ATTITUDES AND ATTRIBUTIONS OF WINNIPEG EMERGENCY NURSES: A CORRELATIONAL SELF-REPORT SURVEY

SUBMITTED BY: MILDRED KATHLEEN LAING

August, 1993

A thesis presented to the University of Manitoba
in partial fulfilment of the requirements for
the degree of Master of Nursing

Winnipeg, Manitoba

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BY

MILDRED KATHLEEN LAING

A Thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

MASTER OF NURSING

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TABLE OF CONTENTS

Page

ABSTRACT

ACKNOWLEDGEMENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER I: INTRODUCTION

Introduction to the problem 1

Significance of the problem 2

Purpose and research questions 2

Definition of terms 3

CHAPTER II: LITERATURE REVIEW 5

Attitudes toward emergency patients 5

Utilization patterns of the emergency department 5

Issues of legitimacy and moral evaluation 7

Dealing with "real emergencies" 13

Studies by Jones, Jones, and Yoder 14

Additional studies about emergency personnel 15

Attitudes toward emergency patients summary 18

Attitudes toward mental illness 18

Effect of age and gender on attitudes 19

Effect of exposure and work experience on attitudes 20

Effect of occupation and profession on attitudes 22

Effect of education on attitudes 24

Effect of labelling on attitudes 26

Patient characteristics and attitudes 28

Additional studies 29

Attitudes toward mental illness summary 30

Conceptual framework 31

Models of Helping and Coping 32

Summary of conceptual framework 36

CHAPTER III: METHODOLOGY

Introduction 38

Research design 38

Setting and population 40

Data collection 42

Measurement instruments 43

Attributions of Responsibility measurement tool 43

Development of emergency vignettes questionaire 43

Attitudes Toward Patients Survey (ATP) 49

Demographic data 51

Procedure 51

Ethical concerns 53

Methods of data analysis 53

Summary 55

CHAPTER IV: RESULTS 56

Data analysis 56

Sample characteristics 57

Response rates 57

Work status of the sample 59

Age of the sample 60

Years of nursing experience for the sample 61

Years of emergency nursing experience for the sample 62

Educational preparation of the sample 63

Tests of normality for the sample 64

Population characteristics 65

Comparing the population and sample 67

Attributions of responsibility made by emergency nurses 68

The individual vignettes 68

Three vignette subscales 71

Testing the emergency vignettes instrument 72

Tests of significance and correlation for emergency vignettes 72

Attitudes Toward Patients Survey 74

The Attitudes Toward Patients subscales 75

Testing the Attitudes Toward Patients Survey 76

Tests of significance and correlation for the ATP Survey 77

The correlation between attributions and attitudes 79

Correlations between attributions and attitudes 80

Effects of sample characteristics 82

Summary regarding sample characteristics 84

CHAPTER V: DISCUSSION AND RECOMMENDATIONS 85

Introduction and summary 85

Discussion and implications for practice 87

The emergency vignettes 88

Preferred models of helping 88

Implications of model selections 89

Implications of making cause or blame attributions 91

Effectiveness of the model selections 93

The Attitudes Toward Patients (ATP) Survey 96

Significance and implications of the ATP findings 97

Significance of relationships between ATP subscales 101

Theoretically aligning the ATP Survey with Models of Helping and Coping 104

The correlation between attributions and attitudes in this study 106

Attributions and attitudes and issues of "legitimacy" 109

Effect of sample characteristics 112

Effect of sample characteristics on attributions 112

Effect of sample characteristics on attitudes 113

Limitations of the study 116

Implications for education 118

Implications for future research 120

Conclusion 123

REFERENCES 127

APPENDICES

A. Critique of instruments used to measure attitudes to mental illness 148

B. Emergency vignettes measurement tool 153

C. Attitudes Toward Patients Scale 157

D. Demographic questionaire 162

E. Letter requesting access to facilities 163

F. Subject information 164

G. Poster 165

H. Announcement for newsletters 166

I. Invitation to participate 167

J. Scatter plots for emergency vignettes 168

ABSTRACT

The emergency department is a major point of entry into the health care system for increasing numbers. This increasing demand strains available resources, necessitating a system of priority setting. Ideally, assessment and disposition of patients should be based on the severity of presenting signs and symptoms, but this may not always be the case. Despite organizational philosophies and policies to the contrary, emergency staff make attributions concerning patients and the "legitimacy" of patients regarding their services.

Attribution making is the cognitive process of ascribing meaning and characteristics to behaviour, taking into account the perceiver's experiences, motivations, emotions, and beliefs. Attributions then mediate emotional reactions, attitudes, and behaviours within the perceiver, which can have significant implications for the care nurses provide. The study was guided by an attribution based framework, entitled Models of Helping and Coping (Brickman, Rabinowitz, Karuza, Coates, Cohn & Kidder, 1982).

The purpose of the study was to examine one consequence of attribution making, attitudes. The research question was threefold: (1) What attributions do emergency nurses make about emergency patients regarding responsibility for cause of problems and responsibility for solution of problems? (2) What is the attitude emergency nurses hold toward patients, especially those classified as psychiatric emergencies? (3) What is the correlation between the attributions of responsibility for cause and solutions, and admitted attitudes toward patients classified as psychiatric emergencies?

The research design was a correlational, self-report survey. Data collection was carried out via three self-report questionaires, which included: 1) the Emergency Vignettes Questionaire; 2) the Attitudes Towards Patients Survey (ATP) (Roskin, Carsen, Rabiner & Lenon, 1986); and

3) a demographic data questionaire. The sample consisted of 102 registered nurses, who worked with adult patients, within the emergency department of the seven Winnipeg acute care facilities.

Descriptive, comparison, and correlational statistics were used to analyze data. Nurses' attributions of responsibility for cause and solution to each vignette were examined. The ATP Survey had seven subscales that measured beliefs regarding the etiology of patients' illnesses and attitudes toward the helper/client relationship. Analysis also involved determining the degree and type of correlation between the attribution subscales and attitude subscales. The effect of sample characteristics (gender, age, years of nursing, years of emergency nursing, practice setting, work status, and education) was tested using t-tests.

Results of the Emergency Vignette Questionaire showed that nurses generally preferred the Medical Model, which assigns low responsibility for cause and solution of a problem to the patient. The second most frequently selected model was the Enlightenment Model, which assigns high responsibility for cause, but low responsibility for solutions to the patient. Ranking of the vignettes, t-tests, and scatter plots suggested that patients with psychosocial emergencies were assigned significantly more responsibility for cause and solution than patients with medical and surgical emergencies. Results of the ATP Survey revealed that nurses generally hold a positive attitude toward patients and prefer a nurturant and empathic nurse/patient relationship. Analysis revealed a significant positive relationship between the Moral Weakness attitude subscale and the Psychosocial Cause and Solution, and Overall Cause and Solution subscales.

Based upon the findings of the study, implications for nursing practice, education, and research was addressed.

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LIST OF FIGURES

PAGE

FIGURE 1 - Kelley and Michela: Process of attribution 31

FIGURE 2 - Diagram of conceptual framework for study 37

FIGURE 3 - Subscales of the ATP Survey and OMI used to predict direction of attitudes 103

FIGURE 4 - Subscales of the ATP Survey aligned according to the Models of Helping and Coping 105

LIST OF TABLES

TABLE 1 - Consequences of attribution of responsibility 34

TABLE 2 - Frequency of medical emergencies listed by emergency nurses 44

TABLE 3 - Frequency of surgical emergencies listed by emergency nurses 45

TABLE 4 - Frequency of psychiatric/psychosocial emergencies listed by emergency nurses 46

TABLE 5 - Average inter-item correlation and reliability of ATP subscales 50

TABLE 6 - Response rates of the sample 58

TABLE 7 - Equivalent full-time status of community and tertiary hospitals, and sample nurses 59

TABLE 8 - Grouped age of community and tertiary hospitals, and sample nurses 60

TABLE 9 - Grouped years of work as a nurse for community and tertiary hospitals, and the sample 61

TABLE 10 - Grouped years of work in emergency for community and tertiary hospitals, and the sample 62

TABLE 11 - Advanced education held by sample nurses 63

TABLE 12 - Educational preparation of community and tertiary hospital, and sample emergency nurses 64

TABLE 13 - Gender, work status, and educational preparation of the population 66

TABLE 14 - Comparison of the population and sample 67

TABLE 15 - Attribution of cause subscores for emergency vignettes 69

TABLE 16 - Attribution of solution subscores for emergency vignettes 69

TABLE 17 - Cause and solution attribution scores for medical, surgical, psychosocial, and overall groups 71

TABLE 18 - T-test and correlation coefficient values for attribution subscales and overall scores 74

TABLE 19 - Results of Attitudes Toward Patients subscales 75

TABLE 20 - Cronbach's alpha for attitude subscales 77

TABLE 21 - T-test and correlation coefficient values for ATP subscales 78

TABLE 22 - Correlation coefficients between attribution and attitude subscales 81

TABLE 23 - Effect of working in community versus tertiary hospital on attitudes 84

CHAPTER I:

Introduction

Introduction to the Problem

The emergency department continues to be a major point of entry into the health care system for large numbers of people. This trend of increasing utilization has been evident for several decades (Geyman, 1980; Lenehan, 1989; Milner, Nicholl & Williams, 1988; Pisarcik, 1980; Roth, 1972b; Walker, 1975; Yoder & Jones, 1982a). A similar trend has been observed for situations broadly classified as "psychiatric emergencies." This classification includes clients defined as mentally ill, victims of abuse, and those in emotional crisis (Coleman & Errera, 1963; Gerson & Bassuk, 1980; Jones, Jones & Yoder, 1982; Nurius, 1983; Seide & Miller, 1983; Voineskos, 1985; Yoder & Jones, 1981).

The increasing demand for emergency intervention places a great strain on available resources and a system of priority setting, known as triage, has become necessary. Triage, from the French language, literally means to sort out. In the emergency department, it is a process by which presenting patients are assessed. Their urgency for care is determined, a priority is assigned and the patient is referred to an appropriate area for care (Rund & Raush, 1981).

Ideally, assessment, diagnosis, and disposition should be based only on the severity of a patient's presenting signs and symptoms. But, this may not always be the case. Despite organizational philosophies and policies to the contrary, Roth (1979) concluded that emergency staff make judgments about the social worth of patients and the appropriateness or "legitimacy" of patients regarding their services. Interpretations are made about the character of patients in a setting where minimal information is available and a long-term relationship is not usually

contemplated. Roth uses the term "moral evaluation" to describe this judgment process, but the underlying concept to which he is alluding is that of attribution.

Significance of the Problem

Attribution is the cognitive process that occurs between an individual's perception of an event and the interpretation about the cause of that event. It is a process that is dependent on the individual's motivation for seeking an interpretation. It is the act of ascribing meaning and characteristics to one's own or others' behaviour, taking into account the perceiver's experiences, emotions, beliefs, and motivations. The attribution, in turn, mediates various emotional reactions, attitudes, and behaviours within the perceiver (Laing, 1989). Attribution making usually occurs in situations that involve unexpectedness, uncertainty, or threat (Lewis, 1988), or when a person feels something needs to be explained. The emergency department can certainly be described as such a situation.

It is accepted that attitudes and beliefs influence actions, which has important implications for the quality of care nurses provide (Bartol & Eakes, 1988). Attributions affect emotions, attitudes, and consequent behaviour. Thus, attributions ultimately affect the type of care a patient receives.

Purpose and Research Questions

The purpose of this descriptive study is to examine attitudes as a consequence of attribution. The research question is threefold. First, what are emergency nurses' attributions toward emergency patients, regarding two specific variables, responsibility for the cause of

problems, and responsibility for the solution of problems? Second, what is the attitude emergency nurses hold toward patients, especially those patients defined as psychiatric emergencies? Third, what is the relationship between the attributions that are made about responsibility for problems and solutions, and attitudes about patients classified as psychiatric emergencies?

Definitions of Terms

For the purposes of this study, the following definitions were used.

An emergency nurse is any nurse, registered with the Manitoba Association of Registered Nurses, who has been employed for at least two years, full time or part time, within the emergency department of any acute care hospital in the city of Winnipeg.

An emergency patient is any adult patient, that is, over the legal age of 18, who presents for treatment to the emergency department of any acute care hospital in the city of Winnipeg, whatever the nature of illness.

A patient with a psychiatric emergency is defined using the criteria laid out by Jones, Jones and Yoder (1982):

1) a person who is a victim of assault such as spouse or elder abuse, rape, gunshot wound, stabbing;

2) a person manifesting psychosomatic symptoms such as tension, nervousness, anxiety or headache;

3) a person manifesting bizarre behaviour, etiology of which may be alcohol, drugs, psychiatric illness or a temporary environmental crisis situation.

Mental illness is any illness that is recognized and listed as a diagnosis within the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM IIIR).

The literature review consists of two main sections. The first section reviews studies involving attitudes and opinions of emergency personnel toward emergency patients. Of particular interest will be "attributions" that have been described in the past. The second section reviews general attitudes toward patients with mental illness. It encompasses most of the major instruments used to measure attitudes toward mental illness. As the data collection procedures used by the researcher can influence the elicited attitudes (McPherson & Cocks, 1983), a brief critique of these instruments is included in Appendix A.

CHAPTER II:

Literature Review

Attitudes Toward Emergency Patients

Utilization Patterns of the Emergency Department

Before one can comprehend the attitudes of emergency nurses, one must examine the environment in which these attitudes are cultivated and the impact that changes in patterns of utilization have had on emergency personnel. Yoder and Jones (1982a) summarized the three most important changes that have occurred over the past three decades:

1) The total volume of visits has risen steadily, and out of proportion to increases in actual hospital admissions, clinic visits and population growth;

2) Psychiatric patients are contributing greatly to the increased Emergency Department use;

3) There is an increasing proportion of non-urgent problems presenting for treatment, while the number of traditional "accident" and emergency patients is decreasing in proportion.

Two other trends have been identified as "inevitable" or already in progress (Pearlmutter, 1987). First, our society is growing older, and elderly clients are using emergency care repeatedly for somatic complaints (Bassuk, Minden & Apsler, 1985; Lloyd, Wilson, Simson & Duncan, 1981; Pearlmutter, 1987). Second, as medical resources become limited, American insurance companies already have become reluctant, or unable to cover costs (Bracken, 1991; Pearlmutter, 1987). Limited resources soon may force insurance companies to call lifestyles into question. They may refuse to pay for clients held to "blame" for their accident or illness, such as someone

intoxicated at the time of trauma, or an AIDS victim (Bracken, 1991). Although no Canadian articles addressing this issue were found, similar trends may be present in Canada.

For some patients, the emergency department is "the only game in town" (Soskis, 1980). Others perceive it as the most convenient health care option (Fisher, 1981; Powers, Reichelt & Jaloweic, 1983; Roth, 1972b) and utilize it as their primary care source (Clement & Klingbeil, 1981; Pisarcik, 1980). Similar findings have been reported by many other authors (Bartolucci & Drayer, 1973; Coleman & Errera, 1963; Gerson & Bassuk, 1980; Geyman, 1980; Hansagi, Norell & Magnusson, 1985; Jones, Jones & Meisner, 1978; Jones et al., 1982; Milner et al., 1988; Nurius, 1983; Roth, 1972b; "What are Accident," 1979; Worth, 1989). Lenehan (1989) depicted the increasing inability to move critically ill patients out of the Emergency, adding yet another strain to an already burdened area. Chronic and "repeater" patients contribute greatly to the total number of emergency department visits (Adityanjee & Wig, 1988; Hansagi et al., 1985; Jacoby & Jones, 1982; Purdie, Honigman & Rosen, 1981; Roth, 1972b; Slaby & Perry, 1980; Voineskos, 1985; Wright, 1989).

The focus of treatment for psychiatric patients has shifted from large custodial hospitals and long-term care to community based mental health centres. As a result, increasing numbers of chronic patients and homeless mentally ill are requiring emergency psychiatric services (Bassuk, 1985). Deinstitutionalization has lead to the emergence of the "new chronic patient." This is the first generation of chronically disabled psychiatric patients, treated only with repeated short term admissions and heavy reliance on community and emergency facilities (Bassuk, 1985; Voineskos, 1985). These patients become involved in a "revolving door" cycle, that is, the cycle of crisis-admission-stabilization-discharge-repeat crisis. This revolving door is still most

frequently located within the emergency department (Gerson & Bassuk, 1980; Fisher, 1989; Merker, 1986; Nurius, 1983; Talbott & Monroe, 1976; Wellin, Slesinger & Hollister, 1987).

Issues of Legitimacy and Moral Evaluation

The increased use of the emergency department as a portal of entry into the health care system has caused increasing conflicts between professionals and patients. This conflict is largely due to discrepancies between the professionals' perception of their roles, and the perceptions of patients using their services (Bartolucci & Drayer, 1973; Coleman & Errera, 1963; Lipson et al., 1987). Phipps (1988), borrowing from the theory of cognitive dissonance, labelled this discrepancy in role perception, "provider-patient dissonance." Roth (1972a, 1972b, 1979) voiced concern that emergency staff will continue to resist the non-urgent use of the department, setting the scene for moral evaluation of patients, and implicit, or sometimes overt, conflict between staff and patients. This moral evaluation involves the making of some specific attributions and the assigning of a "legitimacy" status to patients and their health concerns. Legitimacy is conceptualized as "something that conforms to recognized principles, or accepted rules and regulations" (Webster's New Collegiate Dictionary, 1981). These principles, rules, and regulations, of course, are mandated by the health care professionals themselves.

Legitimacy of the patient has been discussed more fully in this context by several authors (Freidson, 1970; Mannon, 1976; Roth, 1972b, 1979). Using Parson's sick role model as his foundation for classifying illness, Freidson (1970) postulated there are two variables (attributions), which allow us to predict how patients will be received or treated when they become ill. The factors that determine whether their illness will be considered legitimate are: 1) the assignment

of responsibility for their illness state; and 2) the degree of seriousness of the illness ie. minor or serious.

Freidson distinguished between three types of legitimacy:

1) conditional legitimacy - patients are temporarily exempted from normal obligations and gain some privileges so that they can become well again, (eg. minor -a cold; serious - pneumonia);

2) unconditional legitimacy -patients are exempted permanently from normal obligations and obtain additional privileges in view of their helpless situation (eg. minor -scars resulting from trauma: serious -cancer);

3) illegitimate (stigmatized) -patients are exempted from some obligations because they are not held responsible for the illness, but gain few, if any privileges, and take on new handicapping obligations (eg. minor -a stammer: serious -epilepsy).

The management of conditions for which patients are held responsible often involves some type of "punishment." For example, staff may make patients wait, use a brusque manner, or make derogatory remarks about patients in their presence. A common example is the patient, who upon requesting treatment for venereal disease for the third time in a year, is made to wait while staff deal with "real" emergencies. A heart attack victim, on the other hand, is treated quickly and efficiently. The degree of seriousness overrides any responsibility he may be assigned, due to the effect of lifestyle choices on cardiac disease.

Roth (1979) also claimed the moral evaluation and assigning of legitimacy by emergency personnel is dependent on two variables:

1) the application by the staff of concepts of social worth common in the larger society;

2) the staff members' concept of their appropriate work role.

One cannot assume professional training guarantees a "universalistic moral neutrality" (Becker, Geer, Hughes & Strauss, 1961). Though a case may be medically labelled as an illness, nursing personnel are very much influenced by social and moral definitions (Yoder & Jones, 1981). It is safer to assume that people will apply evaluations of social worth common to their culture and will modify their services with respect to their attributions. The manner and degree to which these cultural concepts are applied will vary and affect the quality of the service given (Roth, 1979). One common concept of social worth is the greater value of, and therefore, more aggressive treatment and resuscitation efforts for younger versus older patients (Roth, 1972a 1979; Shelley, Zahorchak & Gambrill, 1987).

Roth (1979) found a generally negative conception of patients during his extensive observational study of six American emergency departments. He described differentiation between patients, into devalued or favoured categories, based on readily perceivable clues such as race, age, mode of dress, language, accents, word usage, and the manner in which the patient addresses and responds to staff members. This value definition and the patient's attributes then reciprocally reinforce one another. Someone may be labelled as "drunk" and treated in a particular manner, or may be treated in a particular manner because they are drunk.

Every worker has a notion of what demands are appropriate, or legitimate, to their position. When the demands fall outside that boundary, they feel the claim is illegitimate (Roth, 1979). What workers do about it is related to several factors, including their alternatives, their power to control the behaviour of others, and their power to select the clientele. Some service personnel, such as lawyers, attempt to control for illegitimate service demands by "selecting" the

clients they like, and avoiding those they do not like. This option is not open to emergency personnel as they cannot refuse to treat a patient.

If one cannot pick desirable clients, a second option is to train the clients so they are closer to the image of the desired client. However, training requires a longer time perspective and commitment. Emergency staff are more interested in directing present behaviour and must rely on immediate compliance (ie. giving orders) (Roth, 1979). Staff insist upon patient "cooperation" so that each work category can perform their appropriate work role. Patients may be scolded for noncompliance with diagnostic or treatment procedures. Emergency staff also have other ways to control the situation (Roth, 1972a). They may ignore, avoid, or keep patients waiting. Information may be withheld or distorted. "Finally, if more subtle techniques fail, the staff can always fall back on physical force to keep order" (Roth, 1972a, p. 47).

A universal complaint heard from most personnel in emergency departments, is that the area is not utilized appropriately, that is, they are "abused" by non-urgent, clinic-type cases (Lipson et al., 1987; Roth, 1972b, 1979). Roth (1979) believed this situation is usually grossly exaggerated. He explained that staff have to justify the rewards received for their labour in part by the burdens they have to endure on the job. They use the purported abuse to justify their existence.

Surgical cases more often are considered legitimate than medical cases, because they are more easily diagnosed and treated. Situations that require more extensive investigation, or where the diagnosis is more subtle or complex, leave the door open for all emergency staff to make a judgment about whether the case is appropriate to, and deserving of their service. Unless the patient is a "regular," which is also considered "illegitimate use," background information on the

patient will not be available. Staff will rely entirely on clues garnered from the mode of arrival, appearance, behaviour, and the type of people accompanying the patient, to assess the situation (Roth, 1979). There is a strong direct relationship between how clinically interesting a problem is perceived to be and how medical students feel about treating patients with that problem (Najman & Arnold, 1984). Of all patients, psychiatric patients are judged the most illegitimate by emergency personnel, as staff do not find them particularly useful for practising their diagnostic or treatment skills (Roth, 1979).

The relationship between social worth and perceived legitimacy is incongruous. The seriousness of a situation can "overcome" moral repugnance, and minor complaints are more acceptable from someone with a higher social worth. The most negative evaluation of a patient therefore occurs when one combines the undesirable character with illegitimate demands. Roth (1979) concluded that any person presenting to the emergency department inevitably sets off a process by which worthiness and legitimacy are weighed. These judgments subsequently become a factor in their treatment.

Mannon (1976) described the legitimacy status evaluations made regarding "problem patients," or patients whose illnesses and medical problems are not amenable to quick, immediate diagnosis and treatment. Problem patients threaten the routine order and function of the emergency department. Problem patients become a management problem and disrupt the necessary balance between demand and resource availability. In consensus with Roth's findings, medical staff conceive their work activity as either legitimate or illegitimate. Patients get evaluated as to whether their case represents a legitimate demand of the staff and resources. Legitimate work is associated with "real" emergencies, including those that involve heroic

measures, or can be treated quickly and coolly. Alcoholics, overdose cases, emotionally disturbed and/or mentally ill patients, patients who defy diagnosis, and "regulars" are most often defined as illegitimate demands on resources (Baker, 1985; Mannon, 1976).

Emergency personnel must continually distinguish between patients who are simply worried, those who have minor illnesses, those who are candidates for sudden deterioration, and those who are critically ill. The fear of making an irrevocable mistake is ever present (Phipps, 1988). Within the first few minutes of a clinical encounter, experienced physicians and nurses begin to generate hypotheses based upon clinical findings, patient cues, and preliminary information. In this process, their judgment is subtly influenced by attributes such as age, sex, social class, economic background, ethnicity, physical appearance or attractiveness, personality, family structure, and diagnosis (Ganong, Bzdek & Manderino, 1987; Johnson, Kurtz, Tomlinson & Howe, 1986). Reactions are not necessarily based on objective data or training, but result from a lifelong conditioning in which stereotypes have been unconsciously integrated into their beliefs. Stereotyping is a convenient way to deal with complexity, because preexisting grouping of ideas are readily available to help in the decision-making (Johnson et al., 1986). Stereotyping and categorizing of psychiatric patients is an especially frequent phenomenon. This labelling, Seide and Miller (1983) feared, may bias staff to discount a patient's physical complaints, thus hindering the diagnosis of a genuine medical condition.

Dealing with "Real Emergencies"

A complaint frequently heard among emergency staff is that patients tend to exaggerate the seriousness of their illness to legitimize the emergency visit. Nyberg (1978) asked emergency patients to rate 20 hypothetical problems regarding perceived threat to life, required promptness of treatment, and category. She found that patients could accurately assess the severity of problems, if provided with clear, meaningful criteria. Contrary to belief, patients judged situations as less severe and categorized them lower than emergency nurses or student nurses. Nyberg cautioned that these findings cannot be generalized as sample sizes were small (N = 20 each group). In contrast, Wood, Rosenthal, and Khuri (1984) reported that psychiatric patients and emergency physicians diverged sharply regarding the need for admission. Voluntary patients (N = 29) overestimated, and involuntary and psychotic patients (N = 92) underestimated their need for hospital care when compared to clinicians.

Emergency personnel protest that patients classified as psychiatric emergencies are not real or "true" emergencies. Jones, Jones, and Yoder (1982a) used urgency categories taken from Lavenhar, Ratner, and Weinerman (1968) to review 720 patient presentations to the emergency department. They reported that while psychiatric and non-urgent patients contributed greatly to the increased use of emergency departments, psychiatric patients were just as urgent as non-psychiatric traditional emergency patients.

Studies by Jones, Jones, and Yoder

Jones, Jones, and Yoder have contributed most to knowledge regarding the attitudes and feelings of emergency nurses about different types of patients presenting to the emergency department (Jacoby & Jones, 1982; Jones et al., 1982; Jones et al., 1978; Jones, Yoder & Jones, 1984; Yoder & Jones, 1981; Yoder & Jones, 1982a, Yoder & Jones, 1982b). Their main study involved surveys and observations collected in the emergency departments of three large urban Northeastern Ohio hospitals (Jones, Yoder & Jones, 1984; Yoder & Jones, 1981; Yoder & Jones, 1982a, Yoder & Jones, 1982b). Although the sample size was small (N = 51), the questionnaire they designed could be useful for a variety of studies, allowing for future replication and generalization.

The patterns that emerged lend support to the assertions of Freidson (1970), Roth (1972b, 1979), and Mannon (1976). Despite a decline in frequency, the most popular patients with emergency nurses are traditional emergency patients, that is, traumas, accidents, cardiac patients, acute medical/surgical patients, and children (Jones et al., 1984; Yoder & Jones, 1982a). The least liked patients include: patients classified as "non-urgent" cases (Yoder & Jones, 1981), traditional psychiatric patients (especially alcoholics), patients needing emotional support, and patients with nonspecific, irresolvable medical problems (Jones et al., 1984; Yoder & Jones, 1982a). Nurses dislike these patients because of frustration and fear, as well as a lack of knowledge about how to deal with them. Feelings aroused by disliked patients include anger, fear, frustration, helplessness, resentfulness, and annoyance (Yoder & Jones, 1982a).

Additional Studies about Emergency Personnel

Baker and Moynihan's (1983) survey of knowledge, attitudes, and concerns indicated that emergency nurses are satisfied and confident in their triage skills, but want more specific knowledge about "emergency type situations." Nurses expressed fear and uncertainty about dealing with psychiatric patients. This study is extremely limited in both scope and sample size (N = 19), and while it reinforces the findings of Jones, Jones and Yoder, results cannot be generalized.

Pejorative attitudes toward those who attempt suicide are held in varying degrees by most people ("A Nurse in Need," 1990; Costigan, Humphrey & Murphy, 1986; Jack & Williams, 1991). Pallikkathayil and Morgan (1988) reported feelings of anger and sorrow in emergency nurses who cared for suicidal patients. Extreme differences existed in how nurses judged the meaning or motive of the act. Suicide can be a desperate act, wanting help, "a waste," or manipulation. The helper's attribution of motivation determines their emotional reaction to the client, which affects their willingness to help and what type of help is offered (Jack & Williams, 1991). Insufficient time and staffing to provide desired care for suicidal patients were nurses' greatest stressors. Other stressors included: the attempter's abusive behaviour, value judgments concerning time spent on a self-inflicted problem and resuscitating someone who wants to die, ineffective disposition or follow-up care for the attempter, and dealing with "repeaters" (Pallikkathayil & Morgan, 1988). Winstead-Fry (1988) questioned whether it is ethical or even realistic to expect a nurse, whose expertise is quick action in physiological emergencies, to have the skills necessary to intervene in the post-suicidal attempt period. Soukas and Lonnqvist (1989) compared emergency room, emergency ward, and intensive care staff regarding their attitude

toward those who attempted suicide. Emergency room staff, where all suicide attempts are first treated, had the least positive attitude. Intensive care staff, who treat the most serious cases, held the most positive attitude. Rund (1984) marvelled that emergency physicians still hold the pervasive belief that people who attempt suicide and are treated well in the hospital will be encouraged to attempt suicide again.

Others reported equally negative attitudes toward victims of rape and battering. Recent attempts to medicalize the area of battering generally have met with resistance. Kurz (1987) described three emergency departments where personnel "saw efforts to respond to battering as detracting from the proper performance of their work, not enhancing it" (p. 70). Staff responded positively to women they perceive as "true victims" - those who are polite, lack discrediting attributes, and some unfortunate event has happened to them. They are more sympathetic to women who are taking action to leave the violent relationship. If the victim has a pleasant personality, it legitimizes the time and attention spent on her. Partial or no responses are made if a woman is "evasive" or inconsistent in her history. A second limiting factor is if the woman has a condition that makes it difficult to interact with her, such as under the influence of alcohol or drugs. Third, staff believe there is nothing they can do to help or "produce results" with these women. Some staff maintain battering is not a legitimate medical concern; others view it as an invasion into a patient's affairs. Medicalization is supposed to mean that moral judgments or attitudes of "badness" are replaced by concepts of illness (Conrad & Schneider, 1980). Kurz (1987) did not find this true for battered women.

King (1988), using Models of Helping and Coping (Brickman et al., 1982) for her conceptual framework, found nurses prefer to use the Medical Model when dealing with battered

women. This was true regardless of practice setting or whether nurses had specific knowledge regarding the topic of battering. While this model does not blame victims for causing their problems, it also assumes they cannot solve their problems. The nurses' second choice was the Moral Model, which attributes high responsibility for both cause and solution to the victim. Neither approach has been found helpful to the victim of battering.

Rape also has been identified as a crisis, but the emphasis of emergency care is the management of the physiological, not the psychological trauma. Attribution of blame for the assault toward the rape victim, Cochrane (1987) noted, is influenced by appearance, behaviour, perceived carelessness, age, and marital status of the victim. Assault by a stranger evokes more sympathy from emergency nurses. No significant difference in attitudes toward rape was found in relation to the respondents' educational level, years of general nursing or emergency experience, or attendance at an educational program on rape. Burgess and Holmstrom (1973) cautioned that "any attitude which blames the victim will serve only to abort any therapeutic relationship before it has a chance to develop" (p. 1745).

Only one study, which consisted of 1000 nurses randomly selected from American Emergency Nurses' Association members, suggested that emergency nurses perceive psychiatric and non-psychiatric patients similarly. Welsh (1991) reported that emergency nurses have well-developed empathy, and found no significant difference in the levels of empathy expressed toward these two types of patients. Nurses in administrative positions also expressed greater empathy than nurses in clinical positions.

It has been suggested that problematic attitudes are inevitably characteristic of night shifts. To explore the impact of shift work on attitudes, Peterson (1985) interviewed (N = 278) or

surveyed (N = 272) emergency nurses from 33 short-term general hospitals (100-499 beds) located in Michigan, Indiana, Ohio, Illinois, Wisconsin, and Minnesota. Analysis revealed greater variation in attitudes between emergency units, than between shifts (Peterson, 1985). The hypothesis that shift work is related to more negative attitudes was not supported.

Attitudes Toward Emergency Patients Summary

In summary, it is evident that emergency personnel do make moral evaluations or attributions about patients. In addition, there emerges a generally negative pattern to the attitudes and opinions that emergency personnel hold about some types of patients. The least valued is the psychiatric patient. Although there appears to be a correlation between the moral evaluations or attributions, and the attitudes that are held, no study has specifically focused on this link. In the next section, the literature on attitudes toward mental illness will be examined more closely.

Attitudes Toward Mental Illness

Mental illness is a special case that readily allows moral judgments to be made. There are no technical criteria to be applied and psychiatric concepts, in their historical development, have been a pseudoscientific replacement of moral judgments (Szasz, 1960). The probability that a mental disorder will be attributed by an observer to an actor is positively related to the degree the actor's behaviour differs from the beliefs and attitudes of the observer (Levinson & Wolf, 1983). Attitudes toward patients labelled as mentally ill are significant because of the impact the professionals' attitudes has upon the actual care received by these patients (Bartol & Eakes, 1988; Cohen & Struening, 1964; Harris, Rich & Crowson, 1985a).

No studies specifically measuring the attitudes of emergency nurses toward mental illness were found. Therefore, attitudes of health care professionals, in general, were reviewed. Yet, one must recall that the attitudes of emergency personal toward patients who attempt suicide (Costigan et al., 1986; Rund, 1984; Pallikkathayil & Morgan, 1988; Soukas & Lonnqvist, 1989), who present with alcohol or drug addiction (Baker, 1985; Corten & Pelc, 1986) or other psychosocial problems such as rape (Cochrane, 1987) or battering (Kurz, 1987), are generally negative. Even the term "psychosomatic" elicits negative connotations and attitudes (Bartol & Eakes, 1988).

Most investigators measuring attitudes toward mental illness attempted to determine the relationship between attitudes and one or more of the following variables: age, gender, exposure or work experience with the mentally ill, occupational or professional level, and education. Several studies examined the effects of labelling someone as mentally ill. Others looked at the link between media exposure or personality characteristics and attitudes. Only one attempted to relate endorsed attitudes to perceived behaviour.

Effect of Age and Gender on Attitudes

Age appears to have little or no affect on attitudes toward mental illness (Cohen & Struening, 1962; Weller & Grunes, 1988). Findings regarding gender, on the other hand, are variable. Some observed that women are less judgmental toward patients, more likely to tolerate patient autonomy (Carsen, Roskin, Rabiner & Marell, 1987; Roskin, Carsen, Rabiner & Lenon, 1986), and more positive to treating patients with social problems (Najman & Arnold, 1984). Alternately, Oyefeso, Osinowo, and Idemudia (1989) claimed males express more positive

attitudes. Cohen and Struening (1962), using the Opinions about Mental Illness questionaire, Fryer and Cohen (1988), using an adjective check list, and Johnson and his colleagues (1986), using videotaped vignettes, found no significant attitudinal effects related to the perceiver's gender.

Effect of Exposure and Work Experience on Attitudes

Findings regarding the effect of exposure or work experience with the mentally ill also vary. Kahn (1976) compared the attitudes of psychiatric nurses (N = 8) and medical/surgical nurses (N = 8), matched for age and education, with student nurses (N = 11). Long term experience on psychiatric wards was related to a more authoritarian and restrictive attitude, and less belief in interpersonal etiology and mental health ideology. Although interesting, the findings cannot be generalized as the samples were small and the questionnaire was not administered under controlled conditions. Marsey (1988) found psychiatric nurses (N = 29) to be more positive and tolerant in their attitudes toward the mentally ill than those (N = 30) from other areas of nursing. In addition, the attitudes remain stable with increasing levels of psychiatric experience. Fryer and Cohen (1988) reported no significant attitudinal effects based on whether the perceiver provides direct care to psychiatric patients, or is support staff, who does not provide direct care.

Hicks and Spaner borrowed items from the Custodial Mental Illness Ideology Scale (Gilbert & Levinson, 1957) and Middleton's 1953 Prejudice Scale (cited in Askenasy, 1974) for their 1962 quasi-experimental study. The hypothesis that psychiatric clinical experience would result in a significantly greater favourable shift in attitudes toward mental illness, than non-psychiatric clinical experience, was strongly supported. Sample sizes were large (N1 = 78;

N2 = 354). Groups included a pretest only group, as well as control and experimental groups, who received both a pretest and a posttest. Following psychiatric clerkship, Roskin and his colleagues (1986) also reported a high sustained endorsement of psychodynamic factors and an increase in acceptance of biological factors as the etiology of mental illness. A small group of control students, with no psychiatric experience, showed none of these changes.

The Attitudes Toward Mental Illness (AMI) questionnaire, developed by Weller and Grunes (1988), was based on the assumption that opportunity for acquaintance increases mutual understanding. The AMI was tested with three groups of nurses, those with maximum, medium, or no contact with the mentally ill. Neither the degree of contact nor previous experience with the mentally ill affected nurses' attitudes toward the mentally ill. On the other hand, Oyefeso and colleagues (1989) found high propinquity subjects (ie. greater contact, such as psychiatric caregivers) held more positive attitudes than low propinquity subjects (hospital personnel who never deliver mental health services).

Mall and Shaw (1987) used vignettes to test female nursing students, holding constant the factors of age, gender, educational background, previous experience with the mentally ill, and work experience prior to entering nursing. Not surprisingly, the group that completed course work and supervised experience with psychiatric patients was better able to perceive the presence and severity of mental illness in the people portrayed, than those with no experience. No other differences were evident. However, sample sizes (N1 = 34; N2 = 37) again were a limiting factor.

Effect of Occupation and Profession on Attitudes

Most studies regarding the effect of occupation or profession show distinct patterns. Using the Opinions about Mental Illness (OMI) scales developed by Cohen and Struening (1962, 1963, 1964, 1965), extensive studies were conducted concerning the attitudes of various health workers toward mental illness. The OMI provides for five separate factor scores. Factor A (Authoritarianism) views the mentally ill as an inferior class requiring coercive handling. A high score shows an authoritarian attitude. For Factor B (Benevolence), the positive pole represents a kindly, paternalistic view whose origins derive from religion and humanism. Factor C (Mental Hygiene Ideology) maintains that mental illness is an illness like any other and uses the medical model. A high score indicates agreement with this belief. Factor D (Social Restrictiveness) views the mental patient as a threat to society, who must be restricted in his functioning. High scores show a high degree of restrictiveness. The positive pole of Factor E (Interpersonal Etiology) reflects the belief that mental illness arises from interpersonal experience, especially deprivation of parental love during childhood. (See Appendix A for further information regarding the OMI scale.)

Cohen and Struening (1963) grouped nineteen occupational categories (N = 8,248) into four clusters, in terms of their attitudes. White collar workers such as nurses, technicians, dentists, and non-psychiatric physicians, scored low on the authoritarianism scale. Other scores were average although nurses scored higher on benevolence than others in the group. Blue collar workers, such as nurses aides, maintenance and kitchen workers, scored high on authoritarianism and social restrictiveness, and low on benevolence, mental hygiene ideology, and interpersonal etiology. Professionals, such as psychologists and social workers, were exactly opposite to the

blue collar workers. Psychologists scored low on the benevolence scale. The fourth group, clergymen and chaplains, was less extreme than professionals. They scored low on authoritarianism and social restrictiveness, and high on mental hygiene ideology. Psychiatrists, who were listed as "unclustered," fell between the clergy and the professionals in their scores.

Cohen and Struening (1964) emphasized that it is important to reduce the degree of authoritarianism. Authoritarian and restrictive atmospheres are negatively correlated with patients' well-being and subsequent discharge rates. Authoritarian and Benevolent Attitude scale results were found to vary across hospitals in different geographical locations for nurses and aides, but not for professionals (Cohen & Struening, 1965). Williams and Williams (1961) reported that aides are more authoritarian and higher on anomie (ie. disorganization of social and personal values) than student nurses, as measured by two scales designed by the investigators. These findings are significant because it appears the general atmosphere of any given hospital is largely determined by the attitudes of the nurses and sometimes, the nurses' aides (Cohen & Struening, 1965; Scott & Philip, 1985).

Roskin and his colleagues (1988) explored the attitudes of health professionals using the Attitudes Toward Patients (ATP) Survey, a 72 question Likert scale they developed. The ATP measures: 1) attitudes toward causality or etiology for organic and psychiatric disorders, which include psychodynamic, biological, and moralistic dimensions; and 2) attitudes toward doctor/patient relationships, which included authoritarian-controlling, nurturant-empathic, and distancing-detachment factors. The original scale also measured attitudes in terms of positive or negative valence toward certain patient types to assess overvaluation versus devaluation. Psychiatrists scored significantly higher in their psychodynamic approach, followed by

psychologists, social workers, and nurses. Social workers scored lowest on the psychodynamic scale regarding the etiology and treatment of organic illness. Nurses had the highest biological orientation, followed by social workers, psychiatrists, and psychologists. No differences were found on the scale measuring "Moral Weakness." Psychiatrists had the highest authoritarian-controlling attitudes. Nurses had the lowest nurturant-empathic scores and were most likely to distance themselves from patients. Psychiatric residents scored significantly higher in the nurturant-empathic scale, higher in the psychodynamic etiology, and lower in the moral-weakness etiology than other physician groups (ie. surgery, medicine, pediatric residents, and medical students) (Roskin & Marell, 1988). The authors accounted for the differences by the personality of the individuals in any given field and the training and clinical experience within the particular discipline.

Effect of Education on Attitudes

The effect of education on attitudes toward the mentally ill appears to be positive (Casco, Natera & Herrejon, 1987). Cohen and Struening (1962) reported education, as determined by occupation, had a substantial negative relationship to the factors of authoritarianism (A) and social restrictiveness (D), and were positively correlated with benevolence (B) and the mental hygiene ideology (C). Other studies, using the OMI instrument, also showed positive changes in attitude related to educational experience. Medical students scored higher on the Mental Hygiene Ideology scale (Gelfand & Ullmann, 1961b) and lower on the Authoritarian and Social Restrictiveness Scales following clerkship in psychiatry (Meltzer & Grigorian, 1972).

Several studies, using the OMI, showed education or training results in positive changes in nursing students' attitudes toward mental illness (Bairan & Farnsworth, 1989; Cheech, 1977; Gelfand & Ullmann, 1961a; Lewis & Cleveland, 1966; Morris, 1964; Smith, 1969). Gelfand and Ullmann (1961a) administered a pre- and posttest to experimental (N = 36) and control groups (N = 23) of student nurses. Bairan and Farnsworth used one group comparison with 185 student nurses in a three year university based program. For all studies, student nurses showed a decrease in authoritarianism and social restrictiveness, and an increase in the mental health ideology. All reported an increase in interpersonal etiology, except Bairan and Farnsworth (1989), who showed a non-significant decrease. Results regarding benevolence vary, but Bairan and Farnsworth (1989) were the only researchers reporting a significant decrease. However, as benevolence expresses a "Christian kindliness point of view," a decrease suggests students are rejecting this "moralistic-paternalistic perspective" (Bairan & Farnsworth, 1989). Gelfand and Ullmann (1961a) cautioned that other factors may be responsible for the positive changes, and attitude changes do not necessarily mean changes in behaviour within the work setting.

Similarly, Olade (1983), in studying the effect of introducing mental health concepts into a three year nursing program in Nigeria, reported positive changes regarding mental hygiene ideology and interpersonal etiology, and reduction in authoritarianism and social restrictiveness. Statistical significance of the changes was not computed. Slimmer, Wendt, and Martinkus (1990) found that an environment, supportive of student learning and personal development, was more significant than clinical site location, in evoking a more positive attitude in student nurses.

Using a semantic differential tool, Eker (1985a) found the attitudes of Turkish clinicians (psychiatrists, social workers, psychologists) and Turkish psychology students, toward mentally

ill patients, were analogous to those of American clinicians. He suggested two explanations for this similarity. First, Turkish psychiatry and psychology have been influenced by Western psychiatry and psychology and clinicians may develop similar attitudes during their academic and practical training. Second, both groups already held similar attitudes before their training.

Calicchia (1981) compared the attitudes of randomly selected mental health professionals (psychiatrists, psychologists, social workers), mental health students working with ex-mental patients (interns and residents), and non-mental health professionals (NMHP) (teachers, lawyers, engineers) (N = 104 or 59% response rate). Instruments included a semantic differential (ie. 28 bipolar adjective pairs) and a social distance measuring device. Results showed that although the general attitude toward people was positive, the view of the ex-mental patient was discernibly negative. The mental health professional group was slightly less so inclined than the NMHP group. Calicchia maintained this study contradicted the findings that education and increased knowledge about patients are positively correlated with a more accepting attitude of ex-mental patients. Besides their negative attitudes, many mental health professionals believe other people are "highly fearful, biased, and ignorant" regarding mental illness (Bissland & Munger, 1985).

Effect of Labelling on Attitudes

Farina and Ring (1965) used male college students to study the effects of "labelling" on the assessment of character and abilities of a partner sharing in a simple task. Using a cross section of diploma and baccalaureate nursing students, Swain (1973) replicated Farina and Ring's study. Swain found the partner who is labelled as an ex-mentally ill patient is rated more negatively by student nurses, as compared to a normal person. Yet, completion of a psychiatric

nursing course positively influenced the ratings. Diploma nursing students, who had completed a psychiatric nursing course compared to those who had not, showed the greatest positive change in their ratings.

Fryer and Cohen (1988) replicated Jones and Cochrane's (1981) work regarding labelling and stereotyping of mental illness and Link's (1987) reported relationship between labelling and expectations of rejection. A modified version of Gough and Heilbrun's (1965) adjective check list was used to test what effect labelling of patients as "psychiatric" or "medical" would have on the attitudes of 97 (N1 = 47 male; N2 = 50 female) newly hired psychiatric hospital employees. Patients labelled as psychiatric were rated as less likable, and viewed as having more unfavourable, and fewer favourable traits. Specifically, psychiatric patients were characterized as more irresponsible, less dependable, and less clear-thinking than medical patients. Fryer and Cohen (1988) concluded, "The overall findings indicate that despite a generation of professional advocacy of the medical model, those charged with the care of psychiatric patients continue to view them as less socially desirable than medical patients" (p. 779).

Berman and Berman (1984) supported this conclusion. Twenty first and second year social work students and 10 accredited social workers were asked to read a clinical interview and rate the client's level of adjustment and prognosis. Clients labelled as psychotic were given more negative ratings than clients described as normal. Surprisingly, the higher the subject's level of training, the poorer was their rating of the psychiatric clients.

Patient Characteristics and Attitudes

Using a semantic differential technique, in a survey of 13 medical interns, Reynolds and Bice (1972) described a hierarchy of attitudes toward 11 types of patients and health professionals. Most medical personnel were rated as more favourable than any type of patient. In negative order, the rating of patients is: acutely ill, chronically ill, emotionally ill, "crock" (ie. patient seen as being without any disease process). Although one cannot generalize the findings from this sample, negative evaluations of any type of patient are of concern.

The data-gathering instrument of Harris and colleagues (1985a, 1985b) has 64 patient characteristics, to which 39 first year internal medicine residents and 39 randomly selected staff physicians were asked to indicate their willingness to treat. Characteristics that elicited the most negative responses clustered in four areas:

1) those that might hinder effective doctor/patient communication;

2) those that might reflect a general societal rejection of certain qualities;

3) those associated with self-destructive tendencies;

4) those associated with psychological problems or aspects of illness.

The authors suggested caution when interpreting these results. The measurement cutoff points were arbitrarily set, and willingness to treat may not necessarily reflect attitudes or actual behaviour displayed. In their follow-up study of the medical resident group, completed after one year of residency, subjects (N = 34) expressed even more negative attitudes toward patients, except in one area, "those associated with self-destructive tendencies" (Harris, Rich & Crowson, 1985b). Alcohol abuse ranks first among all-age physicians as the most negative patient characteristic (Najman, Klein & Munro, 1982).

Additional Studies

Matas, el-Guebaly, Peterkin, Green, and Harper (1985) used a slightly different approach. They examined the effect media coverage of psychiatric issues has on medical and public perceptions of the mentally ill. They reported that education is more significant than age or media exposure for eliciting positive responses to mental illness.

Wilcox (1987) found no correlation between nurses' attitudes toward mental illness and personality styles. The study involved a pretest and a 14 day posttest of a control (N = 50) and experimental group (N = 50), consisting of general medical, surgical, and critical care nurses from an Austin community hospital. The treatment, a two hour lecture/discussion focusing on personality disorders and emotional issues relevant to the medical setting, appears to have positively influenced attitudes. The experimental group showed decreases in both authoritarianism and social restrictiveness.

One study examined the relationship between attitudes endorsed by mental health personnel and how their behaviour was perceived by hospitalized psychiatric patients (N = 188). The OMI scale, among others, was used to measure staff attitudes. Ellsworth (1965) observed that a restrictive attitude, as shown by a high score in Factor D (Social Restrictiveness), did correlate with restrictive and controlling behaviours. A high score in Factor B (Benevolence) should reflect a kindly, paternalistic attitude, but incongruently, it was related to aloof, distant, and dishonest behaviour. Further analysis revealed a core of attitude statements that were endorsed by both restrictive and benevolent staff. These items were positively correlated with the Factor A (Authoritarian) scale. Ellsworth calls this combination of attitudes, "nontraditionalism." Nontraditional staff rejected the traditional concepts that mental illness is caused by lack of will

power, disease of the nervous system, or lack of parental love. They rejected the idea that patients are dangerous, unpredictable or different from normal. These staff were described by patients as warm, sensitive, reliable, and honest, a picture that does not fit with a high score on the authoritarian scale. The findings are noteworthy, but the sample was combined (N = 65 nurses and aides) and it is unclear how many compose each category. Ellsworth (1965) cautioned that endorsing an attitude does not necessarily lead to congruent behaviour. In addition, one must consider the situational demands of the particular treatment area in which the staff must function. Attitudes and behaviours that are effective in one ward setting may not necessarily be effective in another.

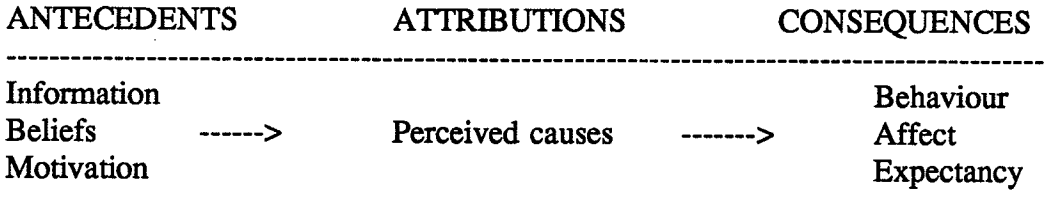
Attitudes Toward Mental Illness Summary

In summary, available studies show distinct attitudinal patterns for different categories of mental health workers, but overall, most show a negative attitude toward the mentally ill. One must continue to consider the factors of age, gender, experience, social class as related to occupational level, and the personalities of individuals as possible influences. Educational programs have been related to positive attitude changes in most studies. Unfortunately, this does not necessarily result in changes in behaviour, or maintenance of this attitude within the work environment.

Conceptual Framework

The conceptual framework used for this study was based on the theory of attribution. Attribution is the cognitive process that occurs between an individual's perception of an event, and the interpretation about the cause of that event. It is the act of ascribing meaning and characteristics to one's own or others' behaviour, taking into consideration the perceiver's experiences, emotions, beliefs, and motivations. The attribution, in turn, mediates various emotional reactions, attitudes, and behaviours within the perceiver (Laing, 1989). Attitudes influence actions, which can have important implications for the quality of care nurses provide (Bartol & Eakes, 1988). Attribution making tends to occur in situations that involve unexpectedness, threat, and uncertainty (Lewis, 1988), or when the motivation to control the environment is strong (Pittman & D'Agostino, 1985). Kelley and Michela (1980) depicted the process of attribution using this simple diagram (see Figure 1).

Figure 1. The process of attribution



From "Attribution Theory and Research" by H. H. Kelley and J. L. Michela, 1980, Annual Review of Psychology, 31, p. 459.

Models of Helping and Coping

The specific model used, called "Models of Helping and Coping," was developed by Philip Brickman (Brickman, Rabinowitz, Karuza, Coates, Cohn & Kidder, 1980, 1982). The model has not been applied to an emergency setting. Its versatility within the medical field has been demonstrated with childbearing clients (Cronenwett & Brickman, 1983), with patients having life-threatening illnesses such as cancer (Degner, Henteleff & Ringer, 1987; Northouse & Wortman, 1990), or AIDS (Moulton, Sweet, Temoshok & Mandel, 1987), and in psychotherapy (Rabinowitz, Zevon & Karuza, 1988; Tracey, 1988). The model has been used to compare nurses' attributions with those of mutual aid organization members (Ryan, 1985), to analyze nurses' evaluations of patient attributions for the cause and future of their illness (Allen, 1990), and to investigate nurses' attributions toward battered women (King, 1988). In addition, Jack and Williams (1991) used the model to analyze why interventions with suicidal patients fail, and Rosenstock (1988) explored the issue of patient compliance.

Brickman and his colleagues (1980, 1982) stated that the manner in which any helper and/or client approaches a helping relationship is dependent on the attributions made regarding two variables. First, who is held responsible for being the origin of the problem? They claim this addresses the questions of "deserving" and blame. Second, who is held responsible for finding the solution for the problem? This involves an assessment of who might be able to control future events. The authors proposed that people may not be consciously aware they are making attributions about personal responsibility, but they cannot, as social actors, avoid making such assumptions.

The combining and mixing of the two variables, responsibility for the cause and responsibility for the solution of a problem, results in four fundamentally different orientations or perspectives to the helping relationship. Each orientation is internally coherent, and in some measure incompatible with the other three. Each has inherent strengths and weakness, advantages and disadvantages. Each set of assumptions makes it easier to solve certain problems or harder to resolve others. The four orientations specify the behaviour expected of a person trying to cope, or trying to help with a problem, and reflects the underlying attitude toward the recipient and the helping relationship. The four orientations are:

1) The Moral Model - the individual is responsible for causing the problem and finding the solution (eg. self-help groups, est training);

2) The Medical Model - the individual is not responsible for causing the problem or finding the solution (eg. modern medicine, psychoanalysis);

3) The Compensatory Model - the individual is not responsible for causing the problem, but is responsible for finding the solution (eg. cognitive behaviour therapy); and

4) The Enlightenment Model - the individual is responsible for causing the problem, but not responsible for finding the solution (eg. Alcoholics Anonymous, Weight Watchers).

Brickman's (Brickman et al., 1980, 1982) general hypothesis was that each set of attributions has characteristic consequences for the competence, status and well-being of the actor. Table 1 summarizes the consequences of responsibility attribution within each orientation (see Table 1). The model that is operationalized by the helper, and the person trying to cope, ultimately can affect whether the relationship will be helpful or effective.

Table 1: Consequences of Attribution of Responsibility in four Models of Helping and Coping

ATTRIBUTION TO SELF OF RESPONSIBILITY FOR PROBLEM	ATTRIBUTION TO SELF OF RESPONSIBILITY FOR SOLUTION	
	HIGH	LOW
HIGH	Moral Model	Enlightenment Model
Perception of Self	Lazy	Guilty
Actions expected of self	Striving	Submission
Others besides self		
Who must act	Peers	Authorities
Actions expected of others	Exhortation	Discipline
Implicit view of human Nature	Strong	Bad
Potential Pathology	Loneliness	Fanaticism
LOW	Compensatory Model	Medical Model
Perception of Self	Deprived	Ill
Actions expected of self	Assertion	Acceptance
Others besides self		
Who must act	Subordinates	Experts
Actions expected of others	Mobilization	Treatment
Implicit view of human Nature	Good	Weak
Potential Pathology	Alienation	Dependency

Taken from American Psychologist, April 1982, page 370.

The effectiveness of using a model, that is, "whether the recipient is better off after the help than before," can vary greatly, depending on the situation in which it is operationalized (Brickman, Kidder, Coates, Rabinowitz, Cohn & Karuza, 1983; Coates, Renzaglia & Embree, 1983; Rabinowitz, Karuza & Zevon, 1984). There are situations more suited to the use of one model versus the others (Brickman et al., 1982). For example, models in which people are held responsible for solutions (Compensatory and Moral models) may be more beneficial to recipients because, theoretically, they are more likely to result in an increase in people's competence than are models in which they are not held responsible for solutions (Medical and Enlightenment Models) (Brickman et al., 1982; Cronenwett & Brickman, 1983; Chrystal, 1988; Rosenstock, 1988). It is unclear whether it is beneficial not to hold people responsible for finding the solution to their problem (Degner et al., 1987; Tracey, 1988).

Brickman's second hypothesis stated that help would contribute to the solidarity and stability of a relationship when it embodied assumptions congruent with the dominant assumptions about status within that relationship (Brickman et al., 1982). For example, when the helping relationship is unequal in status, it will be most stable if the help flows from the superior to the inferior along the lines of the Medical or Enlightenment Models.

A third hypothesis, which is not stated, but implied, was that the helping relationship would be more effective if the helper and recipient were using congruent models. The match or mismatch between attributions is critical in determining whether people seek help when in a crisis, and whether they respond to help when they receive it (Jack & Williams, 1991). Some reseachers suggested that congruence regarding the attribution of cause or blame was more significant than congruence of solutions (Glidden & Tracey, 1989; Stewart, 1989; Tracey, 1988).

Certainly, the helping process could begin sooner if the recipient's and helper's models match (Cohn, 1983). Allen (1990) suggested that patients who accept responsibility for their future, regardless of the helpers' views, are seen as more realistic, coping better, and more liked.

Finally, Brickman (Brickman et al., 1982) proposed that successful treatment may be characterized by the slow movement over time from the Medical or Enlightenment Models, to the Compensatory or Moral Models of helping and coping. Others submit a cyclical approach. For example, Rabinowitz and her colleagues (1988) suggested that all models may be valid at different stages during therapy. Karuza, Zevon, Rabinowitz and Brickman (1982) advised shifting models as the client's perceptions of the problem changes. No specific pattern of change was recommended.

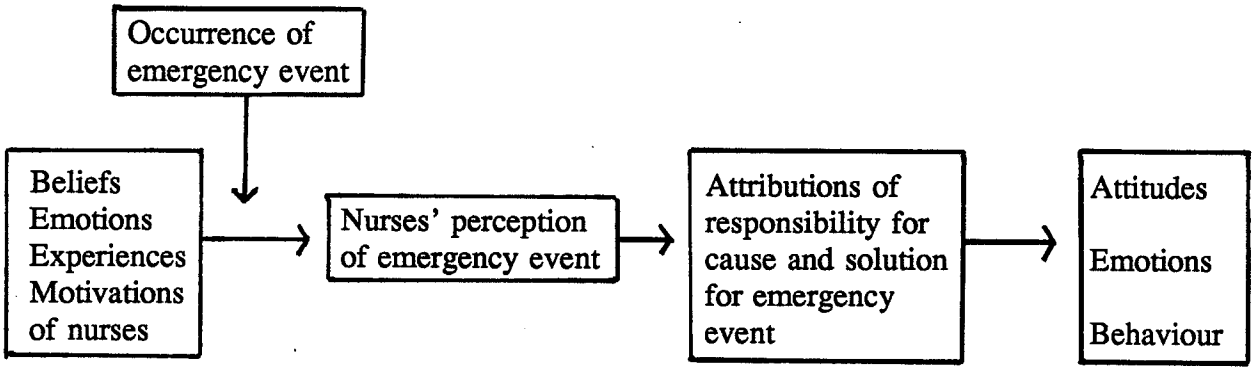
Education (Ryan, 1984), experience (Memmott & Brennan, 1988), bureaucratic organization, or professional group (McGovern, Newman & Kopta, 1986; Rabinowitz et al., 1988) of the helper may dictate what models are acceptable or allowed within any given helping situation. In addition, Tracey (1988) emphasized that the important dimension may not merely be the endorsement of a particular attribution, but the extent in which it is behaviourly reinforced.

Summary of Conceptual Framework

Models of Helping and Coping is a model based on the theory of attribution. It provided the framework for investigating the helping relationship that occurs within the emergency department. When involved in a helping relationship, it is proposed that helpers such as emergency nurses, make specific attributions concerning responsibility for the cause of a problem, and responsibility for the solution to the problem. These two attributions subsequently may

influence their attitudes toward patients and determine the type of help they are prepared to provide to patients. Therefore, attributions of responsibility can have significant implications for the practice of nursing and can affect the quality of nursing care. The conceptual framework for this study can be depicted as in Figure 2.

Figure 2. Conceptual Framework for the study of emergency nurses, using Brickman's Models of Helping and Coping



CHAPTER III:

Methodology

Introduction

The attributions of responsibility for the cause of a problem and for the solution to the problem, which helpers ascribe to a help recipient, influence the helper's attitude and behaviour, and the type of help they are willing provide to the recipient (Brickman et al., 1982). The purpose of this study was to learn what attributions of responsibility emergency nurses ascribe to various types of emergency patients, and how these attributions correlated with the attitude they held toward patients, especially those classified as psychiatric emergencies. Subjects were asked to attribute responsibility for the cause and solution of a problem for 10 typical emergency situations. Their attitude toward psychiatric patients was measured using a tested attitude tool. The researcher determined the relationship between the nurses' attributions of responsibility for illness cause and solution, and their stated attitudes.

Research Design

Eight factors must be considered when selecting a research design: 1) the nature of the research problem; 2) available time; 3) available resources; 4) possible danger to health or safety of people; 5) the exploratory nature of the study; 6) the degree of refinement of the measurements of the variables; 7) the extent to which subjects cooperate; and 8) the degree to which one hopes to explain causality (Abdellah & Levine, 1986). The research design chosen for this study is a quantitative and nonexperimental, an ex post facto or a simple correlational survey design (Abdellah & Levine, 1986; Kovacs, 1985; Polit & Hungler, 1987; Roberts & Burke, 1989;

Wilson, 1989). Ex post facto and correlational can " . . . be used roughly equivalently . . . to designate studies of relationships among independent variables when the variable is not under the researcher's control" (Polit & Hungler, 1987, p. 143). When only two variables are of interest (attributions and attitudes), it is called a simple or one-way correlational design (Shelley, 1984).

Survey research generally serves the purpose of describing characteristics, opinions, attitudes, or behaviours as they exist in a population (Polit & Hungler, 1987; Wilson, 1989). Kovacs (1985) defined correlational survey research as " . . . statistical studies used for the purpose of predicting possible outcomes or results. They require the collection of data on more than one variable from only one group of respondents and aim to show the relationships between the variables" (p. 52).

A correlational survey is considered appropriate if the purpose of the research is to answer the question, "What is the relationship between variable X and variable Y?" (Wilson, 1989, p. 252). Diers (1979) classified this type of factor-relating or relation-searching research as a Level 2 Inquiry. Roberts and Burke (1989) labelled it as a Level 3 Inquiry, because of the presence of a conceptual framework. Both support the choice of a correlational study for the type of research question in this study.

The predominant disadvantage of a correlational study is that a cause-and-effect relationship cannot be established (Polit & Hungler, 1987; Roberts & Burke, 1989; Wilson, 1989). This is due to three factors: 1) the inability to manipulate actively the independent variables; 2) the inability to assign subjects randomly to experimental treatments (ie. they are "self-selected" in that they share a common characteristic or experience); and 3) the increased possibility of faulty interpretation of study results (Kerlinger, 1973).

A correlational method is highly advantageous where experimentation cannot be done because the independent variables cannot be manipulated by the investigator. For example, attributions and attitudes are formulated long before contact with the researcher. It is used when the researcher does not want to manipulate the variables as the purpose of the study is to describe how individuals think or feel. Correlational research is a somewhat inexpensive, efficient, and effective way to collect a large amount of data within a short period. Because correlational research is often strong in realism, it has intrinsic appeal for the solution of practical problems. Although interesting in its own right, it helps lay the groundwork for further rigorous cause-and-effect research (Abdellah & Levine, 1986; Polit & Hungler, 1987; Roberts & Burke, 1989).

Setting and Population

The accessible population consisted of general duty nurses employed, during the study period, in the emergency departments of Winnipeg acute care hospitals. The hospitals included two tertiary centres (Health Sciences Centre [adult] and St. Boniface General Hospital) and five community based facilities (Concordia Hospital, Grace Hospital, Misericordia General Hospital, Seven Oaks General Hospital, and Victoria General Hospital). Selection criteria for nurses in the study were that they be registered with the Manitoba Association of Registered Nurses (MARN), and have worked permanent full-time or part-time, within an emergency department, for at least two years. Part-time nurses had to work at least a 0.2 EFT (Equivalent Full Time), that is, two or more shifts per pay period. All nurses who met the criteria were invited to participate. The researcher used posters, announcements in nursing newsletters, and staff meetings with the nursing personnel to recruit participants.

The number of nurses working in these facilities was 289: Health Sciences Centre (adult) n = 49; St. Boniface General Hospital n = 47; Concordia Hospital n = 38; Grace Hospital n = 48; Misericordia General Hospital n = 34; Seven Oaks General Hospital n = 32; and Victoria General Hospital n = 41. Emergency head nurses and clinical instructors were excluded from the survey because many were involved with validating the Emergency Vignettes tool used in the study. Also, the study was discussed in sufficient detail with them that their answers may have been biased had they participated.

The researcher was aware of several possible extraneous variables that could influence results and planned to assess the impact of these during data analysis. An extraneous variable is "a factor other than a study's independent variable that affects and confounds or confuses interpretation of a study's finding" (Wilson, 1989, p. 726). Although usually associated with experimental studies, if not considered, extraneous variables can seriously confuse the results of any study (Abdellah & Levine, 1986; Polit & Hungler, 1987; Wilson, 1989).

One possible extraneous variable was the effect of practice setting, that is, working in a larger tertiary versus smaller community hospital. The facilities differ in two important ways: 1) the more critically ill patients are transferred to tertiary centres; and 2) tertiary centres had a psychiatric nurse stationed within the emergency department during the study period.

From the literature review regarding attitudes toward patients and mental illness, only occupational category and educational preparation showed consistent significant variation. Members of different occupational groups reported very dissimilar attitudes, and advanced education showed a positive correlation with positive attitudes. As the sample was homogeneous regarding profession, this variable was controlled. The effect of advanced education (eg. degree

in nursing or social sciences, MARN recognized post-diploma course, such as intensive care or emergency nursing programs) was examined through data analysis.

The third possible extraneous variable to be examined was work status. The impact of working shift has been explored in the literature, and contrary to hypothesis, was not significantly correlated to negative attitudes toward patients (Peterson, 1985). However, this researcher's experience suggests that work status has an effect in that nurses who work full-time appear more negative in their expressed attitudes toward patients than nurses who work part-time.

Data Collection

Data was collected using three fixed alternative questionaires. The first questionaire presented 10 typical emergency scenarios and asked nurses to assign responsibility for the cause and the solution to the problem. The second questionaire measured attitudes toward medical/surgical and psychiatric patients. The last questionaire elicited demographic data.

The main advantages of a self-report survey method are that it is easy to administer, direct and versatile, and though it may be energy and time intensive, it is a relatively inexpensive way of collecting vast amounts of information from large numbers of people (Jackson, 1988; Polit & Hungler, 1987; Shelley, 1984). The methodology can be explicitly stated, making it easier to analyze (Roberts & Burke, 1989), evaluate, and replicate (Wilson, 1989). Questionaires are less vulnerable to reactivity and interviewer bias (Shelley, 1984) and are one method that can offer complete anonymity to subjects (Polit & Hungler, 1987; Shelley, 1984). Finally, as the purpose of the study was to determine specific attitudes and attributions, " . . . there is little other alternative than to ask people about those they hold" (Jackson, 1988, p. 28).

A disadvantage of the self-report survey is that one is trying to measure how people think and feel, or sometimes, to remember. People may not answer truthfully or inadvertently may bias their answers (response sets) (Polit & Hungler, 1987; Roberts & Burke, 1989; Shelley, 1984). Also, what people say they believe does not always correspond to how they actually behave in real-life situations (Jackson, 1988). Most authors asserted that information obtained in surveys is somewhat superficial and therefore should be used in extensive, or broad, not intensive, or in depth analysis. In addition, as there is no manipulation of independent variables, one cannot infer cause-and-effect relationships from survey data (Polit & Hungler, 1987; Wilson, 1989).

Measurement Instruments

Attributions of Responsibility Measurement Tool

Development of the Emergency Vignettes Questionaire.

The development of the Emergency Vignettes Questionaire consisted of two phases. The first phase consisted of determining what types of patients emergency nurses would classify as typical urgent medical, surgical, and psychiatric/psychosocial emergencies. The second phase involved validating the four attribution of responsibility statements to be used in the study.

Emergency situations can be divided into three major groups: medical, surgical, and psychiatric/psychosocial emergencies. To decide what types of patients were typical of these groups, a random survey of 25 nurses from two emergency departments was conducted (Laing, 1991). Subjects were required to have two or more years of emergency nursing experience. Fourteen responses were obtained from a tertiary centre and 11 responses from a community hospital. The sample included a head nurse, a unit coordinator, four assistant head nurses, two

assistant unit coordinators, and 17 general duty emergency nurses. Years of emergency experience ranged from 2.5 years to 20 years, with a mean of 9.54 years, and median of 10 years. Sixty percent of the nurses had ten or more years of emergency experience.

Respondents were asked to give three examples, using only patients triaged as "urgent," of what they would define as a typical medical, surgical, or psychiatric/psychosocial emergency. Several nurses gave more than three responses. Nurses from the two centres did not differ in their types of responses. Because low frequency responses could be incorporated with high frequency responses to enhance and authenticate the vignettes, all answers were included. Responses are summarized in table 2, table 3, and table 4, according to descending frequency for each category.

Table 2

Frequency of Medical Emergencies Listed by Emergency Nurses

Medical Emergencies	Frequency
Chest pain/MI	21
Asthma or COPD exacerbation	15
CHF/Pulmonary edema	9
Cerebral Vascular Accident (CVA)	9
Seizures	6 (1 febrile)
Respiratory distress	6
Injury or trauma	3
Head injury	2
Diabetes (hypo or hyperglycemia)	2
Cardiac arrest*	2
Arrhythmias (eg. SVT)	2
Abdominal pain	1
Sepsis	1
Gastrointestinal bleeding	1
Anaphylaxis	1
Renal colic	1

(*Cardiac arrest is categorized as "emergent," according to the Manitoba Health Services Commission.)

Table 3

Frequency of Surgical Emergencies Listed by Emergency Nurses

Surgical Emergencies	Frequency
Appendicitis	10
Bowel obstruction	9
Abdominal aortic aneurysm	9
Abdominal pain, nausea/vomiting	8
Vaginal or pelvic bleeding	7
Gastrointestinal bleeding	7
Ectopic pregnancy	6
Severe lacerations or cut tendons	5
Orthopedic trauma (hip, limbs)	5
Amputations	3
Arterial or vascular occlusion	3
Head injury or intracranial bleed	3
Perforated viscous or bowel	3
Abdominal trauma (eg. stab)	2
Ruptured varices	1
Renal colic	1
Multiple trauma	1
Eye injuries (eg. penetrating)	1

Table 4

Frequency of Psychiatric/Psychosocial Emergencies Listed by Emergency Nurses

Psychiatric/Psychosocial Emergencies	Frequency
Suicidal ideation or attempt	19
Assault or abuse*	17
Psychosis, psychotic reaction	14
Overdoses	10
Aggressive, violent or homicidal behaviour	10
Depression	5
Inability to cope	3
Bipolar -hypomanic phase	3
Alcoholism	2
Situational reaction	1
Personality disorder	1
Violence related to substance abuse	1
Drug abuse	1
Schizophrenia, relapse with psychosis	1
Extra-pyramidal reaction	1

(*The total response for abuse was 17. Abuse was broken down into the following categories: physical = 5; spouse = 4; elder = 3; sexual = 3; and child = 2.)

After combining congruous responses, this researcher developed three medical, three surgical, and four psychiatric or psychosocial vignettes. Personal experience and current emergency nursing texts (Lanros, 1988; Mlynczak-Callahan, 1990; Patrizzi & Tackett, 1984; Parker, 1984; Potter, 1985; Vonfrolio & Noone, 1991) were used to design typical scenarios. Each scenario incorporated some factors that suggested the patient could be responsible for the cause of the presenting problem. Half the vignettes involved females. Two vignettes each, represented patients in their twenties, thirties, forties, fifties, and seventies, to encompass a broad spectrum of adults clients.

Medical vignettes included: 1) chest pain or myocardial infarct; 2) exacerbation of COPD plus respiratory distress; and 3) CHF/pulmonary edema plus respiratory distress. Surgical emergencies included: 1) abdominal pain, nausea, and vomiting plus bowel obstruction; 2) ectopic pregnancy plus vaginal bleeding; and 3) gastrointestinal bleeding plus ruptured varices. Psychiatric or psychosocial emergencies consisted of: 1) suicidal ideation/attempt plus depression; 2) physical assault of spouse plus inability to cope; 3) psychosis/psychotic reaction plus aggressive behaviour; and 4) overdoses plus situational reaction.

The vignettes were presented to ten recognized experts in emergency nursing for validation. The group of experts included: four emergency head nurses, four emergency clinical instructors, and two instructors from the Manitoba Emergency Nursing Program. Years of experience ranged from seven to 22 years, with a mean of 15.5 years. Educational background included: BN (5), Manitoba Emergency Nursing Program (6), intensive care course (2), and master's candidates (one in nursing, one in education). Other educational preparation included: Nursing Unit Administration, Trauma Nurse Specialist, Advanced Cardiac Life Support Instructors, Basic Cardiac Life Support Instructors, Advanced Cardiac Life Support, Certificate in Adult Education, and some university credits. Their written and verbal feedback, regarding the validity and accuracy of portrayal, was taken into advisement, and minor changes were made. The final version of the ten scenarios, randomly ordered, are presented in Appendix B. The developed vignettes are similar to patients described by Jones and Yoder (Jones et al., 1984; Yoder & Jones, 1981, 1982a, 1982b).

The second step in the development of the Emergency Vignettes Questionaire was to validate the four attribution of responsibility statements, adapted from the Helping-Coping

Attribution Scale - therapist (HCAS) by Tracey (1988). The HCAS has four items, which reflect how people assign responsibility according to Brickman's model (Brickman et al., 1982). The four items are: 1) "This client is responsible for his or her current problem"; 2) "Solving this client's problem is more the client's responsibility than mine"; 3) "This client's problem is more a result of the situation he or she is in, rather than his or her own inability to cope"; and 4) "This client would not be able to change without my or other's aid." The HCAS uses a 7-point Likert-type scale with 1 = strongly disagree, and 7 = strongly agree, and 4 indicating a neutral answer. Reverse scoring was used for the third and fourth items. Items one and three were averaged to determine the attribution of cause or blame. Items two and four were averaged to determine the attribution of solution or control. Scores ranged from one to seven. The higher the score, the more responsible the client was held for the cause or solution to the problem.

Tracey (1988) first used the HCAS to measure attributions of responsibility within a psychotherapy situation. One-week test-retest reliability for the blame subscale was .71 and for the control subscale, .68 (n = 30). Internal consistency, using Spearman-Brown Prophecy formula, was r = .45 for blame, and .50 for the control subscale. In testing with independent subjects (n = 12), reliability for blame and control was r = .78 and .68, respectively, and internal consistency was .62 and .60. Correlation between the two subscales was .15, $p > .05$ (Tracey, 1988).

This investigator tested the original HCAS statements using 20 nurses (four nursing supervisors, six medical/surgical nurses, and 10 psychiatric nurses). All items, except the third, were easily understood, conveyed the intended message and required only slight modification to make them applicable to emergency situations. Item three, which attributes responsibility for cause to factors outside the patient, was misinterpreted by 95% of the nurses. Most said it meant

the same, not the opposite of the first statement. They concluded patients could be responsible for their situation. The four items, using several variations of the third statement, were tested again using 15 nurses (four nursing supervisors, four medical/surgical nurses, two recovery room nurses, two intensive care nurses, and three psychiatric nurses). Nurses were asked to select the version that was most precise, and directly opposite in meaning to the first statement. As a result, item three was changed from, "This client's problem is more a result of the situation . . . " to "This client's problem is more a result of external factors, rather than his or her responsibility." The emergency vignettes, with the modified attribution statements are presented in Appendix B. Internal consistency of the adapted items was calculated using the study sample.

Attitudes Toward Patients Survey (ATP)

Following an extensive literature review regarding attitudes toward patients and toward mental illness (see Appendix A), this researcher selected the Attitudes Toward Patients (ATP) Survey, developed by Roskin and his colleagues (Roskin et al., 1986) (see Appendix C). It has been used by Roskin in three studies, with samples of 69, 525, and 115 (Carsen et al., 1987; Roskin et al., 1986; Roskin et al., 1988; Roskin & Marell, 1988). This scale has 72 seven-point, Likert-type items. Endpoints are 1 = strongly disagree, and 7 = strongly agree, with 4 indicating a neutral answer. This questionaire was chosen because it measures opinions about both psychiatric and medical illnesses, their pathogenesis, and the helper/client relationship. Its main focus is attitudes toward psychiatric patients, but this fact is less obvious than with other scales. The 72 items are divided into seven subscales, which fall into two main categories: 1) Etiology-Treatment Approach Subscales; and 2) Doctor-Patient Relationship Subscales. The Etiology-

Treatment Approach Subscales examine attitudes toward the etiology and treatment of psychiatric and medical illness. The subscales are: 1) Psychodynamic Etiology of Psychiatric Disorders (12 items); 2) Psychodynamic Etiology of Organic Illness (10 items); 3) Biological Etiology of Psychiatric Disorders (14 items); and 4) Moral Weakness Etiology of Psychiatric Disorders (6 items). The three subscales that relate to the helper/client relationship include: 1) Authoritarian-Controlling Attitudes (7 items); 2) Nurturant-Empathic Attitudes (10 items); and 3) Distancing-Detachment from Patients (5 items). Inter-item correlation and reliability for each subscale are listed in Table 5.

Table 5

Average Inter-Item Correlation and Reliability of Attitudes Toward Patients Subscales

Subscale	Average Inter-Item Correlation	Cronbach's Alpha
Etiology-Treatment Approach Subscales:		
Psychodynamic Etiology of Psychiatric Disorders	.19	.73
Psychodynamic Etiology of Organic Illness	.18	.68
Biological Etiology of Psychiatric Disorders	.17	.77
Moral Weakness Etiology of Psychiatric Disorders	.23	.64
Doctor-Patient Relationship Subscales:		
Authoritarian-Controlling Attitudes	.17	.59
Nurturant-Empathic Attitudes	.16	.63
Distancing-Detachment from Patients	.21	.58

Roskin and his associates felt the subscales had "face" validity and statistical validity was not tested (Roskin et al., 1988; Roskin & Marell, 1988). For the Etiology-Treatment Approach subscales, the higher the score, the more the subject agrees with that particular belief regarding psychiatric disorders or medical illnesses. High scores on the Doctor-Patient Relationship subscales reflect a tendency toward that type of relationship, whether it is nurturant, authoritarian, or distant.

The ATP Survey was modified slightly to make it more relevant to nursing. In some questions the term "doctor" or "physician" was changed to "nurse" or "health care professional." The change did not affect the context of the question.

Demographic Data

The instrument to obtain the basic demographic data was developed by this researcher (see Appendix D). Demographic data, including gender, age, years of nursing and emergency experience, practice setting, biweekly hours of work (EFT), and educational preparation, was collected to characterize the sample population.

Procedure

Following approval by the ethical review committee of the University of Manitoba School of Nursing, the researcher wrote to request access to the seven institutions named (see Appendix E). Several agencies (Health Sciences Centre, St. Boniface General Hospital, Grace Hospital, Seven Oak General Hospital) required further internal ethical review. Upon receipt of agency approval, the researcher arranged for a meeting with the management and educational staff of

each emergency department, to elicit their support, and to discuss the general procedure and goals of the research.

The researcher requested permission to speak with the general duty nurses of each emergency department at planned staff meetings. During the meetings, potential subjects were provided with basic information about the study and invited to participate (see Appendix F). Head nurses and clinical instructors were asked to support the recruitment process by providing all nurses with the questionaires and by encouraging completion of the same. Coloured posters, appealing for participation, were placed in each emergency department (see Appendix G). Announcements requesting volunteers, were placed in nursing newsletters, such as the Emergency Nurses Department Nurses' (EDNA) newsletter, the Manitoba Association of Registered Nurses' Nurscene, and individual hospital's newsletters (see Appendix H).

Subjects were made aware that there were no foreseeable personal risks or immediate benefits. They were informed of their right to anonymity and confidentiality, and that they could refuse to participate at any point (Canadian Nurses Association, 1983; Kovacs, 1985; Polit & Hungler, 1987; Roberts & Burke, 1989; Shelley, 1984; Wilson, 1989). A written explanation (disclaimer) was provided to subjects with the questionaire (see Appendix I). Voluntary completion of the questionaire implied informed consent to participate (Shelley, 1984).

The researcher arranged additional times to be available in the emergency department to clarify, encourage, or pick up completed forms. To guard against subject coercion to participate, and to ensure confidentiality, subjects placed the completed (or uncompleted) questionaires, sealed in an envelope, into a slotted return box (Jackson, 1988; Shelley, 1984). The box was left

in a prearranged spot, such as the conference room in each emergency department. The researcher offered to provide an abstract of the study to each department upon completion of the study.

Ethical Concerns

A major ethical issue to be considered regarding sampling, was that the investigator was an evening supervisor at one of the agencies (Health Sciences Centre), and as such had indirect power vis-a-vis the participants. This issue was dealt with in the following way. Subjects were assured their participation was voluntary and would in no way affect their job. No list of participants was kept. Subjects were asked to seal their completed (or uncompleted) form in a provided envelope, and place it into a sealed, slotted return box. Only the investigator, thesis committee members, and statistical consultant had access to the raw data, and only group data was reported.

In retrospect, the researcher's position in the facility did not appear to have a negative impact on the Health Sciences Centre subjects. The emergency nurses expressed no concerns about completing the questionaires, and the response was acceptable (43%).

Methods of Data Analysis

When determining what statistics to use in the analysis of data, one must consider the level of data collected, the number of variables being considered, the representativeness of the sample, and whether the sample is normally distributed (Abdellah & Levine, 1986; Blalock, 1979; Jackson, 1983; Jackson, 1988; Kovacs, 1985; Polit & Hungler, 1987; Roberts & Burke, 1989; Shelley, 1984; Wilson, 1989). This researcher used quantitative, univariate descriptive methods

of data analysis, bivariate tests of difference and correlation, and multivariate analysis of variance statistics. A significant portion of the data was collected from summated Likert-type scales. Wherever possible, tables were used to summarize the data.

Descriptive statistics, including the mean, median, range, and standard deviation were used to describe the age, years of nursing, and years of emergency nursing for the sample. Frequency distributions and percentages were used to describe the response rates, gender distribution, work status, and grouped data for the age, years of nursing experience, and years of emergency nursing. For all variables, community, tertiary, and overall group statistics were presented. Tests of normality indicated parametric statistics were appropriate for further analysis.

Basic characteristics of the population (gender, work status, and educational preparation) were summarized using percentages. A comparison of the sample and population, including two sample proportions tests for significant difference, will be provided in table form.

The attributions of responsibility for emergency situations were measured using Likert scales. The mean, median, standard deviation, and rank were determined for the cause and solution subscales of each vignette. Mean, standard deviation, and rank were calculated for the three vignette subscales (Medical, Surgical, and Psychiatric/Psychosocial Vignettes). Scatter plots were used to show the distribution of cause versus solution scores for each vignette, the three vignette subscales, and the overall cause and solution scores. The researcher ascertained what models of helping nurses preferred to use for each vignette, for the three subgroups, and overall.

Paired, two-tailed t-tests were applied to the grouped and overall scores to find out whether significant differences existed between them. Internal consistency for the Medical,

Surgical, and Psychiatric/Psychosocial cause and solutions subscales, and the Overall Cause and Overall Solution subscales, were determined using Cronbach's alpha.

The Attitudes Toward Patients Survey has seven subscales. Standardized mean, median, and standard deviation were calculated for each subscale. Paired, two-tailed t-tests were applied to the grouped subscores and overall scores to determine whether significant differences existed between them. The correlation between the various subscales was determined using Pearson's r.

The next stage of analysis involved determining the degree and type of correlation between the attribution scores and the attitude scale scores, using Pearson's r. Finally, general linear model ANOVA was used to determine the effects of the sample characteristics (gender, age, years of nursing experience, and years of emergency nursing) on the attribution and attitudes scores. Unpaired, two-tailed t-tests were used to determine the effects of several possible extraneous variables on the attribution and attitude subscale results. These variables included practice setting or place of employment, educational preparation, and work or EFT status.

Summary

This chapter has outlined the methods used to carry out a descriptive study aimed at exploring the relationship between emergency nurses' attitudes toward patients and the attributions of responsibility they make regarding cause and solution for 10 typical emergency situations. The ethical issues, population, instruments, data collection procedures, and statistical analyses have been described. The following chapter will describe the results of this study.

CHAPTER IV

Results

Data Analysis

The purpose of this study was to examine attitudes as a consequence of attribution. There are three research questions:

1) What are emergency nurses' attributions toward emergency patients, regarding two specific variables, responsibility for the cause of problems, and responsibility for the solution of problems?

2) What is the attitude emergency nurses hold toward patients, especially those patients defined as psychiatric emergencies?

3) What is the relationship between the attributions that are made about responsibility for problems and solutions and attitudes about patients classified as psychiatric emergencies?

Data for this study was collected over a four month period from February to May, 1992. Three self-report questionaires were given to all nurses working during this period in the emergency departments of the seven acute care Winnipeg hospitals. The questionaires included: the Emergency Vignettes Questionaire, Attitudes Toward Patients Survey, and a Demographic Questionaire. All data was entered into the computer by the investigator, and analyzed using the Number Cruncher Statistical System (NCSS) (Hintze, 1991).

This chapter describes the results of data analysis. Following a discussion of the sample and population characteristics, each research question will be addressed. The effects of the sample characteristics (gender, age, years of nursing experience, years of emergency nursing, level of education, practice setting, and work status) will be examined.

Sample Characteristics

The following section describes the response rates, gender, work status, age, years of nursing experience, years of emergency experience, and educational preparation of the sample.

Response Rates

Of 289 questionaires handed out, 102 (35.3% response rate) were returned. Seventy-one questionaires (69.6%) were returned from community hospitals and 31 (30.4%) from tertiary hospitals. This is representative of the community versus tertiary ratio of emergency nurses in Winnipeg. One questionaire was discarded as the subject did not answer sufficient items to allow analysis. One subject only completed the Attitudes Toward Patients Survey, and not the Emergency Vignettes Questionaire, but completed data was utilized.

Five subjects (5%) reported less than two years of emergency nursing experience. Item by item comparison, using Mann-Whitney two sample tests, revealed no significant differences between the responses of nurses with less than two years and those more than two years of emergency nursing experience. Therefore, these five subjects were included in the sample.

Ninety-four subjects (93.1%) were female, five (4.9%) were male and two (2%) did not report their gender. The response rate for females was 34.68%, and for males, 38.46%. The lowest response rate was from the Grace Hospital (8.33%), which was significantly lower ($p = 0.05$, two-tailed, two sample proportion test) than the overall response rate. The highest response rate was from the Seven Oaks General Hospital (68.75%), which was significantly higher than the overall response rate. A summary of the response rate for each hospital, and total response rates for community and tertiary hospitals, are shown in Table 6.

Table 6

Response Rates of the Sample

Hospital	Total Staff	Response Frequency	Response Rate (%)
Concordia	38	14	36.84
Grace	48	4	8.33
Misericordia	34	17	50.00
Seven Oaks	32	22	68.75
Victoria	41	13	31.71
Total Community	**193**	**70**	**36.27**
Health Sciences	49	21	42.86
St. Boniface	47	10	21.28
Total Tertiary	**96**	**31**	**32.29**
Total Hospitals	289	101	34.95

Work Status of the Sample

Forty-seven subjects (46.5% of the sample) reported they worked full-time and 52 (51.5%) worked part-time. Two (2%) community hospital nurses did not indicate their work status. For the community hospitals, more part-time (57.1%) than full-time (40%) nurses responded, while for tertiary hospitals, the reverse was true (61.3% full-time versus 38.7% part-time). Table 7 compares the equivalent full-time status for community centres, tertiary centres, and the sample.

Table 7

Equivalent Full-time Status of Community and Tertiary Hospitals, and Sample Nurses

Equivalent Full Time	Community Hospitals	Tertiary Hospitals	Total Sample
.2	0	1 (3.2%)	1 (1.0%)
.3	0	0	0
.4	1 (1.4%)	0	1 (1.0%)
.5	12 (17.1%)	5 (16.1%)	17 (16.8%)
.6	6 (8.6%)	1 (3.2%)	7 (6.9%)
.7	15 (21.4%)	3 (9.7%)	18 (17.7%)
.8	3 (4.3%)	1 (3.2%)	4 (4.0%)
.85	3 (4.3%)	1 (3.2%)	4 (4.0%)
Part-Time	**40 (57.1%)**	**12 (38.7%)**	**52 (51.5%)**
Full-time	**28 (40.0%)**	**19 (61.3%)**	**47 (46.5%)**

Age of the Sample

The age of the subjects ranged from 24 to 54 years. Six nurses from community hospitals did not provide their age. The average age of the sample was 36.9 years, median was 36 years, and standard deviation was 7.1 years. The age for community hospital nurses ranged from 26 to 54 years. The average age was 37.5 years, median was 36 years, and standard deviation was 7.6 years. For tertiary hospitals, the range was 24 to 50 years, mean was 35.7 years, median was 35 years, and standard deviation was 5.9 years. Part-time nurses (n = 49) averaged 37.5 years of age, with a range of 26 to 54 years, and a standard deviation of 6.3 years. Full-time nurses (n = 45) were younger with a mean age of 35.9 years, range of 24 to 54 years, and standard deviation of 7.5 years. A comparison of community and tertiary hospitals, and sample is shown in Table 8.

Table 8

Grouped Age of Community and Tertiary Hospitals, and Sample Nurses

Age in Years	Community Hospitals	Tertiary Hospitals	Total Sample
20-24.9	0	1 (3.2%)	1 (1.0%)
25-29.9	8 (11.4%)	5 (16.1%)	13 (12.9%)
30-34.9	14 (20.0%)	5 (16.1%)	19 (18.8%)
35-39.9	23 (32.8%)	10 (32.3%)	33 (32.7%)
40-44.9	6 (8.6%)	8 (25.9%)	14 (13.9%)
45-49.9	7 (10.0%)	1 (3.2%)	8 (7.9%)
50+	6 (8.6%)	1 (3.2%)	7 (6.9%)

Years of Nursing Experience for the Sample

Nurses comprising the sample had worked an average of 14.32 years. The range was 2 to 34 years, median was 15 years, and standard deviation was 6.59 years. Three subjects (3%), working in community hospitals, did not answer this question. The mean and median for community hospitals was 15 years, with a standard deviation of 6.91 years. Range was three to 34 years. Nurses in tertiary hospitals had worked 12.84 years, with a median of 13, standard deviation of 5.67 years, and range from two to 25 years. Table 9 presents the grouped data for years of work as a nurse for the community and tertiary hospitals, and the sample.

Table 9

Grouped Years of Work as a Nurse for Community and Tertiary Hospitals, and the Sample

Total Years of Nursing Experience	Community Hospitals	Tertiary Hospitals	Total Sample
0.0-4.9	2 (2.9%)	3 (9.7%)	5 (4.9%)
5.0-9.9	14 (20.0%)	6 (19.4%)	20 (19.8%)
10.0-14.9	14 (20.0%)	9 (29.0%)	23 (22.8%)
15.0-19.9	23 (32.8%)	8 (25.8%)	31 (30.7%)
20.0-24.9	6 (8.6%)	4 (12.9%)	10 (9.9%)
25.0-29.9	5 (7.1%)	1 (3.2%)	6 (5.9%)
30.0-34.9	3 (4.3%)	0	3 (3.0%)

Years of Emergency Nursing Experience for the Sample

The sample had worked an average of 8.33 years in the emergency department. Four subjects, three from the community, and one from the tertiary hospitals, did not answer the question. Emergency experience ranged from 0.5 to 25 years. The median was eight, and standard deviation was five years. For community hospitals, the average was 8.37, median was eight years and standard deviation was 5.09 years. The range was from 0.5 years to 25 years. Nurses in tertiary hospitals averaged 8.23 years, with a median of 7.5 years and standard deviation of 4.88 years. The range was from one year to 20 years. The grouped data for years of emergency experience for the community and tertiary hospitals, and the sample is presented in Table 10.

Table 10

Grouped Years of Work in Emergency for Community and Tertiary Hospitals, and the Sample

Years of Emergency Nursing Experience	Community Hospitals	Tertiary Hospitals	Total Sample
0.0-1.9	3 (4.3%)	2 (6.5%)	5 (5.0%)
2.0-4.9	14 (20.0%)	6 (19.4%)	20 (19.8%)
5.0-9.9	23 (32.9%)	10 (32.3%)	33 (32.7%)
10.0-14.9	18 (25.7%)	9 (29.0%)	27 (26.7%)
15.0-19.9	7 (10.0%)	2 (6.4%)	9 (8.9%)
20.0-24.9	1 (1.4%)	1 (3.2%)	2 (2.0%)
25.0-29.9	1 (1.4%)	0	1 (1.0%)

Educational Preparation of the Sample

Ninety-three (92.1%) subjects held a diploma in nursing, six (5.9%) nurses held a baccalaureate in nursing, and two (2%) did not respond to this question. Fifty (49.5%) subjects indicated some advanced educational preparation, which included a baccalaureate in nursing. Fourteen subjects gave more than one response. The typical nurse with advanced education was female, 37.17 years of age, had worked 14.29 years as a nurse, and 8.64 years in an emergency department. All five male respondents had some type of advanced educational preparation. Nurses with no additional education were not significantly different ($p = 0.05$, two-sample, two-tailed t-test). They were female, 36.24 years of age, with 14.34 years experience as a nurse, and 8.03 years in emergency. The categories and frequencies of advanced education held by the sample are listed in Table 11.

Table 11

Advanced Education Held by Sample Nurses

Categories of Advanced Education	Total
Training in emergency nursing (Manitoba Emergency Nursing Program 21; other 1)	22
Training in intensive care nursing (St. Boniface 4; Health Sciences Centre 5; other or not given 5)	14
University degree in nursing	6
University degree, or working toward degree other than nursing	8
Nursing Units Administration Certificate	6
Neurological Nursing	2
Coronary Care Course (London, England)	1
Gerontology Certificate	1
Health Care Management Course (Red River Community College)	1
Occupational Health Certificate	1

Other courses listed under additional education were Basic Cardiac Life Support (BCLS) (n = 4), Advanced Cardiac Life Support (ACLS) (n = 11), Advanced Trauma Life Support (ATLS) (n = 3), BCLS Instructor's (n = 2), Patient Assessment (n = 1), and Nursing Management of the Cardiac Patient (n = 1). These were not categorized as advanced education as all were skill oriented, of short duration, and most likely would not have affected attitudes toward patients.

A higher percentage of nurses from tertiary hospitals (67.7%), than community hospitals (41.4%), indicated advanced educational preparation. A comparison of the educational preparation of the community and tertiary hospitals, and the sample is shown in Table 12.

Table 12

Educational Preparation of Community and Tertiary Hospital and Sample Emergency Nurses

Educational Preparation	Community Hospitals	Tertiary Hospitals	Total Sample
Diploma	66 (94.4%)	27 (87.1%)	93 (92.1%)
B.N.	2 (2.8%)	4 (12.9%)	6 (5.9%)
University (other than nursing)	6 (8.6%)	2 (6.4%)	8 (7.9%)
Emergency Program	10 (14.3%)	12 (38.7%)	22 (21.8%)
ICU Program	9 (12.5%)	5 (16.1%)	14 (13.9%)
Other	13 (18.6%)	1 (3.2%)	14 (13.9%)

Tests of Normality for the Sample

Using the Martinez and Iglewicz Normality Test, the variables of work status, age, years as a nurse, and years in emergency, showed normal distribution, at a critical value of 0.05. This held true for both the community and tertiary groups, and the total sample. This allowed the researcher to use parametric statistics for statistical analysis.

Population Characteristics

The first section in this chapter described the characteristics of the sample. This section delineates the characteristics of gender, work status, and educational preparation of the population. This data was obtained from the head nurses of each emergency department. Basic characteristics of the sample and population are compared.

The sample was drawn from a population of 289 nurses working during the data collection period in the emergency departments of the seven acute care Winnipeg hospitals. The community hospitals, Concordia Hospital, Grace General Hospital, Misericordia General Hospital, Seven Oaks General Hospital, and Victoria General Hospital, had 193 (66.8% of population) emergency nurses. Ninety-six nurses (33.2% of population) worked in the tertiary hospitals, Health Sciences Centre and St. Boniface General Hospital. The population included 26 nurses (9%) who had less than two years of emergency nursing experience. Generally, the population was female (95.5%), 60.9% of whom worked part-time. The majority (76.5%) had basic education, that is, a diploma in nursing. Of the nurses who had advanced educational preparation, a greater percentage were from tertiary hospitals (32.3%) than from community hospitals (19.2%). Basic demographic information of the community and tertiary hospitals is compared to the population in Table 13.

Table 13

Gender, Work Status, and Educational Preparation of the Population

Characteristic	Community Hospitals	Tertiary Hospitals	Total Population
Gender:			
Male	5 (2.6%)	8 (8.3%)	13 (4.5%)
Female	188 (97.4%)	88 (91.7%)	176 (95.5%)
Work Status:			
Full-time	76 (39.4%)	37 (38.5%)	113 (39.1%)
Part-time	117 (60.6%)	59 (61.5%)	176 (60.9%)
Educational Preparation:			
Basic	156 (80.8%)	65 (67.7%)	221 (76.5%)
Advanced	37 (19.2%)	31 (32.3%)	86 (23.5%)

Comparing the Population and Sample

A fundamental consideration when analyzing a sample is its representativeness of the population (Polit & Hungler, 1987). The basic characteristics of the population and the sample are compared in Table 14. A two sample proportions test was used to test significant difference.

Table 14

Comparison of the Population and Sample

Characteristic	Number and Percent of Population (N = 289)	Number and Percent of Sample (n = 101)	Difference in Percentages
Work in Community Hospital	193 (66.8)	70 (69.3)	+2.5
Work in Tertiary Hospital	96 (33.2)	31 (30.7)	-2.5
Less than 2 years Emergency	26 (9.0)	5 (5.0)	-4.0
GENDER			
Female	276 (95.5)	94 (93.1)	-2.4
Male	13 (4.5)	5 (4.9)	+0.4
WORK STATUS			
Work Full-time: Combined	113 (39.1)	47 (46.5)	+7.4
Community	76 (39.4)	28 (40.0)	+0.6
Tertiary	37 (38.5)	19 (61.3)	+22.8*
Work Part-time: Combined	176 (60.9)	52 (51.5)	-9.4
Community	117 (60.6)	40 (57.1)	-3.5
Tertiary	59 (61.5)	12 (38.7)	-22.8*
EDUCATIONAL LEVEL			
Basic education only: Combined	221 (76.5)	49 (48.5)	-28.0*
Community	156 (80.8)	39 (55.7)	-25.1*
Tertiary	65 (67.7)	10 (32.3)	-35.4*
Advanced education: Combined	68 (23.5)	50 (49.5)	+26.0*
Community	37 (19.2)	29 (41.4)	+22.2*
Tertiary	31 (32.3)	21 (67.7)	+35.4*

(*Significantly different for $p < 0.05$, two-tailed)

The sample was representative of the population regarding the community versus tertiary ratio, nurses with less than two years of experience, and the female to male ratio. The total and community hospital subjects also were similar to the population in the full-time to part-time ratio. However, for tertiary hospitals, a significantly higher percentage of full-time nurses responded. The population had approximately 40% full-time nurses, but the sample consisted of approximately 60% full-time nurses. In addition, responders from the combined, community and tertiary hospital groups all showed a significantly greater proportion of advanced educational preparation, as compared to the population. Full-time nurses in tertiary centres, and nurses with advanced education in both community and tertiary centres were more likely to respond.

Attributions of Responsibility Made by Emergency Nurses

The Individual Vignettes

The first research question was, "What are emergency nurses' attributions toward emergency patients, regarding responsibility for the cause of problems, and responsibility for the solution of problems?" The tool used to measure attributions of responsibility was the Emergency Vignettes Questionaire. It consisted of 10 emergency scenarios, each followed by four items. Subjects were asked to indicate how strongly they agreed or disagreed with each item, using a seven-point Likert scale. Items one and three were averaged to obtain the attribution of responsibility for cause subscore. Items two and four were averaged to determine the attribution of responsibility for solution subscore. One hundred subjects completed this questionaire.

For each subscore, the higher the value, the greater the responsibility attributed to the patient. The attribution of cause subscores, including the mean, median, standard deviation, and

mean rank for each vignette are listed in Table 15. Solution subscores are described in Table 16. Scores are ranked in descending order.

Table 15

Attribution of Cause Subscores for Emergency Vignettes

Vignette*	Mean Attribution	Median	Standard Deviation	Mean Rank
C Cause (M)	4.31	4.0	1.539	10
I Cause (P)	4.06	4.0	1.459	9
D Cause (P)	3.915	4.0	1.358	8
H Cause (S)	3.785	4.0	1.615	7
G Cause (P)	3.435	3.5	1.618	6
B Cause (P)	3.03	3.0	1.361	5
E Cause (M)	2.93	3.0	1.464	4
J Cause (M)	2.779	2.5	1.426	3
A Cause (S)	2.66	2.5	1.285	2
F Cause (S)	2.435	1.75	1.447	1

(*Code: (S) = Surgical Vignette; (M) = Medical Vignette; (P) = Psychosocial Vignette)

Table 16

Attribution of Solution Subscores for Emergency Vignettes

Vignette*	Mean Attribution	Median	Standard Deviation	Mean Rank
I Solution (P)	2.865	3.0	1.227	10
B Solution (P)	2.775	3.0	1.238	9
D Solution (P)	2.215	2.0	1.153	8
G Solution (P)	2.195	2.0	1.132	7
H Solution (S)	1.815	1.5	0.986	6
C Solution (M)	1.725	1.5	0.925	5
E Solution (M)	1.515	1.0	0.886	4
F Solution (S)	1.5	1.0	0.853	3
J Solution (M)	1.465	1.0	0.820	2
A Solution (S)	1.325	1.0	0.757	1

(*Code: (S) = Surgical Vignette; (M) = Medical Vignette; (P) = Psychosocial Vignette)

Ranking the cause and solution subscores showed that subjects generally attributed higher responsibility for both cause and solution to psychiatric patients, as compared to medical and surgical patients. For all vignettes, except Vignette B (female victim of abuse), the attribution of responsibility for cause subscore was significantly higher ($p = .05$, paired, two-tailed t-test) than the attribution of responsibility for solution subscore. Overall, subjects were more likely to attribute blame to the patient for causing problems, than they are to attribute control to the patient for solving problems.

For this sample of nurses, the Medical Model was the most frequently preferred model of helping. In eight vignettes, the mean attribution scores for both cause and solution fell below four (neutral). This represents the Medical Model, which attributes low responsibility for cause and solution to the patient (Brickman et al., 1982). Two vignettes scored above four for responsibility for cause, but scored below four for responsibility for solution. This typifies the Enlightenment Model, which attributes high responsibility for causing the problem, but low responsibility for solving the problem to the patient. The two vignettes using the Enlightenment Model were C (male patient with exacerbation of COPD) and I (female overdose patient).

Scatter plots, showing the cause versus solution attributions for each vignette revealed that when the Medical Model was the preferred model, the Enlightenment Model was the second most frequently selected choice. For the two vignettes where the Enlightenment Model was preferred, the second most frequent selection was the Medical Model. The Moral and Compensatory Models were selected infrequently. For Vignette B (battered woman), five respondents selected the Compensatory Model, while four chose the Moral Model. Several respondents also preferred the

Moral Model when dealing with the female overdose patient (11%) and the male psychotic patient (5%). These results are displayed in Appendix J.

Three Vignette Subscales

The ten vignettes were grouped into three subscales, a Medical (vignettes C, E, J), a Surgical (vignettes A, F, H), and a Psychosocial subscale (vignettes B, D, G, I). For each subscale, the mean and standard deviation for cause and solution were determined. In addition, the cause and solution scores for the ten vignettes were averaged to find an overall cause and solution score. Again, the Medical Model was the preferred model of helping. For both cause and solution, nurses attributed the highest responsibility to the Psychosocial Vignettes, followed by the Medical Vignettes, and Surgical Vignettes. The results are summarized in Table 17. Scores are ranked in descending order.

Table 17

Cause and Solution Attribution Scores for Medical, Surgical, Psychosocial, and Overall Groups

Vignette Grouping	Mean	Standard Deviation	Mean Rank
Psychosocial Cause (B,D,G,I)	3.611	0.9476	3
Medical Cause (C,E,J)	3.34	1.0249	2
Surgical Cause (A,F,H)	2.56	0.8748	1
Overall Cause	**3.335**	**0.8019**	
Psychosocial Solution (B,D,G,I)	2.514	0.8389	3
Medical Solution (C,E,J)	1.568	0.7115	2
Surgical Solution (A,F,H)	1.543	0.6819	1
Overall Solution	**1.939**	**0.6371**	

Scatter plots showed respondents almost exclusively used the Medical Model for the Surgical Vignettes (98%). However, the Enlightenment Model was the second choice for both

the Medical Vignettes (15%) and the Psychosocial Vignettes (30%). For the Overall Cause versus Overall Solution scores, 10% selected the Enlightenment Model. These results are displayed in Appendix J.

Testing the Emergency Vignettes Instrument

As the Emergency Vignettes Questionaire was an investigator developed tool, internal consistency for the cause and solution subscales was determined using Cronbach's alpha. For the ten cause subscales, the Cronbach's alpha was 0.7433. For the ten solution subscales, the Cronbach's alpha was 0.8303. Because the coefficient alphas are greater than the acceptable standard of 0.70 for reliability (Nunnally, 1978; Polit & Hungler, 1987), these scales can be considered internally consistent, that is, all subparts are measuring the same concept. Cronbach's alpha values also were determined for the combined surgical, medical and psychosocial cause and solution subscores. The following results were obtained: Surgical Vignette cause = 0.4879 and solution = 0.6809; Medical Vignette cause = 0.4622 and solution = 0.7383; Psychosocial Vignette cause = 0.5507 and solution = 0.6630. Only one subscale (Medical Solution) reached 0.70. However, these low results may be due to the small number of items in each subscale.

Tests of Significance and Correlation for Emergency Vignettes

Findings suggest that although nurses generally prefer the Medical Model, they do make different attributions of responsibility for medical, surgical, and psychosocial patients. Paired t-tests were applied to the six grouped vignette subscores and the overall scores to determine whether significant differences existed between them. All except three showed a significant

difference at $p < 0.001$ (two tailed). The Medical Cause versus Psychosocial Cause scores were significantly different at $p < 0.05$. Medical Cause versus Overall Cause and Medical Solution versus Surgical Solution showed no significant difference.

Findings suggest that nurses make more similar attributions for the medical and surgical vignettes than for the psychosocial vignettes. The correlation between the three subscales and the overall cause and solution score was calculated using Pearson's r correlation coefficient. All comparisons, except Surgical Cause versus Psychosocial Cause, reached significance at $p < 0.001$. As the Overall Cause and Solution scores were an average of the Medical, Surgical, and Psychosocial Cause and Solution subscores, the strong correlation between these variables was expected. There also was a strong correlation between Medical Solution and Surgical Solution. Ranking the correlations revealed the highest correlation, for both cause and solution attributions of responsibility, was between the medical and surgical vignettes, followed by the medical and psychosocial vignettes, and lastly, the surgical and psychosocial vignettes. These findings are summarized in Table 18.

Table 18

T-test and Correlation Coefficient Values for Attribution Subscales and Overall Scores

Variables	Mean Difference	t-test Value	Correlation Coefficient
Medical Cause \ Surgical Cause	.7800	9.0222	.5957
Medical Cause \ Psychosocial Cause	.2712	2.5445(a)	.4180
Medical Cause \ Overall Cause	.0055	0.0968(b)	.8337
Surgical Cause \ Psychosocial Cause	1.0513	9.7402	.3006(c)
Surgical Cause \ Overall Cause	.7745	12.3917	.7253
Psychosocial Cause \ Overall Cause	.2768	4.6287	.7788
Medical Solution \ Surgical Solution	.0249	0.5222(b)	.7647
Medical Solution \ Psychosocial Solution	.9454	12.3264	.5209
Medical Solution \ Overall Solution	.3707	10.0116	.8549
Surgical Solution \ Psychosocial Solution	.9704	12.2129	.4698
Surgical Solution \ Overall Solution	.3957	10.0723	.8247
Psychosocial Solution \ Overall Solution	.5748	12.8870	.8521

(Level of significance for t-test: (a) = $p < 0.05$; (b) = no significant difference)
(Level of significance for correlation coefficient: (c) = $p < 0.05$, two-tailed)

Attitudes Toward Patients Survey

The second research question to be addressed was, "What is the attitude emergency nurses hold toward patients, especially those patients defined as psychiatric emergencies?" This aspect was measured using the Attitudes Toward Patients Survey (ATP) developed by Roskin and his colleagues (Carsen et al., 1987; Roskin et al., 1986; Roskin et al., 1988; Roskin & Marell, 1988). Subjects were asked to indicate how much they agreed or disagreed with each of 72 statements, using a seven-point Likert scale. One hundred and one subjects completed the questionaire.

The Attitudes Toward Patients Subscales

Following data entry, several items were reverse scored. The 72 items then were grouped into seven subscales, which fell into two categories. Four subscales related to attitudes toward the etiology and treatment of organic and psychiatric illness. These included: 1) Psychodynamic Etiology of Organic Illness subscale; 2) Psychodynamic Etiology of Psychiatric Disorders subscale; 3) Biological Etiology of Psychiatric Disorders subscale; and 4) Moral Weakness Etiology of Psychiatric Disorders subscale. Three subscales were related to the helper/client relationship, and included: 1) Authoritarian-Controlling Attitudes subscale; 2) Nurturant-Empathic Attitudes subscale; and 3) Distancing-Detachment from Patients subscale. For each subscale, the items were summed and averaged to obtain one score. The higher the value, the greater the agreement with that specific belief or approach. Table 19 summarizes the subscale scores, including mean, median, and standard deviation.

Table 19

Results of Attitudes Toward Patient Subscales

Subscales	Mean	Median	Standard Deviation
BELIEFS REGARDING ORIGIN SUBSCALES			
Psychodynamic Etiology (Organic)	5.169	5.300	.651
Psychodynamic Etiology (Psychiatric)	4.885	4.833	.611
Biological Etiology (Psychiatric)	4.294	4.286	.652
Moral Weakness Etiology (Psychiatric)	3.347	3.500	.967
HELPER/CLIENT RELATIONSHIP SUBSCALES			
Nurturant-Empathic Attitudes	4.771	4.800	.739
Distancing-Detachment from Patients	4.063	4.000	1.069
Authoritarian-Controlling Attitudes	3.036	3.000	.861

The sample scored highest on the Psychodynamic Etiology of Organic Illness subscale, followed by the Psychodynamic Etiology of Psychiatric Disorders subscale and the Biological Etiology of Psychiatric Disorders subscale. This sequence replicates that of Roskin and his colleagues (1988), although their sample of 98 psychiatric nurses scored higher on all factors (Psychodynamic Etiology of Organic Illness mean = 5.8; Psychodynamic Etiology of Psychiatric Disorders mean = 5.20; Biological Etiology of Psychiatric Disorders mean = 4.95). This sample agreed least with the Moral Weakness Etiology of Psychiatric Disorders subscale. Roskin did not provide this score. Of the three helper/client relationships, the most favoured was the Nurturant-Empathic Attitudes approach, followed by the Distancing-Detachment from Patients approach, and the Authoritarian-Controlling Attitudes approach. This also replicates Roskin's study (Nurturant-Empathic mean = 5.12; Distancing-Detachment mean = 3.86; Authoritarian-Controlling mean = 2.73). However, this sample scored higher on the Authoritarian-Controlling Attitudes and Distancing-Detachment from Patients subscales, while Roskin's sample scored higher on the Nurturant-Empathic Attitudes subscale.

Testing the Attitudes Toward Patients Survey

The Attitudes Toward Patients Survey has been used in previous research. The Cronbach's alpha for each subscale in this study are compared to values obtained by Roskin and his colleagues (Roskin et al., 1988; Roskin & Marell, 1988) in Table 20.

Table 20

Cronbach's Alpha for Attitude Subscales

Attitude Subscales	Cronbach's Alpha This Sample	Cronbach's Alpha Roskin et al., 1988
Psychodynamic Etiology (Psychiatric)	.5591	.73
Psychodynamic Etiology (Organic)	.6094	.68
Biological Etiology (Psychiatric)	.6895	.77
Moral Weakness Etiology	.6404	.64
Authoritarian-Controlling Attitudes	.5933	.59
Nurturant-Empathic Attitudes	.6464	.63
Distancing-Detachment from Patients	.6313	.58

Tests of Significance and Correlation for the ATP Survey

Paired t-tests were applied to the subscale means to determine whether significant differences existed between them. The correlation between the various subscores was calculated using Pearson's r. The four Beliefs Regarding Origins subscales showed significant differences between them, as did the three Helper/Client Relationship subscales. The Psychodynamic versus Nurturant subscale and Biological versus Distancing subscale showed no significant difference. The Moral Weakness versus Authoritarian-Controlling subscales showed a significant difference at $p = 0.01$. All other subscales showed a significant difference at $p = .001$. The Psychodynamic and Organic Etiology subscales showed a significant positive correlation, while the Authoritarian-Controlling and Distancing-Detachment subscales showed a significant negative correlation. Results of the t-tests and Pearson's r are summarized in Table 21.

Table 21

T-test and Correlation Coefficient Values for Attitudes Toward Patients Subscales

Variables	Mean Difference	t-test Value	Correlation Coefficient
BELIEFS REGARDING ORIGIN SUBSCALES			
Psychodynamic vs Organic	.2839	4.2252	.4285(c)
Psychodynamic vs Biological	.5911	8.0545	.3195
Psychodynamic vs Moral	1.5388	12.8287	-.1230
Organic vs Biological	.8751	10.3409	.1487
Organic vs Moral	1.8228	14.6068	-.1698
Biological vs Moral	.9477	8.2491	.0217
HELPER/CLIENT RELATIONSHIP SUBSCALES			
Authoritarian vs Nurturant	1.7354	13.8446	-.2343
Authoritarian vs Distancing	1.0275	6.2995	-.4349(c)
Nurturant vs Distancing	.7079	6.1846	.2330
ORIGINS VERSUS RELATIONSHIPS			
Psychodynamic vs Authoritarian	1.8494	17.5517	-.0070
Biological vs Authoritarian	1.2583	13.3374	.2383
Organic vs Authoritarian	2.1334	19.4097	-.0491
Moral vs Authoritarian	.3106	3.3214(b)	.4760(c)
Psychodynamic vs Nurturant	.1140	1.7153(a)	.5246(c)
Biological vs Nurturant	.4771	5.2267	.1362
Organic vs Nurturant	.3980	5.9419	.5379(c)
Moral vs Nurturant	1.4248	9.6627	-.4987(c)
Psychodynamic vs Distancing	.8219	6.8947	.0630
Biological vs Distancing	.2308	1.6772(a)	-.2622
Organic vs Distancing	1.1059	9.4172	.1262
Moral vs Distancing	.7168	4.4740	-.2486

(Level of significance for t-test: a = no significant difference; b = $p < 0.01$)
(Level of significance for correlation coefficient: c = $p < 0.001$, two-tailed)

The Correlation Between Attributions and Attitudes

The third research question was, "What is the relationship between the attributions of responsibility for problems and solutions, and attitudes about patients classified as psychiatric emergencies?" Before addressing this analysis, the researcher briefly will summarize the findings from the first two questions.

The Emergency Vignettes Questionaire showed that for eight of the 10 typical medical, surgical, and psychosocial emergencies depicted, this sample preferred to use a Medical Model (low responsibility for cause and solution). For two emergency situations, they chose to use the Enlightenment Model (high responsibility for cause, but low responsibility for solution). When the vignettes were grouped into Medical, Surgical, and Psychosocial Vignette subscales, the sample preferred the Medical Model. Finally, the Overall Cause and Solution scores also showed the Medical Model to be the preferred model of helping for this sample. The second most frequently selected model was the Enlightenment Model. This was followed by the Moral Model and, lastly, the Compensatory Model, both of which were chosen infrequently.

For the Attitudes Toward Patients Survey, the sample agreed most with the Psychiatric Etiology of Organic Illness subscale, followed by the Psychodynamic Etiology of Psychiatric Disorders subscale, and the Biological Etiology of Psychiatric Disorders subscale. They agreed least with the Moral Weakness Etiology of Psychiatric Disorders subscale. Of the three helper/client relationship subscales, the most favoured was the Nurturant-Empathic approach, followed by the Distancing-Detachment approach, and the Authoritarian-Controlling approach. Generally, the sample appears to have a positive attitude toward patients, including those with psychiatric illness.

Correlations Between Attributions and Attitudes

The statistical procedure used to compute the correlation between the sample's attributions and attitudes was Pearson's r. Two sets of subscale results were used. The first set of results consisted of the subscores from the Emergency Vignettes Questionaire: Medical Cause, Surgical Cause, Psychosocial Cause, Overall Cause, Medical Solution, Surgical Solution, Psychosocial Solution, and Overall Solution. The second set of results was the scores for the seven Attitudes Toward Patients subscales: Psychodynamic Etiology of Psychiatric Disorders, Psychodynamic Etiology of Organic Illness, Biological Etiology of Psychiatric Disorders, Moral Weakness Etiology of Psychiatric Disorders, Authoritarian-Controlling Attitudes, Nurturant-Empathic Attitudes and Distancing-Detachment from Patients. The results are summarized in Table 22.

Table 22

Correlation Coefficients Between Attribution and Attitude Subscores

	Psychodynamic	Organic	Biological	Moral	Authoritarian	Nurturant	Distancing
Medical Cause:	.0933	.2492	-.0359	.2233	.1472	.0649	-.1009
Medical Solution:	-.1055	-.0581	-.0149	.2193	.2795(b)	-.0756	-.1145
Surgical Cause:	-.0805	-.0650	.0060	.1184	.1103	-.0196	-.1484
Surgical Solution:	-.2319	-.2245	-.0822	.2019	.2441	-.1493	-.0323
Psychosocial Cause:	-.1212	-.0715	-.0472	.4120(a)	.2206	-.2574(b)	-.0703
Psychosocial Solution	-.2356	-.1376	-.0824	.2915(b)	.1252	-.2639(b)	-.1944
Overall Cause:	-.0376	.0394	-.0195	.3460(a)	.2159	-.1148	-.1712
Overall Solution	-.2339	-.1640	-.0747	.2918(b)	.2379	-.2122	-.1511

(Two tailed test: a = $p < 0.001$; b = $p < 0.01$)

Five subscales showed a significant correlation, for $p = 0.01$, two-tailed. Two subscales, Psychosocial Cause versus Moral Weakness Etiology and Overall Cause versus Moral Weakness Etiology, reached significance for $p = .001$, two-tailed. The strongest correlation (.4120) was between the Psychosocial Cause subscale and Moral Weakness Etiology subscale.

Respondents who score high on the Moral subscale believe the etiology of psychiatric illness is patients' moral weakness or self-indulgence. A high score on the Psychosocial Cause

or Solution subscales indicates respondents hold patients responsible for causing, or solving, their psychiatric problems. The significant positive correlation ($p = .01$) between the Psychosocial Cause and Solution subscales and the Moral Weakness Etiology subscale suggests that helpers who assign high responsibility for cause and solution (Moral Model) to psychiatric patients, likely would score high on the Moral Weakness Etiology subscale. The significant negative correlation ($p = 0.01$) between the Psychosocial Cause and Solution subscales and the Nurturant-Empathic Attitudes subscale suggests that those who assign high responsibility for cause and solution to psychiatric patients would be less likely to have a nurturant attitude toward them.

Effect of Sample Characteristics

A general linear models ANOVA ($p = 0.05$, two-tailed) was used to analyze the effects of the basic demographic characteristics on the respondents' attributions of responsibility and attitudes toward patients. The group parameters were as described in the sample section. This study showed no significant differences for mean attribution scores based on the respondents' gender, age, years of nursing experience, or years of emergency nursing. No significant differences in the mean scores of the attitude scales, based on gender, age, years of nursing experience, or years of emergency nursing were found.

The effect of several possible extraneous variables on attributions and attitude was considered. These variables included the impact of advanced education versus basic education, working full-time versus part-time, and working in a community versus tertiary hospital (practice setting). The statistical procedure employed was a two sample, two-tailed t-test, $p = 0.001$. For each test, the populations were analyzed, using a F-ratio test, to see if their variances were equal.

As suggested by Hintze (1991), if the probability level of the F-Test was less than .100, the more approximate results for unequal variance were used. Otherwise, equal variance results were used.

When comparing nurses with advanced education (n = 50) versus nurses with only basic education (n = 49), no significant differences were found on any of the attribution or attitude subscales. There also were no significant differences in attributions or attitudes for nurses who worked full-time (n = 46) versus part-time (n = 52). No significant differences were found regarding attributions when comparing nurses from community centres (n = 70) and tertiary centres (n = 31). However, there were significant differences between nurses from community and tertiary hospitals regarding three variables on the Attitudes Toward Patients Survey. Nurses from tertiary centres scored significantly higher on the Psychodynamic Etiology of Psychiatric Disorders subscale, and the Nurturant-Empathic and Distancing-Detachment relationship subscales. The effects of workplace on the respondents' attitudes are displayed in Table 23.

Table 23

Effect of Working in Community Versus Tertiary Hospital on Attitudes

Attitudes Toward Patients Subscales	Community Hospital (n = 70)	Tertiary Hospital (n = 31)	t-test Value
Psychodynamic	4.806	5.065	-1.9912(a)
Organic	5.141	5.232	- .7365(*)
Biological	4.257	4.378	- .8568
Moral	3.452	3.108	1.6679
Authoritarian	3.155	2.766	1.8779(*)
Nurturant	4.644	5.058	-3.0389(*)(b)
Distancing	3.889	4.458	2.5331(a)

(* = Unequal variance used; a = $p < .05$; b = $p < .01$;)

Summary Regarding Sample Characteristics

The effect of sample characteristics on the attributions and attitudes of emergency nurses was tested. These variables included: gender, age, years of nursing experience, years of emergency nursing, level of education, work status (EFT) and practice setting. All variables had no impact on the types of attributions emergency nurses make regarding responsibility for cause and solution for typical emergency problems. However, some significant differences were found between tertiary and community based nurses regarding attitudes toward patients. Nurses from tertiary centres scored significantly higher on the Psychodynamic Etiology of Psychiatric Disorders subscale, and the Nurturant-Empathic Attitudes and Distancing-Detachment from Patients subscales. Gender, age, years of nursing and emergency experience, level of education, and work status appear to have no impact on attitudes toward patients.

CHAPTER V:

Discussion and Recommendations

Introduction and Summary

This chapter will summarize the purpose, conceptual framework, and methodology used in this study. Following a discussion of the findings, the researcher will present limitations of the study, and recommendations for nursing practice, education, and future research.

This study was designed to examine attitudes as a consequence of attributions. The research question was threefold. First, what are emergency nurses' attributions toward emergency patients, regarding two specific variables, responsibility for the cause of problems, and responsibility for the solution of problems? Second, what is the attitude emergency nurses hold toward patients, especially those patients defined as psychiatric emergencies? Third, what is the relationship between the attributions that are made about responsibility for problems and solutions, and attitudes about patients classified as psychiatric emergencies?

The conceptual framework used to guide this study was an attribution-based model entitled Models of Helping and Coping (Brickman et al., 1981, 1982). The model states that the manner in which helpers approach a helping relationship is dependent on the attributions they make regarding two variables. These variables are: 1) who is responsible for causing the problem; and 2) who is responsible for solving the problem. These attributions subsequently may influence the helper's attitudes toward patients and determine the type of help they are prepared to provide to patients.

The researcher used a simple correlational self-survey method. Subjects were asked to complete three questionaires. The Emergency Vignettes Questionaire, designed by the

investigator, asked subjects to assign attributions of responsibility for cause and solution for ten typical medical, surgical, and psychosocial emergency scenarios. The Attitudes Toward Patients Survey (ATP), designed by Roskin and his colleagues (Carsen et al., 1987; Roskin et al., 1986; Roskin et al., 1988; Roskin & Marell, 1988), measured beliefs regarding the etiology and treatment of psychiatric and medical illnesses, and preferred styles for helper/client relationships. Subjects also completed a Demographic Data Questionaire designed by the investigator.

The population consisted of 289 nurses who were working in the emergency departments of the seven acute care facilities in Winnipeg at the time of the study. The sample consisted of 102 subjects, resulting in a 35% response rate.

Tests of normality indicated that parametric statistics could be used. The data was analyzed using the Number Cruncher Statistical System software package (Hintze, 1991). Univariate descriptive statistics included the mean, median, standard deviation, rank, frequency distributions, and percentages. Bivariate descriptive statistics included the Pearson product-moment correlation coefficient r and scatter plots. Inductive statistics included two-sample proportions tests, t-tests, and ANOVA. The effect of the sample characteristics was considered. Internal consistency reliability of the Emergency Vignettes Questionaire and the ATP Survey was tested using Cronbach's alpha.

Results of the Emergency Vignettes Questionaire showed that nurses preferred the Medical Model, which assigns low responsibility for cause and solution of a problem to the patient. The second most frequently selected model was the Enlightenment Model, which assigns high responsibility for cause, but low responsibility for solutions to the patient. Ranking of the vignettes, t-tests, and scatter plots showed that patients with psychosocial emergencies were

assigned significantly more responsibility for cause and solution than patients with medical and surgical emergencies. Results of the Attitudes Toward Patients Survey revealed that nurses hold a positive attitude toward patients and prefer a nurturant and empathic helper/client relationship. Correlational analysis revealed a significant positive relationship between the Moral Weakness Etiology subscale and the Psychosocial Cause and Solution, and Overall Cause and Solution subscales. Analysis also showed a significant negative relationship between the Nurturant-Empathic Attitudes subscale and the Psychosocial Cause and Solution subscales. The results raise several implications for nursing practice, education, and future nursing research.

Discussion and Implications for Practice

In this section, the researcher will discuss the preferred Models of Helping and Coping, their implications, and their effectiveness. Discussion will include several consequences of making cause or blame attributions. The significance and implications of the ATP Survey findings will be addressed. The researcher then theoretically will align the ATP Survey with the Models of Helping and Coping and discuss the correlation between attributions and attitudes in this study. Previous literature suggests that "issues of legitimacy" regarding their services are related to emergency personnel's attributions and attitudes toward patients. This issue will be explored considering the findings of this study. Finally, the effects and implications of sample and extraneous variables on the respondents' attributions of responsibility and attitudes toward patients will be compared with previous findings.

The Emergency Vignettes

Preferred Models of Helping.

For the emergency scenarios depicted in this study, subjects selected two predominant styles of helping. In eight of the 10 vignettes, mean scores showed nurses preferred the Medical Model. Scatter plots of these vignettes showed the second most frequently selected model was the Enlightenment Model. For two vignettes (male COPD patient and female overdose patient), respondents preferred the Enlightenment Model and the Medical Model was the second choice. The Moral Model ranked third in choice and the Compensatory Model ranked last. Both were selected infrequently.

The mean scores for the Medical Vignettes and Surgical Vignettes cause and solution subscales showed a preference for the Medical Model. Scatter plots showed respondents almost exclusively used the Medical Model for the Surgical Vignettes, while a small number used the Enlightenment Model for the Medical Vignettes. Although, the mean cause and solution subscale scores for the Psychosocial Vignettes suggested a preference for the Medical Model, the scatter plot showed that 30% chose the Enlightenment Model. The mean Overall Cause and Overall Solution scores showed nurses generally preferred the Medical Model and only 10% selected the Enlightenment Model.

Implications of Model Selections.

As discussed previously, the combining and mixing of cause and solution attributions results in four different orientations to the helping relationship. Each orientation has inherent strengths and weaknesses; each makes it easier to solve some problems or more difficult to resolve others.

The Medical Model attributes low responsibility for both the cause and solution to the patient. Helpers who prefer a Medical Model perceive clients as ill and incapacitated. This state exempts clients from normal social obligations, but when faced with a problem they are expected to seek and comply with help from "experts," such as health care professionals. One advantage of the Medical Model is that it allows people to claim help without being blamed for their weaknesses. For example, alcoholism, which would be punished under another model, is entitled to treatment. However, as clients are not given responsibility or control for solving their problems, this model can lead to dependency and "learned helplessness" (Brickman et al., 1982).

Although the Medical Model dominates the practice of medicine, Brickman and his colleagues (1980) argued that it has several serious limitations. First, doctors are not supposed to blame patients, yet that is what they are doing when they label diseases as "psychosomatic." The term psychosomatic, originally coined to represent the continuous and joint interaction of the mind (psyche) and body (soma), now evokes negative or ambivalent feelings toward patients labelled as such (Bartol & Eakes, 1988). Second, the success of treatment rests with the experts, which places an immense burden on them always to provide a cure. When diseases progress to the point where cure is impossible, patients are left without coping options, and helpers begin to feel ineffective. Helpers become reluctant to help when they feel they cannot "produce results"

(Kurz, 1987) or can provide only partial solutions (Coates et al., 1983). To cope with their feelings of inadequacy, helpers may resort to distancing manoeuvres (Northouse & Wortman, 1990). Finally, the model fails when health care requires some type of active patient participation, such as prevention behaviour or adherence to a medical regime (Brickman et al., 1980; Jack & Williams, 1991). Compliance usually is greater when patients are held responsible for solutions (Brickman et al., 1982; Clifford, 1983; Rosenstock, 1988). As people assume more responsibility for their health, there is a growing discontent with health care professionals and the Medical Model (Brickman et al., 1980).

The Enlightenment Model attributes high responsibility for cause, but low responsibility for solution to the client. Helpers using the Enlightenment Model view clients as guilty or at least responsible for past behaviour that has precipitated their present problem. Much time is spent "enlightening" clients about how they have caused their problem. To solve the problem, clients are expected to submit themselves continuously to the discipline of the "authoritative moral." The Enlightenment Model places great power in the hands of the helpers who control what recipients believe is their ability to cope with their lives. It can lead to an obsessive concern with the problem and a restructuring of the client's life around the helping relationship (Brickman et al., 1982). Alcoholics Anonymous is a successful application of this model.

The Moral Model assigns high responsibility for cause and solution to the client. The basic belief of helpers who use this model is, "You got yourself into this - now get yourself out." Helpers do not feel obligated or capable of helping because problems are of the clients' making and only they can find the solutions. For example, alcoholism is seen as a sign of weak character, requiring clients to exercise great willpower to solve the problem. The advantage of the model

is that it compels people to take an unequivocal stance toward their lives. Unfortunately, this belief in a "just world" can lead others to blame victims for their misfortunes (Brickman et al., 1982). Taken to the extreme, helpers may accuse sick people of choosing to be sick, or rape victims of choosing to be raped (Rosenstock, 1988). This model makes it difficult for people to ask for help. If clients truly cannot manage to solve their health problems, they will despair and become sicker (Jack & Williams, 1991; Ryan, 1985).

Under the Compensatory Model, clients are not blamed for causing their problems. They are expected to compensate for any handicaps or obstacles imposed on them by acquiring the power or skills needed to overcome the problem. Helpers ask "How may I help you?" Their function is to mobilize necessary resources for the clients. Under this model, alcoholics are not held responsible for their drinking problems, but are expected to get the skills needed to control their urges. The strength of this model is that it allows people to direct their energies toward finding solutions, rather than wasting it on berating themselves. Its drawback is that people may become "burnt out" from continually having to solve problems they did not create (Brickman et al., 1982). If this assumption is correct, it may not be effective for nurses to use this model regularly in their nursing practice.

Implications of Making Cause or Blame Attributions.

Significantly, for most vignettes, respondents were more likely to attribute responsibility for cause (blame) than solution (control). Although it appears beneficial to hold patients responsible for solutions, it is less clear whether it is beneficial to hold patients responsible for cause (Allen, 1990; Brickman et al., 1980, 1982; Karuza et al., 1982). Lewis (1988) considers

the attribution of cause to be a key concept in any problem-solving approach to care - "rational intervention is dependent upon knowing why something is happening" (p. 348).

Edwards (1991) examined whether blaming a patient for illness onset would result in stigmatization of the patient in nurse/patient relationships. Fifty-four student nurses were assigned randomly to two case presentations: 1) patient with AIDS resulting from unprotected sexual intimacy with a known HIV positive lover; and 2) patient with AIDS because of a blood transfusion. Stigmatization was empirically defined by four criterion measures of distancing: time spent with the patient, physical distance from the patient, and scores on the Barrett-Lennard Relationship Inventory rating the nurses' responses to the patient from both the nurse's and patient's perspectives. The study did not show that blaming a patient for the onset of his illness was a stigma that resulted in distancing from the patient. Edwards concluded that even though nurses blame patients for their illness, they do not necessarily distance themselves from these patients.

Ryan (1985) also presumed that nurses rarely consciously base their helping strategies on attributions of responsibility for cause. More frequently, nurses will help patients even if they are held responsible for causing their health problems. Edward's study lent support to these assumptions. Still, holding patients responsible for cause may affect nurses' willingness and the type of help they are prepared to provide. "Nurses make attributions of blame for the cause of health disorders and even if they then provide help, will be righteous in giving" (Ryan, 1985, p. 120).

Effectiveness of the Model Selections.

The effectiveness of any model, that is, whether clients are better off after the help than before, depends on the situation in which it is operationalized (Coates et al., 1983; Rabinowitz et al., 1984). Effective helping can, and does, take place under all models, but some situations may be more suited to the use of one model versus another (Brickman et al., 1982; Coates et al., 1983; Moulton et al., 1987; Northouse & Wortman, 1990). For example, nurses in acute medical/surgical areas may use a Medical Model, while nurses working with psychological problems may find the Compensatory Model more useful. Nurses must become aware and willing to accept the existence of all models in practice, or at least find out what models are being used and decide their effectiveness within different situations (Cronenwett, 1983a).

Many believe the Compensatory Model best justifies the act of helping. Holding clients responsible for solutions empowers them and should result in greater compliance (Brickman et al., 1982; Brickman et al., 1983; Cronenwett & Brickman, 1983; Degner et al., 1987; Jack & Williams, 1991; Rosenstock, 1988). The Medical and Enlightenment Models certainly have proven ineffective when dealing with substance abuse issues (Marsh, 1982; Clifford, 1983). Still, the Medical Model does enable patients to be taken care of during life-threatening situations or when they feel totally overwhelmed (Northouse & Wortman, 1990; Rosenstock, 1988). For emergency staff, who must continually discern whether clients are critically ill or not (Phipps, 1988), the Medical and Enlightenment Models may be most effective as they authorize helpers to assume control. Emergent situations demand emergent responses (Ryan, 1985).

Brickman proposed that a model will be more effective if it supports the dominant assumptions about status within the helper/client relationship. When a relationship is unequal in

status, it will be most stable if help flows from "superiors" (eg. professionals) to the "inferiors" (eg. clients), along the lines of the Medical or Enlightenment Models (Brickman et al., 1982). The literature suggests that emergency personnel perceive the helping relationship to be unequal in status (Bartolucci & Drayer, 1973; Coleman & Errera, 1963; Mannon, 1976, Roth 1972a, 1979). This suggests that from the emergency nurses' perspective, the Medical or Enlightenment Models are the most effective choices.

Effective help also may be characterized by the slow movement from one model to another, or the use of different models during different stages of treatment (Brickman et al., 1982; Karuza et al., 1982; Rabinowitz et al., 1988). Clients have stated they want different types of help during the acute and non-acute phases of their illness (Ryan, 1985). As a patient's ability to assume responsibility or control for solutions increases, the type of help may need to shift from a Medical or Enlightenment Model, where clients assume no responsibility, to the Moral or Compensatory Model, where they assume total responsibility (Brickman et al., 1982). As this process requires time, it is not likely to occur during the patient's emergency visit.

It is proposed that help is more effective when the helper and client use congruent models (Brickman et al., 1982; Stewart, 1989; Tracey, 1988; Young & Marks, 1986). The helping process can begin sooner if the helper and recipient do not have to waste valuable time becoming socialized to one another's model (Cohn, 1983). Jack and Williams (1991) found that the match or mismatch between attributions and attitudes of the helper and recipient was critical in determining whether people sought help when in a crisis and whether they responded to help when they received it.

Some researchers report that congruence of cause attributions is more important than congruence of solution attributions (Glidden & Tracey, 1989; Tracey, 1988). Glidden and Tracey (1989) proposed that for patients to be initially receptive to a therapeutic intervention, blame attributions should match. When the causal attributions of a helper and patient match, the helper perceives the patient as making more realistic attributions (Allen, 1990). Allen (1990), on the other hand, suggested that congruence of future (solution) attributions may be more significant because they are used to evaluate the coping abilities of patients. Regardless of whether helpers and patients agree in their solution attributions, when patients accept responsibility for their future, they are seen as better adjusted, coping better, and are liked more than when they do not accept responsibility (Allen, 1990).

Incongruities in solution attributions may be the basis of "provider-patient dissonance," that is, the perceived discrepancies between helper and clients regarding the helper's role (Phipps, 1988). For example, patients may solicit help from an emergency department when they no longer feel capable of solving their health problems (Jacoby & Jones, 1982; Pisarcik, 1980; Vaughan & Gamester, 1966; Scherzer, Druckman & Alpert, 1980). Patients expect emergency personnel to provide some type of solution to their problem, but staff may not perceive this as an appropriate demand of their role (Roth, 1979). Discrepancies in role perception also may occur when emergency personnel try to provide solutions for patients who do not want to be helped, such as suicide attempters (Ciancutti, 1984; Pallikkathayil & Morgan, 1988). In the Medical Model, the helper defines the solutions to the client's problem and decides when the client has achieved the solution. However, the help recipient may not agree with the helper's definitions (Ryan, 1985).

The Attitudes Toward Patients (ATP) Survey

Following an extensive literature review, (see Appendix A), this researcher selected the ATP Survey to measure attitudes toward patients and psychiatric disorders. This questionaire was chosen because it measures opinions about the etiology and treatment of both psychiatric and medical illnesses, and about the helper/client relationship. Although its main focus is attitudes toward psychiatric patients, this fact is less obvious than with other scales. To date, the ATP Survey had been used only by the developer and his colleagues (Carsen, et al., 1987; Roskin et al., 1986; Roskin et al., 1988; Roskin & Marell, 1988). Roskin did not attempt statistical validity of the instrument, because he felt the items had "face validity" (Roskin & Marell, 1988). However, the ATP can be compared with a validated instrument, the Opinions about Mental Illness (OMI) scale. This scale, developed by Cohen and Struening (1962, 1963, 1964, 1965), has been widely used (Askenasy, 1974; Bairan & Farnsworth, 1989; Creech, 1977; Ellsworth, 1965; Gelfand & Ullmann, 1961a; Gelfand & Ullmann, 1961b; Kahn, 1976; Lewis & Cleveland, 1966; Matas et al., 1985; McPherson & Cocks, 1983; Meltzer & Grigorian, 1972; Morris, 1964; Olade, 1983; Slimmer et al., 1990; Smith, 1969). In the following discussion, whenever possible, comparisons will be made between the two scales.

The findings in this study are similar to those reported by Roskin regarding nurses (Roskin et al., 1988). In both studies, nurses scored highest on the Psychodynamic Etiology of Organic Illness subscale, followed by the Psychodynamic Etiology of Psychiatric Disorders subscale, the Biological Etiology of Psychiatric Disorders subscale, and the Moral Weakness Etiology of Psychiatric Disorders subscale. Both groups preferred a Nurturant-Empathic style of helping, followed by the Distancing-Detachment and Authoritarian-Controlling approaches.

Similarly, using the OMI, Cohen and Struening (1963) reported greatest agreement with their Benevolence factor, followed by the Mental Hygiene Ideology factor, the Interpersonal Etiology factor, the Social Restrictiveness factor, and lastly, the Authoritarianism factor. The significance of the various subscales will be explained in the following discussion.

Significance and Implications of the ATP Findings.

For the four ATP etiology subscales, the higher the score (range = one to seven), the more subjects agree with that particular belief. As listed previously, respondents scored highest on the Psychodynamic Etiology of Organic Illness subscale (mean = 5.169). This subscale reflects the belief that medical and surgical illnesses can be influenced by psychodynamic or mental/emotional factors. A statement that typifies this belief is, "Dangers from cardiovascular disease can be lessened by psychotherapy that promotes reduction of 'Type A' personality traits" (Roskin et al., 1988; Roskin & Marell, 1988).

The scores for several items suggest that respondents readily acknowledge the necessity for psychosocial support for medical and surgical patients. For example, of the 72 items, they disagreed most with the statement, "Dealing with the emotional needs of the medical or surgical patient is not a primary function of the nurse" (mean = 1.822). They also agreed with the items, "Understanding the psychological makeup of the patient makes a nurse more effective" (mean = 5.465) and "Patients have a right to expect special consideration and care when they are suffering" (mean = 5.277).

Following the Psychodynamic Etiology of Organic Illness subscale, respondents agreed most with the Psychodynamic Etiology of Psychiatric Disorders subscale (mean = 4.885). This

subscale advances the belief that psychiatric illness results from early childhood experiences and stresses in family interactions (Roskin et al., 1986). The item, "In order to treat emotional disorders, the psychiatrist must be knowledgeable about unconscious defense mechanisms and how they developed during childhood," is representative (Roskin et al., 1988; Roskin & Marell, 1988). Generally, helpers who work extensively with psychiatric patients, (eg. psychiatrists, psychologists) score higher on this scale than professionals who do not work extensively with psychiatric patients (eg. nurses, medical residents, surgical residents) (Roskin et al., 1988; Roskin & Marell, 1988).

The Psychodynamic Etiology of Psychiatric Disorders subscale is similar to the Factor E (Interpersonal Etiology) scale of the OMI. Factor E reflects the belief that mental illness arises from interpersonal experiences, especially deprivation of parental love during childhood. Cohen and Struening (1963) found that nurses did not differ significantly from other health care professionals on this factor.

The Biological Etiology of Psychiatric Disorders subscale ranked third in this study. This subscale asserts that psychiatric disorders have genetic, physiological, or anatomical origins (Roskin et al., 1986). This belief is typified by the item, "The most promising developments in psychiatric knowledge will come from research in neurochemistry and psychopharmacology" (Roskin et al., 1988; Roskin & Marell, 1988). When compared to social workers, psychiatrists, and psychologists, nurses scored significantly higher on this subscale (Roskin et al., 1988). Roskin believes nurses score higher because their training focuses more heavily on organic medicine (Roskin et al., 1988).

Factor C (Mental Hygiene Ideology) on the OMI also claims that psychiatric illness is like any other illness and uses the medical model. Although nurses scored higher than other "white collar workers" on this scale, they scored lower than psychologists, psychiatrists, and social workers (Cohen & Struening, 1963).

Finally, nurses in this study scored lowest on the Moral Weakness Etiology of Psychiatric Disorders subscale (mean = 3.347). This subscale submits that psychiatric disorders are due to an individual's weakness, self-indulgence, or moral deficiency (Roskin et al., 1986). The item, "Neurotic symptoms indicate a lack of character and little self-control," is typical (Roskin et al., 1988; Roskin & Marell, 1988). The OMI has no comparable scale.

On the three helper/client approaches, respondents in this study scored highest on the Nurturant-Empathic Attitudes subscale (mean = 4.771). High scores on this subscale reflect an attitude of caring, sensitivity, and empathy toward patients. This subscale is typified by items such as, "Feeling truly cared for by the therapist can be a decisive curative factor in the treatment of psychiatric patients" and "Health care professionals must be able to empathize with a patient in order to give helpful treatment" (Roskin et al., 1988; Roskin & Marell, 1988). Although also the first choice for nurses in Roskin's study, they scored significantly lower than psychiatrists, psychologists, and social workers on this scale (Roskin et al., 1988).

Similarly, Factor B (Benevolence) on the OMI scale measures a kindly, paternalistic attitude. However, Cohen and Struening (1963) reported that nurses scored higher on the Benevolence scale than any other group of care providers, such as, doctors, clergy, psychiatrists, psychologists, and paraprofessionals, among others.

The Distancing-Detachment from Patients subscale measures the degree of intimacy the helper prefers within the helper/client relationship. In this study, nurses scored just above neutral (mean = 4.063). The lower the score, the more the subject prefers to distance himself from patients. The higher the score, the more comfortable the subject is with a close relationship. A typical item is, "Feeling of closeness with the patient can interfere with objectivity and effective clinical decision-making" (Roskin et al., 1988; Roskin & Marell, 1988).

A comparable concept is evident in Factor D (Social Restrictiveness) of the OMI, which views psychiatric patients as a threat to family and society, and someone who must be restricted in their functions. Nurses tended to be less restrictive in attitude than nonprofessionals, but more restrictive than psychologists, psychiatrists, clergy, or social workers (Cohen & Struening, 1963).

Finally, the Authoritarian-Controlling Attitudes subscale measures the helper's attitude regarding patient autonomy. The lower the score, the more comfortable the helper is with the patient as autonomous. The higher the score, the more the helper needs control within the helper/client relationship (Roskin et al., 1986). The statement, "Patients ultimately should rely on their doctor's medical expertise, and not research their illnesses independently," represents this scale (Roskin et al., 1988; Roskin & Marell, 1988). The average score for respondents on this scale was 3.036. This subscale is similar to Factor A (Authoritarianism) on the OMI scale. Nurses scored lower than all other health care providers on this scale. When nurses' scores on the five factors were considered, their lowest score was Factor A (Cohen & Struening, 1963).

In summary, this study suggests that the general attitude toward patients, including psychiatric patients, is positive. Respondents seem to realize the importance of mental/emotional factors in medical and surgical illnesses. They tend to see psychiatric illnesses as more

psychodynamically than biologically oriented, and disagree slightly with the belief that psychiatric disorders result from personal weakness or moral deficiencies. Respondents prefer a nurturant helping approach and some intimacy within the helping relationship. Finally, they are willing to see patients as autonomous more than they need to maintain control within the relationship. Comparing the findings using the ATP with findings using a validated attitude toward mental illness scale (OMI) shows both similarities and differences.

Significance of the Relationships Between the ATP Subscales.

Pearson correlation coefficient ($p = 0.001$, two-tailed) analysis of the four etiology belief and the three helper/client relationship subscales revealed several relevant findings (see Table 21). The Psychodynamic Etiology of Organic Illness and Psychodynamic Etiology of Psychiatric Disorders were the only belief subscales to show a significant correlation. For both medical/surgical and psychiatric patients, respondents acknowledge the importance of psychodynamic processes and the psychosocial aspects of illness. This finding strengthens Cronenwett's (1983b) assertion that there has been a shift from a predominantly medical/biological orientation to a more holistic or psychological orientation in nursing education and practice.

Both the Psychodynamic Etiology of Organic Illness and Psychodynamic Etiology of Psychiatric Disorders subscales showed a significant positive correlation with the Nurturant-Empathic Attitudes subscale. As described earlier, the Psychodynamic Etiology of Organic Illness subscale reflects the belief that mental and emotional factors influence the process of medical/surgical illnesses. The Psychodynamic Etiology of Psychiatric Disorders subscale presents

the tenet that psychiatric illnesses are a result of childhood experiences and family dynamics. The Nurturant-Empathic Attitudes reflects a caring and empathic attitude toward patients. The significant positive relationship between these subscales suggests that helpers who recognize the importance of the psychodynamic and psychosocial aspects of medical/surgical and psychiatric illness would tend to prefer a caring, empathic style of helping.

The Authoritarian-Controlling Attitudes and Distancing-Detachment from Patients subscales showed a significant negative correlation. On the Authoritarian subscale, a low score reflects comfort with patient autonomy, while a high score reflects the need to maintain control. On the Distancing subscale, a low score means the subject prefers to distance himself from the patient and a high score means the subject is comfortable with intimacy in the helping relationship. The significant inverse correlation suggests that helpers who perceive patients as autonomous should be more comfortable with a close helper/patient relationship. On the other hand, helpers who need to maintain control likely would choose to distance themselves from patients. This differs from Ellsworth's (1965) findings that "nontraditional" helpers, who scored high on Authoritarianism (Factor A - OMI), still were perceived as warm and sensitive.

The Moral Weakness Etiology of Psychiatric Disorders and the Authoritarian-Controlling Attitudes subscales showed a significant positive correlation. The Moral Weakness belief submits that psychiatric disorders are due to an individual's weakness, self-indulgence, or moral deficiency. As discussed, the Authoritarian subscale measures patient autonomy versus helper control. This relationship suggests that helpers who believe psychiatric illness is due to personal weakness would choose to maintain a high degree of control within the helping relationship. The significant negative correlation between the Moral Weakness and Nurturant-Empathic Attitudes

subscales suggests that helpers who agree with this etiological belief likely would not choose an empathic helping style. The negative relationship between the Authoritarian-Controlling and Nurturant-Empathic subscales is in the predicted direction, but the correlation did not reach significance (-.2343).

Using the Opinions about Mental Illness (OMI) scale, which measures concepts analogous to the ATP, Cohen and Struening (1962, 1963, 1964, 1965) reported similar findings. Subjects who scored high on Mental Hygiene Ideology, Interpersonal Etiology, and Benevolence tended to score low on Authoritarianism and Social Restrictiveness, and vice versa.

Based on the research findings, it is possible to arrange the ATP and OMI subscales on a continuum that could be used to predict the general direction of a helper's attitudes toward psychiatric patients (see Figure 3).

Figure 3: Subscales of the ATP Survey and OMI used to predict direction of attitudes

Positive Attitude Toward Patients	+ <----------> -	**Negative Attitude Toward Patients**
Subject Scores High on the Following Subscales		Subject Scores High on the Following Subscores
ATP SURVEY:		
Biological		
Organic		Moral Weakness
Psychodynamic		Authoritarian-Controlling
Nurturant-Empathic		
Distancing-Detachment		
OPINIONS ABOUT MENTAL ILLNESS:		
Mental Hygiene Ideology		Authoritarianism
Interpersonal Etiology		Social Restrictiveness
Benevolence		

Theoretically Aligning the ATP Survey with Models of Helping and Coping

McGovern et al. (1986) proposed that etiological beliefs and treatment modalities could be aligned according to Brickman's Models (Brickman et al., 1982). For example, theoretically the philosophies of existential, psychodynamic, and family systems therapists suggest a preference for the Compensatory Model (low responsibility for cause, high responsibility for solution). behavioural and biological\medical orientations endorse Medical Model beliefs (low responsibility for cause and solution). Self-help groups and cognitive behaviouralists lean toward the Moral Model (high responsibility for cause and solution).

Similar alignment can be made with the Attitudes Toward Patients Survey subscales. For example, the Psychodynamic Etiology of Organic Disorders, Psychodynamic Etiology of Psychiatric Disorders, and Biological Etiology of Psychiatric Disorders subscales assign low responsibility for cause to the patient. High scores on these subscales, which signify agreement with that belief, should correspond to cause attributions of the Medical or Compensatory Models. The Moral Weakness Etiology for Psychiatric Disorders subscale attributes high responsibility for cause to the patient, as in the Moral and Enlightenment Models.

The helper/client relationship subscales also can be aligned with the Models of Helping and Coping (Brickman et al., 1982). For example, the Moral and Enlightenment Models use exhortion and discipline to "help" their clients. Clients, ardently and repeatedly, are made aware of their responsibility for causing the problems. Helpers preferring these models should score high on the Authoritarian-Controlling Attitudes subscale. The Medical and Compensatory Models are more accepting of clients and higher scores on the Nurturant-Empathic and Distancing-Detachment subscales are predicted. The theoretical alignment of the ATP Survey etiology and

relationship subscales, according to the Models of Helping and Coping, can be shown figuratively (see Figure 4).

Figure 4: Subscales of the ATP Survey aligned according to the Models of Helping and Coping

Enlightenment model
(High cause/low solution)

Moral Model
(High cause/high solution)

Moral Weakness Etiology of Psychiatric Disorders subscale

Authoritarian-Controlling Attitudes subscale

Psychodynamic Etiology of Psychiatric Disorders subscale
Psychodynamic Etiology of Organic Disorders subscale
Biological Etiology of Psychiatric Disorders subscale

Nurturant-Empathic Attitudes subscale
Distancing-Detachment from Patients subscale

Medical Model
(Low cause/low solution)

Compensatory Model
(Low cause/high solution)

This study lends support to these predictions. Subjects generally preferred the Medical Model, which attributes low responsibility for cause to the patient. They agreed most with the Psychodynamic Etiology of Organic Disorders subscale, followed by the Psychodynamic Etiology of Psychiatric Disorders, and Biological Etiology of Psychiatric Disorders subscales. Of the three helper/client relationship approaches, respondents scored highest in the Nurturant-Empathic subscale, followed by the Distancing-Detachment subscale. These ATP subscales also theoretically align with the Medical Model.

Respondents agreed least with the Moral Weakness Etiology of Psychiatric Disorders and Authoritarian-Controlling Attitudes subscales. These two ATP subscales theoretically fit with the Enlightenment and Moral Models, which assign high responsibility for cause to the patient. Still,

subjects did assign higher blame to the patient (ie. use the Enlightenment Model) for two vignettes, the vignette regarding the male patient with exacerbation of COPD and the female overdose patient. Significantly, subjects also selected the Enlightenment Model more frequently for psychiatric patients than for medical or surgical patients. Perhaps as Szasz (1960) has suggested, psychiatric illness is a special case that readily allows moral judgments to be made.

The Correlation Between Attributions and Attitudes In this Study

The relationship between attributions (vignette subscale and overall scores) and attitudes (ATP Survey subscale scores) was analyzed using Pearson correlation coefficient ($p = 0.001$, two-tailed). This analysis revealed several significant relationships (see Table 22). Findings also provide support for the assumption that attributions may affect attitudes.

The Moral Weakness Etiology subscale showed a strong positive correlation with the Overall Cause score (.3460). It showed an even greater positive correlation with the Psychosocial Vignettes Cause score (.4120). The Moral Weakness Etiology scale also showed a moderate positive relationship with the Overall Solution (.2918) and the Psychosocial Vignettes Solution score (.2915). The Moral Weakness Etiology of Psychiatric Disorders scale reflects the belief that psychiatric illness is due to an individual's weakness, self-indulgence, or moral deficiency. Theoretically, the assumptions of the Moral Weakness Etiology scale should correspond with those of Brickman's Moral Model. The strong positive correlation between the Moral Weakness and Psychosocial Cause subscales supports this prediction.

The Nurturant-Empathic Attitudes subscale showed a significant negative correlation ($p = 0.01$, two-tailed) with the Psychosocial Cause (-.2574) and the Psychosocial Solution (-.2669)

subscales. The inverse relationship suggests that the helper who uses the Moral Model (high responsibility for cause/solution) for helping psychiatric patients, will tend to be less nurturant and empathic than a helper who uses the Medical Model (low responsibility for cause/solution). This premise is supported by two previous correlational findings. The first supportive finding is the significant positive correlation between the Moral Weakness and Psychosocial Cause and Solution scores discussed above. The second is the significant negative correlation between the Moral Weakness and Nurturant-Empathic scales discussed earlier.

The Authoritarian-Controlling Attitudes scale consistently showed a positive relationship with the attribution subscales, reaching significance ($p = 0.01$, two-tailed) with the Medical Solution subscale (.2795). The Authoritarian-Controlling Attitudes scale measures at its extremes, patient autonomy (low score) and helper control (high score). The Medical Model assumes that clients cannot solve their problems, but most rely on, and comply with the help of experts. When helpers use a Medical Model, they assume responsibility for solutions, that is, responsibility for control. The positive correlation between the Authoritarian-Controlling score and the Medical Solution score supports this basic tenet of Brickman's Medical Model.

The Psychodynamic Etiology of Psychiatric Disorders subscale showed a moderate negative correlation with the Surgical Solution (-.2319), Psychosocial Solution (-.2356), and Overall Solution (-.2339) subscales. The Psychodynamic Etiology of Psychiatric Disorders scale addresses only the cause of illness, and could align with either the Medical or Compensatory Models. However, the observed inverse relationship between the Psychodynamic Etiology scale and the three Solution scores in this study can be supported by previous research. After analyzing the philosophies of various therapies, McGovern theorized that psychodynamic therapists would

prefer the Compensatory Model, which assigns high responsibility for solution to the patient. When presented with several helping "vignettes," psychodynamic therapists actually assigned low responsibility for solution, thus using a Medical Model (McGovern et al., 1986).

The Psychodynamic Etiology of Organic Illness showed only one moderate positive relationship (.2492), which was with the Medical Cause subscale. As this subscale is measuring beliefs about causes for medical illnesses, this finding is not unexpected. The negative relationship (-.2245) between the Organic and Surgical Solution subscale was not expected. High agreement with the item, "A person's psychological makeup can strongly affect the rate of post-operative recovery" (mean = 6.178), would suggest that respondents recognize the mind/body interaction even for surgical cases. However, as surgical solutions are usually straight forward, "cut and dried," respondents may not believe the patient can assume responsibility for that.

The Distancing-Detachment Attitudes and the Biological Etiology of Psychiatric Disorders subscales showed negligible correlations with any of the attribution subscales. Most relationships were negative.

In summary, the ATP attitude subscales can be aligned with the Models of Helping and Coping in a manner consistent with the model assumptions. Correlational analysis revealed several significant relationships between the attribution scales and the attitude scales. In particular, the Psychosocial Cause and Solution attribution scales, and the Moral Weakness Etiology, Nurturant-Empathic, and Authoritarian-Controlling attitude scales lend support to the assertion that attributions influence attitudes.

Attributions and Attitudes and Issues of "Legitimacy"

The literature suggests that emergency personnel make negative attributions and hold negative attitudes toward certain patients, especially psychiatric patients. Attributions and attitudes toward patients appear to be related to issues of "legitimacy" regarding emergency department resources and services (Freidson, 1970; Mannon, 1976; Roth, 1972a, 1979; Yoder & Jones, 1982a). The relationship is direct, that is, the more positive the attributions or attitudes toward patients, the more legitimate and socially desirable the patient. Acutely ill or surgical patients are deemed more legitimate and socially desirable than complex or chronically ill medical patients. Of all patients, psychiatric patients are considered the least legitimate, and least socially desirable (Baker, 1985; Fryer & Cohen, 1988; Jones et al., 1984; Mannon, 1976; Reynolds & Bice, 1972; Roth, 1979; Yoder & Jones, 1982a).

This study lends some support to these observations. Although mean scores indicate that subjects preferred the Medical Model for most situations, there were notable differences in the degree of responsibility for cause (blame) assigned to each type of patient. Brickman and his colleagues believed that recipients of help are perceived as "legitimate" or deserving of help to the extent that they are not held responsible for causing their problems (Brickman et al., 1983; Rabinowitz et al., 1984). Ranking of the vignettes showed that psychiatric patients generally were assigned more responsibility for causing their problems, followed by medical patients, and lastly, surgical patients. Scatter plots showed even more clearly that psychiatric patients were assigned blame more frequently than medical or surgical patients. Approximately 30% of respondents chose to use the Enlightenment Model for the Psychosocial Vignettes, compared to 15% for the Medical Vignettes, and 2% for the Surgical Vignettes. This model assigns high responsibility for

the cause of the problem to the patient. These more blaming (negative) attributions regarding psychiatric patients suggest they may be perceived as less "legitimate" or deserving of help than medical/surgical patients.

However, this study did not find the attributions and attitudes toward patients were as negative as previous research suggested. The investigator intentionally built factors of blame into each vignette, yet respondents generally preferred the Medical Model, which assigns low responsibility for cause and solution to the patient. Their preference may have been biased because the vignette patients were categorized as "urgent." Urgent patients are perceived as "real" emergencies and are considered legitimate work and a legitimate demand of staff and resources (Mannon, 1976; Roth, 1979). In addition, the seriousness of the illnesses may have overshadowed any responsibility patients were assigned due to their lifestyle choices (Freidson, 1970), or any moral repugnance helpers may have felt (Roth, 1979).

Typically, patients categorized as nonurgent, "regulars," and those who present with complex or vague symptoms are perceived as "illegitimate" demands of emergency services (Baker, 1985; Jones et al., 1982a; Mannon, 1976; Roth, 1979; Yoder & Jones, 1981). These previous findings suggest that respondents should have strongly agreed with the ATP statement that "Patients who habitually present with multiple vague complaints with no somatic reason use up the time and energy of health care professionals who could be helping people with real illnesses." But, the respondents' mean score (4.267) showed only slight agreement with the statement. Their response is more favourable than predicted and warrants further investigation.

Service personnel attempt to control for illegitimate demands on their services by selecting or training their clients. When a long term relationship is not anticipated, personnel must use

other tactics of control (Roth, 1979). Perhaps emergency workers, striving to maintain the delicate balance between demand and resources, choose models of helping where patients are not given control for problem solving. Dissonance within a system causes it to become prohibitive and reactive to maintain stability. The methods used to restore stability are usually in line with the Medical and Enlightenment Models (Chrystal, 1988).

In recent decades, social problems, previously defined in moral or criminal terms, have been legitimized and redefined in medical terms. The willingness to "medicalize" a problem is influenced by social and moral worth definitions (Yoder & Jones, 1981). Alcoholism, drug addiction, aging, pregnancy, and child abuse are examples of "medicalized" situations. "Medicalization" is supposed to mean that moral judgments or attitudes of "badness" are replaced by concepts of illness (Conrad & Schneider, 1980). Recent attempts to medicalize battering have met with some resistance (Kurz, 1987). Kurz (1987) reported that many emergency staff do not see battering as a legitimate medical problem and believe there is nothing they can do to help.

This study did not support Kurz's conclusions. Respondents predominantly chose to use the Medical Model when dealing with a battered woman (Vignette B). Subsequent choices were the Enlightenment (10%), Compensatory (5%), and Moral (4%) Models. Similarly, King (1988) found subjects preferred the Medical Model, despite their practice setting (community versus hospital) or whether they had advanced knowledge about the topic. The advantage of the Medical Model is that it provides help without blame, but it also contributes to helplessness. Therefore, it has not been found effective for helping victims of violence on a long term basis (Brickman et al., 1982; King, 1988).

Effect of Sample Characteristics

Effect of Sample Characteristics On Attributions.

This study showed no significant differences for mean attribution scores based on the respondents' gender. Similar findings are reported by other researchers using the Models of Helping and Coping framework (Karuza, 1979; Karuza, Zevon, Gleason, Karuza & Nash, 1990; Mitchell, 1985). Some researchers report that younger helpers attribute more blame than older helpers (Karuza, 1979; Memmott & Brennan, 1988), but this study found no significant difference in mean attribution scores based on the respondents' age. In previous research, age of the help recipient was more significant in determining the helper's model preference. Helpers prefer Moral and Compensatory Model strategies for young adults and Medical Model strategies for children and the elderly (Karuza, 1979; Karuza et al., 1990; Karuza, Zevon, Rabinowitz & Brickman, 1982; Memmott & Brennan, 1988; Zevon, Karuza & Brickman, 1982).

No significant difference in mean attribution scores was found based on years of nursing experience or years of emergency nursing. There also was no significant difference in mean attribution scores between nurses with basic versus advanced education. Ryan (1985) reported that nurses educated at different levels did not differ in their choice for helping models when a specific disease was not named. When a specific disorder such as alcoholism was named, nurses with higher education assigned more blame and less control than did pre-baccalaureate nurses.

There also were no significant differences in mean attribution scores between nurses who worked full-time versus part-time, or nurses working in a community versus tertiary centre. Ryan (1985) found that choice of helping models differed more by the patient's problem than by practice setting (hospital versus community).

Effect of Sample Characteristics on Attitudes.

This study revealed no significant differences in attitudes based on gender, but as the number of male respondents in this sample was small (n = 5), findings cannot be generalized. Previous studies using the ATP Survey found either no difference based on gender (Roskin et al., 1988), or reported that females were less authoritarian and controlling than males (Carsen et al., 1987; Roskin et al., 1986). Carsen found males tended to see psychiatric illness more biologically and physiologically determined, while women believed it to be more psychologically determined (Carsen et al., 1987). This study also revealed no significant differences based on the respondents' age. This is similar to previous findings regarding attitudes toward mental illness, including studies using the ATP Survey (Roskin et al., 1988).

Researchers report distinct patterns in attitudes toward mental illness based on occupations or professions (Cohen & Struening, 1963, 1965; Roskin et al., 1988). This sample was homogeneous as all respondents were emergency nurses. Similar to previous studies (Cochrane, 1987; Roskin et al., 1988), no significant differences in attitudes toward patients based on years of nursing experience or years of emergency nursing were found. Also, there were no significant differences in attitude between nurses who worked full-time versus part-time.

Previous research suggests that advanced education and training have a positive influence on attitudes toward psychiatric patients (Bairan & Farnsworth, 1989; Casco et al., 1987; Cheech, 1977; Cohen & Struening, 1962, Gelfand & Ullmann, 1961a; Lewis & Cleveland, 1966; Morris, 1964; Olade, 1983; Smith, 1969; Wilcox, 1987). This study found no significant differences in the attitude scores of nurses with basic versus advanced education. Categories of advanced education primarily consisted of emergency care, intensive care, administration, and university

programs (see Table 11). The issue of education and advanced training requires further investigation.

Several studies examined the effect of practice setting on attitudes toward patients. For example, Soukas and Lonnqvist (1989) found distinct differences in attitudes toward suicide attempt patients between emergency, observation, and intensive care staff. In an investigation regarding the effect of shift work on attitudes toward emergency patients, Peterson (1985) found greater variation between emergency units than between shifts. In this study, practice setting was the only variable that significantly affected attitudes.

Tertiary centre nurses scored significantly higher than community centre nurses on the Psychodynamic Etiology of Psychiatric Disorders, Nurturant-Empathic Attitudes, and Distancing-Detachment from Patients subscales. The Psychodynamic Etiology versus Nurturant-Empathic subscales showed a significant positive correlation (.5246). As discussed, one can predict that subjects who believe in a psychodynamic etiology to psychiatric illness are more likely to use a nurturing approach with psychiatric patients.

Several researchers report that increased exposure and clinical experiences with psychiatric patients result in a positive shift toward mental illness (Hick & Spaner, 1962; Meltzer & Grigorian, 1972; Oyefeso et al., 1989; Roskin et al., 1988; Swain, 1973). The effect of contact and work experience was not tested, but this variable may explain why tertiary centre nurses scored higher on the Psychodynamic Etiology and Nurturant-Empathic subscales. Tertiary facilities may treat more psychiatric patients in their departments, thus having greater opportunity for clinical experience with psychiatric emergencies. Manitoba Health Services Commission and individual facilities do not keep statistics that could confirm this point. Tertiary facilities do have

psychiatric nurses stationed in the emergency department and readily available psychiatric residents and physicians who could educate the emergency nurses about psychiatric disorders.

Roskin found that psychiatric clerkship, which included both didactic and clinical experiences, resulted in significant positive changes in etiological beliefs and helper/client approaches (Roskin et al., 1986; Roskin et al., 1988). When the Manitoba Emergency Nursing Program (MENP) was offered, its format included didactic and clinical experience with psychiatric situations. Significantly, the tertiary sample and population had proportionally more nurses who had completed the MENP (two sample, two-tailed proportions test, $p = 0.01$). Still, no significant differences were found between MENP graduates, graduates of other advanced programs, and those with basic education (Duncan's multiple comparison test, $p = 0.05$).

The Nurturant-Empathic Attitudes and Distancing-Detachment from Patients subscales showed a positive, but only moderate correlation (.2330). A high score on the Nurturant-Empathic scale suggests agreement with a caring, empathic helping style. A high score on the Distancing-Detachment scale reflects comfort with an intimate helping relationship, while a low score shows a preference to distance oneself from patients. This correlation suggests that nurses who prefer a nurturant helping style would be more comfortable with a close helper/client affiliation. When compared with social workers, psychiatrists, and psychologists, nurses were more likely to distance themselves from patients (Roskin et al., 1988). This may occur, Roskin explains, because unlike the others, nurses must have daily prolonged close interactions with the most severely ill patients. This factor may make them more prone to burnout (Roskin et al., 1988). Maslach (1982) proposed that a type of distancing behaviour or "detached caring" is necessary to prevent burnout.

Limitations of the Study

The investigator has identified several limitations of this study that must be addressed. First, the generalizability of the study is limited due to several factors. The sample did not represent the population regarding the educational level and work status. Both the community and tertiary centres had a significantly higher percentage of nurses with advanced education respond, and tertiary centres had a significantly higher percentage of full-time versus part-time nurses respond. However, results showed no significant differences in attributions or attitudes based on these variables.

The second factor limiting generalizability was the low overall response rate (35.3%). Some facilities had satisfactory response rates (eg. Seven Oaks General Hospital, Misericordia General Hospital), but others had low response rates (eg. Grace General Hospital, St. Boniface General Hospital). Therefore, one cannot assume that the respondents' attributions and attitudes reflect the true culture and climate of the emergency department. Nurses who did not respond to the questionaire may hold completely different attitudes toward patients.

Several factors seemed to influence the response rate. The investigator returned to each emergency department several times, but no questionaires were obtained after the first retrieval. Potential subjects expressed reluctance to complete the survey because others had told them the questionaires were too long and time-consuming. The response rate was higher in facilities where the investigator was known by the head nurse, clinical instructor or staff. The response rate was higher in facilities where the head nurses had handed out the survey packages individually, or had left one in each individual's mail box, as requested by the investigator. In several facilities, the investigator found the survey packages lying in a pile in the conference room. It also was

higher when the head nurse repeatedly encouraged the subjects and provided work time to complete the questionaires. The head nurse at the facility with the lowest return rate believed the poor response was related to the staff being worn-out from coping with chronic overcrowding and ongoing department renovations.

For future investigation, the researcher would select a shorter questionaire to measure attitudes, as this is the segment that received the most criticism. In addition, the investigator would take further time to explain the study to the head nurses, in hopes of soliciting more cooperation in providing subjects with the package, actively encouraging subjects, and allowing work time for completion of the questionaires.

This study examined attitudes as a consequence of attributions using a self-report survey. One drawback to a survey is that people may inadvertently or intentionally bias their answers (responder bias). As survey information is somewhat superficial, it only can be used in extensive, not intensive analysis. One may determine correlational relationships using survey data, but cannot infer cause-and-effect relationships.

Finally, one must be aware that endorsing an attitude does not mean that displayed behaviour is congruent (Ellsworth, 1986; Jackson, 1988). A change in attitude does not mean necessarily a change in behaviour (Gelfand & Ullmann, 1961a; Tracey, 1988). Many constraints, such as organizational policies, procedures, or philosophies, legislative guidelines, professional socialization and standards, and helpers' personal experiences, can affect attitudes and behaviours (Cronenwett, 1983a; Karuza et al., 1982). In addition, one must consider the situational demands and cultural context of the particular treatment area in which staff must function (Ellsworth, 1965; Roth, 1979).

Implications for Education

For years, nursing has struggled to base education and practice on conceptual frameworks. Some have endeavoured to bridge the perceived chasm between nursing theory and practice (Lewis, 1988). Their struggle has resulted in a proliferation of nursing models, most of which include a definition of health, the client, the environment, and nursing. Because it generates the question "why," Lewis (1988) proposes that attribution of cause should be an essential part of any nursing model that is being used to implement the nursing process. Brickman's model, based on attributions of responsibility for cause and solution, is simplistic, yet multi-faceted and profound. Perhaps it is time to broaden our perspective to include the concept of "helping" and what "help" may mean to the individual patient. Instead of advocating one style of helping, nursing theories should allow for all models of helping and suggest when particular models may be most appropriate. Cronenwett (1983a) and Ryan (1985) illustrated how easily the concept of "helping" within several dominant nursing models can be categorized according to the Models of Helping and Coping.

Nurses also have been struggling to define nursing practice and standards, and the knowledge base and skills that are unique to nursing. It is encouraging that findings suggest there has been a shift in the orientation of nursing, from a heavy biological or medical model emphasis to a more holistic, psychologically based approach. This shift in orientation may represent nursing's budding awareness of their special contribution to health care.

Although this study did not find a significant difference in attributions and attitudes based on education, this is an area that requires further investigation. Previous literature suggests that advanced education has a positive effect on attitudes toward psychiatric patients. Although the

types of advanced education described in this study may broaden one's perspective, many were primarily skill oriented. The amount of knowledge, exposure, or experience with psychiatric situations may not have been sufficient to result in a difference in attitudes. It would appear training must be specific, such as a psychiatric clerkship encompassing didactic and clinical supervision with psychiatric patients (Hicks & Spaner, 1962; Roskin et al., 1988).

One program believed to contain didactic and supervised clinical experiences with psychiatric patients was the Manitoba Emergency Nursing Program (MENP). Analysis revealed that MENP graduates held no significantly different attitudes toward psychiatric patients. However, there have been no controlled studies that measure students' attitudes toward psychiatric patients before entering, and upon completion of the MENP. Emergency department educators and administrators recognize the critical skills needed to deal with physiological emergencies. They encourage and provide advanced training, such as Advanced Cardiac Life Support or Advanced Trauma Life Support. Emergency nurses also must be provided with extensive training on how to deal with psychiatric and psychosocial emergencies.

One aspect of emergency nursing that requires specialized training and clinical experience is that of the triage nurse. The triage nurse plays the most important role in the emergency department, because the patient's initial contact sets the mood for the rest of the emergency room interactions (Gelfant & Lovelace, 1987). It is essential the triage nurse makes an unbiased assessment of each emergency patient. One source of bias may be past training and experiences that focus on client's deficiencies (Rabinowitz, 1988). Another source may be the culture of that particular emergency department and the type of client they predominantly serve. As part of triage training, nurses must become aware of their attributional biases and the impact they have

on consequent attitudes, emotions, and behaviours. Texts and material that deal with the public relations and attitude component of triage should be readily available (Cameron, 1980; Ciancutti, 1977, 1984).

Implications for Future Research

Several research questions emanate from the findings of this study. Gender, age of the helper, level of education, years of nursing practice, years of emergency nursing, and practice setting did not seem to influence nurses' attributions of responsibility. Studies examining the effect of the recipient's age and problem type on a helper's model preference should be considered. Gender, age, level of education, years of nursing practice, and years of emergency nursing also did not affect attitudes. However, there were significant differences in attitudes toward patients based on practice setting, that is, whether nurses worked in a tertiary or community centre.

Several studies have examined the effect of practice setting on nurses' attributions and attitudes toward patients. Ryan (1985) found nurses' attributions about battered women did not differ with practice setting, but others report differences in attitude toward psychiatric patients based on setting (Kahn, 1976; Marsey, 1988; Soukas & Lonnqvist, 1989). Practice setting warrants further investigation to determine what variables account for differences between emergency departments. The investigator also could examine the attributions of responsibility made by nurses within other practice settings, such as, medical, surgical, psychiatric, and intensive care units. Models that are preferred and effective in one practice setting may not be in other settings.

This study examined the relationship between attributions and attitudes. Future research could include the study of other consequences of attributions, such as emotions and behaviours. For example, several researchers have described the emotions evoked by certain emergency patients. Nurses have expressed frustration and fear about dealing with psychiatric patients (Baker & Moynihan, 1983; Pallikkathayil & Morgan, 1988; Yoder & Jones, 1981; 1982a). The relationship between attributions of responsibility and evoked emotions for specific emergency scenarios could be addressed. Future research also should examine whether stated attributions and attitudes reflect observed behaviour in the emergency department.

For the vignettes in this study, which were typical urgent medical, surgical, and psychiatric scenarios, nurses preferred to use the Medical and Enlightenment Models. Future research could investigate whether other types of emergency situations elicit the Moral or Compensatory Models. For example, the literature suggests that nurses would make different attributions of responsibility for nonurgent types of patients.

The importance of congruence regarding attributions has been proposed (Brickman et al., 1982; Stewart, 1989; Tracey, 1988). Future studies could involve asking the patient types depicted by the emergency vignettes about their attributions of responsibility, and the type of help they prefer during the acute and nonacute stages of their problem. The question arises whether incongruence of attributions is more likely with patients classified as nonurgent versus those classified as urgent.

Several investigators discuss the greater social worth of the young versus the elderly (Roth, 1972a; Shelley et al., 1987). Research using the Models and Coping suggests that helpers prefer to use different models for adults versus the elderly and children (Karuza, 1979; Karuza

et al., 1982; Zevon et al., 1982). A study exploring attributions of responsibility for pediatric versus adult or geriatric scenarios may provide new knowledge about the impact of help recipient's age.

One aspect that has not been explored regarding emergency nurses is the effect of culture on attributions and attitudes toward patients. Many may not consider the cultural context when dealing with emergency patients (Lipson et al., 1987; Roth, 1979). Studies, using the Models of Helping and Coping, have shown that different cultural groups do prefer different models (Mitchell, 1985; Young & Marks, 1986) and race influences the frequency of helping (Cronenwett, 1983b). As Manitoba has large aboriginal communities, whose concepts of illness and health are distinct, this area of study could generate rich data. In addition, one must consider the predominant culture of the department or other factors that may influence the attributions, attitudes, and behaviours of emergency nurses.

Presently, medical personnel are becoming more aware of the realities of economic restraint. As resources continue to diminish, one can anticipate changes in utilization patterns and methods of health provision. Those who control the finances may refuse to pay for clients deemed responsible for their illnesses (Bracken, 1991; Pearlmutter, 1987) or use more resources than they deserve (Baker, 1985; Mannon, 1976). One could examine the effect economic restrictions have on emergency personnel's attitudes and attributions, and whether model preferences change in response to unequal demand and resource. Comparing the Canadian medical system with American systems, where clients must pay for services, may uncover another variable affecting model choice.

Although one cannot use correlational research to find out causation, it helps lay the groundwork for further rigorous cause-and-effect research (Abdellah & Levine, 1986; Polit & Hungler, 1987; Roberts & Burke, 1989; Wilson, 1989). The Emergency Vignettes and ATP instruments could be used in an experimental design study to test the effect of education, work exposure, and experience with psychiatric patients. For example, subjects' attributions and attitudes could be tested prior and upon completion of a course regarding the management of psychiatric emergencies. It also would be beneficial to measure nurses' attributions and attitudes when they start a new job in the emergency department, and compare this data to their attributions and attitudes at set increments.

Conclusion

This study used a correlational self-survey method to examine attitudes as a consequence of attributions. Attributions are significant because they may influence helpers' attitudes toward patients and determine the type of help they are prepared to provide to patients. An attribution-based conceptual framework, entitled the Models of Helping and Coping, was used to guide the study. The Emergency Vignettes Questionaire was used to measure emergency nurses' attributions regarding two variables, responsibility for cause and solution of problems. The Attitudes Toward Patients (ATP) Survey measured the attitudes that emergency nurses hold toward medical/surgical and psychiatric patients. This data then was analyzed to determine the relationship between the respondents' attributions and attitudes about patients.

Results of the Emergency Vignette Questionaire suggest that nurses' attributions may be influenced by the situation portrayed, as well as the classification of patient. Overall, respondents

preferred the Medical Model, which assigns low responsibility for cause and solution to the patient. The second most frequently selected model was the Enlightenment Model, which assigns high responsibility for cause, but low responsibility for solutions to the patient. The Moral and Compensatory Models were selected infrequently.

For most vignettes, subjects were more willing to assign blame or cause attributions, than control or solution attributions. Though nurses may blame patients for causing their problems, they provide help and do not necessarily distance themselves from patients. However, whether patients are considered deserving of help may be based on whether they are held responsible for causing their problems. If this is the case, patients with psychosocial emergencies, who are assigned significantly more responsibility for cause than patients with medical/surgical emergencies, may be perceived as less deserving of emergency services.

There are many variables that determine whether help is effective, and what type of help is most effective in a specific situation. The benefits, limitations, and implications of each model were discussed. Although the Medical Model is not flawless, it would appear to be most effective for use in an emergency department, at least for patients classified as urgent or emergent. Still, emergency nurses must remain open to the option that other models may be more effective for nonurgent, regular, or particular types of patients, such as victims of abuse or rape.

Results of the Attitudes Toward Patients Survey were encouraging. Generally, respondents hold a positive attitude toward patients, including psychiatric patients. They seem to acknowledge the importance of psychodynamic factors for both medical/surgical and psychiatric illnesses. Respondents' lower scores on the Moral Weakness Etiology scale suggest a shift away from the belief that psychiatric disorders are due to personal weakness or moral deficiencies. Respondents

preferred a nurturant approach and were comfortable with some intimacy within the helping relationship. Finally, they were more willing to see patients as autonomous than they needed to maintain control within the relationship.

Correlational analysis of the ATP Survey revealed several significant relationships, which were described earlier. Comparison of the ATP Survey with a validated attitude toward mental illness measurement tool supported Roskin's claim that the ATP had "face validity." Based on the discussion, the researcher arranged the ATP subscales on a continuum that could be used to predict the general direction of a helper's attitudes toward psychiatric patients. Statistical analysis supported the researcher's theoretical alignment of the ATP with the Models of Helping and Coping. Finally, the significant relationships between several attribution and attitude subscales supported the assertion that attributions may affect attitudes.

The effect of the sample characteristics were compared with previous findings. There were no significant differences in attributions based on age, gender, years of nursing experience, years of emergency experience, work status, practice setting, or level of education. Only one variable, practice setting, resulted in significant differences in attitudes, in that tertiary centre nurses scored higher on the Psychodynamic Etiology of Psychiatric Disorders, Nurturant-Empathic Attitudes, and Distancing-Detachment from Patients subscales. Future research is needed to determine what factors account for this difference.

The study cannot be generalized because of the small sample size and overrepresentation of respondents with advanced education. Still, the results raise several important implications for nursing practice, education, and future research. Nursing is struggling to base practice and education on conceptual frameworks and Brickman's Models of Helping and Coping could be

part of such a framework. In addition, emergency nurses, especially triage nurses, must be provided with extensive didactic and clinical experience regarding the handling of psychiatric emergency situations. Finally, as with any research, more questions than answers arise. There are many avenues left to explore using both the Models of Helping and Coping framework and the Attitudes Toward Patients Survey.

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APPENDIX A

INSTRUMENTS USED TO MEASURE ATTITUDES TO MENTAL ILLNESS

NUNNALLY'S QUESTIONAIRE

One of the earliest instruments, Nunnally's Mental Health Information Questionnaire (MHIQ), a sixty item Likert format, was developed in 1961. A complete copy is available in Antonak and Livneh (1988). Despite the extensiveness of six years of information gathering, the ten isolated beliefs or concerns, only account for 25% of the total item variance. Reliability scores have not been reported. Although not frequently used now, Nunnally's instrument is the reference used in the development of several other major tools (Cohen & Struening, 1962; Eker, 1985a).

CUSTODIAL MENTAL ILLNESS IDEOLOGY SCALE (CMI)

Gilbert and Levinson's (1957) Custodial Mental Illness Ideology Scale (CMI), a twenty item Likert scale, is designed to place respondents along a single continuum of attitudes ranging from humanism to custodialism, which has a high correlation with the California F authoritarianism scale. Reliability, using a Spearman-Brown corrected reliability estimate is .85. Test-retest reliability are in the mid + .80's (Antonak & Livneh, 1988). Although psychometrically adequate, the unidimensionality of the scale seriously limits its usefulness.

THE STAR ABSTRACTS

The Star Abstracts (Eker, 1985a, 1989; Malla & Shaw, 1987; cited in Rabkin, 1972) consist of a paragraph, written in a nontechnical style, describing behaviour typical to a particular diagnostic entity (eg. schizophrenia, neurotic depression), and require subjects to rank the person in terms of perceived pathology, social distance, or other parameters. Vignettes have the

advantage of allowing respondents to react in a format more comparable to concrete behaviour patterns, under circumstances that allow for a great measure of experimental control (Brockman, D'arcy & Edmonds, 1979). However, Star abstracts have been used more in the public sector (Bhugra, 1989; Eker, 1985b, 1989) than with health professionals (Malla & Shaw, 1987).

OPINIONS ABOUT MENTAL ILLNESS

The multidimensional scale, Opinions about Mental Illness (OMI), is utilized as the main measuring tool in many studies (Bairan & Farnsworth, 1989; Cohen & Struening, 1962; Cohen & Struening, 1963; Cohen & Struening, 1964; Cohen & Struening, 1965; Creech, 1977; Ellsworth, 1965; Gelfand & Ullmann, 1961a; Gelfand & Ullmann, 1961b; Kahn, 1976; Lewis & Cleveland, 1966; Matas et al., 1985; Meltzer & Grigorian, 1972; Morris, 1964; Olade, 1983; Slimmer et al., 1990; Smith, 1969) and as the control in others (Askenasy, 1974; McPherson & Cocks, 1983). Developed by Cohen and Struening (1962), the OMI utilizes items from Nunnally's questionaire, the California F scale, and the CMI. The instrument, a fifty-one item Likert questionaire, provides for five separate scores, and correlation among factor scores are near zero. A critique and complete copy of the OMI scale is available in Shaw and Wright (1967) and Antonak and Livneh (1988).

Cohen and Struening's five factors are:

Factor A: Authoritarianism - highly significant correlation with California F and CMI scale; views mentally ill as inferior class requiring coercive handling. A high score shows an authoritarian attitude. A dominant factor, it accounts for 47% of the shared variance. Reliability ranges from +.77 to +.80

Factor B: Benevolence - the positive pole represents a kindly, paternalistic view whose origins derive from religion and humanism. Accounts for 15% of the variance. Reliability ranges from +.70 to +.72.

Factor C: Mental Hygiene Ideology - an orientation that maintains that "Mental illness is an illness like any other" and uses the medical model. A high score indicates agreement with this belief. This factor accounts for 14% of the variance. Reliability ranges from +.29 to +.39.

Factor D: Social Restrictiveness - views mental patient as threat to the family and society, who must be restricted in his functioning, especially after hospitalization. High scores show a high degree of restrictiveness. It accounts for 14% of the variance. Reliability ranges from +.71 to +.76.

Factor E: Interpersonal Etiology - positive pole of this factor reflects the belief that mental illness arises from interpersonal experience, especially deprivation of parental love during childhood. This accounts for 10% of the variance. Reliability ranges from +.65 to +.66.

THE EFFECTS OF LABELLING - ADJECTIVE AND SEMANTIC INSTRUMENTS

Another set of studies uses labelling and/or the assigning of adjectives to measure attitudes toward patients (Calicchia, 1981; Eker, 1985a; Farina & Ring, 1965; Fryer & Cohen, 1988; Harris, Rich & Crowson, 1985; Jones & Cochrane, 1981; Link, 1987; Swain, 1973). However, as no consistent instrument has been utilized, interstudy comparison is difficult.

ATTITUDES TOWARD MENTAL ILLNESS

In 1988, Weller and Grunes tested a new instrument, the AMI, a tool that again uses a Likert format. The AMI consists of 24 items, which have an internal consistency alpha of 0.79. It is important to note that this study was conducted in Israel, making the country of origin and religion relevant factors to consider. It would be useful to test this scale in different cultures and settings, as it appears to have general applicability.

ATTITUDES TOWARD PATIENTS SURVEY

Another new scale, developed in 1986 by Roskin, Carsen, Rabiner, Lenon, and Marell, entitled Attitudes Toward Patients (ATP) has now been utilized several times, but only by this group and associates.

The authors strongly believe that attitudes, especially toward psychiatric patients have significant impact on clinical decision-making and choice of treatment. Unfortunately, research on this point has been limited by the absence of measuring instruments of appropriate scope and reliability. Therefore, a 72 question Likert-type scale has been developed that measures the following factors:

1) Etiology-Treatment Approach subscales, which measure attitudes toward the causality of psychiatric and organic disorders (etiological set). The factors include psychodynamic, biological and moralistic dimensions;

2) Doctor-patient relationship subscales, which include authoritarian-controlling, nurturant-empathic and distancing-detachment dimensions.

Average inter-item correlation and reliability are summarized in the methods section.

The original scale also measured general attitudes in terms of positive or negative valence toward certain patient types. It used semantic differential scales to assess overvaluation (idealization) versus devaluation.

Although originally, the ATP questionaire was conducted with only 69 medical students (Roskin et al. 1986), its use has been repeated in a study of gender differences (N=127), (Carsen, Roskin, Rabiner & Marell, 1987), differences in attitudes among medical specialities (N=277), (Roskin & Marell, 1988) and attitudes of different mental health professional groups (N=525) (Roskin, Carsen, Rabiner & Marell, 1988).

OTHER PERTINENT INSTRUMENTS DEVELOPED

Other scales such as the "Multiple Choice Attitudes Questionnaire" developed by Reznikoff, Gynther, Toomey, and Fishman (1964) and the Caine and Smail "Attitude to Treatment Questionnaire" used by Scott and Philip (1985) have been found more useful to measure attitudes toward treatment modalities than attitudes toward patients. Scott and Philip do link the treatment choices on their scale with the authoritarian and social restrictiveness factors on the OMI scale. Baker and Schulberg's Community Mental Health Ideology Scale (Rabkin, 1972) is important because it is the forerunner of scales measuring adherence to the community mental health ideology. Froemel and Zolik's (cited Rabkin, 1971) Attitudes toward Mental Illness (ATMI) has been used primarily by its authors and usefulness has not been clearly established.

Numerous instruments and studies have examined public opinions about mental illness (Bhugra, 1989; Rabkin, 1972). Although health professionals are part of the public sector and as such are subject to the same attitude influencing factors, studies of "public opinions" will not be dealt with in this paper.

EMERGENCY VIGNETTES

DIRECTIONS: *Read each emergency situation carefully. After each situation, there are four statements. Please agree or disagree with each statement according to the following scale:*

1	2	3	4	5	6	7
Strongly Disagree	**Moderately Disagree**	**Slightly Disagree**	**Neutral**	**Slightly Agree**	**Moderately Agree**	**Strongly Agree**

A) Twenty-six year old female complaining of sudden, steady, sharp, RLQ abdominal pain, radiating to the right shoulder. She has had a small amount of bright red vaginal bleeding that began as dark spotting eight hours earlier. Last normal menstrual period was ten weeks ago. The patient appears pale, and acutely distressed. Skin is cool and clammy. History: IUD removed 2 months ago; PID three years ago, which was treated with antibiotics.

_____ 1. This client is responsible for causing his or her current problem.

_____ 2. Solving the client's problem is more the client's responsibility than mine.

_____ 3. This client's problem is more a result of external factors, rather than his or her responsibility.

_____ 4. This client would not be able to solve his or her problem without my or other's help.

B) Thirty-five year old female was found lying on her kitchen floor, by a neighbour who became concerned after hearing much commotion coming from the apartment. The patient appears dazed, rocking back and forth and clutching a bloodied towel. Several head and facial lacerations continue to ooze. Emergency records reveal she has been seen for the following in the past year: bruises -not yet diagnosed (NYD), hematoma left eye, dislocated right shoulder, chest pain NYD, request for sleeping pills, and abdominal pain with hematuria.

_____ 1. This client is responsible for causing his or her current problem.

_____ 2. Solving the client's problem is more the client's responsibility than mine.

_____ 3. This client's problem is more a result of external factors, rather than his or her responsibility.

_____ 4. This client would not be able to solve his or her problem without my or other's help.

1	2	3	4	5	6	7
Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree

C) Fifty-three year old male, complaining of "cold-like" symptoms for five days. For the past four hours, he has become increasingly dyspneic, tachypneic and anxious. The patient struggles to breathe through pursed lips, and is using accessory chest muscles. An audible expiratory wheeze can be heard. History: cigarette smoker for 30 years (2 packs/day), but quit 3 years ago. He has been treated for eight episodes of bronchitis, which have become worse with each attack.

_____ 1. This client is responsible for causing his or her current problem.

_____ 2. Solving the client's problem is more the client's responsibility than mine.

_____ 3. This client's problem is more a result of external factors, rather than his or her responsibility.

_____ 4. This client would not be able to solve his or her problem without my or other's help.

D) Forty-five year old male brought to the Emergency Department by the police. He was found standing on a busy street corner, throwing rocks at passing cars because "God told me to kill anything with wheels." Presently, he is verbally abusive, pacing around the room and gesturing at something in the air. The police found a unfilled prescription for phenothiazines, written two weeks ago, in his jacket pocket.

_____ 1. This client is responsible for causing his or her current problem.

_____ 2. Solving the client's problem is more the client's responsibility than mine.

_____ 3. This client's problem is more a result of external factors, rather than his or her responsibility.

_____ 4. This client would not be able to solve his or her problem without my or other's help.

E) Seventy year old female complaining of increasing shortness of breath and swelling of her ankles over the last three days. The patient appears cyanotic, diaphoretic and anxious. Apical pulse is 120 and irregular. Auscultation reveals loud crackles to both lung bases. On examination, the patient has 2+ pitting edema to her knees. History: MI 8 years ago and ventricular hypertrophy. The patient is taking Lasix and Digoxin, but is unsure of the dose or frequency.

_____ 1. This client is responsible for causing his or her current problem.

_____ 2. Solving the client's problem is more the client's responsibility than mine.

_____ 3. This client's problem is more a result of external factors, rather than his or her responsibility.

_____ 4. This client would not be able to solve his or her problem without my or other's help.

1	2	3	4	5	6	7
Strongly Disagree	**Moderately Disagree**	**Slightly Disagree**	**Neutral**	**Slightly Agree**	**Moderately Agree**	**Strongly Agree**

F) Seventy-five year old female complaining of severe mid and lower abdominal cramps, plus nausea and vomiting for the past six hours. The emesis has a fecal color and odor. Examination reveals moderate abdominal distension, and three scars from previous abdominal surgery. Bowel sounds are spasmodic, high-pitched and tingling. History: chronic constipation and anorexia for six months.

_____ 1. This client is responsible for causing his or her current problem.

_____ 2. Solving the client's problem is more the client's responsibility than mine.

_____ 3. This client's problem is more a result of external factors, rather than his or her responsibility.

_____ 4. This client would not be able to solve his or her problem without my or other's help.

G) Thirty-one year old male found by his sister, sitting on the kitchen floor, surrounded by blood. Examination reveals several two inch lacerations across both wrists. The patient appears dishevelled and flat in affect. The sister states he has been experiencing fatigue, insomnia and decreased appetite for the last four months, and that his wife died one year ago today.

_____ 1. This client is responsible for causing his or her current problem.

_____ 2. Solving the client's problem is more the client's responsibility than mine.

_____ 3. This client's problem is more a result of external factors, rather than his or her responsibility.

_____ 4. This client would not be able to solve his or her problem without my or other's help.

H) Fifty-seven year old male complaining of four episodes of vomiting large amounts of bright red blood and clots, within the past hour. He appears anxious, ashen, diaphoretic and almost faints when you help him up onto the stretcher. Pulse rate when lying is 116 beats/minute, which increases to 140 when sitting. History: hepatitis and esophageal varices.

_____ 1. This client is responsible for causing his or her current problem.

_____ 2. Solving the client's problem is more the client's responsibility than mine.

_____ 3. This client's problem is more a result of external factors, rather than his or her responsibility.

_____ 4. This client would not be able to solve his or her problem without my or other's help.

1	2	3	4	5	6	7
Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree

I) Twenty-four year old female is brought to the emergency department by her boyfriend, who found her slumped over in a chair. An empty prescription bottle for sixty, 5 mg valium tablets, filled five days earlier, was found near the patient. The boyfriend states the patient has become increasingly anxious and irritable since she was laid off from her job two months ago. They had argued earlier when he had told her he wanted to terminate their relationship.

_____ 1. This client is responsible for causing his or her current problem.

_____ 2. Solving the client's problem is more the client's responsibility than mine.

_____ 3. This client's problem is more a result of external factors, rather than his or her responsibility.

_____ 4. This client would not be able to solve his or her problem without my or other's help.

J) Forty-two year old, heavy-set male complaining of severe, squeezing, substernal chest pain, radiating into the left shoulder and arm, for the past 45 minutes. The patient appears pale, diaphoretic and anxious. He complains of nausea and vomits once on arrival. The pain is not relieved by rest, antacids or three Nitroglycerine tablets. History: hypertension for 6 years.

_____ 1. This client is responsible for causing his or her current problem.

_____ 2. Solving the client's problem is more the client's responsibility than mine.

_____ 3. This client's problem is more a result of external factors, rather than his or her responsibility.

_____ 4. This client would not be able to solve his or her problem without my or other's help.

• Vignettes developed by M. Laing, 1991
• Format and statements adapted from Tracey, 1988

ATTITUDES TOWARD PATIENTS SURVEY **

Directions: On the following pages you will find a number of statements about health care givers' attitudes toward patients. For each item, place the number that best reflects your feelings on the line provided in front of the question. **Use the following scale:**

1	2	3	4	5	6	7
Strongly Disagree	**Moderately Disagree**	**Slightly Disagree**	**Neutral**	**Slightly Agree**	**Moderately Agree**	**Strongly Agree**

_____ 1. Patients who are well informed about medical matters are likely to receive better treatment.

_____ 2. Medications are effective for a substantial majority of psychiatric disorders.

_____ 3. A major purpose of psychotherapy is to correct feelings of deprivation and traumatization inflicted during childhood.

_____ 4. People who are depressed should stop being so preoccupied with themselves and stay as busy as possible.

_____ 5. Dangers from cardiovascular disease can be lessened by psychotherapy that promotes reduction of "Type A" personality traits.

_____ 6. Most psychiatric illness is due to biological-organic factors.

_____ 7. In the management of metastatic disease, expertise in chemotherapy is more important than the doctor-patient or nurse-patient relationship.

_____ 8. Patients who request prescription medications for pain relief are often addicts.

_____ 9. Even when they ask for it, most patients do not really want to hear what is wrong with them.

_____ 10. When someone talks or act strangely, it is interesting to discover what is going on in their mind.

_____ 11. A good psychiatrist can treat psychological symptoms without delving into a patient's unconscious conflicts.

_____ 12. Reactions to medications for psychiatric illness often depend on subjective attitudinal factors in the patient which health care professionals tend to ignore or discount.

_____ 13. Adult patients relate to health care professionals in ways determined by their interactions with their parents in early life.

1 Strongly Disagree	2 Moderately Disagree	3 Slightly Disagree	4 Neutral	5 Slightly Agree	6 Moderately Agree	7 Strongly Agree

_____ 14. If primary care physicians had more time and patience for listening to their patients, there would be much less need for psychiatrists.

_____ 15. Susceptibility to infections is greatly affected by the patient's emotional state.

_____ 16. Fluctuations in endocrine and metabolic functions can account for most of the reported mood changes in the post-partum period.

_____ 17. Neurotic symptoms indicate a lack of character and little self-control.

_____ 18. Adult patients' reactions to hospitalization are influenced by childhood experiences with illness and injury.

_____ 19. Treating psychiatric patients with medication is the most efficient way to return them to functioning in the outside world.

_____ 20. Feeling truly cared for by the therapist can be a decisive curative factor in the treatment of psychiatric patients.

_____ 21. In order to treat emotional disorders, health care professionals must be knowledgeable about unconscious defense mechanisms and how they developed during childhood.

_____ 22. Patients who request changes in drug dosages are often trying to manipulate the doctor.

_____ 23. It is important to avoid getting emotionally involved when listening to a patient who is feeling depressed.

_____ 24. The major causative factor in schizophrenia appears to be genetic.

_____ 25. The experience of being a hospital patient oneself would make any nurse a much more effective care-giver.

_____ 26. If we listen to them, the needs and concerns of psychiatric patients are not so unlike those of ordinary people.

_____ 27. Understanding the psychological makeup of the patient makes a nurse more effective.

_____ 28. Patients should be fully informed of the side effects of any medications they are given.

_____ 29. Our ability to predict particular behaviours in a patient (such as suicide attempts) is greatly influenced by accurate statistics concerning demographic factors that are related to these behaviours.

1	2	3	4	5	6	7
Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree

_____ 30. The role of emotional factors in the etiology of organic illness have been greatly exaggerated.

_____ 31. Vague notions of "humanistic medicine" undermine the scientific basis of health care practice.

_____ 32. Most psychiatric patients have a strong desire to get better.

_____ 33. Dreams often provide disguised clues about the patient's current problems and underlying conflicts.

_____ 34. In order to understand psychiatric patients, we should try to imagine ourselves in their shoes.

_____ 35. Patients ultimately should rely on the medical expertise of health care professionals, and not research their illnesses independently.

_____ 36. Some individuals express, through somatic symptoms, feelings or conflicts of which they are totally unaware.

_____ 37. The best way to help psychiatric patients is by prescribing medications according to our most up-to-date knowledge of psychopharmacology.

_____ 38. Health care professionals must be able to empathize with a patient in order to give helpful treatment.

_____ 39. Patients who habitually seek a second opinion regarding recommended treatment are often uncooperative, untrusting or otherwise difficult to care for.

_____ 40. Psychological factors can be highly significant in the management of patients with inflammatory bowel disease.

_____ 41. The effectiveness of many medications used in psychiatry is strong evidence that understanding of the patients' inner psychodynamics is irrelevant to treatment.

_____ 42. Methods of quantifying such symptoms as depression, anxiety, or social isolation represent major advances in modern psychiatric diagnosis and treatment.

_____ 43. It is essential for nurses to maintain a stance of professional detachment when listening to patients discuss personal matters.

_____ 44. The careful scientific investigation of biochemical abnormalities found in psychiatric patients would greatly increase our ability to help them.

1 Strongly Disagree	2 Moderately Disagree	3 Slightly Disagree	4 Neutral	5 Slightly Agree	6 Moderately Agree	7 Strongly Agree

_____ 45. Dealing with the emotional needs of the medical or surgical patient is not a primary function of the nurse.

_____ 46. Patients who habitually present with multiple vague complaints with no somatic basis use up the time and energy of health care professionals who could be helping people with real illnesses.

_____ 47. Unconscious feelings, wishes, and conflicts are a source of neurotic symptoms.

_____ 48. Psychiatric patients are very concerned with the difficulties they cause other people.

_____ 49. The relationship between health care professionals and the patient provides essential information about how the patient relates to other people in his/her life.

_____ 50. The most promising developments in psychiatric knowledge will come from research in neurochemistry and psychopharmacology.

_____ 51. People who become severely mentally ill have little will power.

_____ 52. The potential for curing severe psychiatric disorders by means of drugs and other somatic treatments has been overestimated.

_____ 53. A person's psychological makeup can strongly affect the rate of post-operative recovery.

_____ 54. It is difficult for most patients to make educated decisions regarding elective surgery. They should rely on the expertise of health care professionals.

_____ 55. Anti-psychotic drugs merely mask the symptoms of psychiatric illness; they do little to cure the patient of his real problem.

_____ 56. Most psychopathology can be understood in psychodynamic terms.

_____ 57. Psychiatric patients will often do poorly in their treatment if they sense that their caregivers are uncaring or uninterested in their welfare.

_____ 58. Future research will uncover the biochemical bases for most forms of mental illness.

_____ 59. Psychiatric illness has its origin in early childhood experiences within the family.

_____ 60. People who seek psychiatric treatment tend to be dependent and indecisive.

_____ 61. Patients have a right to expect special consideration and care when they are suffering.

1	2	3	4	5	6	7
Strongly Disagree	**Moderately Disagree**	**Slightly Disagree**	**Neutral**	**Slightly Agree**	**Moderately Agree**	**Strongly Agree**

_____ 62. Our modern technical expertise in medical care is a vast improvement over "the good old days" when a kindly bedside manner was all health care professionals could provide for most patients.

_____ 63. Health care suffers when the staff get involved with patients' personal problems.

_____ 64. Knowledge of appropriate techniques of treatment is more important than feelings of liking or affection for the patient.

_____ 65. A fascination with the inner complexities of the human mind is the major factor in attracting some health care professionals to the specialty of psychiatry.

_____ 66. The patient's own view of how effective treatment is can be assumed to be valid in most cases.

_____ 67. It is clear that the science of psychiatry lies in biology rather than psychology.

_____ 68. Theories about patients' inner conflicts are often not that relevant to treatment.

_____ 69. Feelings of closeness with the patient can interfere with objectivity and effective clinical decision-making.

_____ 70. Neurotic patients' problems and unhappiness could be alleviated if they focused on something other than themselves.

_____ 71. The diagnosing physician should determine whether something in the patient's life-style might be contributing to current medical problems.

_____ 72. Genetic profiles and laboratory analyses of serum cholesterol, fatty acids, etc. are far better predictors of cardiovascular morbidity than descriptions of personality style.

In questions 7, 12, 13, 21, 25, 27, 31, 35, 38, 43, 45, 46, 49, 54, 62, 63 and 65, the term *"doctor"*** or ***"physician"*** was changed to ***"nurse"*** or ***"health care professional"*** to make the questionaire more relevant to nursing. The change does not affect the context of the question.

APPENDIX D

DEMOGRAPHIC QUESTIONAIRE

1. I work at the following hospital:(check one)
   _____ a. Community based (eg. Concordia, Grace, Misericordia General Seven Oaks General or Victoria Hospital).

   _____ b. Teaching hospital (eg. Health Sciences Centre, St. Boniface General Hospital).

2. My age is _____ years.

3. I am:
   _____ a) female
   _____ b) male.

4. I have worked as a nurse for _____ years.

5. I have worked as an emergency department nurse for _____ years.

6. Currently, I am working:
   _____ a. full-time
   _____ b. part-time

7. If working part-time, what EFT (Equivalent Full Time) or percentage of full time do you work? _____

8. Education: (check all appropriate categories)
   _____ a. diploma in nursing
   _____ b. baccalaureate in nursing
   _____ c. baccalaureate, other than nursing
   Specify _____
   _____ d. masters in nursing
   _____ e. masters, other than nursing
   Specify _____
   Post graduate courses:
   _____ f. intensive care nursing course, obtained from:
   _____
   _____ g. emergency nursing course, obtained from:
   _____
   _____ h. other (Specify) _____
   _____

APPENDIX E

LETTER OF REQUEST TO USE FACILITY

(Address of hospital)

Dear

I am requesting permission to conduct a study at (name of hospital). This study will investigate the relationship between the assumptions that emergency nurses make about patients, and their expressed attitudes toward patients.

I am a graduate student of the School of Nursing, University of Manitoba. This study is my masters thesis.

Subjects participating in this study will be asked to respond to three questionaires. One is designed to obtain information about how emergency nurses assign responsibility for causing and solving problems, in ten typical emergency situations. The second will measure their attitudes toward patients. The third requests basic demographic data. All responses are anonymous. There are no risks to participating in this study. Subjects will be told they may refuse to participate and that they may withdraw at any time.

This study has been approved by the ethics committee of the University of Manitoba, School of Nursing. My faculty advisors are: Chairperson - Professor A. Gupton (phone number 474-8937); Dr. L. Degner and Dr. E. Adaskin (St. Boniface Research Centre) and Dr. M. Wahn, Department of Sociology, University of Winnipeg. An abstract of the study will be made available to your emergency department following completion of the thesis.

If you have any questions regarding the project, please call me, Milli Laing, at . at any time. I will be calling you in one week (give date) to answer any questions you may have and to make further arrangements.

Sincerely,

Mildred K. Laing

APPENDIX F

ATTITUDES AND ATTRIBUTIONS: A STUDY OF WINNIPEG EMERGENCY NURSES

Verbal Explanation/Invitation to Participate

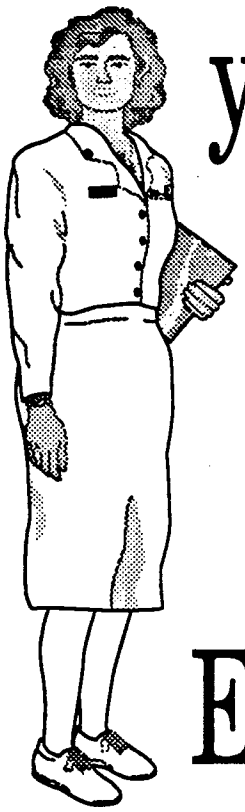
My name is Milli Laing. I am a Masters student in Nursing, at the University of Manitoba. I have been involved with emergency nursing since 1975, as a general duty nurse, a unit coordinator and as an instructor. I am here today because I want to learn more about emergency nurses' attitudes, beliefs and perceptions concerning emergency patients and events.

You are being invited to participate in a research project. You have been invited to participate because of your experience in emergency nursing. All emergency nurses working in the seven Winnipeg emergency departments, are being recruited for this study. You will be asked to give your opinion about statements on a questionaire. The entire study should require no more than a hour to complete. Your participation is voluntary. By responding to the questionaire, you are giving consent to participate in this study.

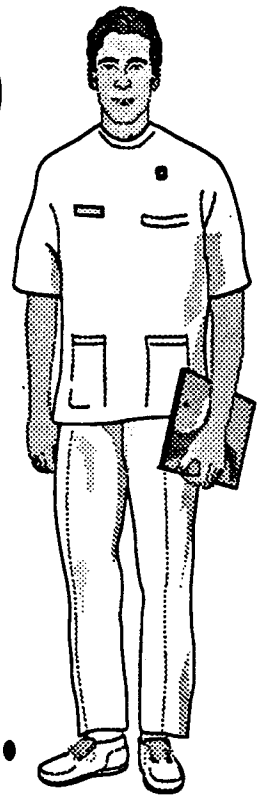
Do you have any questions regarding the study? (Respond to questions, if any). Are you interested in participating? (If answer is yes, hand out questionaires. If answer is no, thank them and terminate the contact.) Should you have any further questions regarding the study, you may contact the investigator, Milli Laing, at any time. My phone number is . I also have left my phone number with your head nurse, and the number is printed on the poster displayed in your department. I will be back in your department (give date) to pick up any questionaires or answer any further questions you may have.

My thesis advisor is Professor A. Gupton (phone 474-8937). Thank-you for your consideration. An abstract of the study will be placed on the bulletin board of your emergency department following completion of the thesis.

ATTENTION!
EMERGENCY NURSES,



you are invited to participate in a study of Manitoba Emergency Nurses.



For more information, contact Milli Laing

APPENDIX H

ANNOUNCEMENT FOR NEWSLETTERS

ATTENTION ALL WINNIPEG EMERGENCY NURSES

Invitation to Participate

You are invited to take part in a master's thesis research project concerning Winnipeg emergency nurses. The purpose of the project is to discover how emergency nurses feel about patients and emergency events.

All nurses who have worked at least two years in a Winnipeg hospital emergency department are being recruited for this study. Your participation involves giving your opinion about statements on a questionaire. The questionaire should take less than 60 minutes to complete. All responses are anonymous and confidential.

For further information, please contact Milli Laing, at (home) or 787-3301 (work).

Thank-you for your consideration.

Milli Laing

APPENDIX I

ATTITUDES AND ATTRIBUTIONS: A STUDY OF WINNIPEG EMERGENCY NURSES

Invitation to Participate

My name is Milli Laing. I am a Masters student in Nursing, at the University of Manitoba.

You are being invited to participate voluntarily in the above named project. The purpose of the project is to discover how assumptions emergency nurses make about patients are related to how they feel about patients. This study is important as it will expand the body of knowledge concerning emergency nursing practise, and has implications for standards of nursing care.

You have been invited to participate because of your experience in emergency nursing. All nurses working in the seven Winnipeg emergency departments, are being recruited for this study. Criteria for participation include: 1) Registration with the Manitoba Association of Registered Nurses; 2) Current employment, full time or at least a 0.2 EFT part time within an emergency department; and 3) Employment for the equivalent of at least two years within an emergency department.

You will be asked to give your opinion about statements on a questionaire. The entire study should require no more than a hour to complete. Your participation is voluntary. By responding to the questionaire, you will be giving consent to participate in this study.

Your name will not appear on the forms. No list of subjects will be kept. Only the investigator, thesis committee members and statistical consultant will have access to the raw data collected. All raw data will be destroyed after the study has been completed. Only group data will be reported. Your participation will have no effect on your job and you may withdraw from the study at any time. You may choose not to answer some or all the questions. There are no known risks and no direct benefits from participating in the study.

The first questionaire will ask you to read 10 emergency situations and respond to four questions after each. The second questionaire will ask your opinion regarding patients. The third questionaire will ask for general demographic information. Please complete the questionaires as soon as possible. To guarantee anonymity and confidentiality, completed (or uncompleted) forms should be sealed in the envelope provided, and placed in the drop box provided for you.

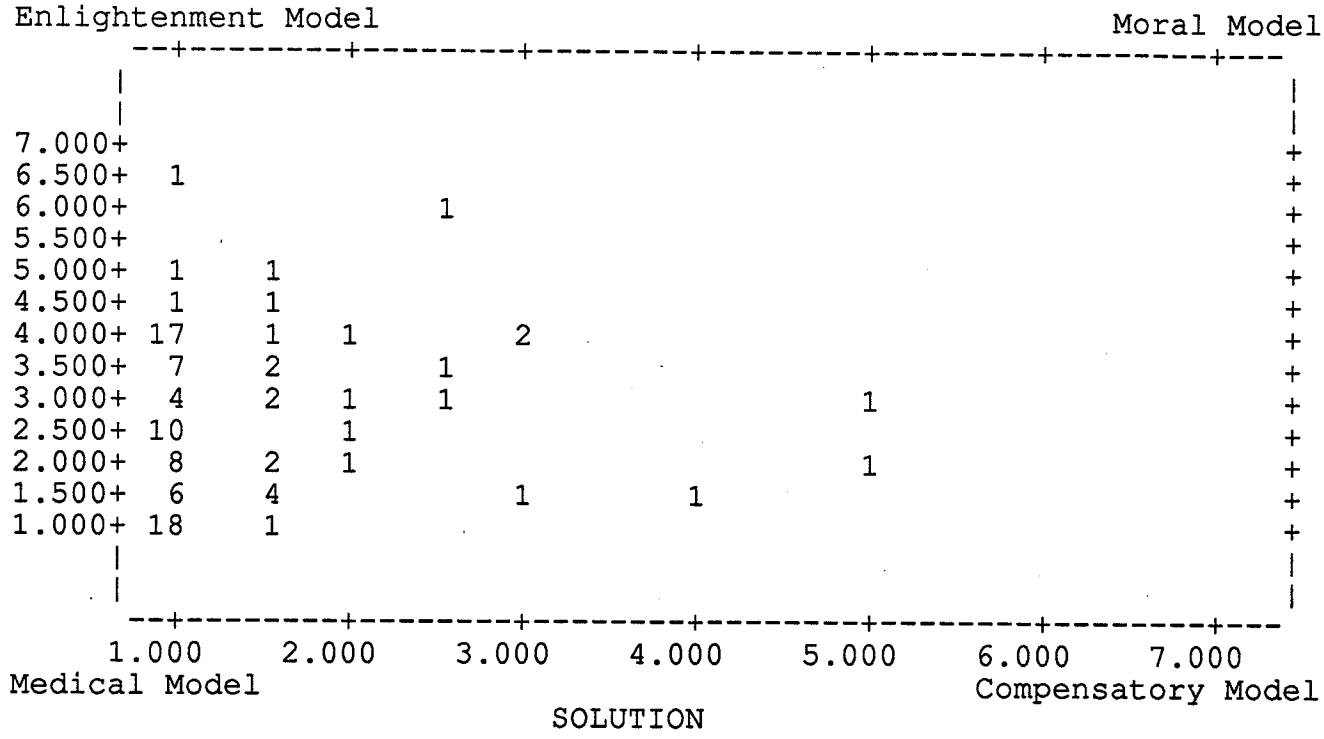
Should you have any questions regarding the study, you may contact the investigator, Milli Laing or my thesis advisor, Professor A. Gupton (phone 474-8937), at any time. An abstract of the study will be placed on the bulletin board of your emergency department upon completion of the thesis. Thank-you for your consideration.

Milli Laing
Phone: (home)
(work) 787-3301

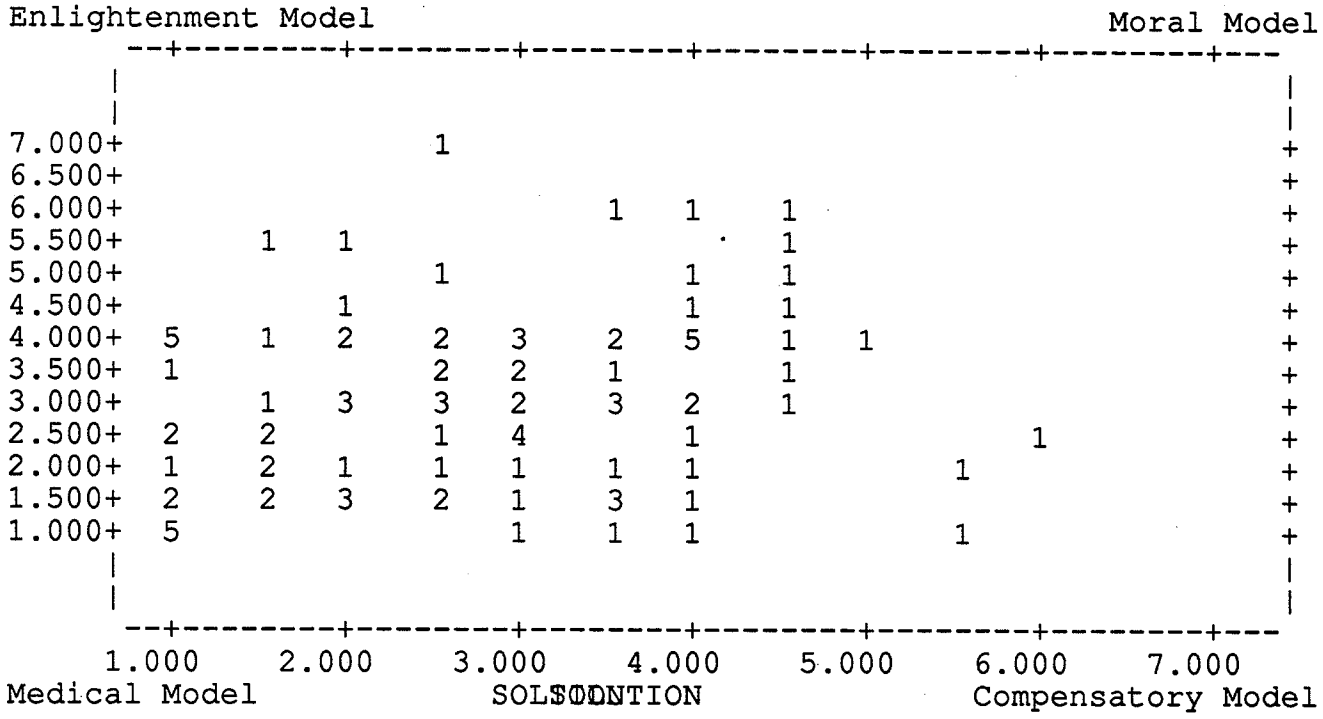
APPENDIX J

SCATTER PLOTS FOR VIGNETTES

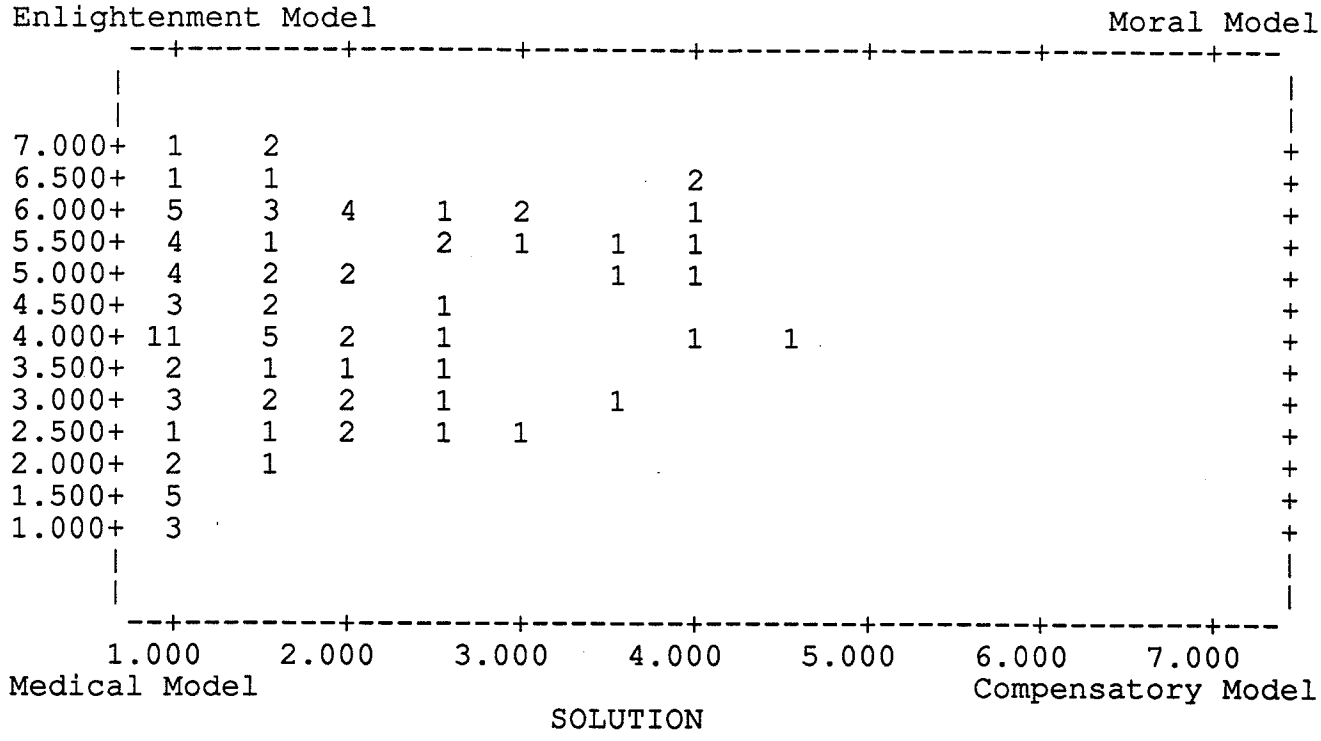
ATTRIBUTIONS FOR VIGNETTE A: FEMALE WITH VAGINAL BLEEDING



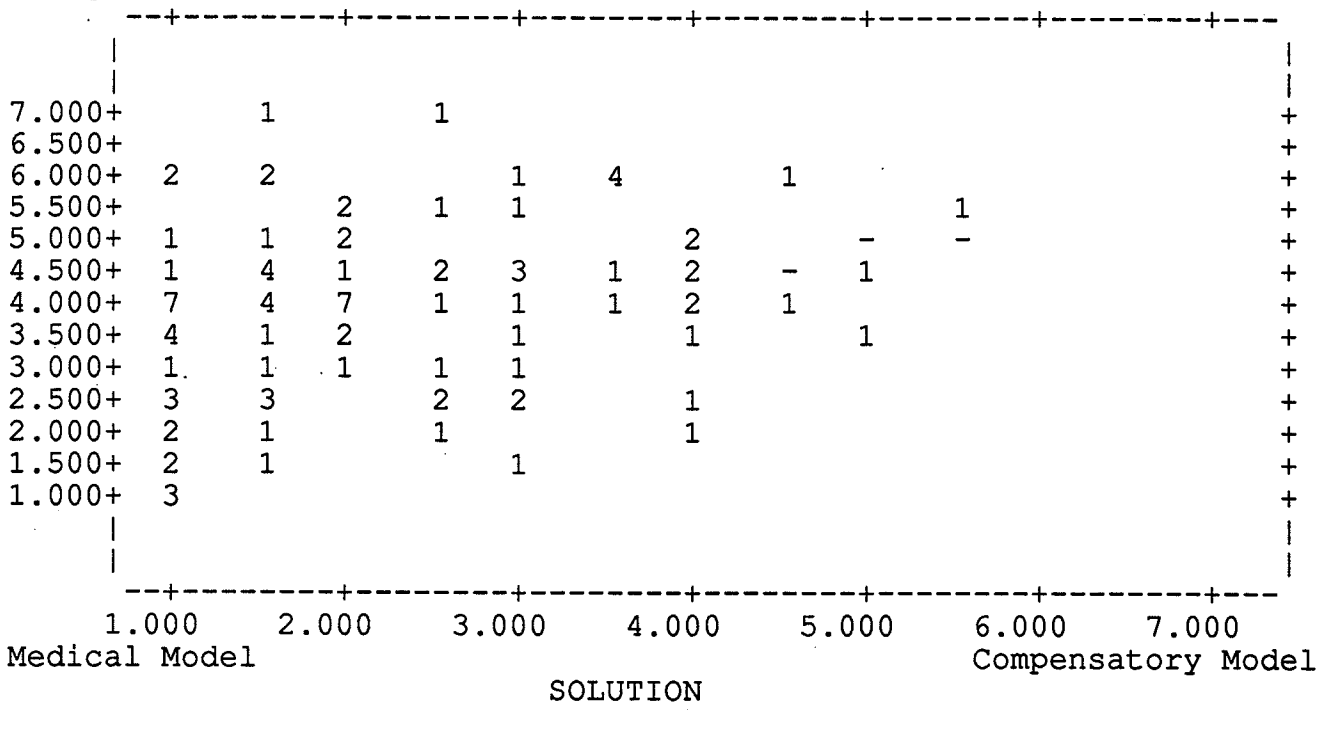
ATTRIBUTIONS FOR VIGNETTE B: FEMALE ABUSE VICTIM



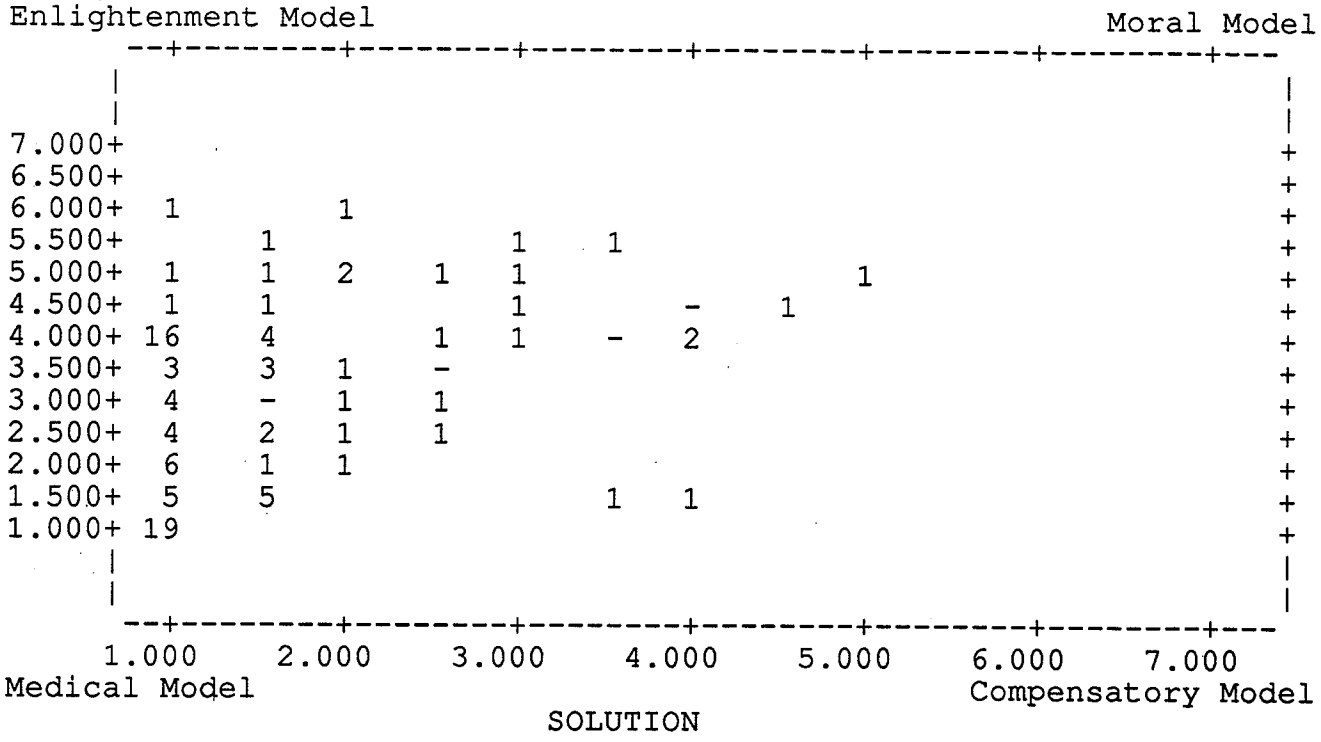
ATTRIBUTIONS FOR VIGNETTE C: MALE PATIENT WITH COPD



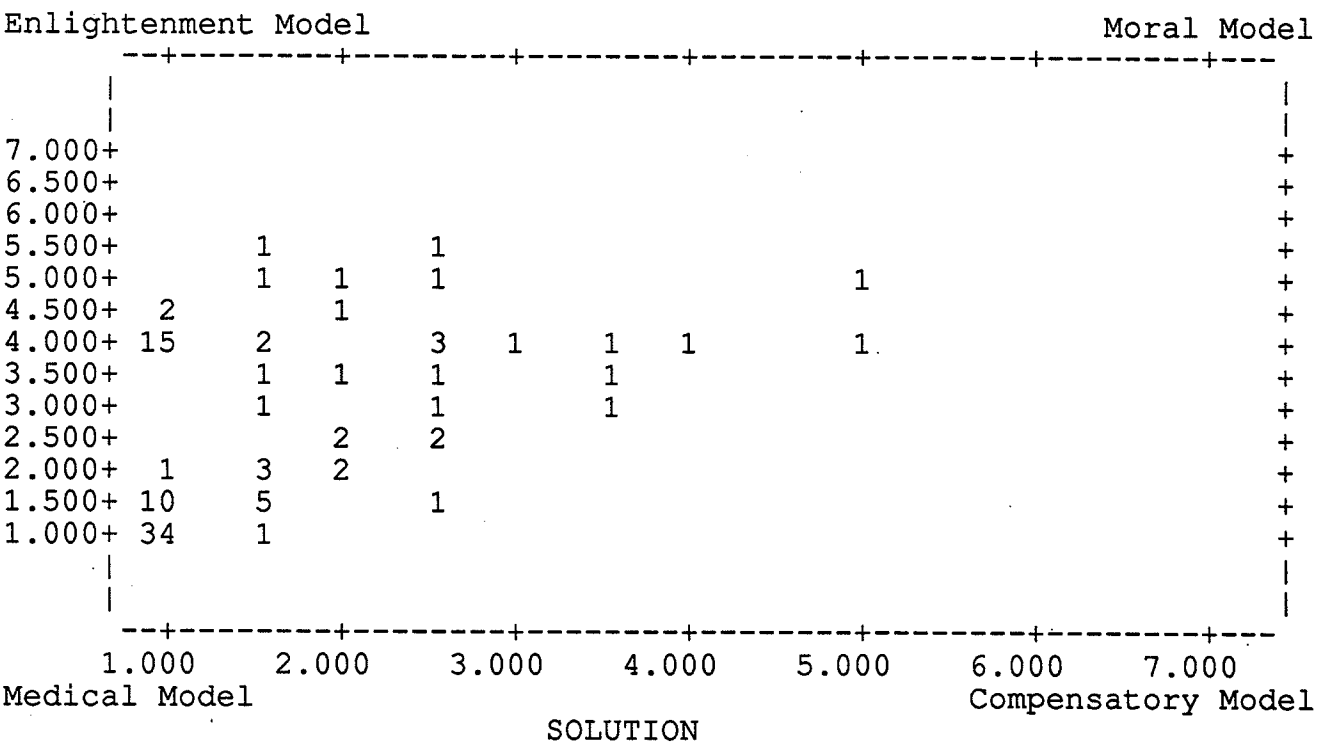
ATTRIBUTIONS FOR VIGNETTE D: MALE PSYCHOTIC EPISODE



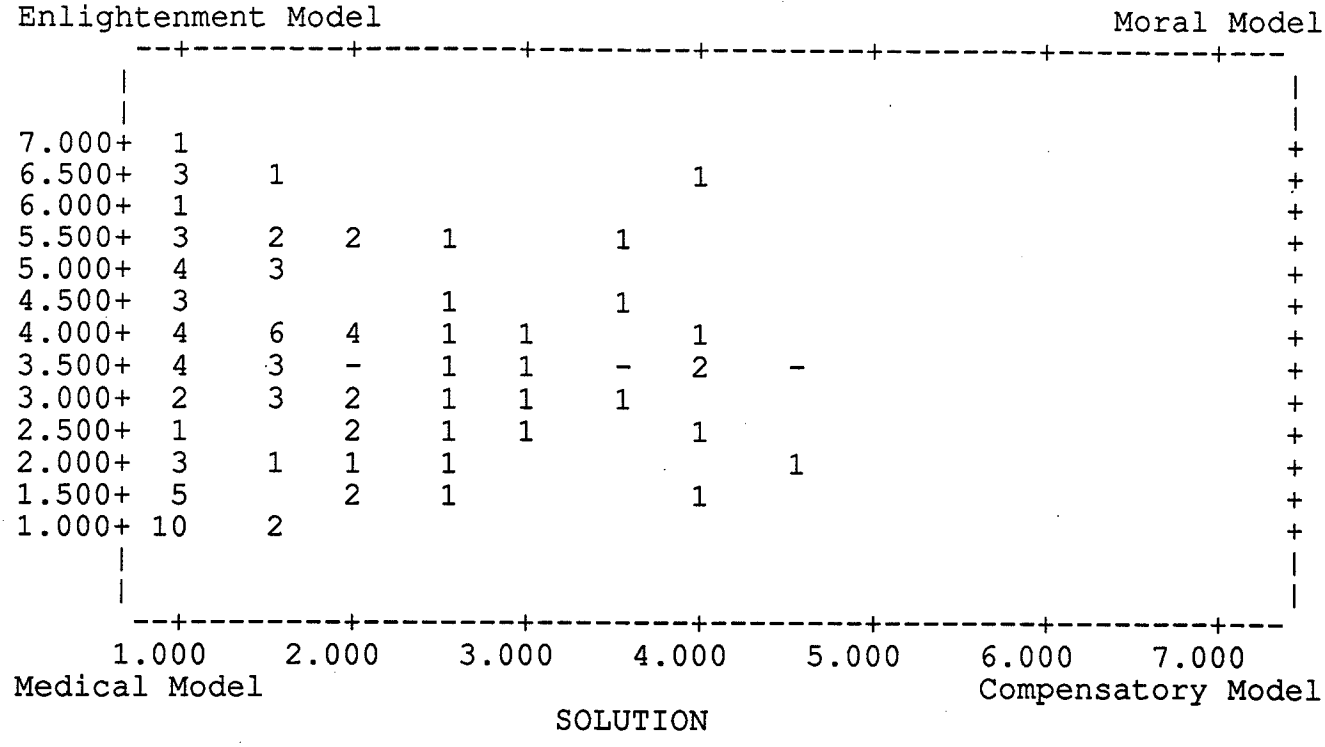
ATTRIBUTIONS FOR VIGNETTE E: FEMALE WITH CONGESTIVE HEART FAILURE



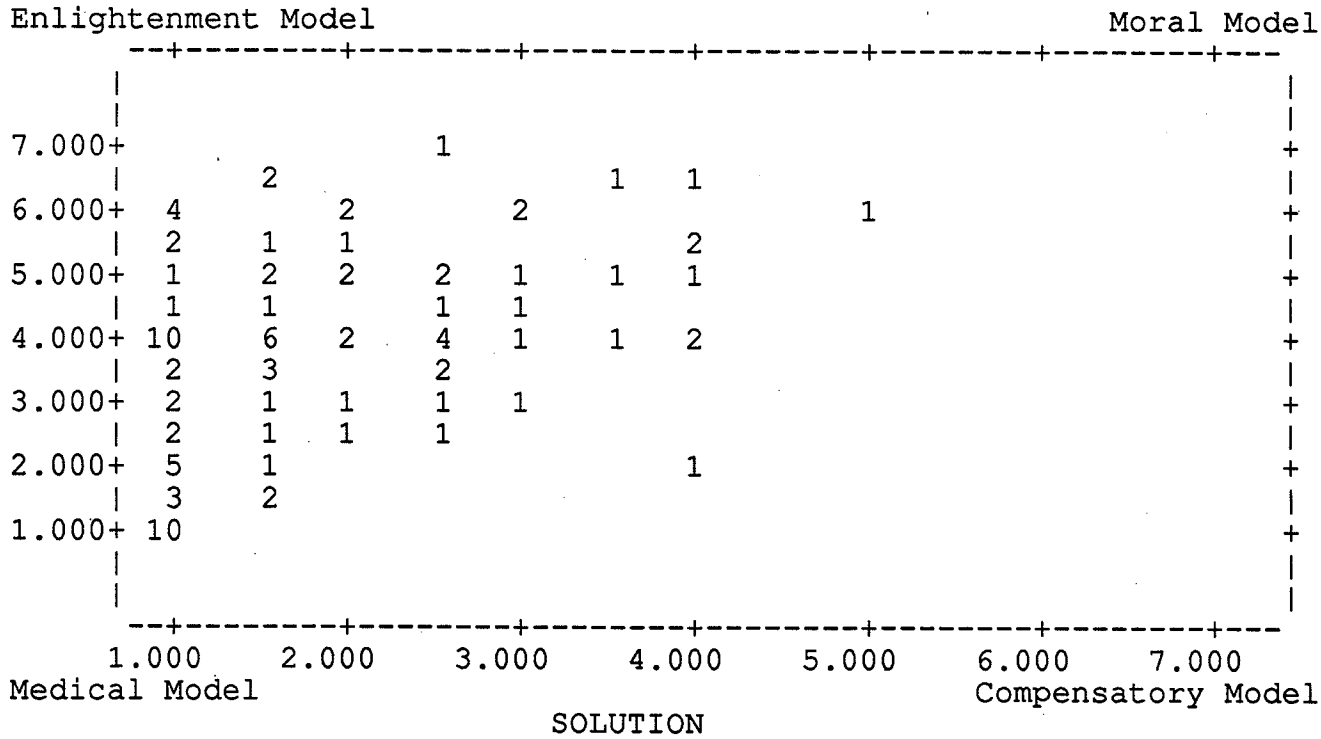
ATTRIBUTIONS FOR VIGNETTE F: FEMALE WITH BOWEL OBSTRUCTION



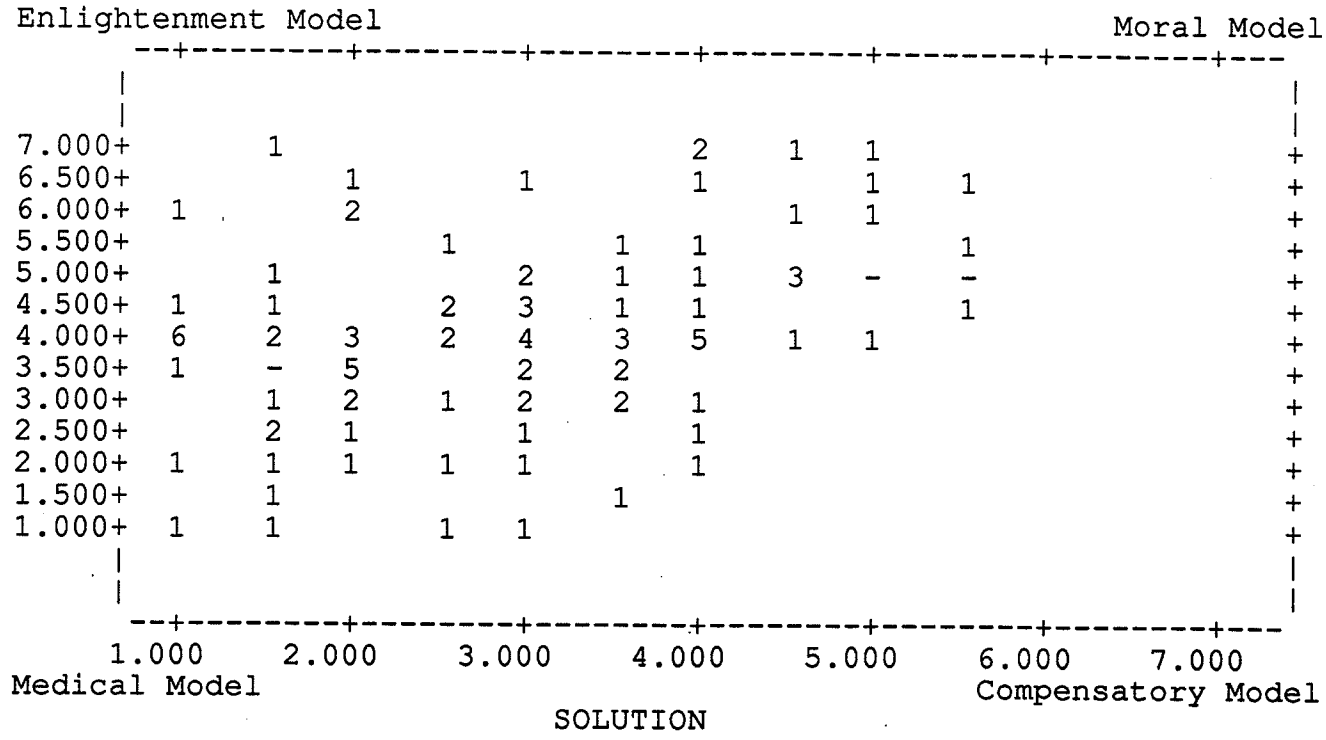
ATTRIBUTIONS FOR VIGNETTE G: MALE SUICIDE ATTEMPT



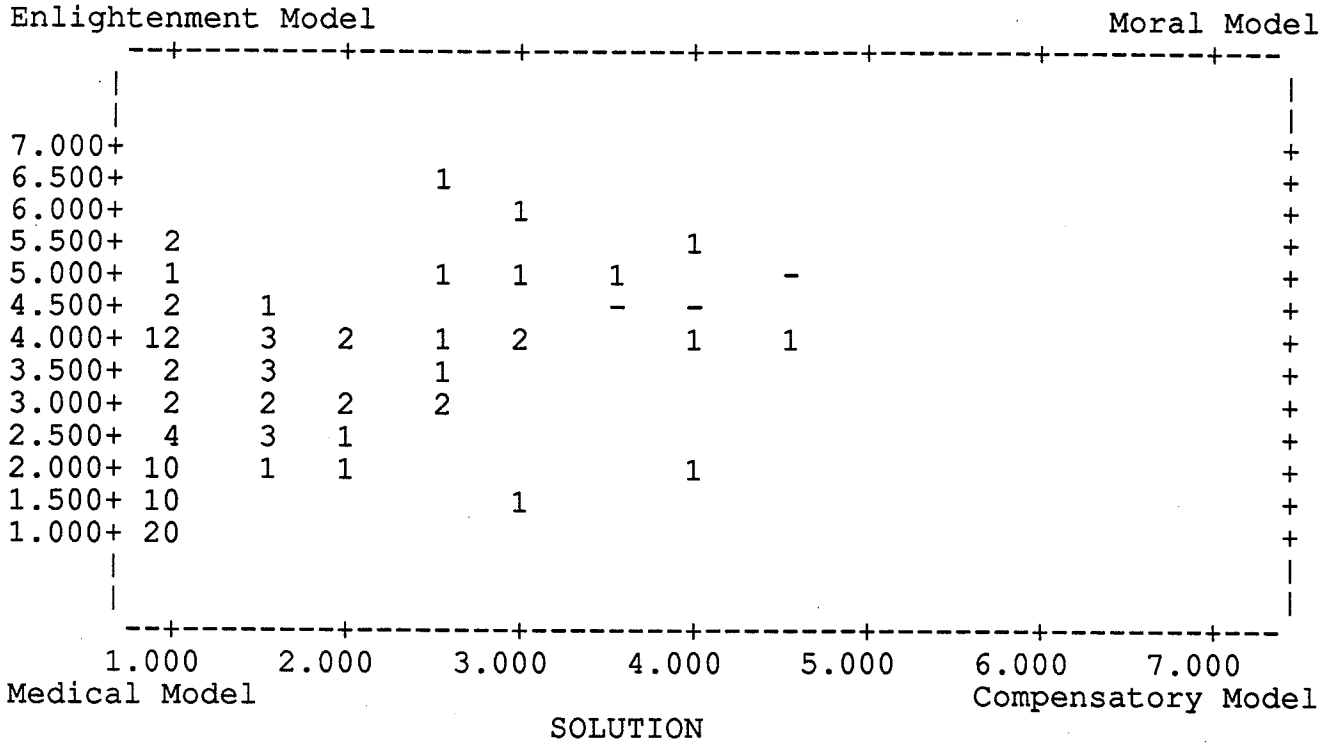
ATTRIBUTIONS FOR VIGNETTE H: MALE WITH GASTROINTESTINAL BLEEDING



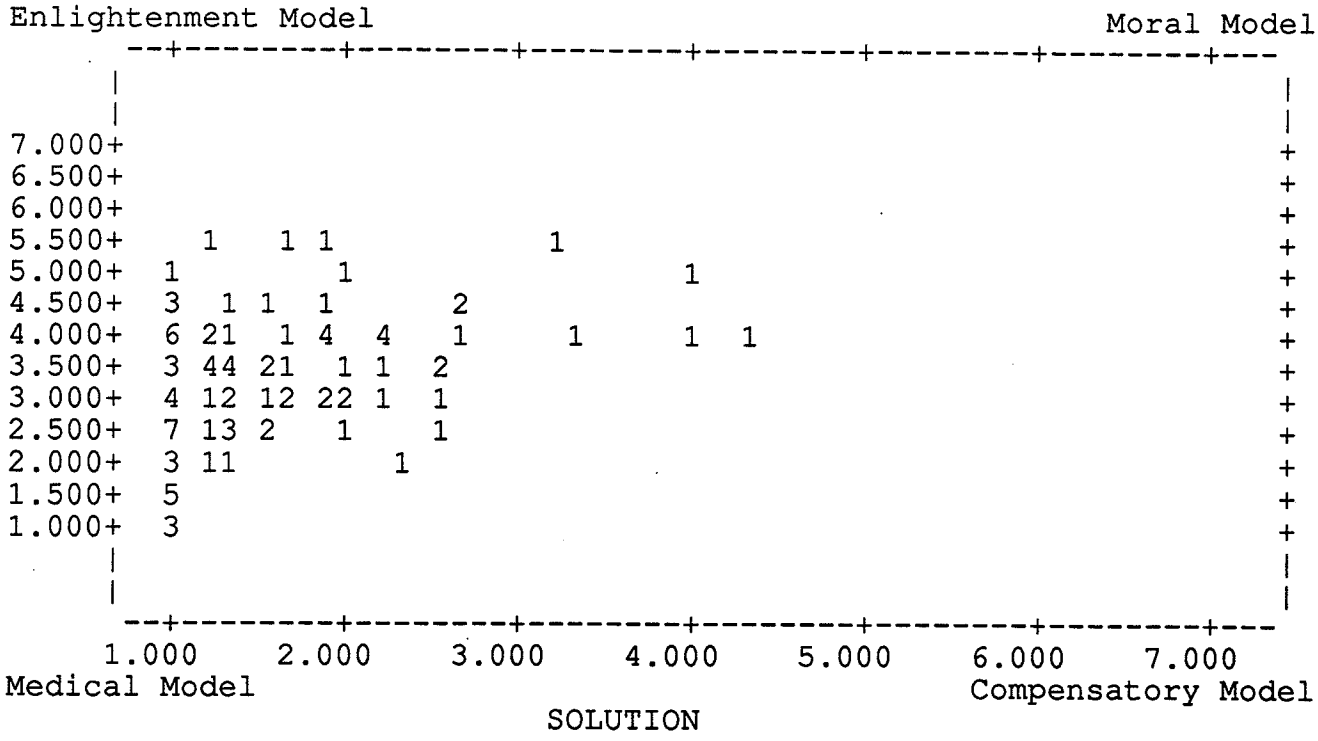
ATTRIBUTIONS FOR VIGNETTE I: FEMALE OVERDOSE



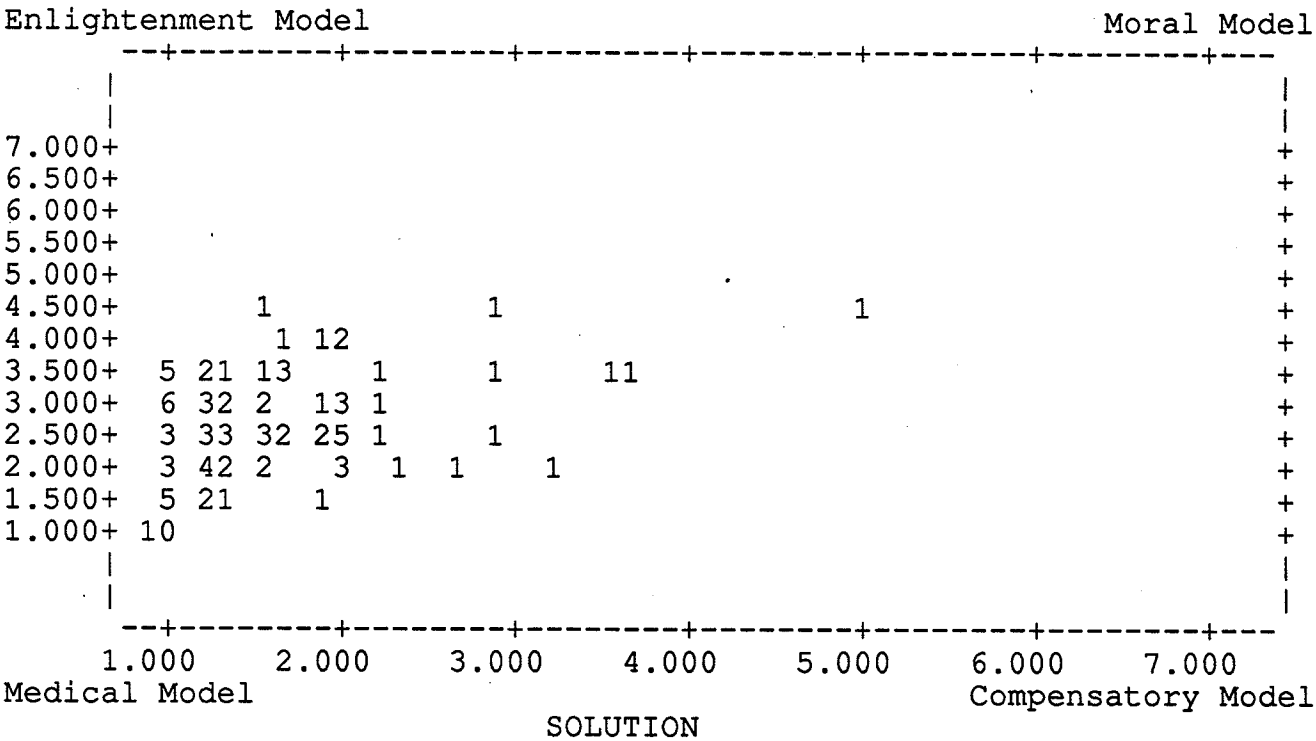
ATTRIBUTIONS FOR VIGNETTE J: MALE HAVING MYOCARDIAL INFARCTION



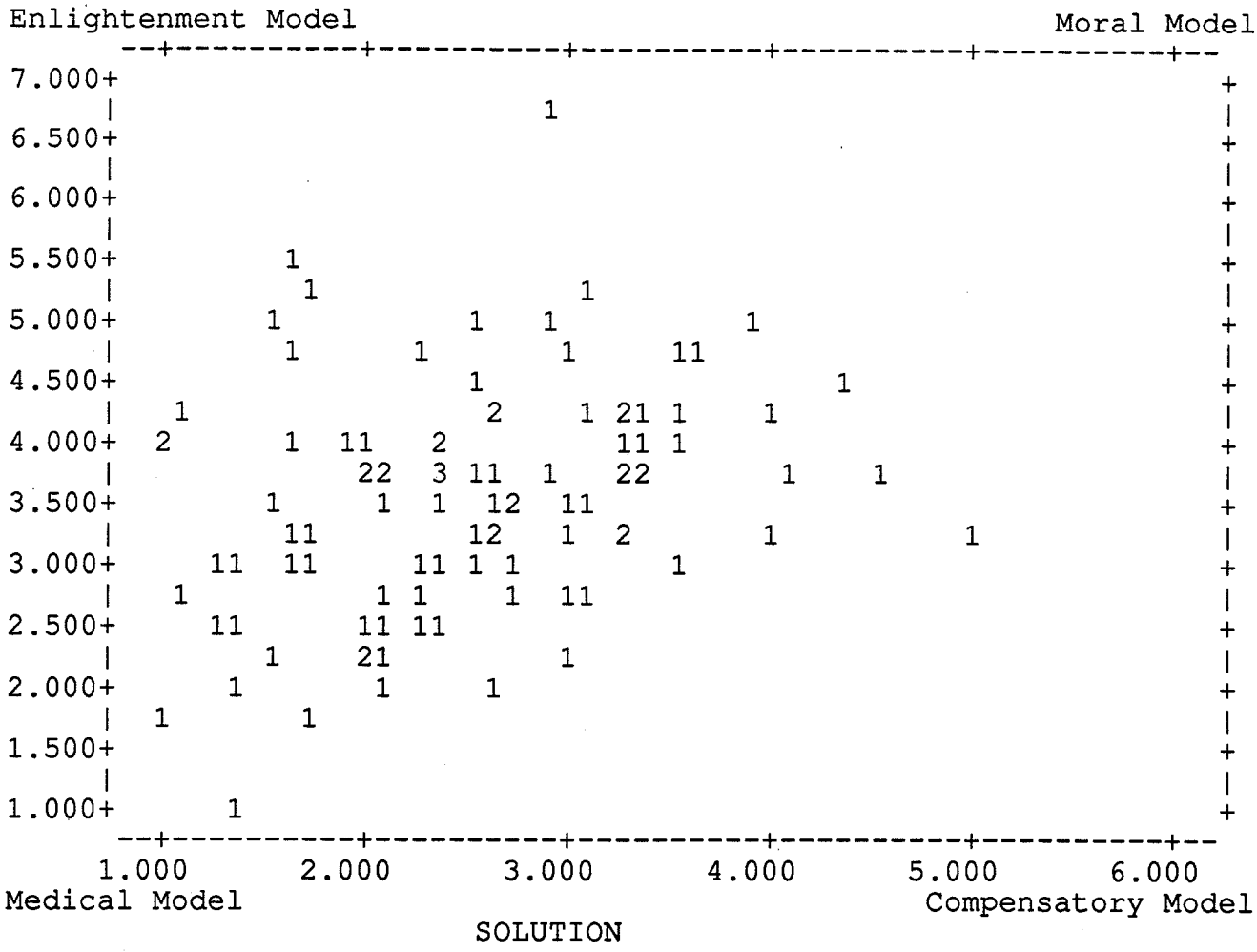
ATTRIBUTIONS FOR ALL MEDICAL VIGNETTES



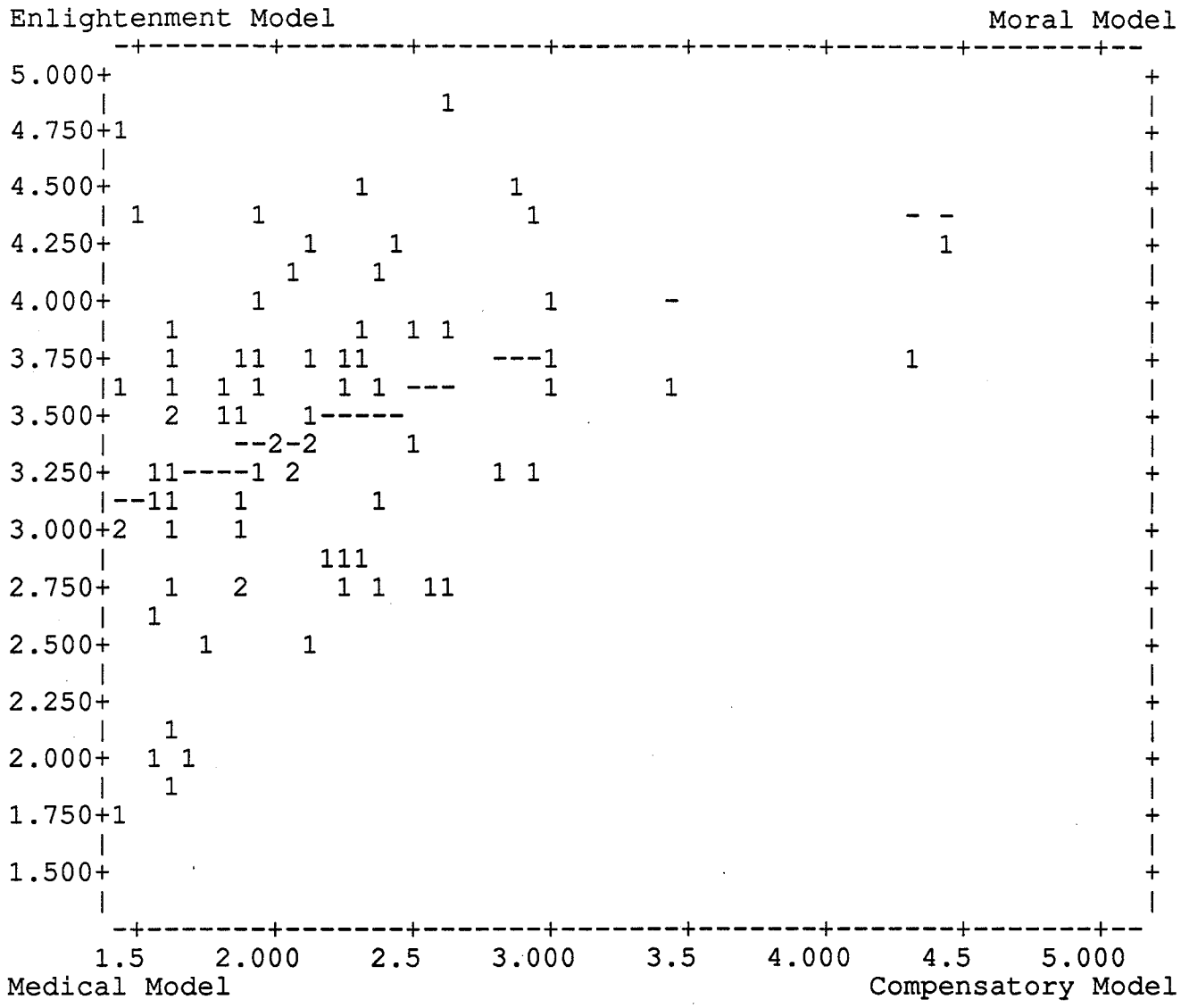
ATTRIBUTIONS FOR ALL SURGICAL VIGNETTES



ATTRIBUTIONS FOR ALL PSYCHIATRIC VIGNETTES



ATTRIBUTIONS FOR ALL VIGNETTES



SOLUTION