A STUDY OF PSYCHIATRIC NURSE DOGMATISM AND PSYCHIATRIC PATIENT VERBALIZATION

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We hereby recommend that the thesis prepared under our supervision by Dana Grace Rankin entitled "A Study of Psychiatric Nurse Dogmatism and Psychiatric Patient Verbalization"

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Dedication

To my father, who's one dream was that his children have the education he never had. I only wish he were here to share this step with me.

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CHAPTER I

Introduction

The basis of the therapeutic or helping process in dynamic psychiatric nursing revolves around nurse-patient communication. Basically, communication involves the exchange of messages between the nurse and the patient. The therapeutic or helping process is promoted when the effect of the message is such that the patient (1) feels that the channels are open for messages and feedback, and (2) feels comfortable to give feedback. A patient's verbalization and feelings provide the nurse with input necessary for client evaluation and assistance. The personality variables of the individual nurses may enter into the relationship with the patient and have an effect on the patient and his responses. One way in which these personality variables are exhibited is in behavior. Nursing literature contains many hypotheses regarding behaviors which facilitate functional, two-way communication, but there is a dearth of empirical data to support these hypotheses.

A personality variable which may be observed in behavior is one's level of dogmatism. If the nurse communicates dogmatism to the patient, this may interfere with the therapeutic or helping process. As nursing research is necessary to provide a statistical data base for effective patient care, this investigation will focus on the effect of dogmatism. Specifically, the purpose of this study is to examine the relationship, if any, between dogmatism in psychiatric nurses and the patient's expressed ease of verbalization.

Statement of the Problem

What is the relationship, if any, that exists between the level of dogmatism of psychiatric nurses and the psychiatric patient's expressed ease of verbalization?

Statement of the Purpose

To determine if there is any relation between the level of dogmatism of psychiatric nurses, and the psychiatric patient's expressed ease of verbalization.

Background and Significance

Early studies on dogmatism and authoritarianism were spurred in the early 1940's as a reaction to anti-Semitism in Nazi Germany. Fromm (1941) and Maslow (1943) presented research on the authoritarian character structure, and "The Authoritarian Personality" by Adorno et al. was published in 1950. Studies of this era primarily investigated personality variables, i.e., dogmatism in relation to ideological content (anti-Semitism) (Rokeach 1960, p. 11).

Investigation of general dogmatism as a personality variable, apart from some particular ideological content was primarily initiated by Milton Rokeach. Rokeach (1954, p. 195) defined dogmatism as (a) relatively closed cognitive organization of beliefs and disbeliefs about reality, (b) organized around a central set of beliefs about absolute authority which, in turn, (c) provides a framework for patterns of intolerance toward others. Dogmatism and a closed belief system are defined synonomously in Rokeach's works. Along these lines Rokeach developed his "Dogmatism Scale," or DS as it will be referred to, in the early 1950's as a tool for measuring dogmatism, which was composed of general

authoritarianism and intolerance. Rokeach's DS has subsequently "been used widely in diverse studies" (Vacchiano, Strauss, Hochman 1969, p. 83).

Viewing dogmatism as a generalized pattern of personality functioning, one might surmise that it could affect interpersonal relationship. Research has generally born out this supposition (Vacchiano, Strauss, and Hochman 1969, pp. 83-85). Burke (1966, pp. 863-868) found a negative correlation between dogmatism and ratings of interpersonal sensitivity. The degree to which a person is perceived as being empathetic and positive in his regard for others was reported by Saltzman (1967, p. 2078) as being negatively correlated to his dogmatism level. Peitchinis (1972, pp. 138-146) reported findings of Truax and Carkhuff (1967) which stated that counsellors who were subjectively judged to be effective were also those who demonstrated openness in their belief systems (or low dogmatism) on the Rokeach Dogmatism Scale.

In searching the published literature, none was found examining the relationship of nurse dogmatism and patient verbalization. Empirical data on this topic could be of value to patient care. Therefore, this will be the focus of this study.

Hypothesis

There is no relationship between the level of dogmatism in psychiatric nurses and the psychiatric patients' expressed ease of verbalization.

Definition of Terms

1. Dogmatism - (a) a relatively closed cognitive organization of beliefs about reality, (b) organized around a central set of beliefs about absolute authority which, in turn, (c) provides a framework for patterns of intolerance toward others (Rokeach 1954, p. 195).
2. Psychiatric Nurse - An individual licensed to practice nursing, either as an RN or LVN who: (a) at the time of the study provides care for patients admitted to a hospital primarily for psychiatric treatment, (b) works either day or evening shift or a combination of both on a full or part time basis, and (c) is not a group therapy leader, and (d) gives written consent to participate in the study by signature on the standard consent form of the host institution.

3. Psychiatric Patient - A patient in a medical center in central Texas who: (a) is admitted to an inpatient psychiatric service with a psychiatric diagnosis, (b) has been a patient for seven full days at the start of the study, (c) has not been excluded from participating by his treatment team, and (d) gives written consent to participate in the study by signature on the standard consent form of the host institution.

4. Ease of verbalization - Subjective feeling of each patient of the degree to which he feels comfortable to talk with each nurse in the study.

Limitations

Variables that were not controlled for by design are:

1. Previous acquaintance of the staff and patient
2. Hawthorne effect
3. Small potential sample size of psychiatric nurses
4. The setting of a government hospital

5. Population of a government hospital being 98 percent male
6. The area in which the nurses take the Dogmatism Scale
7. The time at which the nurses take the Dogmatism Scale
8. The area in which the patient take the patient questionnaire
9. The time at which the patients take the patient questionnaire

Variables that were not controlled for by design, but will be described are:

1. The number of previous hospitalizations at the government hospital in which the study was conducted
2. The setting of the government hospital in which the study was conducted
3. The demographics of the patient population
4. The demographics of the nurse population

Delimitations

Variables that were controlled for are:

1. Language, as only English-speaking persons were included
2. The nurse is a nurse by definition and must meet the following criteria: (a) works either the day or evening shift or a combination of both on a full or part time basis, (b) is not a group therapy leader, and (c) gives written consent to participate in the study by signature on the standard consent form of the host institution
3. The patient is a patient by definition and will meet the following criteria: (a) has been admitted to an inpatient psychiatric service with a psychiatric diagnosis, (b) has been a patient for seven full days at the start of the study, (c) has not been excluded from participating by his treatment team, (d) gives written consent to participate in the study by signature on the standard consent form of the host institution

Assumptions

1. It is assumed that the nurses answered the DS honestly
2. It is assumed that the patients answered the questionnaire truthfully
3. It is assumed that the nurses had a measurable level of dogmatism
4. It is assumed that the patient was aware when he felt at ease to verbalize

Summary

This study was concerned with the level of dogmatism in psychiatric nurses, and the effect, if any, on patient verbalization. Research undertaken on the related topic of authoritarianism in the 1940's dealt primarily with authoritarianism as related to ideological content. Milton Rokeach undertook the study of authoritarianism, or dogmatism as it later developed, as a personality pervasive characteristic which was exhibited at the cognitive, ideological, and behavioral levels. Substantial research has since been done confirming his theories. This study proposed testing his theories in relation to care of psychiatric patients.

Overview of Succeeding Chapters

Chapter II presents the review of literature which includes nursing and psychological literature on therapeutic interactions, Milton Rokeach's research on dogmatism, research done by other individuals on dogmatism and its characteristics, dogmatism or its components as related to care of mental patients, and research related to communication with mental patients. Chapter III contains the steps taken to obtain consenting participants and the criteria for their selection, description of the hospital utilized, the tools which were administered, and the methods by which the data were collected. Chapter IV includes the analysis of data; the results and demographic variables possibly affecting these results. Chapter V presents a summary of the study, the implications, recommendations, and conclusions drawn from this study.

CHAPTER II

REVIEW OF LITERATURE

Nursing Literature

DuGas (1977, p. 134) states that for an individual to feel free to communicate, the nurse must convey warmth and acceptance. DuGas defines warmth as implying genuine liking for people, and acceptance as the ability to understand another person's point of view, and to respect the right of each individual to be different.

Evans (1971, p. 109) states that therapeutic nursing interactions are those which are aimed toward helping the individual, the family, and the community maintain health status and move toward positive mental health. She cites attitudes of warmth, acceptance, objectivity, and compassion as being compatible with such therapeutic interactions.

Haber (1978, p. 73) states that the "core dimensions" or facilitative dimensions of the interpersonal process are:

1. Empathetic understanding
2. Concreteness or clear, direct expression
3. Respect
4. Genuineness
5. Confrontation
6. Immediacy or dealing with the here-and-now

This nursing text goes on to state that conveying a tone of superiority, or conveying opinions in a rigid or dogmatic way are indications of unrecognized, unresolved countertransference reactions, through which the nurse is attempting to regain feelings of personal security. Such countertransference reactions can be counterproductive to therapy (Haber 1978, p. 88).

Therapy was defined by Peplau (1952, p. 62) as an interpersonal relationship which provides for continued growth by facilitating satisfaction of unmet needs. The therapeutic process can then be promoted by a variety of techniques, provided the nursing process is correctly instituted to assist the patient in meeting his needs (Peplau 1952, p. 8). Peplau (1952, p. 9) states that, ". . . the nursing process is educative and therapeutic when the nurse and patient can come to know and respect each other, as persons who are alike, and

yet, different, as persons who share in solution of problems."

Truax and Carkhuff (1967) were reported as stating that accurate empathy, nonpossessive warmth and genuineness are essential characteristics of therapeutic counseling. Accurate empathy is defined as sensitivity and accurate understanding of the client's situation from the client's point of view, with this understanding being communicated to the patient. Nonpossessive warmth refers to an acceptance and unqualified positive regard and concern for the interest of the patient. Genuineness is characterized by sincere, authentic, nondefensive behavior on the part of the counselor (Peitchinis 1972, pp. 138-146).

Rogers (1965, p. 20) states that the primary ingredient necessary to become a skillful counselor is an operational hypothesis or belief in the worth and significance of each individual patient. This hypothesis carries with it: (1) confidence and respect for the individual's ability to be aware of and deal constructively with different facets of his life, and (2) acceptance of the manner in which the patient chooses to deal with his life (Rogers 1965, p. 24). Rogers states that this hypothesis of respect and acceptance can be operationalized and communicated to the patient, only to the

extent that it is an integral part of the therapist's personality (Rogers 1965, p. 21). With the integration of this basic hypothesis, it is implemented to create a therapeutic relationship by the counselor's:

1. assuming the internal frame reference of the client
2. perceiving the world as the patient sees it
3. perceiving the client as he perceives himself
4. laying aside all perceptions from any external frame of reference while doing this
5. communicating this empathetic understanding to the patient

(Rogers 1965, p. 29)

In Rogers' theories as in previously mentioned literature, respect, acceptance, and empathy are presented as necessary components of the therapeutic process.

Characteristics of Nurses

If certain traits are consistently reported in the literature as being conducive to a therapeutic relationship, one might be interested in how nurses compare with these traits. Lentz and Michaels (1965,pp.43-48) took a sample of 384 medical-surgical nurses on the Edwards

Personal Preference Schedule (EPPS) based on a concept of psychological needs. They reported that nurses scored higher than the established norm on needs for order, endurance, and deference, and much lower on dominance. Definitions of EPPS variables may be found in Appendix IV. These scores were compared with results of a study by Navran and Stauffacher (1957, pp. 109-114) on personality characteristics of psychiatric nurses. The psychiatric nurses in Navran and Stauffacher's study also scored higher than the college woman norm in order, deference, endurance, and aggression, and lower in autonomy, affiliation, and exhibition. In comparison with the medical-surgical nurses, psychiatric nurses rated significantly higher on dominance, intraception, and lower on abasement than medical-surgical nurses.

Cohen, Trehub, and Morrison (1965, pp. 316-319) also administered the EPPS to a group of forty-nine psychiatric nurses. The needs on which the nurses scored significantly higher than the norm were reported as order, deference, endurance, and intraception. The needs on which the subjects scored significantly lower were achievement, autonomy, succorrance, and exhibition.

In comparing personality traits of nurse practitioners as compared to nursing students, by use of the EPPS, some reversals of scores may be noted between the two groups. The nursing students ranked lowest in autonomy. They ranked highest, with mean scores all above the sixteenth percentile on needs for order, deference, endurance, abasement, and nurturance. The practitioners, on the other hand, produced mean scores for the four former variables all below the fortieth percentile. The practitioners all tended to rank higher on needs for autonomy, exhibition, dominance, change, and heterosexuality. This would appear to indicate that education has some bearing on traits exhibited (White 1975, pp. 160-162).

Some common results can be noted in these studies, and some have particular reference to the focus of this study--dogmatism. Deference, upon which many nurses ranked high, refers to a respect for superiors, respecting authority, and conforming to custom. Autonomy, on the other hand, a variable that some groups scored low on, involves defying convention, and being critical of authority. These are some aspects of behavior which Rokeach defines as having bearing on one's level of dogmatism.

Milton Rokeach - Research

Rokeach (1960, p. 9) departed from the theories and research of his time on authoritarianism, which were related to ideological content, i.e., Fascism. His goal was to develop an ahistorical concept of authoritarianism that would be applicable to all stages in history (Rokeach 1960, p. 9). His subsequent pursuit was an "analysis of the properties held in common by all forms of authoritarianism regardless of specific ideological, theological, philosophic, or scientific content" (Rokeach 1960, p. 14).

Rokeach's approach was to find or develop a common ground upon which to view personality, ideology, and cognitive behavior. During his investigation he came to view personality as an organization of expectancies and beliefs, with a structure which could be defined and measured. The concept of ideology developed in a somewhat similar fashion, an organization of definable and measurable beliefs and expectancies about an area of thought, as represented within the psychological structure of the individual. Cognitive activities were conceived as definable and measurable mental processes and changes which occur in an individual who has a formed system of beliefs (Rokeach 1960, p. 7). Rokeach proposed that personality,

ideology, and cognitive behavior were all interrelated, affected each other, and had as their basis the same characteristic properties. In application, for example, looking at how one remembers can give clues to their belief system and personality.

Rokeach further hypothesized that each individual has a set of beliefs and expectations that are accepted as true, and a set that are accepted as false, which together form the belief-disbelief system. This belief-disbelief system is formed along a continuum from open to closed; the more closed the system, the more dogmatic the person (Rokeach 1954, p. 195). The degree of dogmatism was then related to the degree of characteristic properties which he defined.

The characteristic properties which Rokeach defined in relation to the degree of dogmatism or open and closed belief system (as they are used synonomously in this paper) were compiled and reported as follows. The more closed the system:

1. The greater the belief in absolute authority sources
2. The more the content of the belief system is perceived as different from the disbelief system
3. The more information regarding similarities between the belief and disbelief system is perceived as irrelevant

4. The greater is the denial of events or information which threaten or contradict the belief system

5. The greater is the adherence to contradictory beliefs, i.e., the belief in freedom for all and at the same time believing some groups should be restricted

6. The more a disbelief system most similar is perceived as threatening and, therefore, rejected, i.e., reformed Judaism as opposed to conservative Judaism

7. The less compromise there will be with the most similar disbelief system

8. The greater will be the discrepancy between amounts of knowledge possessed related to one's belief system and disbelief system

9. The more the disbelief systems are perceived as being distant to the belief system

10. The greater will be the change in a belief if the change is perceived as emanated from authority

11. The greater will be the altering and reinterpretation of facts or events prior to assimilation, so that they no longer appear contradictory

12. The more the avoidance of contact with stimuli which threaten validity of the belief system

13. The more the present will be perceived as relatively unimportant in its own right--but, only as a passageway to something better in the future

14. The more will be the perception of the present as unfair and full of suffering

15. The greater the confidence in one's accurate understanding of the future

16. The greater is the manifest anxiety and/or employment of defense mechanisms to deal with this anxiety (Rokeach 1954, pp. 196-198)

Rokeach then developed the Dogmatism Scale to tap these characteristics.

Dogmatism was then defined in Rokeach's work as:

> . . . (a) a relatively closed cognitive system of beliefs and disbeliefs about reality, (b) organized around a central set of beliefs about absolute authority which, in turn (c) provides a framework for patterns of intolerance and qualified tolerance toward others (Rokeach 1954, p. 195).

General authoritarianism and general intolerance were then presented as the cognitive components of dogmatism, which he hypothesized were measured by the Dogmatism Scale (Rokeach 1954, p. 196).

To test his hypothesis regarding dogmatism, Rokeach conducted several research studies. To validate that his hypothesis that the Dogmatism Scale did actually measure general authoritarianism more accurately than the California F and Ethnocentrism Scale, Rokeach compared test results. He administered the tests to a group of Catholics, Protestants, and non-believers. The results showed that some individuals left-of-center (non-believers) and right-of-center (Catholics) scored high

on the Dogmatism Scale and Opinionation Scale. However, only persons right-of-center scored high on California F and Ethnocentrism. This, therefore, supported the hypothesis that the Dogmatism Scale does measure general authoritarianism, apart from ideological content, or right authoritarianism (Rokeach 1960, p. 129).

Rokeach administered the Dogmatism Scale and the Gough-Sanford Rigidity Scale to 109 college students to measure differentiating characteristics of dogmatic versus rigid subjects in problem solving situations. The subjects were observed and timed in problem solving situations, with varying degrees of experimenter input in assisting with solving the problem. There was no significant difference between closed and open subjects on analysis or breakdown of individual beliefs. There was a reported relationship between high dogmatism, or closed belief system scores and difficulty in synthesized or integrating new information which contradicted their everyday beliefs. The opposite correlation was found with rigidity scores, with high rigidity being associated with difficulty in analysis (Rokeach 1960, p. 193). This supported one of Rokeach's hypotheses that dogmatism and rigidity in an individual were separate and definable variables.

In continuation with these same problem solving experiments, Rokeach noted some relationships to total problem solving time when the form in which clues were given was manipulated. One group received written clues which they could keep in front of them during the problem solving situation, and one group could read the clues once and utilize information from memory for problem solving. Each group contained fifteen high dogmatism scorers and fifteen low dogmatism scorers. In general, those solving by memory took longer than those using the clue cards. Also, those who scored high on the Dogmatism Scale took on an average of seven minutes longer to solve the problem than open individuals, regardless of the method of clue presentation. This latter finding seems to support Rokeach's hypothesis that closed-minded individuals have more difficulty in relating new belief systems to old belief systems and confirms the difficulty with information synthesis reported in the previous study (Rokeach 1960, pp. 201-203, 213).

In a further attempt to understand thought processes characteristic to persons with open and closed systems, particularly in relation to integration of new information and synthesis for problem-solving, high and low dogmatics, some with and some without experience with

chess, were given a chessboard problem. Once again, if Rokeach's hypotheses are borne out, the following would be expected:

1. Those who play chess should synthesize faster than those who do not play chess
2. Open and closed chess players would have similar synthesis times since no new information integration would be necessary
3. Non-chess playing, open persons should synthesize faster than non-chess playing, closed persons due to mental resistance to letting in new or different information or ideas on the part of the latter group

All of the hypothetical expectations were empirically observed. In particular, it was noted that open, non-chess players solved the problem ten minutes faster than closed non-chess players (Rokeach 1960, p. 222).

In an attempt to test the hypothesis that highly dogmatic persons hold opinions that emanate from the perceived "sources" of authority and these beliefs are isolated from each other, he reformulated the problem as a positive transfer of thinking. Therefore, if his hypothesis was correct, closed individuals should show

less positive transfer of learning from one problem-solving situation to another than open individuals (Rokeach 1960, p. 230). The results did support this hypothesis (Rokeach 1960, p. 242).

Rokeach also ran an experiment to test out the hypothesized characteristics that closed individuals were less able to see logical contradictions between beliefs and were dependent on sources of authority for truth and integrity. To do this a problem without a solution was presented, analogous, except for one additional stipulation, to a problem presented to these same subjects earlier (Rokeach 1960, p. 247). If the hypothesis were true, closed subjects would have less information communication within the belief system, and "trust" that the authority would not give an unsolvable problem. These persons would, therefore, have greater difficulty in assimilating contradictory information, leading to the conclusion that the problem had no solution. Reported results were that close-minded individuals persisted twice as often as open individuals that the problem was solvable (Rokeach 1960, p. 253).

Rokeach also tested his hypothesized characteristic that the more dogmatic the person the more beliefs perceived as dissimilar will be rejected. Subjects of

six major Christian denominations were given the Dogmatism Scale and then asked to rank, in order of perceived similarity to their own religion: Catholic, Episcopalian, Lutheran, Presbyterian, Methodist, Baptist, Jewish, Mohammedan religions, and atheism. The subjects were then given a five-item questionnaire to answer regarding association with individuals in each religion to determine level of rejection. A sample question, for example, was, "I am willing to have a ___ marry into my family" (Rokeach 1960, p. 299). In general the more a faith was perceived as dissimilar from one's own, the more it was rejected. More specifically, persons with high scores on the Dogmatism Scale more consistently rejected those perceived as dissimilar than did those with low scores (Rokeach 1960, p. 309).

In a survey study Rokeach tested out behavioral manifestations associated with belief systems. His results indicated that as similarity of religious belief increases, so does the probability:

1. That a person will enroll in that demoninational college
2. Of change of membership to that denomination church
3. Of premarital and marital harmony

4. Of interfaith marriage with individuals of "similar" religion

Rokeach interprets these findings as being behavioral manifestations of cognitive thought and, therefore, substantiating his hypothesis of their interrelationship (Rokeach 1960, p. 331).

As mentioned previously Rokeach also suggested that the extent to which the belief-disbelief system is closed is related to the individual's cognitive defenses against anxiety. He, therefore, hypothesized that the higher the level of dogmatism or authoritarianism, the higher the manifest anxiety will be. In extension he further hypothesized that levels of openness-closedness and associated anxiety can be traced to childhood experiences (Rokeach 1960, p. 347). American Catholics, English Communist, and New York College students were administered the Dogmatism Scale, the section of the MMPI for measure of anxiety, and a questionnaire designed to tap attitudes toward parents, identification formed, and anxiety symptoms manifested in childhood (i.e., bed-wetting, nail biting). Several relations were shown:

1. Scores on dogmatism and anxiety correlated between .36 to .64 in subjects tested
2. Middle and high scores on the Dogmatism Scale reported less permitted expression of ambivalence to parents in childhood and more reported "glorification"
3. Middle and high scorers reported restricted exposure to influence of individuals outside the home
4. Middle and high scorers reported a greater frequency of behavioral manifestations of anxiety in childhood

These findings are interpreted by Rokeach as follows:

> . . . suppressed expression of ambivalence toward parents----→ anxiety and to narrowing of identification with individuals outside the family--------→ development of closed belief system (Rokeach 1960, pp. 364-365).

Rokeach and Bonier carried out a multi-phasic study on time perspective, dogmatism, and anxiety. The Dogmatism Scale was administered and subjects scored as either open or closed. Responses to the Thematic Apperception Test, a test on which the client is shown a picture and asked to respond with a story, were analyzed

in several ways. The researchers noted that there was no difference in the frequency of past responses. Consistently, however, the open group gave more present responses, and the closed group gave more future responses, without any overlap in scores. For example, percentages for future tense responses of the open group ranged from 3 to 17 percent, with a 21 to 48 percent range for the closed group. This substantiates Rokeach's hypothesis that closed persons are future, rather than present, oriented. No relation was found between dogmatism and time span covered in the story, however (i.e., into the future). On rating for anxiety, from subject behavior and story topics, the closed group ranked significantly higher than the open group, with means of 3.3 and 2.3, respectively. Also, sixteen out of fifty stories from the closed subjects dealt with threatening situations, whereas none of the open persons' stories contained this facet (Rokeach 1960, pp. 382-383).

Further Research on Dogmatism and Its Characteristics

Subsequent to Rokeach's presentation of his theories regarding dogmatism, research was done by other researchers to investigate characteristics related to dogmatism.

By administering the Rokeach Dogmatism Scale, Bieri's adaption of the Role Repertory Test (REP) of Cognitive Complexity, and Taylor's Manifest Anxiety Scale, Burnette (1973, pp. 1740-1741) identified some characteristics associated with dogmatism. In this study no relationship was found between the level of dogmatism and cognitive complexity. A relationship between high scores on the Dogmatism Scale and higher levels of trait anxiety were reported, however.

A study of Higginbotham (1976, p. 34) presented some concurring information. The Mooney Problem Check List (College Form), the Manifest Anxiety Scale, the Rokeach Dogmatism Scale, and an irrationality measure derived from the irrational beliefs as specified by A. Ellis (1957), were administered to 135 college students. The hypothesis of a significant correlation between irrationality, number of problems, manifest anxiety, and dogmatism were all supported. These studies support

Rokeach's hypothesis that dogmatism is related to anxiety level.

Dirkes (1974, p. 4013) suggested that open-minded individuals perceived a balance of positive and negative feedback, whereas close-minded persons perceived an imbalance. However, when the Rokeach Dogmatism Scale was compared with a feedback inventory, neither of the predicted relationships was verified.

Davis et al. (1975, pp. 375-381) compared scores on the Dogmatism Scale with behavior checklist ratings of T-group members. Members with low dogmatism scores were rated as being more open about themselves, more oriented toward the here-and-now, and less apt to give negative feedback. These characteristics support and validate Rokeach's theory. However, no relation was found between dogmatism scores and ratings for positive feedback. Members with high dogmatism scores were rated higher for contributions to the group, but not significantly.

Another study on group interactions and dogmatism was done by Talley and Vamos (1974, pp. 278-282). They administered the Dogmatism Scale to 24 graduate students and compared scores with contents of paragraphs written by the students on their feelings after each of twelve

unstructured group sessions. It was reported that high dogmatism scorers were significantly more concerned than low dogmatism scorers with:

1. The organization, structure, and physical setting of the group
2. The goals, evaluation, and satisfaction with the group
3. The topics discussed in the group

A study to determine the extent to which dogmatic and nondogmatic persons exhibit their characteristics in a group situation was done by Zagona and Zurcher (1964, pp. 255-264). The reported results were that high dogmatics:

1. Exhibit a more active concern over leader selection (Rokeach has suggested that high dogmatics are more leader-oriented)
2. Exhibit a greater need for structure than for expression and spontaneity
3. Exhibit greater disturbance when the group leader did not meet up to role expectations of an authority figure
4. Exhibit decreased conviction and group cohesion when challenged by an authority figure

Varies (1974, p. 4661) found similar results in a study on decision making. He reports that high dogmatics exhibit greater decision wavering and incongruency of choice under conditions of negative feedback than do low dogmatics. There was no relation between dogmatism and congruency of choice in an analogous control group which received no feedback.

Compared results of the Rokeach Dogmatism Scale and Asch's vertical line test reported by Long (1971, pp. 37-45) indicated some relationship between the level of dogmatism and modifications of judgment. The relationships reported were:

1. Overall judgment modification was higher among subject receiving peer input
2. High dogmatics made more judgmental modifications when receiving information from peers than from subordinates or superiors
3. Low dogmatics favored superior information sources

The latter two findings are in opposition to Zagona and Zurcher's findings (1964) and Rokeach's theory that high dogmatics tend to make judgments or form opinions in accordance with superior authority sources.

A particular type of judgment formation was researched in a study done by Robbins (1975, p. 84) on the relation of impression formation and dogmatism (as measured by the Dogmatism Scale). Reportedly dogmatic subjects:

1. Gave more extreme stability ratings
2. Expressed greater liking for the agreed-with source
3. Took in less information before passing "final judgment"
4. Showed a tendency to prefer explaining away impression discrepant information rather than withhold judgment

A similar result was reported in a study by Burke (1966, pp. 863-868). This researcher administered the Dogmatism Scale twice to a group of 118 college students: (1) first with the standard instructions to answer with their own personal opinion, and (2) second as they believed an "average college student would answer it." On the basis of his study and other similar studies, Burke reported that compared with nondogmatic subjects, dogmatic subjects:

1. Were more stereotype in their thinking
2. Utilized a more narrow range of information in their decision making
3. Exhibited less sensory acuity and social perception

Bordeleau et al. (1970, pp. 166-168) researched the relationship between an authoritarian attitude and age, educational level, time spent with the patients, and seniority of members of a mental hospital treatment team. No relationship was found between authoritarian attitude and either time spent with the patient or seniority. With increased age, however, there appeared to be an increase in the authoritarian attitude toward the psychiatric patients. A significant negative relationship was found between educational level and authoritarian attitude.

Similar results were reported in a study of student and registered psychiatric nurse opinions about mental illness was presented by Robinson (1973, pp. 235-238). One of the variables tested was authoritarianism, which in this context is characterized by submission, anti-intraception, and a perception of the mentally ill as an inferior class requiring coercive handling. The

results of this study indicated that the older nurses had higher levels of authoritarianism than nursing students, and that junior nursing students exhibited higher levels of authoritarianism than senior nursing students. This would seem to indicate that authoritarianism varies conversely with age or experience, and inversely with education.

A similar relationship between authoritarianism and education was also reported by Walsh (1971, p. 526). In comparing five attitudes of nursing students, she reported that social restrictiveness and authoritarianism toward the mentally ill significantly decreased with courses in psychiatric nursing. Morris (1964, p. 137) likewise states that authoritarian attitudes can be modified, and "this is a function of the psychiatric nursing experience."

Vacchiano, Strauss, and Schiffman (1968, p. 84) studied personality variables related to dogmatism and presented significant findings. Scores on the Edwards Personal Preference Schedule, The Tennessee Self-Concept Scale, and the Sixteen Personality Factor Questionnaire were correlated with scores on the Dogmatism Scale. In correlation with the EPPS, dogmatism was found to be positively related to succorrance, and negatively related to intraception and change (definitions in

Appendix IV). In comparing scores on the Tennessee Self-Concept Scale and Dogmatism Scale, dogmatism was found to relate positively to such factors as defensiveness, maladjustment, personality disorder, and neurosis, and negatively with self-image aspects (i.e., self-esteem, self-satisfaction, physical and personal self). When compared with results of the Sixteen Personality Factor Questionnaire, an "interpretive relationship" was seen between dogmatism and the Sixteen Personality Factor Questionnaire variables of conformity, restraint, conservatism, emotional instability, and tenseness (Vacchiano, Strauss, and Schiffman 1968, pp. 83-85). Correlations are presented in Appendix VI. Although correlations are low, these results presented an interpretive personality sketch of a dogmatic individual. Individuals of this type could have an effect on patient care.

Treatment of Mental Patients

Fracchia (1972, pp. 483-485) examined the relationship between personal adjustment, as measured by the Emotions Profile Index and authoritarian attitudes on the Opinions About Mental Illness Scale. Authoritarian attitudes, as measured by this scale, would reflect the

belief that mentally ill persons comprise an inferior class requiring coercive handling. No association between personal adjustment and authoritarian attitudes toward the mentally ill was found.

Results of a study by Moody (1971, pp. 172-175) from administration of the Custodial Attitude Inventory and Strole's version of the F-scale of authoritarianism indicated that attitudes of authoritarianism were associated with custodial rather than humanistic attitudes in treating alcoholics. Information regarding education and occupation of the head of each subject's household were also compared with these scores. From the results it was suggested that individuals from middle class backgrounds, with low authoritarian scores, possessed attitudes conducive to successful rehabilitation of alcoholics.

Hood (1974, pp. 543-549) reported that high dogmatics held more stereotype attitudes toward the mentally ill. These stereotype attitudes or cognitive rejection decreased, however, after a course on deviance in a normal classroom situation. However, after this course, high dogmatics increased their affective rejection of the mentally ill.

Utilizing the Dogmatism Scale, Crum and Rowlands (1978, pp. 42-49) looked at the relationship of open and closed-mindedness to change of opinions or inferences about psychiatric patients when progressively provided with additional information about these patients. They reported that low dogmatic subjects would most often change inferences on the basis of additional data, the high dogmatics less often, and interestingly, the intermediate group changed the least. High dogmatics also demonstrated greater initial confidence or confiction than low dogmatics in regard to their inferences about the patients. These researchers suggest that this supports Rokeach's theory that this behavior is utilized by high dogmatics to defend against anxiety. This also appears to support Rokeach's theory that more highly dogmatic persons tend to deny or disregard information which contradicts their internally formed belief system.

Boland (1974, pp. 5615-5616) compared subjectively judged counselor ability with scores on the California Psychological Inventory, the Strong Vocational Interest Blank, the Guilford Zimmerman Temperament Survey, and the Rokeach Dogmatism Scale. The correlations reported as significant were in two areas. Those individuals who presented a moderate need to make a

favorable impression, and those who were open in their belief systems were judged to be effective counselors.

In regard to treatment approach Noble (1971, pp. 11-17) reported that dogmatism, as measured by a shortened form of the Rokeach Dogmatism Scale, was not related to the theoretical framework of patient approach, i.e., psychotherapeutic versus somatotherapeutic. She also found no relation between dogmatism and the role orientation that the nurses took in treatment.

Canter (1963, pp. 124-127) conducted a study with comparing dogmatism, as measured by the Dogmatism Scale and F-scale, to attitudes toward mental patients, assessed by the AMP questionnaire, a "locally devised instrument," and effectiveness in clinical work, determined by instructor rating and a "specially" developed Interpersonal Relations With Patients (IRP) Scale. She reported a "general confirmation of the expectancy" that high dogmatism was associated with both a negative attitude toward mental patients and lower ratings on clinical effectiveness, especially in aspects related to interpersonal contacts. Canter further states that these results cannot be interpreted to indicate low levels of effectiveness in subsequent working situations.

Communication

The relationship of dogmatism to verbal communication was referred to by Rokeach in proposal of his theory. He stated, ". . . dogmatism is manifested almost necessarily in situations involving person-to-person communication" (Rokeach 1954, p. 196). The effect of the variable of dogmatism as manifested in behavior has been subsequently commented on and researched.

Satir (1964, p. 135) defines open and closed interaction systems in much the same way that Rokeach does. She states that in a closed system the principle rule appears to be that everyone have the same opinions and feelings, with honest self-expression impossible, and differences reviewed as dangerous. On the effects of such an interactional system Satir further states, "The limitations placed on individual health and growth are obvious, and I have found that emotional or behavioral disturbance is a certain sign that the disturbed person is a member of a closed family system" (Satir 1964, p. 135). On the other hand, in open systems, the individual can verbalize what he thinks and feels. Therefore, the individual is able to negotiate for reality and personal growth without fear of detriment to himself or others in the communicational system.

Matthews (1962, pp. 154-162), in measuring nurses' responses to simulated patient statements found that only 30 percent of the nurses gave responses subjectively categorized, according to operational definitions, as person-positive and person-centered. The remaining 70 percent of the responses were in categories of either neutral, rule-centered, judgmental, or threatening. Only eight of a sample of 122 nurses were evaluated as having given one or more responses that encouraged the patient to disclose what he was experiencing. It was also noted that as the years since graduation increased, patient-centered responses decreased.

One of the seven psychological instruments used by Mlott (1976, pp. 19-23) to assess personality correlates of psychiatric nurses was the Rokeach Dogmatism Scale. As compared with six other nursing specialties, psychiatric nurses ranked second lowest in dogmatism, with renal nurses ranking lowest. These findings were interpreted as confirming the results of previous research that the lower the dogmatism scores the higher the predisposition to communicate with clients. "In addition, low authoritarianism is likely to reveal itself in more effective work with patients, more tolerance of others having differing belief systems, and more open-mindedness"

(Mlott 1976, p. 20). The conclusions are in concurrence with Rokeach's hypothesis.

In extensive search of the literature, this researcher found only one article in which communicative ease, as perceived by the patient, was reported. Wogan (1970, pp. 356-362) administered the MMPI to both patients and therapist, and after two weeks of therapy each filled out a scale rating components of therapy. Therapists who rated higher on MMPI on anxiety and somatization and lower on repression were rated higher on communicative ease. It may be noted here that a correlation between authoritarianism and anxiety level has been reported (Burnette 1973, pp. 1740-1741; Higginbotham 1976, p. 34; and Rokeach 1960, p. 364). Patients rated themselves as progressing more rapidly in therapy with therapists who scored higher on subtlety and lower on repression. Wogan suggests that patients perceive interactions to be more therapeutic with therapists who are able to acknowledge anxiety, or unpleasant experiences in himself and who do not tend to deny symptoms in himself, or exhibit repression.

The majority of studies on dogmatism as related to therapeutic effectiveness and communication report characteristics conducive to therapeutic effectiveness and communication ease from the perception of third person observers or supervisors. It would appear that there has been little empirical data compiled on the patient's perception of qualities which contribute positively and negatively to therapeutic effectiveness and communicative ease. Specifically, in reviewing the literature, no research study report was found on level of dogmatism and the patient's perceived ease of verbalization.

CHAPTER III

PROCEDURE FOR THE COLLECTION OF DATA

Introduction

This investigation was an analytic survey. Kerlinger defines survey research as studying

> . . . large and small populations by selecting and studying samples chosen from the population to discover the relative incidence, distribution, and inter-relations of sociological and psychological variables (Kerlinger 1973, p. 410).

In analytical surveys the presence of potentials or dynamic forces, or inferences of relationships are drawn from quantitative data by means of statistical tools (Leedy 1974, p. 114). With the lack of control over extraneous variables inherent in a nonexperimental design, at best an associative relationship between the variables rather than a causal relationship will be established (Abdellah and Levine 1965, p. 212).

This study was conducted to determine if any relationship could be found between the level of dogmatism of psychiatric nurses and psychiatric patients'

expressed ease of verbalization. Clearance and approval to conduct this study was obtained from the researcher's thesis committee, the Human Rights Committee of the Texas Woman's University, and the Research Committee and Human Rights Committee at the government hospital where the study was conducted.

Setting

The data for this study were collected at a government hospital in central Texas. Three psychiatric units with a total capacity of 110 beds were used. One unit was specifically designated as the alcohol treatment unit, and the other two were for general psychiatry. All units were open, or unlocked. Patients were able to ambulate freely about the hospital, with the requirement that they sign in and out. The staffing in this setting usually consisted of two registered nurses, one licensed practical nurse, and one or two orderlies on each unit during the day shift. The psychologist and psychiatrist for each unit also had offices which directly connected to the patient day room. On the evening shift there was a registered nurse or licensed practical nurse on each unit with one or two orderlies on each unit.

Population

The population of this study was a convenience sampling of nurses (registered nurses and licensed practical nurses) who, at the time of the study, May 24 through June 7, 1978: (1) worked either the day or evening shift, or a combination of both on a full or part time basis, (2) were not group therapy leaders, and (3) gave written consent to participate in the study by signature on the standard consent form of the host institution. The majority of the potential population was Caucasian, registered nurses, forty to forty-five years of age, with an average of fifteen years experience.

Enlistment of nurse participants was initiated by the clinical nurse specialist in psychiatry. She told the nurses that a graduate student would be requesting their participation in a hospital-approved study as a part of her thesis. Information sheets identifying the investigator, the purpose, the requirements, and potential risks and benefits of the study were distributed on the units. The researcher was available on the units to answer any questions and clarify any information as necessary. Signatures were obtained on the information sheets and written consent to participate was obtained on the standard hospital consent form.

There was a potential sample of fifteen nurses. Four declined to participate, and four were eliminated because they were group therapy leaders. This left a total of seven nurses. Two of the seven nurses worked part time on two units. Since, by definition, these nurses were not excluded from the study, they were considered as a part time nurse on each of two units, and they were included on the patient questionnaires on both units. Therefore, the sample totaled nine.

The population of psychiatric patients for this study were those who met the following criteria: (1) were admitted to an inpatient psychiatric service with an accompanying psychiatric diagnosis and had been an inpatient for at least seven full days at the start of the study (May 24, 1978), (2) have not been excluded from participating by the treatment team of nurses, psychiatrist, and psychologist associated with their case, (3) had given written consent to participate in the study by signature on the standard consent form of the host institution.

The clinical nurse specialist in psychiatry also was of assistance in the initial phases of enlisting patient participation in the study. The researcher was introduced by the charge nurse at the beginning of the

patient unit meeting on each unit. Further introduction was made by the researcher, and verbal explanation of the purpose, requirements, and potential risks and benefits of the study were given in accordance with information sheets which were then subsequently passed out to each patient. Questions were answered as necessary, and the information sheets signed by the patients. Written consent to participate was given by signature on the standard consent form of the host institution. The majority of the potential population was Caucasian, over forty years of age, with one to two previous psychiatric admissions.

The census at the time of the study was sixty-two patients, equally distributed among the three units. Twenty-five patients consented to participate and returned their questionnaires. Three patient questionnaires were discarded for incompleteness, resulting in N=22.

Tools

The tool that was used to determine the level of dogmatism of the psychiatric nurses is the Dogmatism Scale developed by Milton Rokeach. The theories and research related to the Dogmatism Scale are most extensively reported in his primary reference, The Open and Closed Mind (1960). The scale was developed by listening to and observing persons whom Rokeach and his associates

intuitively perceived to be closed minded, or dogmatic. Rokeach then deductively defined the characteristics of open and closed systems and constructed statements to tap these characteristics to form the Dogmatism Scale (Rokeach 1960, p. 72) (Appendix I).

The primary purpose of the Dogmatism Scale (DS) was to measure individual differences in openness or closedness of belief systems. In extension Rokeach (1960, pp. 71-72) states,

> Because of the way we have defined open and closed . . . , the scale should also serve to measure general authoritarianism and general intolerance. . .

which he theorized were the two components of dogmatism.

To substantiate that the Dogmatism Scale does actually measure what it purports to measure, Rokeach used the "method of known groups." In one such test where professors selected "most" and "least" dogmatic students, according to Rokeach's definitions. However, when the students were subsequently given the Dogmatism Scale, there was a nonsignificant correlation. In another such study psychology students selected from among their personal friends and acquaintances those whom they considered high dogmatics and those they considered low dogmatics. These persons were subsequently given the Dogmatism Scale

and the results were very significant ($p = .01$) (Rokeach 1960, p. 103).

During this same time period, W. T. Plant (1960, p. 164) administering the Dogmatism Scale and the California F Scale (Adorno, Frenkel-Brunswick, Levinson, and Sanford 1950) to American College students reported that the Dogmatism Scale was a better measure of general authoritarianism than the California F Scale ($N = 2350$).

Zagona and Zurcher (1964, pp. 255-264) in selecting groups for extremes of open-closed systems by use of the Dogmatism Scale. The groups were then observed to determine the extent to which dogmatic and nondogmatic characteristics would be demonstrated in a group situation. The characteristics of high dogmatics demonstrated were: (1) Leader orientation and active concern over leader selection, (2) a need for structured topics and situations rather than spontaneous expression, (3) disturbance when authority figures did not meet up to role expectations, and (4) waivering of conviction and decreased group cohesion when challenged by an authority figure. The researchers reported that "virtually every dogmatism hypothesis tested here was confirmed" (Zagona and Zurcher 1964, p. 264).

Kerlinger and Rokeach (1966, pp. 391-399) did factor analysis of the California F Scale (for the measure of authoritarianism) and the Dogmatism Scale (DS). In a second order factor analysis they demonstrated that the DS represented a generalized authoritarianism independent of a particular ideological content.

The Dogmatism Scale came out in five editions with revisions, by addition and deletion of questions to increase reliability. A table of "Reliabilities, Means, and Standard Deviations of Successive Forms of the Dogmatism Scale" may be seen in Appendix II.

The questionnaire for administration to the patients was developed by the researcher (Appendix III). This instrument was evaluated for face validity by three experts in psychological measurement, doctoral candidates in psychology, and one Ph.D. in psychology, and two doctoral candidates who had completed all requirements for a Ph.D. except their dissertation. All three experts had completed at least two courses in research design, and three courses in statistics at the graduate level.

Data Collection

The data for this study were collected over a one-week period for the patients (May 24 through May 31, 1978) and a two-week period for the nurses (May 24 through June 7, 1978). The DS for the nurses' completion were distributed along with an information sheet explaining the purpose of the study, the requirements, potential risks, and benefits of the study. As the arrangement for a specific area and time for the nurses to complete the DS could not be arranged in accordance with the practicality of the working conditions, the nurses were requested to complete the DS at their leisure and return them either to the researcher or in a collection envelope provided for each unit. All forms had been coded by an uninvolved individual and were returned in an envelope bearing the nurse's code letter and unit to maintain anonymity. Any envelopes returned to the researcher were slipped into a folder with other returned envelopes in such a way as to avoid the researcher's seeing the code letter. The nurses were also given written assurance that specific results of the study would not be shared with their employer or peers.

The patient questionnaires were distributed during the same time interval as the nurses'. The patients were provided with an oral and written description of the study analogous to that provided for the nurses. As it was not possible to secure a specific area of privacy for the patients to complete the questionnaire, they were requested to complete the questionnaire at their leisure and comfort. The patients were then requested to return the forms to the researcher or in a collection envelope provided on each unit. The patient questionnaires were anonymous, bearing only the unit number and were returned in envelopes bearing only the unit number. The patients were assured that the results would not and could not be shared with the nursing personnel.

Treatment of Data

The instructions for statement response on the DS were as follows: "Write +1, +2, +3, or -1, -2, -3, depending on how you feel in each case:

+1 - I agree a little
+2 - I agree on the whole
+3 - I agree very much

-1 - I disagree a little
-2 - I disagree on the whole
-3 - I disagree very much"

(Rokeach 1960, p. 73).

For all statements agreement or a positive number is indicative of high dogmatism, and disagreement or negative scores are indicative of low dogmatism. The total score on the DS is obtained by addition of scores on all items (Rokeach 1960, p. 70).

On the patient questionnaire, the "never," "rarely," "once in a while," "fairly often," "often," "most of the time," always," responses were assigned numerical value, zero through six respectively, and averaged for each nurse. The dogmatism level of the nurses was compared with the average of the patients' scores for ease of verbalization in a Pearson Product-Moment Correlation Coefficient. A t-test was done to determine significance. The .05 level of significance was observed.

Summary

Specified approval for research involving human subjects was obtained, and methods for obtaining participant consent conducted accordingly. Participants were enlisted according to study definitions, and written consent for participation was given by participants on the standard consent form of the host institution.

The Rokeach Dogmatism Scale was administered to nurse participants (N=9) to determine their levels of dogmatism. Patient participants (N=22) completed a questionnaire on which they were asked to express their felt ease of verbalization.

The scores the nurses received on the DS and from the patients were compared for correlation by a Pearson Product Moment Correlation Coefficient. A t-test was then performed to determine the level of significance.

CHAPTER IV

ANALYSIS OF DATA

This chapter presents the analysis of data. The data for this study were collected over a two-week period, May 24 to June 7, 1978, on three psychiatric units of a government hospital in central Texas. Demographic data on the study populations were collected and categorized and will be presented utilizing descriptive statistics. One hypothesis was proposed in this study: There is no relationship between the level of dogmatism in psychiatric nurses and psychiatric patients' expressed ease of verbalization. This relationship was analyzed by utilizing the Pearson Product Moment Correlation Coefficient, and t-test to examine the nurses' scores on the Dogmatism Scale and the patients' ratings of the nurses. These data follow the demographic data reported.

The demographic data for the nurse population were collected from the nurses themselves. For the nurse population the demographic data considered relevant and collected were sex, race, age, education, years of nursing experience, and years of psychiatric nursing experience. Means presented for all data which were

collected in interval form were figured by the mean of each interval. Correlations between these demographics and dogmatism scores were calculated. Means presented for all data which were collected in interval form were figured by the mean of each interval.

The patient demographics were obtained from the patients' charts by the researcher rather than in conjunction with their questionnaires. This was done because it was felt that questionnaires void of any personal identification would elicit more truthful responses from the patients about the nurses. Therefore, patient responses cannot be statistically correlated with their demographics, but will be described. The patient demographics collected were sex, race, age, education, diagnosis, and number of previous psychiatric hospitalizations in the study setting.

One variable for consideration in viewing the data outcome is the sample size. Two nurses declined to participate, and four nurses who were group therapy leaders were excluded from participation by study definitions. A resulting sample size of N=9 (dogmatism scores) was obtained. With a sample size this small, it is difficult to determine any level of significance.

Demographic variables associated with both sets of participants which may have had an effect on this research are: sex, race, and age. The populations were each homogeneous, with 100 percent of the nurses female, and 100 percent of the patients male. This was a representative sample of the hospital populations.

Both groups of participants were fairly similar according to race. The nurse population was 86 percent Caucasian, and 14 percent Black, which is a fair racial representation of the nurses in this setting. The patient population was 91 percent Caucasian, 4.5 percent Black, and 4.5 percent Puerto Rican. A representative population would have included a larger percentage of Blacks; however, the majority declined to participate.

Computing the mean age of the nurses by the mean of each range yielded a mean of 43 years, with a median range of 46 - 50. The mean patient age was 43.53 years, with a median of between 49 - 50 years. Both study populations were a fair representation of the hospital population for age. The sex, race, and age demographics of the study populations are presented in Table 1.

TABLE 1

COMPARISON OF NURSES' AND PATIENTS' SEX, RACE, AND AGE BY PERCENTAGE

NURSES			PATIENTS		
Sex					
Sex	Percentage	Number	Sex	Percentage	Number
Female	100	7	Female	0	0
Male	0	0	Male	100	22
Total	100	7	Total	100	22
Race					
Race	Percentage	Number	Race	Percentage	Number
Caucasian	86	6	Caucasian	91	20
Black	14	1	Black	4.5	1
--			Puerto Rican	4.5	1
Total	100	7	Total	100.0	22
Age					
Age	Percentage	Number	Age	Percentage	Number
20-25	0	0	21	4.5	1
26-30	14.29	1	25	9.0	2
31-35	14.29	1	28	4.5	1
36-40	0	0	30	4.5	1
41-45	14.29	1	35	9.0	2
46-50	14.29	1	44	4.5	1
51-55	28.57	2	47	4.5	1
56-60	14.29	1	48	4.5	1
			49	4.5	1
			50	9.0	2
			51	4.5	1
			52	4.5	1
			53	9.0	2
			54	13.5	3
			61	9.0	2
Total	100.00	7	Total	100.0	22

A study population of 100 percent female nurses and 100 percent male patients, in the researcher's opinion, could influence the results of this study. From the researcher's experience it has been noted that many times patients who are in an all male hospital living situation, will make special effort to socialize and communicate with females involved in the environment. This variable situation would, in all likelihood, increase the patients' ratings of the nurses. On the other hand, some patients who have lived under these conditions of minimal female contact become institutionalized to the point that it is difficult for them to talk with females. This could cause a lowering of patient ratings. The similar racial compositions of both groups could also have had an effect on the results of this study. Persons of similar racial or ethnic backgrounds are often able to relate and communicate more easily than persons from dissimilar backgrounds. The racial balance of the populations may have predisposed patients to verbalization ease, and, therefore, increased patient ratings.

The age demographics may have had effect on the results similar to the race demographics. Persons of similar age may also experience greater ease of verbalization with each other than between persons of dissimilar

age. Also, as mentioned earlier, authoritarian attitudes have been seen to increase with age (Bordeleau et al. 1970, pp. 1166-1168; Robinson 1972, pp. 235-238). These age related authoritarian attitudes have also been reported to be associated with negative stereotype attitudes and custodial rather than humanistic attitudes toward the mentally ill (Hood 1974, pp. 543-548). If these attitudes are projected, they could typically have decreased patients' verbalization ease and their rating.

Closely associated to age are the nurse demographic variables of nursing experience and experience in psychiatric nursing. The mean number of years in nursing was sixteen years, with 86 percent of the nurses having more than six years, and 28.57 percent having 31 or more years of nursing. The mean number of years working on psychiatry was 6.14 years. Had all nurses in this setting been included in this study, these means may have been somewhat higher. In viewing this nursing population by percentage for years of experience on psychiatry, the following was noted: 14.29 percent with less than 2 years; 28.58 percent with less than 5 years; 71.42 percent had more than 6 years; and 42.85 percent of these (the largest single category) had 11-15 years. Nurse experience demographics are presented in Table 2.

TABLE 2

YEARS OF NURSING EXPERIENCE AND YEARS OF PSYCHIATRIC NURSING EXPERIENCE BY PERCENTAGE

Number of Years in Nursing	Percentage	Number	Number of Years in Psychiatric Nursing	Percentage	Number
0 - 2	0	0	0 - 2	14.29	1
3 - 5	14.29	1	3 - 5	14.29	1
6 - 10	28.57	2	6 - 10	28.57	2
11 - 15	28.57	2	11 - 15	42.85	3
16 - 20	0	0	16 - 20	0	0
21 - 25	0	0	21 - 25	0	0
26 - 30	0	0	26 - 30	0	0
31 - 35	28.57	2	31 - 35	0	0
Total	100.00	7	Total	100.00	7

The years of experience of the nurses in this study may have had an effect on the results. Mathews (1962, pp. 154-162) reported that patient centered responses decreased as years since graduation from nursing school increased. However, nurses with less experience may be less certain of how to conduct themselves, and have difficulty placing themselves in the counseling role (Haber et al. 1977, p. 73). Yalom (1974, p. 142) states that it is often difficult for the beginning therapist to recognize the implications in different interpersonal transactions, or the interpersonal process.

Generally, a beginning nurse is not as skilled in interpersonal relationship as an experienced psychiatric nurse or psychotherapist (Evans 1971, p. 132) although they may be more open minded in dealing with psychiatric patients (Bordeleau 1970, pp. 1166; Robinson 1973, pp. 235-238; Hood 1974, pp. 543-548).

The nurse population for this study consisted of 29 percent licensed practical nurses and 71 percent registered nurses. The mean years of education for the nurses was 14.3 years. This was lower than would be representative of the nursing population in this setting. The mean years of education of the patient population was 12.3 years, with 60.07 percent having twelve years or less. A total of 39.93 percent had attended college, with 9.09 percent of these receiving baccalaureate degrees, and 4.55 percent a master's degree. These demographic data are itemized in Table 3.

As might be expected, the nurse participants in this study had more years of formal education than the patients. An individual's level of knowledge is a factor in one's ability to send and perceive messages and the depth with which one communicates. If the nurse then does not accommodate to the patient and communicate on a level which the patient can understand, a definite block

Table 3

COMPARISON OF NURSE-PATIENT EDUCATION
BY PERCENTAGE

Nurses' Years of Education	Percent of Total	Number	Patients' Years of Education	Percent of Total	Number
13 (LPN)	29	2	6	4.54	1
14 (ADRN)	14	1	8	9.09	2
15 (RN			10	4.54	1
diploma)	57	4	11	4.54	1
			12	36.36	8*
			13	18.18	4
			14	4.54	1
			15.75	4.54	1
			16	9.09	2
			18	4.54	1
Total	100	7	Total	100.00	22
Mean years:	14.285		Mean years:	12.307	

*Twelve years education was attributed to persons who had taken a high school equivalency exam. Of this segment of the population, four had less than ten years formal education with an equivalency exam.

to communication can occur and affect patients' ease of verbalization, regardless of other personality variables. The level of education of the individual nurse can also affect nurse characteristics and communication with patients. White (1975, pp. 160-162) reported that there was a positive relationship between years of education and autonomy, flexibility, and leadership qualities. It is the researcher's opinion that these nurse characteristics can facilitate communication with patients. Robinson (1972, pp. 235-238) reported that education of the nurses had a negative relationship with authoritarian attitudes characterized by perception of the mentally ill as an inferior class requiring handling, and a positive relationship to introspection, interest in the feelings and motives of others, and a tendency to analyze the behavior of others. Attitudes of social restrictiveness and authoritarianism toward the mentally ill were reported by Walsh (1971, p. 526) to decrease significantly with courses in psychiatric nursing. These results indicate that attitudes and characteristics which develop with increased education have a positive effect on nurse-patient communication.

Patient participants in this study represented a variety of diagnoses. Alcoholics comprised one unit in the study and represented the largest diagnostic category with 41 percent of the total population. A portion of this segment had an accompanying neurotic diagnosis, but were categorized according to their primary admitting diagnosis of alcoholism. The second largest group was depressives, comprising 22.5 percent, and the paranoid schizophrenics the third largest, with 14 percent. The remainder of the diagnostic categories were: drug-dependence, depression with anxiety, organic brain syndrome, schizophrenia--catatonic suspected, and obsessive compulsive in a schizoid personality, each representing 4.5 percent of the population. From the standpoint of diagnostic categories, this population was 44.5 percent drug dependent, 22.5 percent affective disorders, 4.5 organic disorder, 4.5 percent personality disorder, and 18.5 percent psychosis. These data are presented in Table 4 and are fairly representative of this population.

Patient personality characteristics, as may be reflected in their diagnosis, could also have affected their responses about the nurses, regardless of any personality variables which the nurses themselves possess. Alcoholics, for example, are often dependent personalities

TABLE 4

DIAGNOSIS AND DIAGNOSTIC CATEGORIES OF PATIENT PARTICIPANTS BY PERCENTAGE

Diagnostic Categories	Diagnosis	Percentage	N
Drug Dependence	Alcoholism	41.0	9
	Drug dependence - alcohol and amphetamines	4.5	1
Affective Disorders	Depression	22.5	5
	Depression with Anxiety	4.5	1
Personality Disorder	Obsessive Compulsive - in a schizoid personality	4.5	1
Organic	Organic Brain Syndrome	4.5	1
Psychotic	Schizophrenia - catatonic suspected	4.5	1
	Schizophrenia - Paranoid	14.0	3
Totals		100.0	22

with a low tolerance for anxiety (Rowe 1970, p. 103). Manipulation is often employed in an attempt to meet dependency needs and decrease anxiety. These attempts often take on the character of deception through insincerity, fabrication, rationalization, or denial (Haber et al. 1977, p. 294). The patients on the alcohol unit may have responded more positively about the nurses than is reality-oriented if, for example, denial of any social difficulty was operating.

The two general psychiatry units used in this study had a different variety of patient than the alcohol unit, i.e., those with diagnoses of depression and of schizophrenia, some of these paranoid types. The premorbid personality of depressive individuals is often described as shy, sensitive, and pessimistic (Rowe 1970, p. 137). The depressive state further carries with it loss of interest and withdrawal from social contacts, even discouraging them as offered, and ambivalence or angry feelings which interfere with social intercourse (Haber et al. 1977, p. 309; Rowe 1970, p. 137). Therefore, the depressive patient's characteristic social withdrawal, and at times, own ambivalence or anger, could have affected his expressed ease of verbalization.

Within the schizophrenic regression is considered the primary cognitive defense utilized (Haber et al. 1977, p. 224; Rowe 1970, p. 157). This regression often results in withdrawal from or loss of interest in the environment or relationships, and impairment of reality testing (Haber et al. 1977, pp. 224-226). Although all participants were sufficiently reality-oriented to be on an open unit, some of their own withdrawal or misinterpretation of reality may have affected their felt or expressed verbalization ease. When the facet of paranoia is added to the schizophrenic personality, the elements of suspicions or mistrust of others and the defense of projection are often in operation. Therefore, it is possible that the paranoid patients responded about the nurse in relation to their own general mistrust or the projection of their own feelings of not being easy to talk to.

Along with diagnosis, the number of psychiatric admissions to the hospital where the study was conducted could have had an effect on patient responses. The average number of admissions of the patient population to the government hospital where the study was conducted was 3.06, with 54.54 percent of the patients were on their first or second admission at the time of the study.

Numbers of patients were fairly evenly distributed between third and sixth admission, with this group totalling 40.91 percent of the total population. The remaining 4.55 percent of the population, represented by one individual, was on his ninth admission. These data are fairly representative of the population as a whole. The admission demographics are itemized in Table 5.

TABLE 5

PSYCHIATRIC ADMISSIONS OF THE PATIENT POPULATION TO THE STUDY SETTING BY PERCENTAGE

Number of Admissions	Percentage of Patients	Total Number of Patients
1	27.27	6
2	27.27	6
3	9.09	2
4	9.09	2
5	13.64	3
6	9.09	2
7	0	0
8	0	0
9	4.55	1
Total	100.00	22

Those patients with repeated psychiatric admissions to the study setting may have become comfortable with the surroundings and/or developed rapport with the

staff. This could have potentially increased their ease of verbalization with the nurses, regardless of other variables. Those on their first admission were likely less comfortable in this environment and with its nursing staff. This could have predisposed to decreased ratings of verbalization ease, as would be expected for an individual in a strange environment.

The first step taken in testing the hypothesis was to compute the dogmatism scores. Dogmatism scores were computed by the standard method of adding the numerical values accorded to levels of agreement with each statement. The range of possible scores was -120 through +120, with negative scores indicating low dogmatism, and positive scores indicating high dogmatism. The patients' responses to a Likert-type scale regarding ease of verbalization with each nurse were attributed values of zero through six by the researcher, with six indicating high verbalization ease. The mean rating for each nurse was then calculated. The dogmatism score and the mean patient rating for each nurse were set up in tabular form. These data were analyzed by a Pearson Product Moment Correlation Coefficient was then computed with a resulting correlation of -0.39. Level of significance, as computed by a t-test was $p < .25$. Although a trend

may be indicated, the correlation was nonsignificant. The hypothesis of this study was, therefore, rejected.

The dogmatism scores of the nurse population (N=9) reflected low dogmatism, with a mean score of -22.44. Only one nurse had a positive score for high dogmatism. The remainder of the nurses had scores from -17 to -47 on the low dogmatism side of the scale. Low dogmatism has been correlated with therapeutic effectiveness in previous studies (Canter 1963, pp. 124-127; Moody 1971, pp. 172-175; Boland 1973, pp. 5614-5616; Mlott 1976, pp. 19-23). The results of this would tend to support the literature, as it was noted that: (1) the nurses generally obtained low dogmatism scores and patient ratings all above average, and (2) the nurses with the two highest dogmatism scores received the two lowest patient ratings (Table 6).

The overall mean patient rating for the nurses was 4.4. The mean patient rating for the nurses on the alcohol treatment unit, Unit I, was 5.3, which was the highest of all units. Mean patient ratings of 4.1 and 4.3, respectively, were obtained on Units II and III for general psychiatry. The nurses who worked both Units I and II in the evenings received different patient ratings on each unit, which would tend to indicate that some

TABLE 6

NURSE DOGMATISM SCORES AND MEAN PATIENT RATINGS FOR EASE OF VERBALIZATION

Unit	Nurses' Code	Dogmatism Score	Mean Patient Rating
I	B	-17	5.2
Alcohol	E	-35	5.3
Treatment			
II	A	-47	4.5
General	B	-17	3.5
Psychiatry	E	-35	4.5
	F	+48	3.8
III	A	-35	4.1
General	B	-33	4.1
Psychiatry	C	-31	4.6
		Mean: 22.44	Mean: 4.4

N=9 on Table 6 because nurses B and E on Units I and II worked both units on evening shift at the time of the study.

variables other than the nurses' personality characteristics had an effect on the ratings. Nurse B on Units I and II, with a dogmatism score of -17, received a patient rating of 5.2 on Unit I for alcohol treatment, and a 4.5 on Unit II for general psychiatry. Nurse E on Unit I and II, with a dogmatism score of -35, received a patient rating of 5.3 on Unit I, and a 4.5 on Unit II. The dogmatism scores and mean patient rating for each nurse are presented in Table 6.

Demographics collected on the nursing population are: sex, race, age, education, years of nursing experience, and years of psychiatric nursing experience, were correlated with their dogmatism scores. All yielded nonsignificant correlations. A trend was seen, however, in the negative correlation between education and dogmatism ($p < .125$). This negative correlation is supported in the literature (Walsh 1971, p. 526; Robinson 1973, pp. 235-238), and also carries with it implications for nursing.

Conclusion

An analytic survey involving seven nurses and twenty-two patients at a government hospital was undertaken to investigate the relationship, if any, of nurse dogmatism and patients' verbalization. The nurses' level of dogmatism was determined by their scores on the Rokeach Dogmatism Scale (Appendix II), and the patients' expressed ease of verbalization with each nurse was measured by a researcher-developed questionnaire (Appendix

IV). The dogmatism scores and the mean patient rating for each nurse was ascertained as described in "Treatment of Data," put in a table, and presented in Table 1. Statistical tests applied to these data indicated a trend, and yet no significant correlation could be shown. Therefore, from this study, no relationship between the level of dogmatism of psychiatric nurses and psychiatric patients' expressed ease of verbalization was shown, and the hypothesis was rejected. The variables which may have affected these results are a small sample size, patient characteristics, previous hospitalization, and/or previous nurse-patient acquaintance, setting and population of a government hospital, nursing education and experience, and patient education. Only one variable, nurse education, approached a significant correlation with level of dogmatism.

CHAPTER V

SUMMARY

The purpose of this analytic survey was to examine what relation, if any, exists between the level of dogmatism of the psychiatric nurses' and the psychiatric patients' perceived ease of verbalization. The theoretical basis and tool for this study were the works of Milton Rokeach. In his primary work, The Open and Closed Mind, 1960, he proposed his theory of dogmatism. In accordance with his theory, Rokeach developed his Dogmatism Scale for measuring general authoritarianism and general intolerance, the components of dogmatism. Numerous studies can be found in the literature validating the Dogmatism Scale (Plant 1960, p. 164; Zagona and Zurcher 1964, pp. 255-264; Kerlinger and Rokeach 1966, pp. 391-399.) Reliability for the Dogmatism Scale are presented in Appendix III.

The Dogmatism Scale was given to psychiatric nurses (n=7) at a government hospital in Central Texas. The psychiatric patients at this hospital were given a

questionnaire on which they were asked to express their felt ease of verbalization with each nurse. The data were categorized, then analyzed by a Pearson Product Moment Correlation Coefficient. Level of significance was set $\alpha = .05$. No statistically significant correlation between the level of psychiatric nurse dogmatism and the psychiatric patients' ease of verbalization was determined by this study.

A trend was approaching, however, as dogmatism scores and patient ratings were compared. It was shown that those nurses with the lower dogmatism scores (reflected in the literature as correlating with increased therapeutic effectiveness) had the higher patient rating scores.

Conclusions

1. There was no statistically significant correlation between the level of psychiatric nurse dogmatism and the psychiatric patients' ease of verbalization determined by this study. However, the sample size, the setting, the population, and other variables in this study may contribute to this outcome.

2. There was no statistically significant correlation obtained between nurse dogmatism scores and the demographic variables of sex, race, age, years of nursing experience, and years of psychiatric nursing experience.

3. There was no statistically significant correlation between the educational level of the nurses and their dogmatism scores although a trend was noted ($p < .125$).

4. With a sample size of N=7, partially due to exclusion of group therapy leaders, it is difficult to determine any level of significance.

5. The population variables of sex, race, and age may have an effect on the patients' ease of verbalization and consequent patient ratings.

6. The sexual demographics of the groups studied, nurses 100 percent female and patients 100 percent male, may have increased the patients' ratings due to transference and limited female contact in this setting, or decreased patient ratings due to loss of socialization skills with the opposite sex from institutionalization.

7. The similar racial compositions of the nurse and patient groups may have led to increased patient scores due to the influence of ethnocentric variables.

8. The similar age levels of the nurse and patient groups may have predisposed the patients to increased ease of verbalization and consequent high patient ratings for the nurses.

9. Years of nursing experience and/or years of psychiatric nursing experience may affect a nurse's approach, which may affect the patients' communicative ease and related patient ratings in this study.

10. Discrepancies in the educational levels of the nurse and patient population, in situations where the nurses generally have more education than the patients, may be a block to patient verbalization and result in lower patient ratings.

11. Patient personality characteristics, as may be reflected in their diagnosis, has an effect on their responses about the nurses.

12. Patients with alcoholism diagnoses gave high nurse ratings.

13. Patients with affective disorders or psychosis gave low nurse ratings.

14. The number of previous psychiatric hospitalizations at the hospital where the study was conducted may have affected the patients' ease of verbalization.

15. The nurses with the two highest dogmatism scores received the two lowest patient ratings.

16. The results of this study can be generalized to the sample population in this study only.

Implications for Nursing

Components of the therapeutic interpersonal patient relationship have been theorized and studied in recent years. However, no substantial empirical data base has been established regarding personality variables of nurses which can affect this relationship in the research that has been done on characteristics associated with dogmatism, which is primarily psychological, appeared to indicate its negative relationship to therapeutic effectiveness. In a search of the

literature no research was found on the effect of nurse dogmatism on patient verbalization. In this study on this topic no relationship was found. This indicates that more research in nursing is necessary to form an adequate data base for clarification of personality variables which affect ease of verbalization, particularly nurse dogmatism and ease of verbalization.

In the research available dogmatism is reported to be negatively correlated to therapeutic effectiveness. Knowledge of empirical data forms the basis for evaluation. Introspection is then necessary for each nurse to identify characteristics one possesses, and evaluate them for therapeutic effectiveness. Only when objective self-awareness is established can the nurse plan for the development of the therapeutic self.

As evidenced in the literature (Walsh 1971, p. 526; Robinson 1973, pp. 235-238) and by a trend in this study, that dogmatism is also negatively associated with education. Therefore, education seems to be one of the keys to therapeutic effectiveness. If increased education decreases dogmatism and increases therapeutic effectiveness, it is imperative that quality education be provided in nursing schools and in continuing education for all areas of nursing, but particular to this

context, psychiatric. It is the ethical responsibility of all nurses to see that such high standards of education are established and maintained.

Patient characteristics also have an effect on the therapeutic relationship. As was seen in the analysis of data, the alcoholic patients expressed more ease of verbalization than did the patients with neurotic and psychotic diagnoses. Therefore, psychiatric patient personality must be taken into consideration when evaluating verbalization ease. Emphasis on characteristics and therapeutic approach associated with individual diagnostic categories should appropriately be emphasized in nursing education. To promote quality patient care, it is imperative that psychiatric care agency provides and encourage continuing education, with similar diagnostic emphasis for its employees. Nurses must also take responsibility to take advantage of learning opportunities, become aware of the significance of patient personality variables, and practice individualized therapeutic approach.

There is a need for nurses to develop an empirical data base on the significance of the demographic variables sex, race, and age, in interpersonal relationships. This would facilitate the development

of a validated therapeutic approach. Principles of this nature could be beneficially utilized at all levels of nursing.

Recommendations

Based on the results of this study and analysis of demographic variables, the following recommendations are made.

1. That further research be done on the relationship between the level of psychiatric nurse dogmatism and psychiatric patient verbalization in different settings with larger populations

2. That further research be done on the relation of other individual personality variables of nurses to patients' ease of verbalization

3. In future studies on nurse-patient communication, all nurses who the patient has contact with should be included

4. That studies on patient communication be undertaken including all members of the health care delivery system

5. That further studies be undertaken to determine the effect of an individual's education on his communication system

6. That further research on nurse dogmatism and patient verbalization with nurse and patient populations of heterogeneous sexual composition, and greater variety of ages than this study setting provided

7. That further research be undertaken to determine the effect of sex, race, and age variables on nurse-patient relationships and communication

8. More extensive investigation of the relationship of years of experience in nursing and/or psychiatric nursing to the nurses' approach to patients and patient communicative ease

9. That patient personality and demographic variables be related to their perceived or expressed ease of verbalization

10. That further research be done comparing different patient diagnosis to expressed ease of verbalization

11. That further research be done on nurse-patient communication as related to different levels of acquaintance

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APPENDIX I

DOGMATISM SCALE

APPENDIX I - DOGMATISM SCALE

The following is a study of what the general public thinks and feels about a number of important social and personal questions. The best answer to each statement below is your personal opinion. We have tried to cover many different and opposing points of view; you may find yourself agreeing strongly with some of the statements, disagreeing just as strongly with others, and perhaps uncertain about others; whether you agree or disagree with any statement, you can be sure that many people feel the same as you do.

Mark each statement in the left margin according to how much you agree or disagree with it. Please mark every one. Write +1, +2, +3, or -1, -2, -3, depending on how you feel in each case.

+1:	I AGREE A LITTLE	-1:	I DISAGREE A LITTLE
+2:	I AGREE ON THE WHOLE	-2:	I DISAGREE ON THE WHOLE
+3:	I AGREE VERY MUCH	-3:	I DISAGREE VERY MUCH

_____ 1. The United States and Russia have just about nothing in common.

_____ 2. The highest form of government is a democracy and the highest form of democracy is a government run by those who are most intelligent.

_____ 3. Even though freedom of speech for all groups is a worthwhile goal, it is unfortunately necessary to restrict the freedom of certain political groups.

_____ 4. It is only natural that a person should have a much better acquaintance with ideas he believes in than with ideas he opposes.

_____ 5. Man on his own is a helpless and miserable creature.

APPENDIX I - DOGMATISM SCALE

_____ 6. Fundamentally, the world we live in is a pretty lonesome place.

_____ 7. Most people just don't give a "damn" for others.

_____ 8. I'd like it if I could find someone who would tell me how to solve my personal problems.

_____ 9. It is only natural for a person to be rather fearful of the future.

_____ 10. There is so much to be done and so little time to do it in.

_____ 11. Once I get wound up in a heated discussion I just can't stop.

_____ 12. In a discussion I often find it necessary to repeat myself several times to make sure I am being understood.

_____ 13. In a heated discussion I generally become so absorbed in what I am going to say that I forget to listen to what the others are saying.

_____ 14. It is better to be a dead hero than to be a live coward.

_____ 15. While I don't like to admit this even to myself, my secret ambition is to become a great man, like Einstein, or Beethoven, or Shakespeare.

_____ 16. The main thing in life is for a person to want to do something important.

_____ 17. If given the change I would do something of great benefit to the world.

_____ 18. In the history of mankind there have probably been just a handful of really great thinkers.

APPENDIX I - DOGMATISM SCALE

_____ 19. There are a number of people I have come to hate because of the things they stand for.

_____ 20. A man who does not believe in some great cause has not really lived.

_____ 21. It is only when a person devotes himself to an ideal or cause that life becomes meaningful.

_____ 22. Of all the different philosophies which exist in this world there is probably only one which is correct.

_____ 23. A person who gets enthusiastic about too many causes is likely to be a pretty "wishy-washy" sort of person.

_____ 24. To compromise with our political opponents is dangerous because it usually leads to the betrayal of our own side.

_____ 25. When it comes to differences of opinion in religion we must be careful not to compromise with those who believe differently from the way we do.

_____ 26. In times like these, a person must be pretty selfish if he considers primarily his own happiness.

_____ 27. The worst crime a person could commit is to attack publicly the people who believe in the same thing he does.

_____ 28. In times like these it is often necessary to be more on guard against ideas put out by people or groups in one's own camp than by those in the opposing camp.

_____ 29. A group which tolerates too much differences of opinion among its own members cannot exist for long.

APPENDIX I - DOGMATISM SCALE

_____ 30. There are two kinds of people in this world: those who are for the truth and those who are against the truth.

_____ 31. My blood boils whenever a person stubbornly refuses to admit he's wrong.

_____ 32. A person who thinks primarily of his own happiness is beneath contempt.

_____ 33. Most of the ideas which get printed nowadays aren't worth the paper they are printed on.

_____ 34. In this complicated world of ours the only way we can know what's going on is to rely on leaders or experts who can be trusted.

_____ 35. It is often desirable to reserve judgment about what's going on until one has had a chance to hear the opinions of those one respects.

_____ 36. In the long run the best way to live is to pick friends and associates whose tastes and beliefs are the same as one's own.

_____ 37. The present is all too often full of unhappiness. It is only the future that counts.

_____ 38. If a man is to accomplish his mission in life, it is sometimes necessary to gamble "all or nothing at all."

_____ 39. Unfortunately, a good many people with whom I have discussed important social and moral problems don't really understand what's going on.

_____ 40. Most people just don't know what's good for them.

(This is an exact replication of DS from Rokeach 1960, p. 73.)

APPENDIX II

RELIABILITIES, MEANS, AND STANDARD DEVIATIONS OF SUCCESSIVE FORMS OF THE DOGMATISM SCALE

APPENDIX II - RELIABILITIES, MEANS, AND STANDARD DEVIATIONS OF SUCCESSIVE FORMS OF THE DOGMATISM SCALE

Form	Number of Items	Group	No. of Cases	Reliability	Mean	SD
A	57	Mich. State U. I	202	.70	182.5	26.2
B	43	New York colleges	207	.75	141.3	27.2
C	36	Mich. State U. II	153	.73	126.9	20.1
		Mich. State U. III	186	.71	128.3	19.2
		Purdue U.	171	.76	----	----
D	66	English Colleges I	137	.91	219.1	28.3
E	40	English Colleges II	80	.81	152.8	26.2
		English workers	60	.78	175.8	26.0
		Ohio State U. I	22	.85	142.6	27.6
		Ohio State U. II	28	.74	143.8	22.1
		Ohio State U. III	21	.74	142.6	23.3
		Ohio State U. IV	29	.68	141.5	27.8
		Ohio State U. V[a]	58	.71	141.3	28.2
					143.2	27.9
		Mich. State U. IV	89	.78	-----	----
		VA Domiciliary	80	---	183.2	26.6
			24	.93	-----	----
			17	.84	-----	----

[a]The Ohio State U. V reliability was obtained by a test-retest, with five to six months between tests. The reliability of .84 for the VA group was obtained in the same way with at least a month between tests.

(SD = standard deviation)

(This is the exact replication from Rokeach 1960, The Open and Closed Mind.)

APPENDIX III

PATIENT QUESTIONNAIRE

APPENDIX III - PATIENT QUESTIONNAIRE

The best answer to each statement is your own personal feeling. These answer sheets are coded to maintain confidentiality. Please return only this answer sheet in the envelope and seal it.

	Never	Rarely	Once in a while	Fairly often	Often	Most of the time	Always
I feel at ease to talk to nurse A	—	—	—	—	—	—	—
I feel at ease to talk to nurse B	—	—	—	—	—	—	—
I feel at ease to talk to nurse C	—	—	—	—	—	—	—
I feel at ease to talk to nurse D	—	—	—	—	—	—	—
I feel at ease to talk to nurse E	—	—	—	—	—	—	—
I feel at ease to talk to nurse F	—	—	—	—	—	—	—

(This is an investigator-developed questionnaire.)

APPENDIX III - PATIENT CODE SHEET

These answer sheets are coded to maintain confidentiality. The letters were assigned simply by chance. Please discard this part of the answer sheet.

Nurse A -

Nurse B -

Nurse C -

Nurse D -

Nurse E -

Nurse F -

(This is an investigator-developed questionnaire.)

APPENDIX IV

DEFINITIONS OF EDWARDS PERSONAL PREFERENCE SCHEDULE (EPPS)

APPENDIX IV - DEFINITIONS OF EDWARDS PERSONAL PREFERENCE SCHEDULE - EPPS

1. Achievement -	To accomplish something different; to be a success; to do one's best.
2. Deference -	To respect superiors; to respect authority; to accept leadership; to conform to custom.
3. Order -	To like order; to aim for perfection in detail; to have things planned and organized.
4. Exhibition -	To be the center of attention; to make an impression; to have an audience.
5. Autonomy -	To be free to do what you want; to defy convention; to be critical of authority.
6. Affiliation -	To please and win affection; to be loyal to friends; to form strong attachments.
7. Introception -	To be introspective; to be interested in motives and feelings; to analyze the behavior of others.
8. Succorance -	To desire sympathy; to want encouragement; to have others interested in your problems.
9. Dominance -	To dominate others; to be a leader; to influence others to make decisions.
10. Abasement -	To feel inferior; to feel guilty; to feel timid; to withdraw from unpleasant situations.
11. Nurturance -	To sympathesize with others; to be generous with others; to encourage others.

APPENDIX IV - DEFINITIONS OF EDWARDS PERSONAL PREFERENCE SCHEDULE - EPPS

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12. Change -	To try new and different things; to like to travel; to experience novelty and change.
13. Endurance -	To persist; to keep at a task until it is finished; to put in long hours of uninterrupted work.
14. Heterosexuality -	To enjoy heterosexual activities; to be interested in the opposite sex.
15. Aggression -	To criticize others publicly; to tell others what one thinks of them; to become angry.

(This is a replication from Navran and Stauffacher 1957, pp. 109-114.)

APPENDIX V

SIGNIFICANT CORRELATIONS BETWEEN DOGMATISM AND 59 PERSONALITY SCALES

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Test	Correlation with Dogmatism*
EPPS	
Intraception	-.21
Succorance	.25
Change	-.25
TSCS	
Self-esteem	-.34
Self-satisfaction	-.38
Behavior	-.28
Physical self	-.31
Moral-ethical self	-.25
Personal self	-.31
Distribution score	-.21
True/false ratio	-.24
Defensive	.30
General maladjustment	.31[a]
Personality disorder	.26[a]
Neurosis	.35[a]
16 PF	
C Affected vs. emotionally stable	-.31
E Humble vs. assertive	-.25
H Shy vs. venturesome	-.24
Q_1 Conservative vs. experimenting	-.23
Q_4 Relaxed vs. tense	.24

a Scale is inverted
* p .05

(This is an exact replication from Vacchiano, Ralph; Strauss, Paul S.; and Schiffman, David C. 1968. Personality Correlates of Dogmatism.)