the part of professionals, and in particular the psychiatrist, to weaken their influence on treatment procedures and ward routine. This situation developed, according to them, as the full implication of the new treatment mandate unfolded and they found increasing opposition to the traditionally tight bond they felt should exist between a head nurse and nursing assistants. Thus the attempt to structurally alter this relationship was interpreted as a way of reinforcing their powerlessness in the ward. As one nursing assistant stated "...what voice we may have had in running this ward seems to be gradually disintegrating." (12, PNA), or as another person commented,

...slowly but surely our position in the ward is changing. Where before we felt that at least the head nurse was concerned about our feelings about how things should work this doesn't appear to be the case now. It seems to me that all this teamwork stuff has simply confused everybody about their place in the ward. (15, PNA)

Following three months of observation in the ward, it became apparent that this interpretation of the situation was reaffirmed among staff in Clique A, to the point where it was gradually adopted as a legitimation for the development of a new pattern of action. In fact, informal social interaction among this particular clique focused primarily

on their thoughts regarding their increasing lack of meaningful representation during decision making sessions. The way in which they began to derive this understanding of their social milieu can be seen in the following comments.

The way things are now we're expected to openly discuss things in policy and team meetings but I don't feel right about this. For one thing it makes you very vulnerable to criticism from the other cliques and for another, people might think I'm incompetent. In either case it was better when we were just responsible to the head nurse, not only for information about what's going on but to express our ideas as well. I guess I'm just not willing to risk my job by openly discussing my opinions with others. The drawback of course is that I lose out in any decision-making going on.... (14, PNA)

My policy is to keep my mouth shut about the changes around here since I feel that with a few exceptions only, people can't be trusted. For example, I think rather than making us equal partners, the whole notion of teamwork seems to be placing all the power in the hands of Dr. _____ since nobody else, especially nursing assistants seem to be aware of the distribution of responsibility at this point. Really I think nursing assistants put their job on the line when they try to actively take part in decision-making. (19, PNA)

I like things clear-cut and routine whereas now my responsibilities seem foggy and uncertain. Around here if you miss one meeting you feel as though you've been left in the dark because nobody takes the time to communicate messages. As for having a chance to let your opinion count towards a decision forget it, if your not present you don't have an opinion. (13, PNA)

This last statement was one of many that referred to nursing assistants' growing concern about being excluded from the "...main stream of decision-making simply because we're off duty." (12, PNA) Approximately mid-way along in this study, their predominant interpretation of the situation included expressions of powerlessness in terms of being encouraged to offer major directives in the organization of the ward and treatment procedures. According to nursing assistants, there was a direct relationship

here to their impression that the concept of teamwork simply served to complicate what for them was once a clearly routinized social system. It was also apparent that they found it difficult to define the impending outcome of "...this very confusing and upsetting situation..." (10, PNA) With two exceptions only (nursing assistants, 17 and 18), they gradually became convinced that somehow they were slowly losing ground, as various occupational categories became increasingly nebulous and consequently others' role-enactment more difficult to comprehend. Furthermore, the way in which nursing assistants related to the decision-making process represented a major contradiction between the psychiatrist's theoretical conceptualization of teamwork and what happens during the course of everyday life in the ward. As one nursing assistant candidly remarked,

If I didn't worry so much about keeping this job maybe I would speak my mind but right now there seems to be so much tension building up that I'd rather keep quiet than risk creating any more trouble. (13, PNA)

Or as another person stated,

Nursing assistants will never get together as long as the shift hours are broken up the way they are now. For one thing the professional staff never miss a meeting whereas we can't put forward a united front if we're absent three-quarters of the time. (19, PNA)

Eventually as the project continued into its fifth month, nursing assistants began to articulate their feelings of powerlessness and especially the difficulties they were confronted with in terms of participating in decision-making. At this point fieldnotes collected following ward meetings, indicated their attempts to focus their hostility on professionals, as they began to describe their actual position in the ward as subordinate to them.

In spite of what the psychiatrist may say around here, nursing assistants are not equal in importance to professional staff, nor does what we say hold as much weight. (19, PNA)

As they were unable to define formal regulations stipulating the way in which they could legitimately contribute to decision-making in the ward, nursing assistants increasingly interpreted such a process "...as simply not existing within our reach." (11, PNA) This understanding of the ongoing system, coupled with their expressions of inferiority and fear about losing their job, appeared to encourage nursing assistants to utilize this situation to rationalize the following pattern of social interaction observed during the final stages of research.

To begin, nursing assistants described the "...network of communication in the ward..." (15, PNA) in very negative terms in order to illustrate, once more, professionals attempts to exclude them from,

...any important decisions that have to be made. For example, if we don't know what's going on or is expected to go on during a meeting and we're off duty how can be possible make our position clear?" (14, PNA)

On the other hand, "...unless somebody from your own clique attended the meeting you never even hear about new policy or ward routine decided on during the meeting." (19, PNA) This latter statement could have been issued by any one of the psychiatric nursing assistants or seniors, as each person indicated in a variety of ways, during the course of the final stages of research that,

Communication is so poor in this ward that few people are fully aware of what is going on, although I know that most staff feel that the atmosphere is very hostile and tense because of the uncertainty derived from this lack of information. (15, PNA)

General observations made at this time support the suggestion that as they internalized their lack of decision making opportunity in terms of powerlessness and subordination to professionals, there was a noticeable decrease in social interaction between nursing assistants and professional personnel.

This situation becomes even more problematic when the complex relationship between members of the various cliques in the ward is considered. Although some degree of mutual support was shared between members of the same clique, the consensus of opinion recorded at this time suggests that this alone did not ease their feelings about the tense, hostile atmosphere that existed among staff in the ward. Instead, as illustrated in chapter five, people appeared to come to grips with the situation by attempting to eliminate any kind of action that might contribute to an increase in the general atmosphere of hostility and tension among staff in the ward. For example, nursing assistants issued several comments concerning this, indicating their determination to adopt an indifferent attitude towards what they had at one time regarded as a worthwhile function of their job, namely, being a part of the "...chain of decision making in the ward". (11, PNA) For these people, the question of decision-making illustrated once more the kind of social injustice incurred by them since the redefinition of the treatment program. In this case they began to define themselves as more or less existing in a permanent situation, fundamentally subordinate to professionals regardless of the nature of the officially ascribed organization of a therapeutic treatment milieu.

A majority of nursing assistants appeared to resign themselves to

this fate (there were two exceptions, members 17 and 18, who believed that "...nursing assistants really are an equal part of the medical team even if we don't get much of a chance to actually make important decisions." (17, PNA) and they expressed considerable restraint in terms of "risking" anything more than "...very superficial participation with professional staff." (13, PNA) In fact, from the observations recorded at this time it was apparent that they were prepared to accept a somewhat passive position vis-a-vis professionals dominance in the ward, as a way of sustaining some kind of working order in their surrounding environment. This outcome, while consciously shaped by nursing assistants, does not appear to provide them with a great deal of personal satisfaction, as the following description concerning the ward as workplace and treatment environment illustrates.

To some extent I realize that its necessary to pretend that all is well in this ward even though I don't believe for a minute that this is true. I guess I've given up thinking things might change around here so what's the use in even trying to participate in these meetings, its simply not worth the effort anymore. Like other nursing assistants I shut up and try to get along when it's absolutely necessary for mine and everybody else's sanity. I'd probably leave tomorrow if I could find another job things are that oppressive around here. (15, PNA)

I used to think it was important to at least make some effort to learn about what was going on in the ward. But gradually this information became more and more difficult to obtain and as I miss so many meetings myself I began to lose interest. Really what's the use in bringing things up now, nothing is going to change and there would only be more quarrelling among the staff. (12, PNA)

The atmosphere around here is so tense I'm sure the patients can't possibly improve. I know that I'm near my wits end. I keep thinking that if I just do my job

and ignore other people's problems, some kind of peace and order might develop.... (10, PNA)

It took me a while to learn that my opinion doesn't really count and that in fact the psychiatrist and head nurse think nursing assistants are just out to cause trouble if we try to voice suggestions in ward meetings. In order to survive in this place and perform my duties with patients I often just pretend to go along with the decisions made by professional staff so there won't be any trouble. (16, PNA)

2. Senior nursing assistants' loss of decision-making power

Senior psychiatric nursing assistants' responses recorded at this time illustrated a similar trend, although their initial reaction to their loss of decision-making power erupted in a more hostile manner. However, like the nurses discussed above, the way in which they came to grips with the evolving situation was very similar. For seniors their participation in the ward became problematic when they were compelled to take part in the activity program, thereby restricting what for them had at one time been a fairly close relationship with the head nurse. For example, seniors used to meet for several hours each day with the head nurse, during which time they were consulted about everyday happenings in the ward. The activity program placed new demands on their time, thus restricting seniors' traditional job performance as liaison between nursing assistants and head nurse since they were no longer permitted these extended private sessions with the head nurse. As one senior remarked "...at least under the old rules we could feel a little important, that our job was a necessary one for the smooth, orderly functioning of the ward." (9, Sr. NA) Now seniors viewed their position as one resulting from a decrease in personal power, that is, they were no longer in line

to "...get the inside information on who's doing what and how around here." (8, Sr. NA) This being the case, the opportunity arose less often for them to make suggestions about the program or to express an opinion about how things were operating in the ward. This "...cut in responsibility lowers our prestige around here to the point where I really wonder what I'm supposed to be doing now that my contact with the head nurse is almost minimal." (7, Sr. NA) For seniors the new treatment mandate created severe problems in terms of the nature of their job performance and the kinds of expectations others might legitimately place on them. The data indicate that over time these feelings of ambiguity and uncertainty about their job performance increased, particularly in relation to their perceived powerlessness in the decision-making process.

Corresponding to the period of observation concerning nursing assistants' responses mid-way along in the study (as discussed in the section immediately above), seniors felt that their job was placed into considerable jeopardy by nursing assistants. For example, nursing assistants appeared very reluctant to cooperate with seniors by openly passing on information concerning daily happenings in the ward so that,

...when by chance my opinion is requested about how nursing assistants feel about certain areas of the program I have little information to go on. Needless to say I find nursing assistants' lack of cooperation very embarrassing as it restricts my relationship with the head nurse practically to the point where I become totally powerless.... (7, Sr. NA)

This perceived lack of cooperation on the part of nursing assistants, coupled with the psychiatrist's determination to implement the activity program and the concept of teamwork, contributed to seniors' feelings that the traditional nursing hierarchy was being destroyed. According to one

senior, the psychiatrist was "...really using the whole notion of teamwork to withdraw our right to actively participate in decision-making in this ward and also to try and break up our close relationship with the head nurse." (9, Sr. NA) Several references were issued by seniors, particularly during the latter half of the data collection, to the effect that the psychiatrist was attempting to "...destroy the bond between the head nurse and seniors in order to have firmer control over the ward." (Sr. NA), and that this was the "...real purpose underlying the new treatment orientation." (8, Sr. NA)

In response to this definition of the situation, seniors initially attempted to verbalize their hostility towards the psychiatrist and the new treatment mandate; however, as the observations recorded during the final stages of the study indicate, they too slowly adopted a line of action that is candidly expressed in the following statement.

There isn't really much point fighting for an equal share in the decision-making around here since there appears to be no possibility of such a situation occurring. The only alternative left now is to accept things as they are or at least pretend to, or leave the job. As I can't do the latter I guess I'll just have to go on as I do now, and try to avoid as much hassle as possible. (8, Sr. NA)

3. Child care workers participation in decision-making: a pattern of withdrawal

Child care workers evolved their interpretation of their relationship to the decision-making process in terms very different from nurses, as the following discussion will illustrate. As mentioned in an earlier chapter of this thesis, both child care workers joined the ward during the initial stages of the redefinition of the treatment mandate and unlike

nurses they had no previous experience upon which to judge their present set of responsibilities and duties. Unlike nurses, they expected their position regarding decision-making to evolve as they gradually came to terms with their occupational duties in the ward. Initially they accepted the concept of teamwork and believed that eventually things would work out in terms of a distribution of responsibility, power and decision-making.

I think its just a matter of time until we iron out the cracks in this new program and things start functioning as a therapeutic community. For example, the concepts of democracy and decision-making take time to develop but I'm sure that everything will work out. (5, CCW)

It was not long, however, until this optimism was replaced by serious questioning on the part of child care workers regarding the length of time it took for others to make decisions and put into operation "...even the most basic premises of a therapeutic treatment milieu." (6, CCW) In fact, statements issued by them and recorded mid-way through the seven month period of research, indicate serious doubts concerning the outcome of their participation in policy and report meetings. The level of verbal output for them was high during the initial phase of research; however, this too diminished as they questioned the usefulness of their contributions in terms of the general "shape" of the ward as a therapeutic setting. The pattern of social interaction that evolved reflected this growing uncertainty about the meaningfulness of their efforts toward sharing decision-making in a democratic social milieu. Furthermore, over time they began to realize that nurses did not accept the psychiatrist's interpretation of teamwork and the distribution of responsibility and decision-

making within the framework of a therapeutic treatment orientation. Nurses' interpretation of the social system was viewed, not only as a fundamental contradiction to the goals of the newly ascribed treatment mandate, but as a major source of conflict among staff. For example, child care workers felt that,

...a great deal of the confusion and inactivity existing in this ward derives from nursing assistants determination not to cooperate within the framework of teamwork. By this I mean accepting a share of the responsibility should things go wrong in return for which we all receive an equal share in the division of power and decision-making. (6, CCW)

This kind of reasoning served as child care workers' legitimation for their own lack of participation in formal decision-making, that is,

...after the psychiatrist spends three-quarters of every meeting giving nursing assistants a pep talk and trying to explain her position once more, there never seems to be time for discussion and concrete decision-making on specific agenda items. Things get swept over time and time again to the point now where I'm almost convinced that the reason the psychiatrist rules, is very simple--some things must get done.... (5, CCW)

Observations recorded during the final stage of research indicate that in most situations in the ward, including policy-making meetings, activity sessions and community meetings, child care workers consciously withdrew from social interaction with nurses and during the last month of observation from contact with professionals as well. In this way, they attempted to avoid "...conflict between staff as much as possible." (6, CCW), and also to conserve "...a lot of energy that would otherwise be wasted in a situation that simply isn't ready to operate within the framework of a democratic treatment setting." (6, CCW) As this pattern of withdrawal was observed, child care workers developed the following kind of legitimation

for this action:

I am very much aware of the fact that I've reached the point where I don't really care about what is going on in the ward as far as the total setting is concerned. It's impossible to change things and in fact I've given up trying. My goal now is to avoid contact with others especially where treatment is concerned and to try and work with my own group of kids in my own way. (5, CCW)

B. Professional members' participation in decision-making

The discussion so far has presented paramedicals' interpretation of their relation to the process of decision making in the ward, particularly in terms of the distribution of power and responsibility. We turn now to professionals, understanding of this process, both in relation to their individual participation and their interpretation of others' positions regarding this process.

1. Head nurse

The transition from a traditionally structured social milieu to one formally redefined as a therapeutic treatment setting was viewed as a highly problematic experience for the head nurse. In fact, a consideration of the head nurse's responses to questions concerning her participation in decision-making made one thing increasingly apparent, as the study continued: since the initial phases of this transition, she has become more dissatisfied with her relationship to nurses, on one hand, and to the general reconstruction of the social structure, on the other. According to the head nurse, the new treatment mandate called for "...a flattening of the hierarchy in the ward." (3, HN), in order to present everyone with an equal opportunity to participate in constructing daily programs in the ward. Ideally, this new set-up was created as a way of

encouraging social interaction among staff, thereby increasing communication and the exchange of ideas regarding treatment procedures. With this kind of contact evolving in the ward staff would be expected to contribute to decision-making and in turn to accept a share in the over-all responsibility of sustaining an environment conducive to active social therapy.

Comments recorded very early in the study suggested that, almost since the beginning of the new program, the head nurse felt skeptical about how nurses would be able to cope with these new demands, "...since nobody seems very clear about the practical ways of going about organizing, these changes." (3, HN) This assumption was made by the head nurse on the basis of difficulty she experienced coming to grips with the new treatment mandate and hence ward routine. The following statement illustrates the head nurse's position.

The official redefinition of treatment policy occurred a little over eight months ago and still I have difficulty coming to grips with my job. By this I mean that I'm uncertain about how my job has changed or should change in relation to new treatment mandate.

It was, according to the head nurse, only after several months of "...attempting to determine the kind of changes that would be appropriate to the new treatment orientation..." (3,HN), that she realized the full impact these changes would have on her job performance. This was

especially true regarding her relationship to nursing assistants. For example,

Slowly I'm coming to realize that nursing assistants no longer discuss their problems with me or their ideas about how things should work around here. There seems to be a general lack of communication in the ward, partly because they are unsure about their place in the ward operating outside a traditional hospital hierarchy.
(3, HN)

Responses illustrating this trend continued throughout the study, to the point where the head nurse felt that her own job "...was being seriously jeopardized by nursing assistants' refusal to communicate with me."

(3, HN) When asked to elaborate on this point the head nurse discussed the difficulties she experienced trying on the one hand to understand nursing assistants' opinions about everyday life in the ward and on the other, trying to take into account their potential reactions to situations that required a concrete decision on her part.

The head nurse viewed nursing assistants' lack of cooperation in trying to come to terms with the new treatment mandate as a source largely responsible for her own ineffectiveness regarding,

...important decision-making in the ward. For example, it is increasingly difficult for me to determine how nursing assistants may react toward my decisions since they refuse to talk to me about important issues.
(3, HN)

The fieldnotes indicate that the magnitude of this problem increased for the head nurse, such that nurses' relationship with her was defined as the primary target responsible for

...what must be viewed as a growing conflict of interest among staff. The difficulty will probably increase since nursing assistants refuse to contribute

to decisions that must be made. Yet, I'm sure from watching them after meetings and whatever that they are not happy with what is going on. (3, HN)

During the fourth month of study, the fieldnotes indicate the line of action eventually adopted by the head nurse in relation to her interpretation of others' concern with sharing responsibility and decision-making in the ward.

There seems to be so much unspoken hostility in this ward I find myself always trying to second guess people's motives and opinions about things going on. This makes life very difficult especially when it comes to taking direct action on important issues concerning ward routine. Sometimes I think I should just go ahead with my plans rather than even trying to consult nursing assistants since their feedback is of so little help to me. (3, HN)

In fact, during the final five weeks of data collection the head nurse's comments reinforced this proposed line of action. Observations recorded also indicate that she almost totally withdrew from any kind of formal contact with nursing assistants,

...since its really a waste of time trying to take them into account in order to make particular decisions when really I'm becoming more and more convinced that they don't care one way or the other.... (3, HN)

Over time, the head nurse adjusted her pattern of action accordingly, that is, less and less time was spent trying to encourage cooperation among staff, to the point where she was prepared to act autonomously whenever possible.

I've reached the stage where I feel even if I have to take things into my own hands some kind of action must be taken.... (3, HN)

In this way, she appeared to legitimate her decision to formulate her future requests, more in terms of "...orders to be obeyed..." (3, HN),

rather than "...waiting around for the others to share in the decision-making." This action was interpreted by the head nurse not only "...as the only way to get things done..." but as "...a necessary form of action in order to maintain not only some semblance of order around here but my personal sanity too." (3, HN)

Basically the process evolving here is similar in nature to the kind of pattern created by paramedics. As the previous discussion indicated, they acknowledged a period of uncertainty regarding their relationship to decision making within the framework of the new treatment mandate. Eventually, like paramedics, the head nurse appeared to consciously choose to withdraw from social interaction whenever possible, in order to continue functioning in line with her interpretation of her duties in the ward.

2. Psychiatrist

An examination of the statements issued by the psychiatrist with regard to the way in which decisions were made in the ward and her relationship to this process reflects her understanding "...of the most crucial aspects of the goal we are attempting to reach in the ward."

(1, Psychiatrist) When requested to elaborate on this point, the psychiatrist described the fundamental premises underlying the formation of a therapeutic milieu, particularly in terms of shared responsibility and decision-making. Accordingly, as recorded during the first week of the project, "...the traditional hierarchy of medical personnel should by definition no longer exist in this ward since it has been officially abolished." (1, Psychiatrist) However, the psychiatrist admitted that such a goal had not yet been attained although her responses during this period indicate that she remained optimistic.

The program has only been going for eight months now and while I realize that things could be much better I am very hopeful that we will soon see some positive action. (1, Psychiatrist)

The way in which this action was to develop, according to the psychiatrist, was in terms of paramedicals' acceptance of,

...a share in the over-all responsibility of the ward. By this I mean that they must be ready to accept an active role in decision-making and consequently they must learn to accept responsibility for their actions. (1, Psychiatrist)

The psychiatrist believed that as team leader she should be encouraging paramedicals to conform to this framework and while recognizing that "As chief-of-service it is still my duty to veto any decision that I feel is detrimental to the residents' treatment." (1, Psychiatrist) She also expressed a very strong need for feedback from the staff. This kind of verbal feedback was to be used as a means of understanding paramedicals' opinions on important issues, particularly as the psychiatrist felt these opinions were instrumental to the positive or negative outcome of the new treatment program. Thus to a large extent the psychiatrist like the head nurse defined her relationship with paramedicals as a crucial variable in the performance of her own job. Furthermore, like the head nurse, the psychiatrist's statements concerning this relationship gradually began to indicate a growing dissatisfaction with paramedicals' "...apathy and apparent lack of concern for my efforts to take their wishes into account when trying to establish guidelines for treatment." (1, Psychiatrist)

This situation became increasingly problematic for the psychiatrist to the point where fieldnotes collected in the sixth month of the study illustrate a marked shift towards a pessimistic interpretation of the situation.

I am fully aware now that nursing assistants wouldn't think twice about sabotaging my plans if they don't fit with what they want to do. Obviously this increases the difficulty with decision-making in the ward since I can never rely on their cooperation. (1, Psychiatrist)

Observations recorded at this time indicate a decrease in social interaction between paramedicals and psychiatrist, and as the latter remarked,

I feel that my professional training doesn't allow me to give up completely although I must admit that I do try to avoid some of the continual conflict that exists between staff in the ward. (1, Psychiatrist)

What this means however is that the psychiatrist consciously decreased the frequency of her requests to paramedicals regarding their personal opinions on issues calling for concrete decision-making. The fieldnotes also show noticeable declines in the number of new issues raised by the psychiatrist in policy making meetings while on the other hand, particularly in the final month of study, I observed several structural changes in ward routine.

Although the psychiatrist continued to appeal to paramedicals for their support concerning the program it also became apparent that, feeling that this support would not be forthcoming, she gradually accepted

...more and more of the burden of decision-making since nothing would ever get done if I continued to wait for nursing assistants to express their thoughts about various issues. (1, Psychiatrist)

The psychiatrist considered this pattern of action to be her only alternative, in order to keep the ward functioning with some degree of order and to ease some of the tension between staff and hence maintain the ward as a treatment milieu. Recognizing that this calls for cooperative social interaction among staff the psychiatrist expressed the opinion that if she

encouraged rather than demanded "open communication", "sharing responsibility" and peaceful "interaction" then possibly there would remain the potential that together people might create and over time sustain the ward as a therapeutic community. In the meantime, however, the psychiatrist felt it necessary to "...take things in my own hands and hope that eventually nursing assistants might decide to cooperate in operating the ward as a therapeutic milieu." (1, Psychiatrist) This kind of interpretation of the situation provided the psychiatrist with a legitimation for the apparent increase in autonomous decision-making as a way of sustaining orderly social interaction among people while encouraging the evolution of a therapeutic treatment milieu as a framework for social order in the ward.

3. Occupational therapist and social worker

The fieldnotes concerning the social worker's and occupational therapists participation in decision-making in the ward illustrate a similar pattern of action. For example, both people initially expressed an enthusiastic position regarding sharing responsibility and decision-making in the ward. That is, not only did they consider it important to share in the process of decision-making in terms of issues directly related to their individual job performances but also on a general level concerning the maintenance of a democratic setting for the residents. However, as the study continued they acknowledged a growing disenchantment with the,

...meaninglessness of putting so much time and effort into working out new ways of coping with the new treatment mandate, finally arriving at important decisions only to be continually thwarted by non-professional staff. (2, OT)

Other comments concerning this situation illustrated their

increasing feelings of powerlessness as they attempted to encourage paramedicals to "...take a serious interest in working out ways of organizing treatment within the framework of a therapeutic milieu."

(4, SW) As the project entered its fourth month, it became apparent from statements in this area that the situation was creating a more serious problem for them rather than moving toward some kind of solution. In fact, the data suggest that they,

...decided that the struggle to maintain some degree of community decision-making in this ward is simply not worth the effort. Besides I have no way of enforcing my requests regarding the general organization of the ward. (2, OT)

The fieldnotes collected at this time provide considerable evidence indicating their decision to withdraw from major decision-making events in order to concentrate specifically on duties directly related to their individual job performances. As this required a decrease in the amount of time allocated to social interaction with paramedicals the social worker and occupational therapist appeared prepared to act accordingly.

Furthermore, the data indicate that the underlying legitimation for this kind of action rested upon their feelings that by acting in this way, they were no longer contributing to "...what has come to be regarded by most staff as an extremely hostile social environment. (4, SW) Once again the fieldnotes demonstrate people's attempts,

...to at least try and encourage peaceful interaction among members even if this means we have to ignore a great deal that goes on around here. (4, SW)

C. Brief summary and concluding remarks

The regularity with which the above pattern emerged, confirmed earlier findings (described in chapter five) regarding people's determination

to demonstrate orderly social interaction whenever necessary. At other times, as this chapter concludes, members of the staff simply learned to avoid confrontation with others. This relative isolation provided staff with an opportunity to exert their energy according to their definition of the work situation and their function in this plan.

Nursing assistants appeared to resign themselves to a position of self-acknowledged subordination to professionals in Dixon. For example, to demand equal participation in decision-making appeared too great a risk; firstly, others might define them as incapable of working in a psychiatric setting and secondly, the possibility of being replaced in the ward appeared too great. The irony in this situation becomes very apparent when the implications of a therapeutic milieu are considered. To begin with, the psychiatrist emphasized a flattening of the traditional hierarchy and a democratization of decision-making processes and hence the redistribution of responsibility, as a major goal. However, as Jones (1972 : 8) recognized in his work involving the construction of therapeutic communities, democratic values can be interpreted as both gratifying and depriving.

In Dixon, nursing assistants interpreted the demands placed on them in terms of teamwork as a way of destroying the bond between head nurse and nurses. This being the case, nursing assistants felt they were deprived of a concrete, visible place in the "chain of decision-making." Extra demands such as implied by the activity program also placed them into a situation which they defined as follows,

With this new program, we don't really share in therapy with professionals. We do their job for

them, while they sit in their offices working out more abstract schemes for us to do. (19, PNA)

Nurses also resented the fact that, during activity hours, they were directly responsible to the occupational therapist rather than the head nurse, which further broke traditionally close ties between them and the head nurse. Nursing assistants found themselves in a double bind situation. On one hand, they received verbal communications from the psychiatrist implying a democratic treatment mandate, on the other, they interpreted her line of action as demanding that nurses act democratically and still believe that they are not a part of a coercive social system.

As this chapter illustrated, this situation became too problematic for nurses. In fact, as the previous chapter (five) began to suggest, nurses gradually removed themselves from an active position in negotiating everyday life in the ward. This transition, as I attempted to show in chapters three through six, was one that developed slowly over a period of several months. The decision-making process provides an excellent example of how these people chose a line of action that legitimated their withdrawal from as much public social interaction as possible. This was necessary in order to demonstrate the appearance of orderly social interaction among people in the ward. The preservation of this interpretation of the situation was paramount in order that some degree of social order be sustained in the ward. This interpretation of how a working consensus should operate, can best be understood within the framework of a pragmatic compatibility between all members of the staff.

Seniors also adopted a similar line of action. The notion of a democratic treatment setting was interpreted as a way of depriving seniors

from their traditional position of power in the ward. The reasons for this were twofold: first, the psychiatrist's demands that they participate in therapy and hence the activity program and second, this additional work deprived them of close contact with the head nurse and therefore an indirect opportunity to contribute to decision-making in the ward. Also the flattening of the social structure removed seniors from a relative position of power in the ward. For example, given the low level of occupational mobility (Jones, 1972: 9), afforded seniors they felt they must achieve a position of prestige within this system. With a decrease in occupational differentiation between staff, they interpreted their position as one lowered to the point of merging with nursing assistants.

As this chapter illustrated, on the basis of this situation seniors gradually began to withdraw from participation in formal policy making. They felt that their opinions were not really viewed as important, and furthermore that if they voiced an honest opinion, that conflict and turmoil would continue to erupt among staff. As this was to be avoided, seniors consciously decided to,

...accept things as they are. Peace and order must be restored in this ward if anything like treatment is to get done. (7, Sr. NA)

In order to avoid conflict situations with others, who did not share their therapeutic orientation towards treatment, child care workers gradually became less vocal in policy meetings. Unlike nurses, their legitimation for this line of action derived from their interpretation that if others could not operate with the context of a therapeutic milieu, then in fact there could be no such treatment setting. Child care workers

felt that if social interaction was avoided as often as possible, their own job performance would be less problematic, as others' lines of action need not be considered. In turn, they would not interfere with others' definitions of the work situation. In this way, they too attempted to construct the appearance of a compatible working relationship with others in the ward.

The pattern of action sustained by professionals was examined at length in this chapter. According to these people, a democratic approach towards treatment failed, because nurses refused to cooperate with them, by accepting their share of responsibility for the operation of this program. Believing the situation to be beyond their influence, professionals decreased their attempts to encourage cooperation within a therapeutic and hence democratic treatment setting. They continued to operate in the ward by performing their own jobs in isolation from nurses and by avoiding open confrontation with them, although they realized the degenerative nature of the treatment program. In this way, they adopted a laissez-faire approach to others' role enactment, in order to exist in the ward for some purpose, that is the fulfillment of their own duties.

APPENDIX A

INTERVIEW SCHEDULE

A Job Description re: Subject's Job Description

1. How did you learn what was expected of you in the job?
2. Do you think your introduction to the ward was effective in helping you learn your job?
3. Do you have a formal job description?
4. What is expected of you in this job?
5. Is there a discrepancy between your job description and what you actually do?
6. What do you consider to be the source of your dissatisfaction?
7. Do you feel that different treatment perspectives make you unsure of what is expected of you?
8. Do the expectations that others have of you prevent you from fulfilling your personal goals on this ward?

B Job Description re: Subject's Expectations of Other Staff's Job Description

1. What do you think other members of the staff are supposed to do? (to include all other status groups).

DECISION MAKING

A Communication of Decisions

1. How does the "chain of responsibility" affect communication of information on this ward?
2. What do you think are the main results of ineffective information communication within the 'chain of responsibility'?
3. Are there formal procedures for communicating formal decisions made at meetings?
4. What do you think are the main procedures for communicating formal decisions?
5. Do you think these formal procedures are adequate?
6. When decisions are made by other staff do they take the time to clarify what they mean and what is involved in carrying out the decision?

B. Does Subject See Himself in Role of Decision Maker

1. Do you think it worthwhile for you to participate in decision making?
2. Do you feel comfortable talking to anyone on this ward about suggestions you may have?
3. Do certain people make all the decisions around here, while others are responsible for carrying them through?

EXPRESSIONS OF DISSATISFACTION, FRUSTRATION,
ANNOYANCE, HOSTILITY WITH JOB

1. Are there aspects of your job which annoy you?
2. Would you like to make changes in your job?
3. What changes would you make?

TECHNICAL PROBLEMS

1. Are there some aspects of your job such as attending meetings, participating in activities, "baby-sitting" and/or paper work that you dislike?
2. Why do they annoy you?

CIRCUMSTANCES PREVENTING STAFF FROM
MAINTAINING GOALS THAT THEY SEE
AS PART OF THEIR JOB

RE: Ward Situation

1. Are there circumstances on the ward that prevent you from doing what you would prefer to do?
2. What are they?
3. What do you think you can do about them?
4. Are you satisfied with your job?
5. Does it give you a chance to do things you enjoy?

RE: Others

6. Do other staff prevent you from fulfilling your goals?
7. How?

APPENDIX B
QUESTIONNAIRE

PLEASE CIRCLE APPROPRIATE LETTER.

1. Which of the following best describes how you feel nursing assistants on this ward carry out their duties?
 - A. I feel that they do everything that is in their job description
 - B. I feel that they do almost everything that is in their job description
 - C. I feel that they do some of the things in their job description
 - D. I feel that they do none of the things in their job description

2. Do you feel that there is a difference between the actual duties nursing staff perform and those performed by staff classified as activity workers?
 - A. Yes, I feel there is a difference
 - B. Some of the duties are different and some are the same
 - C. No, I do not feel there is any difference
 - A. Taking care of the physical needs of the children
 - B. Helping to make decisions at ward policy meetings
 - C. Planning the children's activity program
 - D. Working with children in activities
 - E. Seeing children placed in either their own homes or in foster homes
 - F. Attending to the administrative needs of the ward
 - G. Satisfying the emotional needs of the children

3. Of the above statements which one do you think most nursing assistants find:
 - A. Most rewarding on this ward A B C D E F G
 - B. Least rewarding on this ward A B C D E F G

4. Of the above statements which one do you think the Head Nurse finds:
 - A. Most rewarding on this ward A B C D E F G
 - B. Least rewarding on this ward A B C D E F G

5. Of the above statements which one do you think the psychiatrist finds:
 - A. Most rewarding on this ward A B C D E F G
 - B. Least rewarding on this ward A B C D E F G

6. Of the above statements which one do you think the social worker finds:
 - A. Most rewarding on this ward A B C D E F G
 - B. Least rewarding on this ward A B C D E F G

7. Of the above statements which one do you think the occupational therapist finds:
- A. Most rewarding on this ward A B C D E F G
B. Least rewarding on this ward A B C D E F G
8. Of the above statements which one do you consider to be:
- A. Most rewarding on this ward A B C D E F G
B. Least rewarding on this ward A B C D E F G
9. Do you know what duties are expected of you by those in positions other than your own?
- A. I almost always know what is expected of me
B. I am sometimes unclear about what is expected of me
C. I very seldom know what is expected of me
D. I almost never know what is expected of me
10. Do you feel that staff members in positions other than your own are willing to accept suggestions that you may want to make about the children's treatment?
- A. Yes, other staff members are willing
B. No, other staff members are not willing
11. Are these suggestions used to alter activity programs?
(ANSWER THIS QUESTION ONLY IF YOU REPLIED YES TO THE ABOVE QUESTION)
- A. Yes, they are used to alter the program
B. Suggestions are sometimes used to alter the program
C. No, they are not used to alter the program
12. In most jobs people usually receive assignments from someone else. Would you please tell me who gives you assignments?
- A. The Head Nurse
B. The Senior Nursing Assistant
C. The Psychiatrist
D. Other (specify)
13. We assume that every staff member cannot attend all meetings. When decisions are made at meetings, at which you are not present are you informed about these decisions?
- A. I feel that I am sufficiently informed about these decisions
B. I feel that I am sometimes informed about these decisions
C. I feel that I am insufficiently informed about these decisions
D. I feel that I am never informed about these decisions

14. Do you feel that you are informed about the daily ward situation, for example, about on the spot decisions that affect the children, as often as you should be?
- A. I am nearly always informed about these daily decisions
 - B. I feel that I am sometimes informed about these daily decisions
 - C. I am almost never informed about these daily decisions
15. When other staff inform you about decisions e.g. ward policy decisions, are you generally clear about what is meant?
- A. Yes, I am generally clear about what is meant
 - B. Sometimes I am clear and sometimes I'm not
 - C. No, I'm generally not clear about what is meant
16. If you wanted to make a suggestion in the ward's program, depending upon the nature of the suggestion, to which person or persons would you go?
17. As a member of the team working on this ward, would you say that you participate in deciding the children's treatment program as often as you would like to?
- A. I always have the opportunity to participate
 - B. I usually have the opportunity to participate
 - C. I seldom have the opportunity to participate
 - D. I never have the opportunity to participate
18. Is there another job either within the hospital or outside which you would prefer?
- A. Yes
 - B. No
19. Which of the following best describes what most often happens when you make a complaint about something on this ward?
- A. My suggestions are considered and acted upon
 - B. My suggestions are considered and not acted upon
 - C. My suggestions are not considered
 - D. My suggestions are considered but acted upon only temporarily
20. Please check one of the following:
- Do you feel you spend _____ too much time with the therapeutic treatment program on this ward
- _____ just enough time with the therapeutic treatment program on this ward
- _____ not enough time with the therapeutic treatment program on this ward

21. Do you think some of the activities you are required to perform are a waste of time?
 - A. Yes
 - B. No

22. If you answered yes to the above question, please check any of the following that fall into that category:
 - A. Supervising in the cafeteria
 - B. Taking care of the "paper work" on the ward
 - C. Attending meetings on the ward
 - D. Taking the children on outings
 - E. "Baby-sitting" the children while meetings are in progress
 - F. Working in group activities
 - G. Collecting and returning activity equipment
 - H. Other (Please specify)

23. Are there some things you would like to do with the children but simply do not have the time, because of other job requirements?
 - A. Yes, there are some things I would like to do but do not have the time
 - B. No, I have time to do the things I want to

24. If you answered yes to the above question what job requirement most often prevents you from doing some things on the ward that you would really enjoy?

25. Do you find it necessary to postpone or delay some aspect of your job because situations develop on the ward that demand your immediate attention?
 - A. This happens very often
 - B. This sometimes happens
 - C. This seldom happens
 - D. This almost never happens

26. Which of the following best describes how you feel about the ward's daily programming:
 - A. I feel it should not be interrupted once started
 - B. I feel it should be interrupted under very important circumstances only
 - C. I feel it should always be interrupted when other circumstances develop

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