HOSTILITY REACTIONS IN TRAUMA PATIENTS

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CHAPTER I

INTRODUCTION

In recent years trauma has come to the forefront as another area of specialization in both medicine and nursing. The primary focus has been on meeting the demands of a crisis situation and helping the patient achieve physiologic stability.

Once the patient's physiologic condition has been stabilized, a secondary concern is his emotional response to illness. Many emotional reactions occur in the patient due to the inherent unexpectedness of traumatic injury. The person who has experienced a traumatic injury may have hopes, plans, relationships, and even his self-image devastated in an instant. The degree of emotional response depends upon many factors such as the patient's coping ability and the extent of his injury.

This study will consider one type of emotional response, hostility. All men are capable of becoming hostile if they are prevented from obtaining satisfaction of their goals. A situational crisis such as a traumatic accident may temporarily or permanently prevent man from attaining his goals. Each individual will exhibit his own

unique patterns of coping with the crisis brought about by a traumatic injury.

Statement of Problem

The problem of this study was to determine whether or not trauma patients exhibited manifestations of hostility as a result of their injury compared to patients having a common surgical procedure.

Purposes

The purposes of this study were:

1. To determine whether or not trauma patients exhibited hostility

2. To determine whether or not there was a difference between the hostility reaction of trauma patients and the hostility reaction of appendectomy and cholecystectomy patients

3. To determine the subclasses of hostility that were exhibited such as assault, indirect hostility, irritability, negativism, resentment, suspicion, and verbal hostility

4. To determine whether or not there was a difference between the hostility reaction of traumatized men and the hostility reaction of traumatized women

Background and Significance

Trauma is a problem of increasing magnitude in the United States. It is the leading cause of death in the first three decades of life and ranks overall as the fourth leading cause of death in this country. Annually, 50 million injuries occur and over 10 million are disabling (United States Bureau of the Census 1975). Each year over 100,000 deaths occur from accidents in this country. In World War II, 290,000 United States battle deaths occurred, and at the same time, 450,000 United States civilians died from accidental causes (Schwartz 1974).

Injury effects the whole person. It is the person as a whole who responds to an injury with his personal methods of adaptation. His entire personality is the major factor that determines overall response to the injury. Tomlinson (1974) describes four reactions to trauma that are considered normal adaptations. These reactions are regression due to forced dependency, depression from the functional loss, anxiety as to the outcome of the injury, and reasonable denial of the extent and degree of injury.

Lee (1970) describes four phases in the recovery from traumatic injury. They are impact, retreat, acknowledgement, and reconstruction. The impact phase is essentially a state of shock after the original encounter

with the critical situation. When the reality of the situation becomes apparent, anxiety increases and the patient may retreat through denial. This gives the patient a chance to obtain some relief from the trauma and reorganize his coping abilities. In the acknowledgement phase, the patient accepts reality. A wide variety of behaviors may be exhibited here ranging from withdrawal to open rebellion. Reconstruction is the last phase in which the patient reorganizes his body image and social values. He also accepts any rehabilitative treatment necessary.

A person's concept about himself and the world may be permanently and unfavorably altered if the posttraumatic adaptation is unsuccessful (Tomlinson 1974). Consequently, there is a development of chronic anxiety states, depression, and fatigue as well as guilt, anger, and aggression. The aftermath of trauma may be characterized by chronic sorrow and discouragement. The patient may blame himself and others for his traumatic injury (Tomlinson 1974).

The hospitalized patient rarely exhibits hostility of a physically dangerous kind (Ryder 1972). His hostility is more likely to be verbal. Some of the manifestations of hostility are attack, violence, and revenge as well as sarcasm, teasing, gossip, and passive obstructiveness. Rothenberg (1971) cites a difference between feeling hostile

and being hostile. When a person feels hostile, he wishes or intends to inflict harm, pain, or some type of destruction on another. Being hostile, however, always involves the actual inflicting or trying to inflict some type of physical or psychological destruction on another. In either case, hostility is usually associated with a destructive component.

Nursing is concerned with the total picture of the patient and considers all of his needs, not just the physiologic survival needs. Luckmann and Sorenson (1975) feel that a patient cannot be adequately cared for unless he is made to feel safe, secure, loved, and like one who belongs instead of an outsider. The hostile patient is not always easy to recognize. The patient may express his hostility overtly. However, because society shuns the expression of hostility, it may be expressed in a covert manner. The nurse must recognize each individual's reaction to stress and identify and implement precise actions to assist the patient in coping. The patient must be given opportunities to discuss how he feels and what he is concerned about without feeling guilt or embarrassment (Roberts 1976).

Buss and Durkee (1957) developed an inventory for assessing different kinds of hostilities. They felt that a statement such as "he is hostile" is ambiguous because it could apply to both a man who beats his wife and a man who

is spitefully late for appointments. Clearly, they are both exhibiting different types of hostility. In his work with depressed patients, Weissman (1971) sees hostility as being elicited in certain situations and in relationship to certain persons. Consequently, hostility can vary from time to time depending on the situation.

Hypothesis

The following hypothesis was tested in this study: There would be no difference in the test scores of the trauma patients and the control group of appendectomy and cholecystectomy patients.

Definition of Terms

The definition of terms that were used in this study was:

Trauma patient--an individual who has been hospitalized as a result of an injury sustained from a violent force such as a gunshot, stabbing, or motor vehicle accident.

Appendectomy patient--an individual who has undergone a surgical procedure for the removal of an intact appendix with no other complicating factors.

Cholcystectomy patient--an individual who has undergone a surgical procedure for the removal of an inflamed gallbladder with no other complicating factors.

Hostility--a term which covers many diverse behaviors and attitudes. It involves either the wish or the actual infliction of some type of destruction, psychological or physical, upon another.

Limitations

The limitations of this study were:

1. The possibility that a patient may already have been hostile prior to his injury
2. The different socioeconomic and cultural backgrounds of the patients
3. The willingness of the patient to spend time answering the questionnaire
4. The test score reflected only how the patient responded at that particular point in time
5. Medications may have altered the hostile response
6. The different phases of recovery may have affected the responses

Delimitations

The delimitations of this study were:

1. Patients who were hospitalized as a result of a traumatic injury such as a gunshot, stabbing, or motor vehicle accident

2. Male and female patients between twenty-four and forty years of age who were posttrauma or postsurgery and were on a surgical unit

3. Patients who were mentally and physically capable of answering questions

4. Patients who were high school graduates

5. Patients who were able to read English and answer their own questionnaire

6. Patients without a diagnosed or suspected head injury

7. Patients who were not hospitalized as a result of self-inflicted injuries

Assumption

The assumption was that a crisis situation provokes emotional reactions in man which requires the use of coping mechanisms to return to a state of stability.

Summary

A patient experiences many emotional reactions as a result of hospitalization. The traumatically-injured patient must deal with feelings that result from the sudden and unexpected nature of his illness. Hostility is one emotional reaction that may result. The problem was to determine whether or not trauma patients exhibited

manifestations of hostility as a result of their injury as compared to patients having a common surgical procedure.

Chapter II contains a review of literature. The emotional response to hospitalization, crisis theory, and changes in body image are discussed. The trauma patient, hostility, and nursing care of the hostile patient are also presented.

The procedure for collection and treatment of data are described in Chapter III. The data were collected through the use of the Buss-Durkee Inventory. The inventory assesses attitudinal and motor components of hostility.

Chapter IV describes the analysis of data which was accomplished through the calculation of an analysis of variance. A summary of findings, conclusions drawn as a result of the study, implications for nursing, and recommendations for further studies are contained in Chapter V.

CHAPTER II

REVIEW OF LITERATURE

The trauma patient finds himself in a sudden and unexpected situation for which he is emotionally unprepared. A thorough understanding of the effects of a traumatic injury is necessary for a nurse to assess a patient's behavioral status. Chapter II reviews the emotional response to hospitalization, crisis theory, changes in body image, the trauma patient, hostility, and nursing care of the hostile patient.

Emotional Response to Hospitalization

The emotional reactions to illness are the feelings that are associated with the illness. How an individual reacts to illness at any given time is influenced by a variety of factors. Some of the more significant factors include the individual's perception of the reality of the situation, the accepted reaction to the illness by the individual's particular culture, and the individual's personality, emotional make-up, and past experiences with illness (Polenz 1975). According to Luckmann and Sorensen (1975), reactions to illness may also be influenced by a person's self-concept, his pattern of mental defense, and

his personal philosophy of life. Other factors influencing individual reactions are age, social status, general state of personal happiness, and financial position.

In view of all the factors influencing a person's response to illness, it is easy to understand why each individual responds in a unique way. The same illness can elicit different responses from different patients. One patient may accept his illness very calmly, whereas another patient with the same diagnosis may become very depressed or argumentative (Luckmann and Sorensen 1975). Polenz (1975) felt that a patient's behavior may be determined by his perception of the illness, therefore, the actual seriousness of the illness is not always the governing factor of a patient's behavior during hospitalization.

People go to a hospital when they are sick, have pain, or cannot function in their usual manner. Their whole life is "interrupted and disrupted" (Polenz 1975, p. 17). Illness and hospitalization serve as a reminder that man is vulnerable and mortal. The feelings of anxiety, fear, or sadness about being ill will always be present in the hospitalized person. Luckmann and Sorensen (1975) devised a list of fears commonly found in the hospitalized patient. These fears are: being in a strange place such as a hospital, equipment, pain; being "experimented" on;

having to suffer as punishment for past misbehavior; being abused, neglected; having one's feelings hurt or in other ways being treated impersonally; being left alone or isolated from loved ones, or loss of function or loss of self-control; death; and burdening others. Thomas (1972) adds to this the fears of mutilation and the future.

Crisis Theory

The word crisis has been indiscriminately used in everyday language, and, therefore, has taken on many subjective meanings. The word originally comes from the Greek word "krisis" which means "to separate." In medicine it usually refers to that change in disease which indicates whether the result is to be recovery or death. In international relations a crisis most often refers to an event or a conflict, the outcome determining war or peace. Its connotation is that of a decisive moment, a turning point (Aguilera 1974).

Its specific meaning in crisis intervention is derived from Caplan's definition which defines crisis as

> occurring when a person faces an obstacle to important life goals that is, for a time, insurmountable through the utilization of customary methods of problem solving. A period of disorganization ensues, a period of upset, during which many abortive attempts at solution are made (1961, p. 18).

The definition of crisis as given by Brammer is

> a state of disorganization in which the helpee faces frustration of important life goals or profound disruption of his life cycle and methods of coping with stress. The term crisis usually refers to the helpee's feeling about the disruption, not to the disruption itself (1973, p. 114).

Crisis theory has been developed in the past few decades as a method which offers immediate help to a person in need of reestablishing emotional equilibrium. A person in a crisis situation faces a problem that he cannot solve by using coping mechanisms that have been successful in the past. A person in this situation feels that he is unable to solve his own problem and is caught in a state of great emotional upheaval (Aguilera 1974). A state of emotional equilibrium and the maintenance of this state is a constant goal of all individuals. When customary problem-solving techniques are no longer effective for a given individual, his equilibrium is upset.

Evans (1971) listed four points that a crisis poses. They are a threat or danger to life goals, tension and/or anxiety, awakening of unresolved problems in the past, and a turning point in which healthy or unhealthy adaptation can occur.

According to Caplan (1961), a crisis is usually self-limiting and can last anywhere from four to six weeks. The goal of crisis intervention is to resolve the immediate crisis and to restore the individual to the level of

functioning that existed before the crisis state. Major character changes are not expected as the therapy is aimed toward helping the individual solve a specific problem.

Crisis intervention utilizes two types of approaches in resolving crises situations. The generic approach focuses on the particular characteristics of the crisis rather than on the psychodynamics of each individual involved. The treatment plan is aimed toward adapting a resolution to the crisis. The other method is called the individual approach and is generally used in cases which do not respond to the generic approach. A professional psychiatric worker is essential in the individual approach as the interpersonal and intrapsychic processes of the individual in crisis are analyzed (Aguilera 1974).

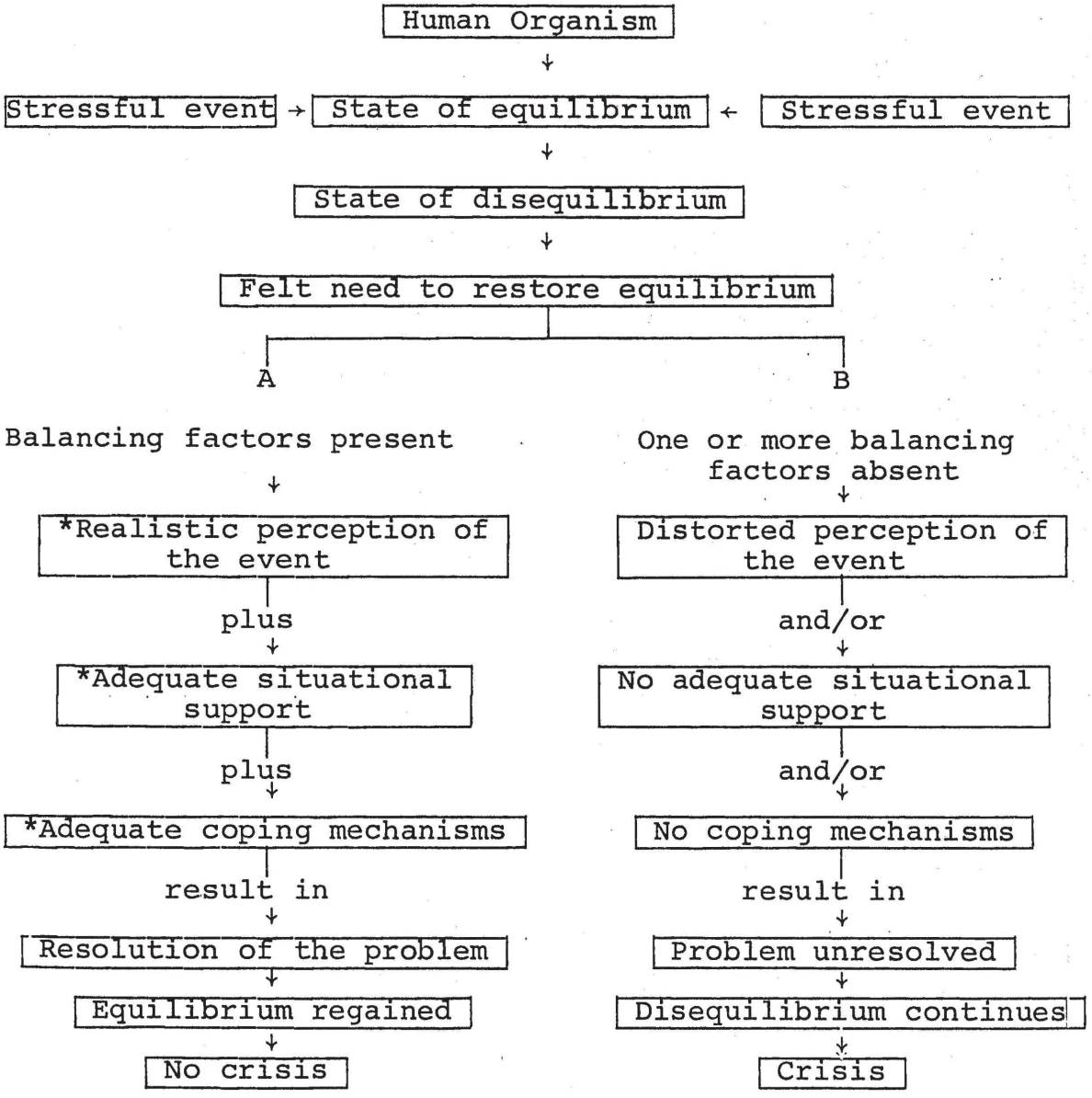
Aguilera (1974) related four steps that are utilized in crisis intervention. The first step is assessment of the individual, his problem, and the precipitating events that led to the crisis. Next, the therapeutic intervention is planned and designed to restore the individual to his precrisis level of equilibrium. The third step in the problem-solving process is intervention. It is aimed at helping the individual gain an understanding of his crisis, helping him bring into open his present feelings, exploring with him coping mechanisms, and reopening the social world.

In the last step, the crisis is resolved and realistic plans for the future are set.

Figure 1 represents how the human organism responds to crisis. Column A lists the balancing factors that need to be present for the restoration of equilibrium. Column B lists the sequence of events with one or more balancing factors absent. The first balancing factor that must be present is the perception of the event. This includes what the event means to the individual, how it is going to affect his future, and whether or not he can look at it realistically. The second balancing factor is that of the available situational supports. Situational support (Caplan 1974) refers to those persons who are available and can be depended upon to help solve the problem. The individual also needs adequate coping mechanisms to restore equilibrium.

Coping mechanisms are the actions that people usually take when they have a problem. Coping has been called an "overused and overgeneralized" term to describe managing the problem and solving the crisis (Barrell 1974, p. 5). Coping mechanisms allow the person to relieve his stress and restore or maintain his self-esteem as he solves the problems connected with his crisis.

Types of coping behavior that contribute to favorable outcomes are those related to one or more of the following tasks:



*Balancing factors

Fig. 1. Effect of balancing factors in a stressful event (Aguilera 1974, p. 61).

> 1) keeping a distress within manageable limits; 2) maintaining a sense of personal worth; 3) maintaining or restoring relations with significant other people; 4) enhancing prospects for recovery of bodily functions; and 5) increasing the likelihood of working out a personally valued and socially acceptable situation after maximum physical recovery has been attained (Hamburg, Adams, and Brodie 1976, p. 164).

Coping behavior is very individualistic but may be influenced by the person's society, culture, and age group (Evans 1971). Each individual learns how to use many methods to cope with anxiety and reduce tension through the process of daily living. Individualized life-styles are developed around these patterns of response and are very necessary to maintain equilibrium. Coping mechanisms are activated consciously or unconsciously and may be either overt or covert. The person may try to think out his problem or talk it out with a friend. He may temporarily withdraw from the sitution to reassess the problem. Some people are more demonstrative and cry out their problems or try to get rid of their feelings of anger and hostility by swearing, kicking a chair, or slamming doors. The selection of a particular response such as aggression or withdrawal is based upon actions that were successful in similar situations in the past (Aguilera 1974).

Changes in Body Image

Prior to hospitalization, the patient had several roles and sources for his identity. He was a husband, father, and worker or a wife, mother, and worker--a person with individualized skills, interests, and hobbies. Once hospitalized, all things that assist man in functioning and coping with life are taken away. The patient's clothing is removed and he is separated from his family, his friends, his activities, and his occupation. Robinson stated that the person is transformed from an "independently functioning, productive adult who is autonomous into a dependent, regressed, and passive individual (1972, p. 9). The person is now forced to assume the new and unfamiliar role of a patient.

Security and a sense of self-esteem are significantly influenced by how a person perceives or evaluates his body (Roberts 1976). Norris described body image as

> the constantly changing total of conscious and unconscious information, feelings, and perceptions about one's body in space as different and apart from all others. It is a social creation developed through the reflected perceptions about the surfaces of one's body and responses to sensations originating from the inner regions of the body as the individual copes with a kaleidoscopic variety of living activities. The body image is basic to identity and has been referred to as the somatic ego (1970, p. 42).

Simply stated, body image refers to the way a person sees his own body.

One of the first theories regarding body image was that of Sigmund Freud's psychoanalytic concept. The focus of his theory was three bodily areas or zones which he called the oral, anal, and genital areas. The individual must succeed in coping with the changing demands of each area in succession and integrate these into his total body scheme in order to develop a mature body image (Stafford-Clark 1969).

McCloskey (1976) cited that body image is only part of a person's total self-concept. A person's perception of his physical self, along with his ego identity which is his "social self" and includes his moods, social status, profession, and so on, shapes what he feels about himself as a person. An individual's beliefs, values, goals, and other people's opinion of him are other significant factors which influence his self-perception.

Body image is a constantly changing phenomenon. A newborn has no body image at birth. As the infant gradually becomes aware that he is a separate entity from his parents, he begins to develop a body image. When he begins to master control over his body parts and functions, this body image is further enhanced. By the time a person reaches adulthood,

control of body parts has been completely integrated into what he thinks of himself (McCloskey 1976).

An individual cherishes the wholeness of his body. In the American culture, the whole body represents beauty and the achievement of beauty. Stability and psychological equilibrium depend in part upon the body being intact and its function being consistent. Any changes in intactness requires the patient to make adjustments to maintain psychological equilibrium (Wells 1975). The loss or threatened loss of that function is very frightening to the individual (McCloskey 1976).

Immediately after an injury, the patient continues to perceive his body in the preinjury image. However, with the physical alterations caused by an injury, the individual will be eventually forced to alter his concept about self and body image. According to Lee (1970), the transition is a lengthy process and the patient must assimilate the injury into his self-concept and body image. Lee (1970) identified four phases through which an individual must pass after an injury--impact, retreat, acknowledgement, and reconstruction.

During the impact phase, the patient first experiences a state of psychological and perhaps physiological shock after the occurrence of the injury. This initial reaction occurs at the time of the injury or when the

individual becomes consciously aware of his injury (Roberts 1976).

> A crisis such as physical trauma generates a series of phenomena geared for the return to the preexisting state of affairs. When in the life experience of a person a crisis occurs that changes the appearance of his body, the event is recognized by everyone in his social milieu. The recognition of the change prevents the return to the previous state of affairs and demands a process of adjustment. The person must find a new way of approaching personal, interpersonal, and social aspects of living (Lee 1970, pp. 577-578).

Shontz (1965) felt that the word adjustment or adaptation is most applicable in a crisis situation because the person can no longer return to a previous way of living but instead must change and approach life in a new way.

Each patient experiences some type of loss. It may be loss of function, loss of a part, or loss through disfigurement. The patient may experience changes in his behavior associated with his loss. The nurse may assess a wide range of behavior during the impact phase. Some of the behaviors displayed are despair, discouragement, passive acceptance, anger, and hostility (Roberts 1976).

The next phase is called retreatment. As the shock phase subsides, the patient becomes aware of the reality of his problem. His first reaction is to run but generally the immobilization created by his injury does not allow him to do this. Instead, he may retreat emotionally through

denial. Denial is one of the "most common mental mechanisms evidenced when people are under the stress of diagnosis and illness" (Evans 1971, p. 154). Luckmann and Sorensen (1975) pointed out that a patient will often regress as a defense against the stress he is under. During the retreat phase, the patient organizes his strength and coping abilities in order to deal with the situation and facilitate recovery.

Since body image provides a basis for identity, any change in body structure or function may be perceived as a threat (Norris 1970). In order to meet his needs for security, each person develops certain patterns of behavior. In some cases, these patterns may depend heavily on certain body organs. If these organs have become injured, the threat is greater than if the organs are insignificant to the patient. The threat to the self-system depends not only upon the degree of physical disability, but also upon the alteration in self-concept that occurs as a result of the physical disability (Kiening 1972). Following any alteration, the patient is continually reminded of it by the pain, the dressing, the stitches, and the "team" attending him (Wells 1975). Medical and nursing activities may be potentially threatening to the patient. The patient may find himself submitting to intrusive procedures such as an

intravenous line, central venous pressure line, oxygen mask, or a chest tube. Each intrusion reminds him of how ill he is and,coupled with the injury itself, threatens the patient (Roberts 1976).

Threats may force the patient to avoid reality by retreating into topics of thought or discussion that focus on someone or something else such as the patient's family or business. This diverts energy away from himself. Thus, the retreat phase allows the patient to mobilize energy that will be necessary for the acknowledgement that an illness or injury has occurred. Inevitably, the patient must deal with his loss and its future implications (Roberts 1976).

The behavioral manifestations of denial may be seen by the refusal to accept or participate in treatments such as the refusal to learn how to transfer from the bed to the chair. The patient may believe that if he ignores the treatments, the problem will disappear (Roberts 1976).

The patient has suffered an injury that has resulted in a changed physical appearance. If he is to continue his daily living, the patient must face reality. The acknowledgement phase may be a very difficult time for the patient. The task of this phase is to assist the patient and his family to acknowledge the alteration which he equates with the loss of his body image. The patient realizes that he can no

longer retreat and he mourns his loss, regardless of the degree of severity. The loss of function or part, or disfigurement affects the patient's individuality and uniqueness, and creates a lowered self-esteem (Roberts 1976).

During the acknowledgement phase, the patient will discuss the details or events that led to his injury and subsequent hospitalization. The patient will be anxious and needs reassurance or support regarding his future from both the nursing staff and his family. The family also may need help to acknowledge the patient's injury (Lee 1970). They may also focus on peripheral topics. If the patient had been in an intensive care unit, the family may have been frightened from the environmental shock and remained in the impact phase. In addition to this, the family may not focus on the patient as a husband or father but instead, they may focus on the horror of his loss or disfigurement (Roberts 1976).

If the patient successfully goes through the other stages, acknowledgement will happen. The nurse assesses her patient's acknowledgement when he asks questions such as "How long will it be before my stitches come out?" Once the patient has acknowledged his loss verbally, he is ready to move into the reconstruction phase (Lee 1970).

During the reconstruction phase, the patient attempts to adapt to the changes in his body image. He has survived the physical loss and he must now resolve the psychological and social difficulties (Roberts 1976).

Reconstruction will occur in varying degrees and will be strongly influenced by the financial and social implications the loss holds for the patient (Tomlinson 1974). The patient realizes his own strength with the assistance of other supportive systems such as the family, social worker, minister, psychiatrist, nurse, and physician. Throughout the crisis state, these systems served as sources of energy, strength, and motivation for the patient (Roberts 1976).

The patient and members of the supportive systems work together to help him achieve the goal of the highest level of reconstruction attainable. The patient may feel a more positive attitude toward living life to the fullest as he feels that he has been given a second chance. He may pay more attention to his new image and will have a new appreciation of his family. Most importantly, the reconstruction phase involves "interaction and integration of the patient with other patients and with members of his family" (Roberts 1976, p. 90). Every interaction the patient has is an experience with a social encounter. The

success or failure of these encounters will determine how the patient will react to social interactions outside the hospital environment (Roberts 1976).

Adaptation to alterations in body size, structure, or function depends in part on the patient's coping ability. In addition to coping ability, adaptation is also influenced by the nature of the threat, its meaning to the patient, the response from others significant to him, and the assistance available to the patient and his family during periods of change (Norris 1970).

The Trauma Patient

The traumatically injured patient enters the hospital rapidly and unexpectedly. As a result of his injury, he may suffer from a wide variety of anatomic disorders. A traumatic accident is usually a stressful event with additional tension and anxiety being created by hospitalization.

Hamburg, Adams, and Brodie have found that sudden, severe physical disability is an "extreme test of coping resources" (1976, p. 164). Robinson (1972) and Gottschalk (1968) related that the traumatically-injured patient experiences alterations in body image which he cannot prepare for in advance. After the shock of the trauma wears off, these people have more difficulty adjusting to the

attack on their body image than those who can plan their admission and are able to call upon their defense mechanisms prior to hospitalization.

Gottschalk (1968) cited that individuals who have been in car accidents have powerful emotional reactions as a result of this exposure to potential destruction. This includes instances where there has been a close brush with death as well as instances where the threat of fatal outcome has been minimal. All accidents or near accidents arouse in the individual the fear of death.

Hamburg, Adams, and Brodie (1976) listed several primary adaptive tasks that the traumatically-injured patient must face. They are a threat to survival; fear of permanent physical disability or disfigurement; pain with prolonged physical discomfort; the possibility of unpleasant procedures or surgery; and a long, tedious recovery.

In addition to problems directly associated with the injury, other psychological problems may complicate the situation. The patient may believe that his own negligence caused the injury or that it was the fault of a person he trusted. Separation from family and friends at a time when the patient needs them the most, deprives him of one of his main sources of gratification. Depression and self-pity may result from an overwhelming feeling of loneliness and

homesickness. One of the most common sources of concern is how the injury will affect future plans. The patient's vocation or recreational activities may be at stake. The patient may be disturbed by the enforced dependence on others and physical helplessness may exaggerate his feelings of inadequacy. Injuries to the genitalia and perineum present concerns regarding sexual functioning to the patient. Many patients feel that their capacity to be loved by others is threatened by their disability. Circumstances connected with the injury or difficulties in subsequent care may arouse a considerable amount of hostility in the patient (Hamburg, Adams, and Brodie (1976).

Luckmann and Sorensen (1975) indicated that the attitudes of other people are obvious to the patient and will influence his own reaction to the injury as well as his self-image. Mutilating and disfiguring injuries may evoke strong reactions of disgust, fear, and revulsion in others which the patient will sense.

It is felt that the "many grave psychologic threats of a nearly fatal injury or severe prolonged illness place the patient in danger of being overwhelmed by emotionally painful stimuli" (Hamburg, Adams, and Brodie 1976, p. 166).

According to Gottschalk (1968), the patient should be given an opportunity to verbalize all of his emotional

reactions soon after the traumatic experience as this dissipates the possibility of a traumatic neurosis. Titchener describes a traumatic neurosis as "anxiety, easy-startle reactions, and dreams that relive and rework the moment of the accident in an attempt to master the feeling from it" (1960, p. 206).

In order for the traumatically injured patient to recover successfully, both physical and mental adaptive mechanisms must function properly and have adequate time to do so. Some of the patient's early attempts at psychologic adaptation may be inappropriate as he may try to solve his problems by using defensive patterns that worked for him in the past. Under the stress of the injury, the patient may be unable to make rational decisions (Luckmann and Sorensen 1975).

Hostility

Hostility can be a very broad and ambiguous concept. It is examined here in terms of hostility that is evoked by traumatic external events and acted out for a brief period of time. This paper is not concerned with hostility that is a part of a permanent character trait and is acted out as part of an accustomed way of life.

Sigmund Freud postulated that the tendency toward aggression is primarily an instinctual drive. Freud called

this a death instinct (Thanatos) as it represented an organism's wish to return to a tensionless state or a state of nothingness. He also postulated a life instinct (Eros) which opposes the death instinct. According to Freud, the life instinct seeks release from the tension of simply living. The life of each person can be seen as a struggle between the life and death instincts. The struggle ends only when the life instinct is no longer capable of opposing the death instinct. The stronger the death instinct in an individual, the more he must direct his aggression outward against objects and people in order to gratify this instinct (Stafford-Clark 1969).

Behavioral research points to the fact that aggression is not of an instinctual nature as theorized by Freud, but rather it is a learned response. Horney (1945) explicitly rejected the death instinct. She attributed the individual's response to "basic anxiety" as the cause of hostility and aggression. Basic anxiety was defined as ". . . the feeling a child has of being isolated and helpless in a potentially hostile world" (Horney 1945, p. 41). There are three patterns of response to this feeling: moving toward, moving against, and moving away from people. Normally, the individual utilizes all three approaches and is capable of shifting his approach to meet

the demands of a particular situation. The individual who continually moves against people is an aggressive personality. He feels that the world is hostile and reacts by striking out first. Horney (1945) believed that hostility is a tendency which is rooted in rejection.

Saul described hostility as a "disease of the personality, transmittable from person to person and group to group, and basically, by contact from parents to children, from generation to generation" (1956, p. 4). He further described hostility as a motivating force, either conscious or unconscious, to injure or destroy an object or person, usually accompanied by the feeling or emotion of anger. Hostility seeks no socially constructive end. Saul referred to hostility as "part of a basic biological adaptive mechanism" (1956, p. 8) which man uses to cope with threats, irritations, and frustrations by withdrawing from them or by destroying them.

Hostility has also been defined as "a feeling of antagonism accompanied by a wish to hurt or humiliate others, which may produce subsequent feelings of inadequacy and self-rejection owing to loss of self-esteem" (Kiening 1972, p. 188).

Buss (1961) claimed that hostility is a learned attitudinal response. It involves negative feelings and

negative evaluations of people and events. The response involves the interpretation and evaluation of stimuli, but the negative evaluations have no impact on others until they are verbalized. When they are verbalized, the hostile response takes the form of negative labels like derogatory comments such as "I hate you."

Hostility is usually not verbalized openly. "Typically, it is implicit, consisting of the mulling over of past attacks on oneself, rejections, and deprivations" (Buss 1961, p. 12). If the hostile response is verbalized such as telling the person he is disliked, the presence and intensity is apparent. However, if the hostility is not verbalized, it must be inferred from other types of aggressive behavior (Buss 1961). Kiening (1972) stated that a hostile person may not be aware of his covert hostility. The covert hostility may unknowingly be translated into behavior that is perceived by another person as hostile.

Rothenberg (1971) pointed out that hostility does not allow the object of the feeling or action to remove the threat or obstruction. Rather, it aims to destroy the object itself.

Many authors use the words aggression and hostility interchangeably. Buss (1961) made a distinction between the terms hostility, aggression, and anger. He defined

aggression as "a response that delivers noxious stimuli to another organism (1961, p. 96). This includes inflicting pain or injury on others as well as verbal aggression such as threats and derogatory remarks.

Because hostility may be passively expressed, not all hostile responses are necessarily aggressive. The hostile response must be verbalized in the presence of the victim to be aggressive. To say "I hate him" to oneself is hostile but it is not an aggressive response until the victim hears it (Buss 1961).

Hostility eventually may lead to aggression. A person may mull over his past rejections, attacks, and disappointments for a lengthy period of time. These hostile feelings may erupt into aggressive acts when the opportunity presents itself. Hostility is specifically aimed at a particular individual or group of people whereas aggression is more generalized (Buss 1961).

Saul (1960) felt that hostility is a more precise term than aggression. Aggression is ambiguous as it may imply initiative and activity which are not necessarily hostile. Getting a good job done may imply constructive aggression but not hostility.

Anger is an emotional reaction with facial-skeletal and autonomic components. Anger is a transient feeling

which may or may not be present in aggression. It may be one of the drives that leads to aggression, but it is not the sole drive for aggression (Saul 1956).

Anger is usually a short-lived reaction. Hostility is a more enduring response that builds up slowly and persists long after the anger has dissipated. The longer the anger reaction endures, the more likely it will become associated with hostility. Buss stated that "if there is an excess of the antecedents of anger (attacks, frustration, annoyances) there is likely to be an excess of hostility" (1961, p. 204). Because the development of hostility depends on the individual's being angered, Buss (1961) called hostility a conditioned anger response. However, hostility lacks the autonomic and postural components of anger.

Flynn (1969a) regarded hostile behavior as an attempt to release anger and also to attain the goal, such as release from frustration.

Buss proposed that hostility develops through an "observation-labeling response" (1961, p. 13). The process of observing is so closely related to the process of labeling or categorizing that the two occur more or less simultaneously. Buss felt that it was almost "impossible to observe punishment being inflicted without making a

negative labeling response" (1961, p. 13). The negative term then becomes part of the observation.

The observation-labeling response combined with an anger reaction are the basis for hostility. If the victim of an attack can fight back, his anger level may drop rapidly without allowing time for a conditioned anger or hostility response to develop. If the attack consists of rejection, the victim may be isolated and unable to counter-attack. Instead, he mulls over the rejection, setting the basis for later hostility (Buss 1961).

Rosenstiel (1973) studied how a person reacts to frustration. As a result of his tests, he concluded that outbursts of hostility and aggression are determined primarily by circumstances and occupy only "brief temporal intervals" (p. 22).

Dollard (1939) proposed a frustration-aggression theory. According to this theory, frustration develops from interference with goal-directed activity. The frustrated individual becomes angry, leading to feelings of hostility and aggression. Figure 2 represents the formula of this idea.

Solomon (1970, p. 64) used the term "primary aggression" to describe hostility and attack that is "reactive and proportional" to a frustrating situation. To

overcome small doses of threat adds to the strength of the personality and assists the individual to meet future threats.

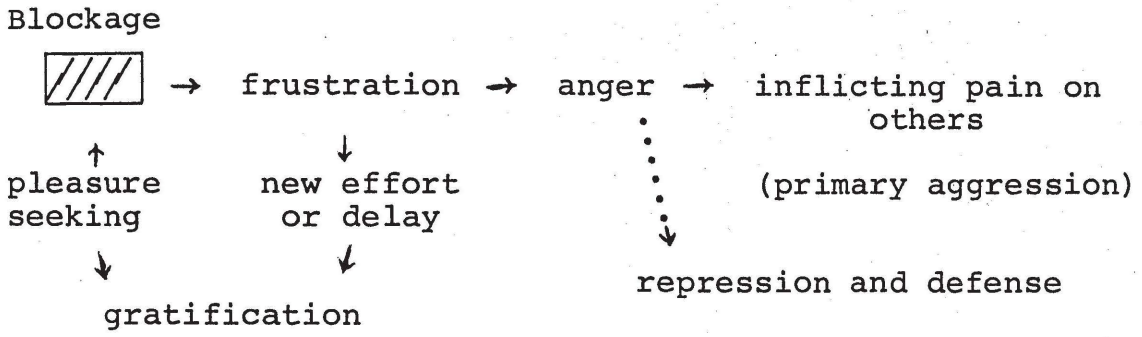


Fig. 2. Effect of frustration on aggression. (Solomon 1970, p. 59).

Scott (1958) earlier published material related to aggression in which he stated that frustration was highly likely to produce aggression but also may result in other kinds of behaviors. The frustration-aggression theory is a learned response, and, therefore, it is more likely seen in a situation where the individual has a habit of being aggressive.

Kiening (1972) identified three factors that may lead to the development of hostility in the hospitalized patient. First, a person experiences frustration, loss of self-esteem, or unmet needs. He is frustrated by the restrictions imposed on him by his injury. He is forced into a dependency role and his self-esteem becomes

threatened. Second, hostility develops when a situation occurs in which the patient holds expectations of himself or others and these expectations are not met. The patient may expect the medical and nursing staff to restore him to his previous level of wellness but due to his injuries, this may be virtually impossible. The third factor that may lead to the development of hostility is that the patient may feel inadequate or humiliated and as a result, he experiences hostility. Kiening (1972) further identified three ways in which a patient can respond: (1) repressing the hostility and withdrawing, (2) denying the feeling and overreacting by being extremely polite and compliant, or (3) engaging in some type of verbal or nonverbal behavior that is overtly hostile.

One important characteristic of hostility is its personal and unique meaning for each person. This uniqueness develops from "past experiences, good or bad, from values the individual has learned from his parents and incorporated into himself, from his biological potential, and perhaps even his genetic endowment (Flynn 1969a, pp. 155-156).

Roberts (1976) expressed the belief that overt hostility may be the result of excess energy. All the anxiety accumulated in the shock and retreat phases converts to energy as the patient begins to acknowledge his injuries.

The amount of energy that accumulated depends on the degree of stress experienced by the patient. If the patient actively denied his injuries for fear of confronting the threat, the patient may not realize the amount of energy he is accumulating. The patient under stress must eventually channel his excess energy into an "output action level" which can be either constructive or destructive (Roberts 1976, p. 203).

The patient who yells, curses, and is generally unpleasant and uncooperative is easily recognized as hostile. The covert expressions of hostility are not always readily identified. A patient may be silent because he is depressed, indicating hostility that is turned inward upon himself (Saul 1960). He could also be resentful, withdrawing from a perceived threat or seething with anger to such a degree that he dare not speak. Nonverbal cues such as facial expression and bodily posture may indicate that the patient feels hostile. Because it is socially unacceptable to display anger overtly, the patient may turn his excess energies inward. According to Kiening (1972), he may be unaware of his hostile impulses and the reasons for many of his actions as hostility often operates at an unconscious level.

Behavior indicating the presence of hostility varies considerably with the individual. Kiening (1972) pointed out that not all people are alike in their ability to feel and express anger so it may be difficult to assess the degree of hostility present by the manner in which it is expressed or the intensity of its expression. The manner in which a person acts out his hostility may differ according to the circumstances and the degree of stress he is under. An individual who has been in good health all his life experiences tremendous stress when he is confronted with an injury, especially one that leads to disability or disfigurement. Nor is it always possible to detect who is the focus of the patient's hostility as there is a tendency to displace this feeling on someone less threatening and less likely to retaliate (Kiening 1972).

Hostile behavior in a patient indicates an underlying anxiety. It may represent the patient's attempt to deny, or avoid facing, a feeling of helplessness. It may be an expression of the patient's inability to cope with a perceived threat of loss. According to Roberts (1976), the threats consist of loss of biological, psychological, and social integrity. The loss of biological integrity results from changes in the homeostatic process caused by the injury. Threat to psychological integrity may be a result

of loss of independence and self-respect. Separation from family and occupation threatens the patient's social integrity. The patient may be using hostile behavior as a defensive tactic in times of danger or stress (Crowell 1967). Behind his thorny and bristly exterior, the hostile individual may be really insecure and using this behavior as a facade to cover up his insecurity (Evans 1971).

Nursing Care of the Hostile Patient

The hostile patient is probably one of the most difficult patients to deal with in nursing. Hostility can hamper and impair a patient's progress. The manifestations of hostility may be seen as a continuum with behavior ranging from overly polite to extreme forms which may be externalized such as depression or suicide. In day-to-day contacts with surgical patients, the nurse usually encounters hostility that is of a milder nature.

Each patient expresses his hostility in different ways which are unique to him. Sarcastic and abusive remarks are one form of overt expressions of hostility. The person may be argumentative, demanding, or verbally attacking. According to Kiening, this behavior is "usually motivated by fear and a distorted perception of a threat to the self or the self-image" (1972, p. 194). The hostility is then displaced onto another object or person which in some way

symbolized the danger. When overt hostility is first encountered in a patient, the nurse may have a tendency to run from the situation or to make a counterattack, both of which are understandably natural but neither one of which benefits the patient (Evans 1971). Crowell (1967) recommended that the first step in helping a patient deal with hostility is that the nurse be aware of her own reactions to his hostility so that they do not prevent her from relating to him in a therapeutic manner. If the nurse reacts calmly, her manner may act as comfort and negative feedback to the hostile patient. The nurse must learn to control her own anxiety as anxiety itself is rapidly communicated to others.

McCloskey (1976) listed five steps necessary in order to intervene therapeutically. They are (1) know and understand the nature of the threat, (2) assess how the patient perceives the threat, (3) identify and reinforce the patient's coping abilities, (4) help others significant to the patient, and (5) coordinate care and mobilize community resources.

Hostile behavior is not a matter of quick impulse but rather something that has happened to precipitate it. The nurse cannot act on any assumptions or hunches that she has until she validates them with the patient. She should

recognize the patient's feelings and direct her response to the patient's concerns and not avoid the issue. Brooks (1967) reminded the nurse to focus on the patient, not his behavior. The patient's behavior is only a symptom of his conflict and to focus on his hostility may only reinforce it. The patient needs an opportunity to continue and to clarify what he is saying. The nurse should accept the patient's feelings without indicating approval or disapproval and not belittle or negate them. Because the nurse does not make value judgments, the patient is able to maintain his pride and dignity (Crowell 1967).

The patient will become less hostile if the nurse can help him identify what threatens him and help him toward resolving the problem. The nurse must first assess her patient's readiness to examine the threatening situation. She assists the patient in ventilating his feelings and thus focus on himself as a person rather than a victim who must survive his crisis. Talking together is one constructive way of channeling energy that might otherwise be used for the expression of hostility. The patient needs reassurance that a certain amount of hostility may be a normal adaptive response to injury (Roberts 1976).

The nurse should assist the patient in identifying the target of his anger. The patient may believe that he himself

is the harmful agent if he feels that he is a burden to his family and those providing his care (Roberts 1976). In a case where the patient's hostility was displaced on his family, he will have to explore the reason why this occurred. A family relationship could become badly damaged as a result of such displacement. The nurse may have to work with the family in helping them to understand the patient's needs. A psychiatric consultation should be sought if evidence of a real personality problem exists so that professional therapy can be instituted if so indicated (Kiening 1972).

Silence or avoidance must be dealt with tactfully before any meaningful communication or therapeutic nursing intervention can take place. The nurse may tell the patient that she has noticed his silence or avoidance, and she may ask if something is wrong. In recognizing that the patient appears troubled, the nurse conveys her concern and willingness to help. This action may bring about further silence or an angry outburst from the patient. Regardless, the nurse must be prepared to accept the patient as he is and continue to meet his nursing needs as best possible (Kiening 1972).

The patient may be initially reluctant to speak about what is bothering him. This situation requires empathy

and sensitivity on the part of the nurse. Kiening (1972) cited that pushing a patient into revealing what he is not ready to discuss can be harmful and intensify the anxiety that may have caused the problem in the first place. He may need time to discover how far he can trust the nurse. Evans (1971) recommended that the nurse take the initiative even if she anticipates a hostile encounter. Trust may not be established right away, but persistent interest is communicated to the patient and this bolsters his self-esteem. A patient who is hostile, and especially if he is suspicious, will be aware of the nurse's actions with his family, other patients, and the staff. If one nurse communicates an impersonal, hasty manner to the patient, he may expect the same treatment from all members of the profession and, therefore, prevent the development of trust. Evans (1971) suggested that the nurse empathize with the patient and assess his situation so that she can be aware of the expectations he holds for her. Belittling the nurse may result when she has not supported the patient's ego or gained his trust, and, therefore, may still be threatening to him.

Crowell (1967) listed several ways in which the nurse may contribute to hostility during "normal care." This includes invasion of privacy with enemas and rectal

thermometers, telling the patient he cannot have his pain medication yet, sticking him with needles, awakening him in the middle of the night for medications, making him get up when every movement is painful, limiting what he can and cannot eat, asking his visitors to leave, and taking away his personal possessions.

Flynn (1969b) believed that hostile behavior is not always bad. Rather, it may be the first sign that the patient is getting better. What is called "demanding" and "unreasonable" behavior of a patient may actually be an attempt on his part "to maintain his dignity as a human being, in a highly institutionalized, impersonal setting" (Kiening 1972, p. 190). It is not always easy to distinguish between hostility which is motivated by the desire to hurt and that which is merely healthy self-assertion.

> A person whose needs for growth and self-realization are really threatened is acting in a mature way when he takes a stand for himself. The nurse needs to be perceptive in order to assess what is healthy and necessary for this person. Social pressures within the system still operate all effectively in silencing the adult who feels aggrieved and angry at his unwelcome--and often unforeseen--situation (Kiening 1972, p. 190).

This patient benefits from care that is freed from the institutional routine and is highly individualized.

The nurse should assist the patient to find socially acceptable outlets for his hostile and aggressive

feelings. Evans (1971) listed several activities that may help the hospitalized patient release his aggression and prevent him from turning it inward. They are (1) pounding or hitting a mattress; (2) for immobilized patients, a set of exercises requiring muscles that are not immobilized; (3) "participating" in a much-loved television game; (4) watching a boxing or wrestling match where someone else does the "clobbering;" (5) being able to discuss a favorite competitive game and how effective one is in it; (6) the identification with a particular ball team, horse, or driver of a racing car, and watching, hearing about, or discussing their competitive actions; or (7) more occupational therapy consults for patients.

It is essential that the nurse have an understanding of the dynamic bases of hostility and the behavioral processes which hostility activates. When the nurse sees behavior indicative of hostility, she needs to validate her assumptions with the patient. Then she should assist him to describe and clarify what it is that he is experiencing and the possible reasons for these feelings. To provide therapeutic intervention, the nurse must be aware of her own reactions and accept the patient without giving either approval or disapproval. She must be skilled in detecting the patient's unspoken wish for setting limits. The efforts

the nurse exerts to alleviate the circumstances causing hostility are most important. This enables the patient to maintain pride and self-respect. The nurse assists him to grow in self-understanding and to achieve his optimal level of health.

Summary

The nurse is in a unique position to assess her patient's psychological needs. In order to intervene effectively, she must understand the reasons for his behavior. If the patient is hostile, the nurse must understand the dynamics of hostility and the behavioral processes which it activates.

Chapter III contains the procedure for collection and treatment of data. The data were collected through the use of the Buss-Durkee Inventory. The inventory assesses both attitudinal and motor components of hostility.

Chapter IV describes the analysis of data which was accomplished through the calcualtion of an analysis of variance. A summary of findings, conclusions drawn as a result of the study, implications for nursing, and recommendations for further studies are contained in Chapter V.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

A nonexperimental explanatory research design was used in this study (Abdellah and Levine 1965). A causal relationalship was being sought between a traumatic accident and hostile feelings in hospitalized patients.

Setting

The setting for this study was an 800-bed teaching hospital. This institution is a county, acute care facility located in the Southwest. Written permission was obtained to use this institution as the setting for this study (see appendix A).

Population and Sampling Technique

Through the use of convenience sampling technique (Abdellah and Levine 1965), three surgical units were sampled. These units admitted general surgery and trauma patients. One unit had a maximum capacity of forty-one patients. The other two units had a maximum capacity of thirty patients each. Patients were admitted primarily to double occupancy rooms but also may have been in a four-bed ward. These units were chosen as sample units because

they frequently admit trauma patients and appendectomy and cholecystectomy patients.

The experimental group consisted of trauma patients. The control group for the study consisted of appendectomy and cholecystectomy patients. These patients were chosen because they are as similar as possible to the experimental group with the exception of the independent variable of a traumatic accident. They were also chosen because an appendectomy and a cholecystectomy are recognized as common surgical procedures that normally do not cause any unusual emotional reactions in the patient.

The trauma patients on the selected units were chosen according to the following criteria:

1. Patients who were hospitalized as a result of a traumatic injury such as a gunshot, stabbing, or motor vehicle accident

2. Male and female patients between twenty-four and forty years of age who were posttrauma or postsurgery and were on a surgical unit

3. Patients who were mentally and physically capable of answering questions

4. Patients who were high school graduates

5. Patients who were able to read and answer their own questionnaire

6. Patients without a diagnosed or suspected head injury

7. Patients who were not hospitalized as a result of self-inflicted injuries

8. Patients who were willing to sign Texas Woman's University's form B, the Consent to Act as a Subject for Research and Investigation after a brief explanation of the study had verbally been given to him

The appendectomy and cholecystectomy patients on the selected units were chosen according to the following criteria:

1. Patients who had undergone a surgical procedure for the removal of an intact appendix or an inflammed gallbladder with no other complicating factors

2. Male and female patients between twenty-four and forty years of age who were postsurgery and were on a surgical unit

4. Patients who were mentally and physically capable of answering questions

4. Patients who were high school graduates

5. Patients who were able to read and answer their own questionnaire

6. Patients who were willing to sign Texas Woman's University's form B, the Consent to Act as a Subject for

Research and Investigation after a brief explanation of the study had verbally been given to him

A total of forty patients were sampled in this study.

Tool

A standardized tool was used in assessing hostility in trauma patients. The tool was developed by Dr. Arnold H. Buss, a psychologist, and Ann Durkee, a sociologist, for the study of normal as well as abnormal personalities. It was a true-false questionnaire with seventy-five items (see appendix B). The patient was asked to answer the questions with a yes or no to minimize the feeling of taking a test. Hostility was evaluated in seven subclasses. The subclasses were assault, indirect hostility, irritability, negativism, resentment, suspicion, and verbal hostility (see appendix C).

There is also a subclass entitled guilt which composed nine of the test items. Whereas, it did not test hostility, the presence of guilt may inhibit the expression of hostility. Guilt has been defined as "feelings of being bad, having done wrong, and suffering pangs of conscience" (Buss 1957, p. 344).

Originally, the Buss-Durkee Inventory was administered to eighty-five college men and eighty-eight college women. Product-moment correlations were computed for men

and women separately. They are presented in tables 1 and 2, respectively. Two of the men's correlations were above .50 and none of the women's correlations were above .50. This suggested that the various scales were "tapping at least partially independent behaviors" (Buss 1957, p. 347).

TABLE 1

INTERCORRELATIONS FOR MEN

Variable	Assault	Indirect Hostility	Irritability	Negativism	Resentment	Suspicion	Verbal Hostility
Indirect hostility	.28						
Irritability	.32	.44					
Negativism	.30	.27	.20				
Resentment	.16	.33	.44	.31			
Suspicion	.11	.27	.26	.38	.58		
Verbal hostility	.40	.40	.66	.25	.37	.21	
Guilt	-.03	.28	.24	.08	.27	.25	.16

Source: Buss 1957, p. 347.

TABLE 2

INTERCORRELATIONS FOR WOMEN

Variable	Assault	Indirect Hostility	Irritability	Negativism	Resentment	Suspicion	Verbal Hostility
Indirect hostility	.38						
Irritability	.30	.31					
Negativism	.27	.34	.29				
Resentment	.14	.23	.30	.23			
Suspicion	.11	.19	.30	.15	.45		
Verbal hostility	.37	.19	.44	.30	.22	.21	
Guilt	-.07	.05	.16	.01	.33	.27	.10

Source: Buss 1957, p. 348.

Buss (1957) used Thurstone's centroid method to extract two factors from each correlation matrix. The factor loadings are presented in table 3. Only factor loadings of .40 and over were considered meaningful. Buss used this basis to define two factors. The first factor was defined by resentment and suspicion for men and by resentment, suspicion, and guilt for women. The second factor was defined by assault, indirect hostility,

irritability, and verbal hostility for both sexes. Negativism was included in this factor for women. These two factors roughly paralleled hostility and aggression. Resentment and suspicion fell under the heading of hostility as they dealt with attitudes that involved negative labels such as, "People are no damn good." Assault, indirect hostility, irritability, and verbal hostility came under the heading of aggression or having to do with a variety of attacking responses. The guilt and negativism loadings did not fit too well. However, only five questions in the inventory pertained to negativism.

TABLE 3

ROTATED FACTOR LOADINGS FOR MEN AND WOMEN

Variable	Men			Women		
	I	II	Commonality	I	II	Commonality
Assault	.17	.54	.27	.19	.61	.38
Indirect hostility	.19	.40	.37	.00	.48	.38
Irritability	.11	.57	.60	.14	.47	.44
Negativism	.23	.22	.25	-.03	.48	.34
Resentment	.59	.12	.55	.57	.04	.45
Suspicion	.66	-.02	.60	.54	.02	.45
Verbal hostility	.05	.63	.64	.04	.49	.44
Guilt	.29	.03	.14	.50	.28	.33

Source: Buss 1957, p. 348.

It has been established that social desirability determines to some extent the individual's response to inventory items. This tendency may be more significant in a hostility inventory as it deals with behaviors that are generally considered as socially unacceptable. In attempting to facilitate an individual's admitting socially undesirable behavior, Buss (1957) utilized three item writing techniques.

First, it was assumed that the socially undesirable state already existed and the subject was asked only whether he expressed it in a certain manner. An example of this is, "When I get mad, I say nasty things." Second, justification was provided for the occurrence of aggression as exemplified by "Whoever insults me or my family is asking for a fight." Third, the inventory included the use of idioms common in everyday life and used by individuals to describe their behavior and feelings to others. One such idiom used is, "If somebody hits me first, I let him have it."

Buss (1957) found that the correlation between social desirability and the probability of endorsing the item to be .27 for men and .30 for women. This suggested that the influence of social desirability has a small but significant effect on the individual's response.

Although there are no standard reliability and validity scores, the Buss-Durkee Inventory has been used

rather frequently as a tool to measure hostility. A study reported by Paul D. Knott (1970) from the University of Denver provided validation for the Buss-Durkee Inventory. Knott administered the Buss-Durkee Inventory to 110 male students in a general psychology class. The top nine scores (m = 57.17; range = 54-60) and the bottom nine scores (m = 14.02; range = 11-16) were used in the study. The subjects were placed in a situation where they received mild electrical shocks on six of sixty trials, and they were given the opportunity to shock other subjects.

The following results were obtained: A = the first trial on which the shocked subject retaliated with a shock to the other subject, B = the total number of trials in which the shocked subject shocked the other, and C = the mean intensity shock level used. Table 4 shows the differences between the high hostility (HH) and low hostility (LH) subjects on the measures using correlated t tests. Knott (1970) felt that the Buss-Durkee Inventory did an excellent job of predicting which subjects would be hostile.

Written persmission was obtained from Dr. Buss for use of the Buss-Durkee Inventory. A demographic information sheet was added to the inventory (see appendix D).

TABLE 4

DIFFERENCES BETWEEN HIGH HOSTILITY AND LOW HOSTILITY SUBSCORES ON THREE MEASURES OF AGGRESSIVENESS

Measure		High Hostility Subjects	Low Hostility Subjects	t (df=8)
A--first retaliation	M	13.00	35.89	3.48
	SD	3.28	21.09	
B--total trials	M	27.78	16.33	2.32
	SD	12.26	13.15	
C--intensity shock	M	4.97	3.01	2.31
	SD	1.51	1.97	

Source: Knott 1970, p. 808.

Data Collection

Data collection began on October 6, 1976, and ended December 7, 1976. The patients were selected by looking at the Kardex on the unit to ascertain whether or not they met the criteria of the study. The chart was then checked to insure that the information on the Kardex was correct. If the patient met the criteria, the charge nurse was approached and asked whether or not the patient was able to answer the inventory. If the charge nurse said yes, the patient was approached and given a brief explanation of the study (see appendix E). He was then asked if he was willing to participate in the study. If the patient agreed, he was

given form B, Consent to Act as a Subject for Research and Investigation, to sign (see appendix F) and a copy of the inventory.

Treatment of Data

The presence of hostility was measured by means of the Buss-Durkee Inventory. It was administered to a test group and a control group. The test group consisted of trauma patients who had met the specified criteria. The control group consisted of appendectomy and cholecystectomy patients who met the same requirements as the patients in the test group. Both groups were controlled for socio-economic status, sex, age, and diagnosis.

Of the seventy-five statements in the inventory, fifteen are no answers and the remaining sixty are yes answers (see appendix B). A no answer to those marked with an N is indicative of a hostile response as is a yes answer to the remaining sixty statements. For each hostile response, the patient was assigned a score of 1 point.

A preliminary analysis of variance was performed to insure homogeneity of the control group. Comparison of the test group and the control group was done by a multi-way analysis of variance. Product-moment correlations were computed for men and women separately. After significant

relationships were established, a factor analysis was performed to determine the different subclasses of hostility that were exhibited.

Summary

A nonexperimental explanatory research design was used in this study (Abdellah and Levine 1965). An 800-bed county, acute care hospital was used as the setting for this study. Three surgical units were sampled through the use of convenience sampling technique (Abdellah and Levine 1965).

Trauma patients and a control group of appendectomy and cholecystectomy patients were given the Buss-Durkee Inventory, a self-report questionnaire designed to evaluate the presence of hostility.

Chapter IV describes the analysis of data which was accomplished through the calculation of an anslysis of variance. A summary of findings, conclusions drawn as a result of the study, implications for nursing, and recommendations for further studies are contained in Chapter V.

CHAPTER IV

ANALYSIS OF DATA

A nonexperimental explanatory research design was used in this study (Abdellah and Levine 1965). A causal relationship was being sought between a traumatic accident and hostile feelings in hospitalized patients. Chapter IV presents the results and interpretations of the findings. The statistics used to analyze the data are included.

The analysis of data was conducted in accordance to the following purposes:

1. To determine whether or not trauma patients exhibited hostility

2. To determine whether or not there was a difference between the hostility reaction of trauma patients and the hostility reaction of appendectomy and cholecystectomy patients

3. To determine the subclasses of hostility that were exhibited--assault, indirect hostility, irritability, negativism, resentment, suspicion, and verbal hostility

4. To determine whether or not there was a difference between the hostility reaction of traumatized men and the hostility reaction of traumatized women

Characteristics of the Sample

A total of fifty-two questionnaires were given to the trauma group and the control group. Five questionnaires were not completed. One was discarded as it was from a patient in the control group who developed complications after receiving the questionnaire. Six patients were not high school graduates, invalidating their questionnaires. Forty questionnaires were retained for the study. This included ten men and ten women in the control group, and ten men and ten women in the trauma group. All the patients were between twenty-four and forty years of age (see appendix G).

Presentation of Findings

The data consisted of raw subtest scores on each of seven subtests, each subtest measuring some aspect of hostility. The subtests were assault, indirect hostility, irritability, negativism, verbal hostility, resentment, and suspicion. Each person tested was classified according to the five variables--group, sex, age, socioeconomic status, and diagnosis. Only the first three classifications were retained for the analysis.

The control group consisted of ten patients who had an appendectomy and ten patients who had a cholecystectomy.

A preliminary analysis of variance indicated no difference in hostility levels between these two groups of patients and they were subsequently considered as comprising one control group of twenty patients.

The test group consisted of twenty patients who had suffered one of three traumatic injuries. Three injuries were either a gunshot wound, a stab wound, or a motor vehicle accident. Table 5 shows the pattern of observation for the control and test groups for the three classifications--group, sex, and age.

TABLE 5

NUMBER OF OBSERVATIONS FOR EACH CLASSIFICATION

Age Group	Control Group		Trauma Group	
	Men	Women	Men	Women
24 - 31 years	7	7	7	7
32 - 40 years	3	3	3	3

Analysis of Variance

A multivariate analysis of variance was performed on the seven subtest scores. Since the raw test scores are based on different numbers of items, the raw scores were transformed to proportions by dividing each test score by the number of items for that test.

The arcsin transformation was then made to obtain a stable variance of the proportions. The analysis was performed on this transformed data. The data were analyzed for the main effects of group, sex, and age. The data were also analyzed for the interaction effects of group-sex group-age, sex-age, and group-sex-age. Only the group and sex main effects, and the group-sex-age interaction effect were found to be significant at the 10 percent level. The mean values for each classification in each group are in tables 6 and 7. The hypothesis that there would be no difference in the test scores of the trauma patients and the control group of appendectomy and cholecystectomy patients was rejected.

Viewing the seven subtests as forming a seven-dimensional random variable, the analysis implied that differences in means existed depending only on the group, sex, and group-sex-age effects. For individual subtests, this result was not uniform. For each subtest, at least one of these factors was significant. Other factors may also have been significant. These other factors, however, do not contribute to the overall differences in mean subtest scores.

Factor Analysis

Factor analysis is a statistical method used to analyze a number of observations made on one sample. It is

TABLE 6

MEAN SCORES BY CLASSIFICATION FOR THE CONTROL GROUP*

	Assault	Indirect Hostility	Irritability	Negativism	Verbal Hostility	Resentment	Suspicion
Men							
24-31	5.29	3.14	4.57	3.00	6.29	3.57	4.86
	(1.61)	(1.41)	(1.37)	(1.76)	(1.54)	(1.44)	(1.53)
32-40	7.00	1.67	2.67	2.67	9.00	3.00	4.33
	(1.99)	(0.88)	(1.02)	(1.64)	(1.97)	(1.31)	(1.43)
Women							
24-31	4.14	3.29	4.57	1.71	6.57	2.71	4.71
	(1.39)	(1.28)	(1.38)	(1.25)	(1.58)	(1.22)	(1.51)
32-40	4.00	4.67	6.33	1.67	6.00	2.33	4.00
	(1.33)	(1.63)	(1.77)	(1.21)	(1.49)	(1.11)	(1.36)

*Raw score (transformed score).

TABLE 7

MEAN SCORES BY CLASSIFICATION FOR THE TEST GORUP*

	Assault	Indirect Hostility	Irritability	Negativism	Verbal Hostility	Resentment	Suspicion
Men							
24-31	6.29	5.00	5.29	2.57	8.57	3.86	5.71
	(1.87)	(1.69)	(1.54)	(1.61)	(1.94)	(1.53)	(1.72)
32-40	6.67	5.00	7.33	3.33	8.67	6.67	6.33
	(1.95)	(1.69)	(1.92)	(1.93)	(1.93)	(2.31)	(1.85)
Women							
24-31	3.57	5.00	7.57	2.86	7.86	5.57	4.86
	(1.22)	(1.68)	(1.98)	(1.70)	(1.78)	(1.98)	(1.53)
32-40	3.67	4.33	4.00	0.67	5.33	4.33	3.00
	(1.26)	(1.52)	(1.28)	(0.89)	(1.38)	(1.66)	(1.15)

*Raw score (transformed score).

a two-step process which begins with correlating the seven subtests to determine if they can be accounted for by using fewer variables. The product-moment correlations were computed for men and women in each group separately. The correlation matrices are presented in tables 8 and 9. Each table contains several correlations greater than .50. This suggests that the different behaviors may not be independent. Rather, these behaviors have enough overlap or communality that they measure the same thing to a significant degree.

A factor analysis of the correlation matrices shown in tables 8 and 9 would indicate the clusters of variables that have a relatively high intercorrelation. The factor analysis not only indicates which behaviors go together, but also the degree to which any behavior is related to or belongs in a particular factor or group of variables. The indicator is called the factor loading of that behavior. It is possible for a behavior to belong in more than one factor. Generally, it will have a heavier factor loading for one factor than for the others. The overall degree to which a behavior correlates with that factor is reflected by the size of the factor loading.

The principle axis method was used to extract two factors from each correlation matrix. The axes were then rotated to similar simple structures so that the factor

TABLE 8

INTERCORRELATIONS FOR THE CONTROL GROUP

Variable	Assault	Indirect Hostility	Irritability	Negativism	Verbal Hostility	Resentment
Men						
Indirect hostility	.25					
Irritability	.35	.40				
Negativism	.59	.36	.68			
Verbal hostility	.76	-.03	.25	.26		
Resentment	.72	.35	.74	.79	.57	
Suspicion	.67	.23	.78	.74	.52	.94
Women						
Indirect hostility	.30					
Irritability	.71	.39				
Negativism	.32	.02	.10			
Verbal hostility	.85	.32	.74	-.10		
Resentment	.22	-.04	.05	.82	-.11	
Suspicion	.20	.48	.37	.16	.17	.34

TABLE 9

INTERCORRELATIONS FOR THE TEST GROUP

Variable	Assault	Indirect Hostility	Irritability	Negativism	Verbal Hostility	Resentment
Men						
Indirect hostility	.77					
Irritability	.64	.37				
Negativism	.36	.43	.35			
Verbal hostility	.72	.41	.55	.24		
Resentment	.30	.04	.77	.54	.23	
Suspicion	.07	.08	-.05	.16	.09	-.06
Women						
Indirect hostility	.04					
Irritability	-.03	.60				
Negativism	.57	.26	.30			
Verbal hostility	.12	.77	.66	.49		
Resentment	.39	.65	.50	.57	.51	
Suspicion	.11	-.11	-.16	.63	.04	.42

loadings would be comparable. These factor loadings and commonalities are presented in tables 10 and 11.

If only factor loadings of .50 and over were considered meaningful, the factors were defined as shown in table 12. For men in the control group, resentment and suspicion loaded equally and with the same weights on both factors. This agreed with the correlation matrix (table 8) where resentment and suspicion were highly correlated with each other and with all other behaviors except indirect hostility. For women in the test group, resentment also loaded equally on both factors. The large values for the commonalities (tables 10 and 11) indicated that the two factors generally accounted for a large portion of the test variance.

Within this study, there seemed to be some evidence to support the conclusion that Factor 1 was generally associated with irritability, verbal hostility, and resentment, and Factor 2 with negativism. To the extent that comparison with the Buss-Durkee analysis is valid, Factor 1 seemed in reasonable agreement with their Factor 2.

Limitations of Analysis

A word should be said about the assumptions made in performing the analyses. Both analyses required the assumption of independence of the variables. As indicated by the correlation matrices (tables 8 and 9), independence is

TABLE 10

ROTATED FACTOR LOADINGS FOR THE CONTROL GROUP

Variable	Men			Women		
	I	II	Commonality	I	II	Commonality
Assault	.86	.27	.81	.86	.23	.79
Indirect hostility	-.15	.74	.56	.59	.02	.35
Irritability	.30	.82	.76	.88	.06	.78
Negativism	.43	.76	.76	.03	.93	.86
Verbal hostility	.93	-.07	.86	.91	-.16	.85
Resentment	.69	.67	.93	-.01	.96	.91
Suspicion	.68	.64	.87	.44	.39	.34
Average			.79			.70

TABLE 11

ROTATED FACTOR LOADINGS FOR THE TEST GROUP

Variable	Men			Women		
	I	II	Commonality	I	II	Commonality
Assault	.41	.85	.88	.04	.66	.43
Indirect hostility	.15	.85	.74	.91	.02	.82
Irritability	.85	.32	.83	.86	-.05	.74
Negativism	.58	.30	.42	.33	.87	.87
Verbal hostility	.35	.70	.61	.87	.18	.80
Resentment	.96	-.09	.93	.64	.59	.76
Suspicion	-.22	.36	.17	-.15	.80	.67
Average			.65			.73

questionable. Also, factor analysis is a method of analysis best suited for large data sets. Conclusions reached on the basis of only forty observations are, at best, highly variable.

TABLE 12

FACTORS FOR EACH GROUP-SEX COMBINATION

Group	Sex	Factor 1	Factor 2
Control	Men	Assault, verbal hostility, resentment, suspicion	Indirect hostility, irritability, negativism, resentment, suspicion
	Women	Assault, indirect hostility, irritability, verbal hostility	Negativism, resentment
Test	Men	Irritability, negativism, resentment	Assault, indirect hostility, verbal hostility
	Women	Indirect hostility, irritability, verbal hostility, resentment	Assault, negativism, resentment, suspicion

Summary

A multivariate analysis of variance was performed on the seven subtest scores to determine the effects of the variables. It was found that the group and sex main effects, and the group-sex-age interaction effect were significant at the 10 percent level.

Product-moment correlations were computed for men and women separately. Several of the correlations were greater than .50 which suggested that the different hostility behaviors may not be independent. The principle axis method was used to extract two factors from each correlation matrix. Factor 1 was generally associated with irritability, verbal hostility, and resentment, and Factor 2 with negativism.

In Chapter V, a summary of the findings and conclusions were drawn as a result of this study. Implications for nursing and recommendations for further studies are included.

CHAPTER V

SUMMARY, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

The problem of this study was to determine whether or not trauma patients exhibited manifestations of hostility as a result of their injury compared to patients having a common surgical procedure. The analysis of data rejected the hypothesis that there would be no difference in the test scores of the trauma patients and the control group of appendectomy and cholecystectomy patients. A summary, conclusions, implications, and recommendations are presented in Chapter V.

Summary

A nonexperimental explanatory research design was used in this study. A causal relationship was being sought between a traumatic accident and hostile feelings in hospitalized patients.

The setting was an 800-bed teaching hospital. This institution is a county, acute care facility located in the Southwest. Three surgical units were sampled. These units admitted both general surgery and trauma patients.

Data were collected by the utilization of the Buss-Durkee Inventory. The tool was developed by Dr. Arnold H. Buss, a psychologist, and Ann Durkee, a sociologist. It was a true-false questionnaire with seventy-five items. Hostility was evaluated in seven subclasses. The subclasses were assault, indirect hostility, irritability, negativism, resentment, suspicion, and verbal hostility.

A multivariate analysis of variance was performed on the seven subtest scores to determine the effects of the variables. It was found that the group and sex main effects, and the group-sex-age interaction effect were significant at the 10 percent level.

Product-moment correlations were computed for men and women separately. Several of the correlations were greater than .50 which suggested that the different hostility behaviors may not be independent. The principle axis method was used to extract two factors from each correlation matrix. Factor 1 was generally associated with irritability, verbal hostility, and resentment, and Factor 2 with negativism.

Conclusions

As a result of this study, the following conclusions are made:

1. Trauma patients were more hostile than the control group of cholecystectomy and appendectomy patients

2. Traumatized men were more hostile than traumatized women

3. A significant difference existed in test scores depending upon a group-sex-age interaction

4. Two factors emerged from the subclasses of hostility that were exhibited: (a) irritability, verbal hostility, and resentment, and (b) negativism

Implications

This study has implications for instructors of nursing. In planning total patient care, nursing students need to be aware of the trauma patient's reaction to his injury and his potential for exhibiting a form of hostile behavior.

Nursing inservice instructors have a responsibility to upgrade the quality of nursing care given in an institution. Because the concept of the trauma patient is relatively recent, continuing education could assist the graduate nurse to develop an understanding of the emotional aspect involved in the care of these patients.

Implications for nurse researchers are to determine what other factors may influence the trauma patient's

hostility level. Further research could be done to investigate the differences in the hostile response of men and women.

This study has implications for nurses who work with trauma patients. In identifying her own role as a trauma nurse, the nurse should be aware of the emotional needs of the trauma patient. The nurse should understand the manner in which hostility may be exhibited and appropriate nursing interventions.

Recommendations

The following recommendations are offered as possible studies related to the findings of this study:

1. Replication of this study using larger samples in both the control group and the test group

2. Investigate whether or not there are other variables that affect hostility scores such as stress, change in body image, strange environment, separation from family, altered schedule, etc.

3. Compare the differences between male and female emotional reactions to injury and illness

4. Administer the Buss-Durkee Inventory to a variety of patients such as diabetics, cardiacs, maternity patients, etc. and determine significant differences in their results

APPENDIX A

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS

DALLAS CENTER
3810 Inwood Road
Dallas, Texas

HOUSTON CENTER
1130 M.D. Anderson Blvd.
Houston, Texas 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Parkland Memorial Hospital

GRANTS TO Mary Kane R.N., B.S.N.

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem: The problem of this study will be to determine whether or not trauma patients exhibit manifestations of hostility as a result of their injury as compared to patients having a common surgical procedure. Appendectomy and cholecystectomy patients will be used for the patients having a common surgical procedure.

The conditions mutually agreed upon are as follows:

1. The agency (may) ~~(may not)~~ be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) ~~(may not)~~ be identified in the final report.
3. The agency ~~(wants)~~ (does not want) a conference with the student when the report is completed.
4. The agency is (willing) ~~(unwilling)~~ to allow the completed report to be circulated through interlibrary loan.
5. Other: Would like report on analysis of data

Date October 5, 1976

Signature of Agency Personnel

Mary Kane
Signature of student

Geraldine M. Gonzales
Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original - Student; first copy -- agency; second copy -- T.W.U. College of Nursing.

APPENDIX B

PATIENT QUESTIONNAIRE

Please place a Y (yes) or N (no) in front of the question you are answering.

1. _____I seldom strike back, even if someone hits me first.

2. _____I sometimes spread gossip about people I don't like.

3. _____Unless somebody asks me in a nice way, I won't do what they want.

4. _____I lose my temper easily but get over it quickly.

5. _____I don't seem to get what's coming to me.

6. _____I know that people tend to talk about me behing my back.

7. _____When I disapprove of my friend's behavior, I let them know it.

8. _____The few times I have cheated, I have suffered unbearable feelings of remorse.

9. _____Once in a while I cannot control my urge to harm others.

10. _____I never get mad enough to throw things.

11. _____Sometimes people bother me just by being around.

12. _____When someone makes a rule I don't like, I am tempted to break it.

13. _____Other people always seem to get the breaks.

14. _____I tend to be on my guard with people who are somewhat more friendly than I expected.

15. _____I often find myself disagreeing with people.

16. _____I sometimes have bad thoughts which make me feel ashamed of myself.

17. _____I can think of no good reason for ever hitting anyone.

18. _____When I am angry, I sometimes sulk.

19. _____When someone is bossy, I do the opposite of what he asks.

20. _____I am irritated a great deal more than people are aware of.

21. _____I don't know any people that I downright hate.

22. _____There are a number of people who seem to dislike me very much.

23. _____I can't help getting into arguments when people disagree with me.

24. _____People who shirk on the job must feel very guilty.

25. _____If somebody hits me first, I let him have it.

26. _____When I am mad, I sometimes slam doors.

27. _____I am always patient with others.

28. _____Occasionally when I am mad at someone I will give him the "silent treatment."

29. _____When I look back on what's happened to me, I can't help feeling mildly resentful.

30. _____There are a number of people who seem to be jealous of me.

31. _____I demand that people respect my rights.

32. _____It depresses me that I did not do more for my parents.

33. _____Whoever insults me or my family is asking for a fight.

34. _____I never play practical jokes.

35. _____It makes my blood boil to have somebody make fun of me.

36. _____When people are bossy, I take my time just to show them.

37. _____Almost every week I see someone I dislike.

38. _____I sometimes have the feeling that others are laughing at me.

39. _____Even when my anger is aroused, I don't use "strong language."

40. _____I am concerned about being forgiven for my sins.

41. _____People who are continually pestering you are asking for a punch in the nose.

42. _____I sometimes pout when I don't get my own way.

43. _____If somebody annoys me, I am apt to tell him what I think of him.

44. _____I often feel like a powder keg ready to explode.

45. _____Although I don't show it, I am sometimes eaten up with jealousy.

46. _____My motto is "Never trust strangers."

47. _____When people yell at me, I yell back.

48. _____I do many things that make me feel remorseful afterward.

49. _____When I really lose my temper, I am capable of slapping someone.

50. _____Since the age of 10, I have never had a temper tantrum.

51. _____When I get mad, I say nasty things.

52. _____I sometimes carry a chip on my shoulder.

53. _____If I let people see the way I feel, I'd be considered a hard person to get along with.

54. _____I commonly wonder what hidden reason another person may have for doing something nice for me.

55. _____I could not put someone in his place, even if he needed it.

56. _____Failure gives me a feeling of remorse.

57. _____I get into fights about as often as the next person.

58. _____I can remember being so angry that I picked up the nearest thing and broke it.

59. _____I often make threats I don't really mean to carry out.

60. _____I can't help being a little rude to people I don't like.

61. _____At times I feel I get a raw deal out of life.

62. _____I used to think that most people told the truth but now I know otherwise.

63. _____I generally cover up my opinions of others.

64. _____When I do wrong, my conscience punishes me severely.

65. _____If I have to resort to physical violence to defend my rights, I will.

66. _____If someone doesn't treat me right, I don't let it annoy me.

67. _____I have no enemies who really wish to harm me.

68. _____When arguing, I tend to raise my voice.

69. _____I often feel that I have not lived the right kind of life.

70. _____I have known people who pushed me so far that we came to blows.

71. _____I don't let a lot of unimportant things irritate me.

72. _____I seldom feel that people are trying to anger or insult me.

73. _____Lately, I have been kind of grouchy.

74. _____I would rather concede a point than get into an argument about it.

75. _____I sometimes show my anger by banging on the table.

APPENDIX C

DEFINITION OF TERMS USED ON THE INVENTORY

These terms were defined for use in the inventory as follows:

Assault--physical violence against others. This includes getting into fights with others but not destroying objects.

Indirect hostility--both roundabout and undirected aggression. Roundabout behavior and undirected gossip or practical jokes is indirect in the sense that the hated person is not attacked directly but by devious means. Undirected aggression, such as temper tantrums and slamming doors, consists of a discharge of negative affect against no one in particular; it is a diffuse rage reaction that has no direction.

Irritability--a readiness to explode with negative affect at the slightest provocation. This includes quick temper, grouchiness, exasperation, and rudeness.

Negativism--oppositional behavior, usually directed against authority. This involves a refusal to cooperate that may vary from passive noncompliance to open rebellion against rules or conventions.

Resentment--jealously and hatred of others. This refers to a feeling of anger at the world over real or fantisized mistreatment.

Suspicion--projection of hostility onto others. This varies from merely being distrustful and wary of people to beliefs that others are being derogatory or are planning harm.

Verbal hostility--negative affect expressed in both the style and content of speech. Styles includes arguing, shouting, and screaming; content includes threats, curses, and being overcritical (Buss 1957, p. 343).

ITEMS COMPRISING THE HOSTILITY-GUILT INVENTORY*

(N = No items)

Assault:

1. Once in a while I cannot control my urge to harm others. (9)
2N. I can think of no good reason for ever hitting anyone. (17)
3. If somebody hits me first, I let him have it. (25)
4. Whoever insults me or my family is asking for a fight. (33)
5. People who continually pester you are asking for a punch in the nose. (41)
6N. I seldom strike back, even if someone hits me first. (1)
7. When I really lose my temper, I am capable of slapping someone. (49)
8. I get into fights about as often as the next person. (57)
9. If I have to resort to physical violence to defend my rights, I will. (65).
10. I have known people who pushed me so far that we came to blows. (70)

Indirect hostility:

1. I sometimes spread gossip about people I don't like. (2)
2N. I never get mad enough to throw things. (10)
3. When I am mad, I sometimes slam doors. (26)
4N. I never play practical jokes. (34)
5. When I am angry. I sometimes sulk. (18)
6. I sometimes pout when I don't get my own way. (42)
7N. Since the age of ten, I have never had a temper tantrum. (50)
8. I can remember being so angry that I picked up the nearest thing and broke it. (58)
9. I sometimes show my anger by banging on the table. (75)

Irritability:

1. I lose my temper easily but get over it quickly. (4)
2N. I am always patient with others. (27)

---

*The numbers in parentheses indicate the sequence of items in the mimeographed form of the inventory.

3. I am irritated a great deal more than people are aware of. (20)
4. It makes my blood boil to have somebody make fun of me. (35)
5N. If somebody doesn't treat me right, I don't let it annoy me. (66)
6. Sometimes people bother me just by being around. (11)
7. I often feel like a powder keg ready to explode. (44)
8. I sometimes carry a chip on my shoulder. (52)
9. I can't help being a little rude to people I don't like. (60)
10N. I don't let a lot of unimportant things irritate me. (71)
11. Lately, I have been kind of grouchy. (73)

Negativism:

1. Unless somebody asks me in a nice way, I won't do what they want. (3)
2. When someone makes a rule I don't like, I am tempted to break it. (12)
3. When someone is bossy, I do the opposite of what he asks. (19)
4. When people are bossy, I take my time just to show them. (36)
5. Occasionally when I am mad at someone, I will give him the "silent treatment." (28)

Resentment:

1. I don't seem to get what's coming to me. (5)
2. Other people always seem to get the breaks. (13)
3. When I look back on what's happened to me, I can't help feeling mildly resentful. (29)
4. Almost every week I see someone I dislike. (37)
5. Although I don't show it, I am sometimes eaten up with jealousy. (45)
6N. I don't know any people that I downright hate. (21)
7. If I let people see the way I feel, I'd be considered a hard person to get along with. (53)
8. At times I feel I get a raw deal out of life. (61)

Suspicion:

1. I know that people tend to talk about me behind my back. (6)
2. I tend to be on my guard with people who are somewhat more friendly than I expected. (14)
3. There are a number of people who seem to dislike me very much. (22)

4. There are a number of people who seem to be jealous of me. (30)
5. I sometimes have the feeling that others are laughing at me. (38)
6. My motto is "Never trust strangers." (46)
7. I commonly wonder what hidden reason another person may have for doing something nice for me. (54)
8. I used to think that most people told the truth but now I know otherwise. (62)
9N. I have no enemies who really wish to harm me. (67)
10N. I seldom feel that people are trying to anger or insult me. (72)

Verbal hostility:

1. When I disapprove of my friends' behavior, I let them know it. (7)
2. I often find myself disagreeing with people. (15)
3. I can't help getting into arguments when people disagree with me. (23)
4. I demand that people respect my rights. (31)
5N. Even when my anger is aroused, I don't use "strong language." (39)
6. If somebody annoys me, I am apt to tell him what I think of him. (43)
7. When people yell at me, I yell back. (47)
8. When I get mad, I say nasty things. (51)
9N. I could not put someone in his place, even if he needed it. (55)
10. I often make threats I don't really mean to carry out. (59)
11. When arguing, I tend to raise my voice. (68)
12N. I generally cover up my poor opinion of others. (63)
13N. I would rather concede a point than get into an argument about it. (74)

Guilt:

1. The few times I have cheated, I have suffered unbearable feelings of remorse. (8)
2. I sometimes have bad thoughts which make me feel ashamed of myself. (16)
3. People who shirk on the job must feel very guilty. (24)
4. It depresses me that I did not do more for my parents. (32)
5. I am concerned about being forgiven for my sins. (40)
6. I do many things that make me feel remorseful afterward. (48)

7. Failure gives me a feeling of remorse. (56)
8. When I do wrong, my conscience punishes me severely. (64)
9. I often feel that I have not lived the right kind of life. (69)

APPENDIX D

PATIENT INFORMATION

(Please check one.)

1. Age: 24-27 _____

   28-31 _____

   32-35 _____

   36-40 _____

2. Sex: Male _____

   Female_____

3. Education: High school graduate _____

   Did not graduate from high school _____

   College graduate _____

4. Yearly family income: Less than $6,000 _____

   $6,000 to $10,000 _____

   Over $10,000 _____

5. Diagnosis: _____
   (will be taken from chart)

APPENDIX E

EXPLANATION TO THE PATIENT

My name is Mary Kane. I am a registered nurse and currently working for a master's degree in nursing. As part of the course requirements I am doing a research study involving the feelings of hospitalized patients. It is important for the nurse to understand how the patient feels in order for us to help them through their hospitalization. To find out what some of your feelings are now, I have a questionnaire with seventy-five yes or no items. There are no right or wrong answers. Your name will not be used. Do you have any questions? (At this time, a brief explanation is given for any questions.) Do you feel able to fill out the questionnaire? Are you willing to sign a release form giving me permission to give you a questionnaire? (If the patient agrees, he will be told the following.) Do not dwell on the questions but answer with your first thoughts. I will return tomorrow to see if you have finished. Your assistance is most appreciated.

APPENDIX F

TEXAS WOMAN'S UNIVERSITY

(Form E -- Oral presentation to subject) 97

Consent to Act as a Subject for Research and Investigation:

I have received an oral description of this study, including a fair explanation of the procedures and their purpose, any associated discomforts or risks, and a description of the possible benefits. An offer has been made to me to answer all questions about the study. I understand that my name will not be used in any release of the data and that I am free to withdraw at any time.

: _____ _____
Signature Date

_____ _____
Witness Date

Certification by Person Explaining the Study:

This is to certify that I have fully informed and explained to the above named person a description of the listed elements of informed consent.

_____ _____
Signature Date

_____ _____
Position

_____ _____
Witness Date

APPENDIX G

DEMOGRAPHIC DATA FOR THE CONTROL GROUP

Sex	Diagnosis	Age	Income	Assault	Indirect Hostility	Irritability	Negativism	Verbal Hostility	Resentment	Suspicion	Guilt
Male	Cholecystectomy	24-27	<6,000	7	2	6	5	8	6	8	5
Male	Cholecystectomy	28-31	>10,000	7	6	3	3	6	4	5	2
Male	Cholecystectomy	28-31	>10,000	4	4	1	2	4	1	1	1*
Male	Cholecystectomy	36-40	6-10,000	6	2	2	3	9	2	2	2
Male	Appendectomy	24-27	6-10,000	1	1	2	1	3	1	2	4
Male	Appendectomy	24-27	<6,000	6	7	5	4	7	4	7	3
Male	Appendectomy	28-31	<6,000	7	5	6	3	11	6	7	3
Male	Appendectomy	28-31	<6,000	5	4	7	3	5	3	4	2
Male	Appendectomy	32-35	6-10,000	7	1	2	1	10	2	4	1
Male	Appendectomy	36-40	<6,000	8	2	4	4	8	5	7	2
Female	Cholecystectomy	24-27	<6,000	6	3	9	3	9	3	5	4
Female	Cholecystectomy	28-31	<6,000	4	4	6	0	8	2	8	4
Female	Cholecystectomy	28-31	<6,000	5	1	6	1	8	2	2	5
Female	Cholecystectomy	28-31	<6,000	4	2	2	6	1	1	2	3
Female	Cholecystectomy	36-40	<6,000	1	2	4	1	3	2	3	5
Female	Cholecystectomy	36-40	<6,000	6	8	10	1	9	1	6	9
Female	Appendectomy	24-27	<6,000	2	5	1	1	5	1	3	4
Female	Appendectomy	28-31	<6,000	5	5	5	3	7	6	6	7
Female	Appendectomy	28-31	6-10,000	3	3	3	3	3	4	7	4
Female	Appendectomy	36-40	<6,000	5	4	5	3	6	4	3	8

*College graduate.

DEMOGRAPHIC DATA FOR THE TRAUMA GROUP

Sex	Diagnosis	Age	Income	Assault	Indirect Hostility	Irritability	Negativism	Verbal Hostility	Resentment	Suspicion	Guilt
Male	Gunshot wound	24-27	6-10,000	4	3	4	2	6	4	6	5
Male	Gunshot wound	28-31	<6,000	5	5	6	4	5	5	5	3
Male	Gunshot wound	28-31	>10,000	4	2	4	2	10	3	7	6
Male	Gunshot wound	32-35	<6,000	5	4	6	4	9	7	5	9
Male	Stab wound	24-27	<6,000	9	5	9	2	12	6	4	8
Male	Stab wound	24-27	>10,000	8	6	3	3	8	3	6	6*
Male	Stab wound	36-40	<6,000	6	4	7	2	6	6	7	7
Male	Motor veh. acc.	24-27	6-10,000	9	8	7	4	12	4	7	4
Male	Motor veh. acc.	28-31	>10,000	5	6	4	1	7	2	5	4*
Male	Motor veh. acc.	36-40	<6,000	9	7	9	4	11	7	7	6
Female	Gunshot wound	24-27	>10,000	1	4	8	3	6	5	7	3*
Female	Gunshot wound	28-31	<6,000	4	3	5	2	7	5	6	3
Female	Gunshot wound	28-31	<6,000	7	6	8	5	8	8	6	9
Female	Stab wound	24-27	<6,000	2	6	9	1	9	5	1	3
Female	Stab wound	32-35	6-10,000	1	5	2	0	6	4	4	2
Female	Stab wound	32-35	<6,000	6	6	7	2	7	6	3	3
Female	Motor veh. acc.	24-27	<6,000	4	5	5	4	8	6	8	9
Female	Motor veh. acc.	24-27	>10,000	5	5	8	4	9	4	3	5
Female	Motor veh. acc.	24-27	6-10,000	1	6	10	1	8	6	3	4*
Female	Motor veh. acc.	32-35	6-10,000	4	2	3	0	3	3	2	1

*College graduate.

APPENDIX H

TEXAS WOMAN'S UNIVERSITY

DENTON, TEXAS 76204

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THE GRADUATE SCHOOL
P.O. BOX 22479, TWU STATION

October 19, 1976

Miss Mary Kane
6607 E. Lovers Lane #109
Dallas, Texas 75214

Dear Miss Kane:

I have received and approved the prospectus for your research project.

Best wishes to you in the research and writing of your thesis.

Sincerely,

Phyllis Bridges

Phyllis Bridges
Dean

PB:le

cc: Ms. Goosen
Dr. Chinn

APPENDIX I

TEXAS WOMAN'S UNIVERSITY
RESEARCH INSTITUTE
DENTON, TEXAS 76204

104

BONE METABOLISM LABORATORY
BOX 23546, TWU STATION
PHONE (817) 387-5305

October 4, 1976

Ms. Mary Kane
Texas Woman's University
Dallas Center
Dallas, Texas

Dear Ms. Kane:

The Human Research Review Committee has reviewed and approved your program plan, "Hostility reactions in trauma patients".

Sincerely yours,

George P. Vose, Chairman
Human Research Review Committee

cc Ms. Goosen
Dr. Bridges

RESEARCH AND INVESTIGATION INVOLVING HUMANS

Statement by Program Director and Approved by Department Chairman

This abbreviated form is designed for describing proposed programs which the investigators consider there will be justifiable minimal risk to human participants. If any member of the Human Research Review Committee should require additional information, the investigator will be so notified.

Copies of this Statement and a specimen Statement of Informed consent should be submitted at the earliest possible time before the planned starting date to the chairman or vice chairmen listed below:

Denton Campus (Submit five copies)

Mr. George Vose, Chairman
Dr. Calvin Janssen, Vice-Chairman
Dr. Marjorie Keele
Dr. Aileene Lockhart
Dr. Carolyn Rozier

Houston Campus (Submit five copies)

Dr. Helen Ptak, Vice-Chairman
Dr. Laura Smith
Mrs. Patricia Smith
Mrs. Irene Robertson

Dallas Campus (Submit one copy)

Dr. Opal White, Vice-Chairman
Mrs. Geraldine Logue
Mrs. Patricia Pardies

Title of Study: Hostility Reactions In Trauma Patients

Project Director(s): Geri Goosen

Bennie Harsanyi, Dr. Deanne French

Graduate Student: Mary Kane

Estimated beginning date of study: 9/20/76 Estimated duration: 11/12/76

1. Brief description of the study (use additional pages or attachments, if desired, and include the approximate number and ages of participants, and where they will be obtained).

The problem of the study is to determine whether or not trauma patients exhibit manifestations of hostility as a result of their injury. The trauma patients that will be studied are specifically those who have been hospitalized as a result of a violent force such that sustained from a gun-shot, stabbing or motor vehicle accident. A 75 item yes or no questionnaire designed to measure hostility will be (see attached sheet)

2. What are the potential risks to the human subjects involved in this research or investigation? "Risk" includes the possibility of public embarrassment and improper release of data. Even seemingly nonsignificant risks should be stated and the protective procedures described in (3) below.

The only potential risk involved in this study would be invasion of the privacy of the patient.

3. Outline the steps to be taken to protect the rights and welfare of the individuals involved:

1. A verbal explanation of the study will be given to the patient.
2. No names will be used.
3. The patient will be told he does not have to participate in the study if he so desires.

4. Outline the method for obtaining informed consent from the subjects or from the person legally responsible for the subjects. Attach documents, i.e., a specimen informed consent form. These may be properly executed through completion of either (a) the written description form, or (b) the oral description form which are available from the committee chairman or may be reproduced from the attached specimen copies. Other forms which provide the same information will be acceptable.

The patient will be given an oral explanation of the study. The explanation is:

"My name is Mary Kane. I am a registered nurse and currently working for a masters degree in nursing. As part of the course requirements, I am doing a research study involving the feelings of hospitalized patients. It is important for nurses to understand how a patient feels in order for us to help him through his hospitalization. In order to find out what some of your feelings are now, I have a questionnaire with seventy-five yes or no items. There are no right or wrong answers. Your name will not be used. Do you have any questions? (At this time, a brief explanation will be given for any questions). Do you feel able to fill out the questionnaire? Are you willing to sign a release form giving me permission to give you a questionnaire? (If the patient agrees, he will be told the following). Do not dwell on the questions but answer with your first thoughts. I will return tomorrow to (see attached sheet)

1. (cont.)
administered. The questionnaire was developed by Dr. Arnold H. Buss, a psychologist. The scores of the trauma patients will be compared to those of the patients who have had an intact appendix removed surgically. The patient population will be between 24 and 40 years of age. They will be taken from the trauma and general surgery units at Parkland Memorial Hospital. Those units are 2E, 2W and 9S. A total of 40 patients will be included in the study.

4. (cont.)
see if you have completed the questionnaire. Your assistance is most appreciated."

At this time, the patient will be asked to sign Texas Woman's University's form B, the Consent to Act as a Subject for Research and Investigation.

5. If the proposed study includes the administration of personality tests, inventories, or questionnaires, indicate how the subjects are given the opportunity to express their willingness to participate. If the subjects are less than the age of legal consent, or mentally incapacitated, indicate how consent of parents, guardians, or other qualified representatives will be obtained.

After an explanation of the study is given to the patient, he will be asked if he wishes to participate in the study. He will also be told that he does not have to participate in the study. The subjects will be at least 24 years old and mentally capable of answering the questionnaire.

(Signed)_____ _____
Program Director Date

(Signed)_____ _____
Graduate Student Date

(Signed)_____ _____
Dean, Department Head, or Director Date

Date received by committee chairman:_____

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