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San Jose State University

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**A PHENOMENOLOGICAL NEEDS ASSESSMENT OF
SEXUAL MINORITY PATIENTS IN AN
ACUTE PSYCHIATRIC SETTING**

A Thesis

Presented to

The Faculty of the Department of Occupational Therapy

San Jose State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

by

Richard Bookwalter

December 1995

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APPROVED FOR THE DEPARTMENT OF OCCUPATIONAL THERAPY

Elizabeth Cara, MA, OTR, MFCC

Anne MacRae, Ph.D., OTR

Lynne Andonian, OTR

APPROVED FOR THE UNIVERSITY

Serena H. Stanford

ABSTRACT

A PHENOMENOLOGICAL NEEDS ASSESSMENT OF SEXUAL MINORITY PATIENTS IN AN ACUTE PSYCHIATRIC SETTING

by Richard Bookwalter

This study examines how sexual minority patients admitted to an acute psychiatric unit at San Francisco General Hospital (SFGH) experience their needs. Phenomenological interviews were conducted with five self-identified gay or bisexual men exposed to the Gay and Lesbian Focus Program at SFGH.

The data were analyzed from the attitude of occupational therapy, with an emphasis on the needs identified by patients and their relevance to psychiatric occupational therapy treatment and frames of reference. The study reveals that need, as experienced by the subjects, is a phenomenon arising from the individual's desires, fears, and expectations about himself, other people, and the world around him. The subjects identify specific needs in the following areas: daily living skills, objects in the environment, social support, intangible environmental qualities, specific types of interactions with others, time/schedule adjustments, group activities, assistance with interactions with the environment, and information.

Acknowledgments

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Liz Cara provided much-needed advice on all aspects of the project, injecting “magic” into my interview techniques and helping me shape this document. Anne MacRae not only inspired and unlocked the mysteries of phenomenology for me, but she also drove me home. Lynne Andonian was the creative mind behind the decision to ask patients their opinion, the persuasive recruiter of subjects, my teacher during my first internship, and the clinician who offered that critical real-world perspective.

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CHAPTER 1

INTRODUCTION

Purpose

The intent of this research is to examine how lesbian, gay, and bisexual patients exposed to the Gay and Lesbian Focus Program (Unit 7B) in the Department of Psychiatry at San Francisco General Hospital (SFGH) experience their needs. Of particular interest is gay, lesbian, and bisexual patients' perceptions of their needs during their hospitalization, their work with the staff on 7B, and their experience with occupational therapy (OT). Information from this study will be used to inform program planning at SFGH.

Statement of the Problem

In August 1994, San Francisco General Hospital established a Gay and Lesbian Focus Program on one of its acute inpatient psychiatric units (7B). SFGH is the public hospital serving residents of the City and County of San Francisco, California, and 7B is a 22-bed locked unit. The program is one of six at SFGH that attempt to meet the special cultural needs of certain target populations (the other programs focus on Asians, Latinos, African Americans, women, and people infected with the human immunodeficiency virus, or HIV; Dillard et al., 1992).

This study grew out of a recommendation by the Lesbian, Gay, and Bisexual Task Force in the SFGH Department of Psychiatry to design an

anonymous questionnaire to assess the needs of sexual minority patients in the Lesbian and Gay Focus Program on 7B (Lynne Andonian, personal communication, November 4, 1994). This recommendation is consistent with the hospital's larger effort to deliver appropriate, patient-centered care, and its Continuous Quality Improvement (CQI) process (San Francisco General Hospital, 1994). Gay, lesbian, and bisexual patients themselves were to be asked what their needs were, to inform program development and to assess the appropriateness of existing services for sexual minority patients (Lynne Andonian, personal communication, November 4, 1994).

However, some staff members on 7B had previous negative experience with anonymous questionnaires that were improperly developed, failed to contain items that accurately reflected patient concerns, and were not useful. It was decided that a descriptive study involving a small group of patients might be an appropriate starting point, and that a more extensive survey could be conducted later. While the findings from a small-scale study would not necessarily be generalizable to the larger patient population on 7B, they could be expected to uncover issues of concern to patients that do not arise during routine patient-caregiver interactions. Once the concerns of a few

patients were identified, further research could determine the frequency of these concerns in the larger patient population.

Research Questions and Definitions

Research Question

What is the experience of need for lesbian, gay, and bisexual patients in acute psychiatry?

Sensitizing Questions

The following questions guided the research:

1. What needs do gay, lesbian, and bisexual patients on SFGH unit 7B identify as relevant to their hospitalization and treatment?
2. To what degree do gay and lesbian patients' experiences with and views of occupational therapy match the conceptualizations presented by current occupational therapy frames of reference?

Definitions

Brewin, Wing, Mangen, Brugha, and MacCarthy (1987) describe "need" as a term with "a range of connotations, including a state of want or destitution, a condition requiring some extraneous aid, and an imperative call or demand for some provision" (p. 971), but consider the term "ambiguous about the extent to which action is required" (p. 971). The authors' excellent discussion of need in the health care literature cites Bradshaw's distinction between felt need, which is experienced by

patients, and expressed need, which is both experienced and communicated (as cited in Brewin et al., 1987).

Externally-defined need is classified as either normative (based on the judgment of professionals) or comparative (based on comparisons with the circumstances of other people or reference groups; Brewin et al., p. 972). Brewin et al. state that needs are composed of both factual and value elements, include judgments about what is acceptable and unacceptable. This dichotomy leads the authors to conclude that “need” cannot be objectively defined, but must be understood in terms of the person or group identifying it (Brewin, et al., p. 972). The phenomenological approach to this study, described in Chapter 3, is thus ideally suited to learning about the needs experienced by psychiatric patients on 7B.

One of the thorniest issues in research on gay men, lesbians, and bisexuals is finding identifying terminology that is descriptive and inclusive, but not too cumbersome to use effectively. As Dynes and Donaldson (1992) put it, writers have “commonly confused the phenomenon of homosexual attraction with the absence of heterosexual attraction” (p. ix), giving rise to the use of the term “bisexual.” “Homosexual” is also deemed unacceptable because it tends to be associated with men and not with women (Scott, 1991) and emphasizes

the sexual aspects of the gay and lesbian experience at the expense of emotions, social groupings, and culture. Further clouding the issue of definition is the distinction between gay or lesbian identity and sexual behavior, which may not coincide (Cabaj, 1992; Hammersmith & Weinberg, 1973/1992).

For this paper, the terms “heterosexual,” “bisexual,” “lesbian,” and “gay” will be used, because they are the terms used on the Multidisciplinary Assessment Data Base form used in the Department of Psychiatry at San Francisco General. (A copy of this form is in Appendix A.) Patients are routinely asked to identify themselves using one of these terms during their initial interview with a social worker on 7B. The terms therefore refer to patients’ self-defined identity rather than their behavior. “Sexual minority” will be used as an umbrella term to include the gay, lesbian, and bisexual groups. In descriptions of the work of authors who do not make the distinction between identity and behavior, the terms “homosexual” and “homosexuality” may also be used to describe men and women sexually and emotionally attracted to people of the same gender.

Limitations of the Study

The preferred method for identifying the special needs of gay, lesbian, and bisexual patients in acute psychiatry would be to compare

the needs described by a representative sample of heterosexual psychiatric inpatients with the needs described by a representative sample of gay, lesbian, and bisexual psychiatric inpatients.

Unfortunately, even if truly representative samples could be recruited (an open question), such a study is beyond the resources of the investigator. A smaller-scale project was developed to generate new knowledge that can inform comparative survey research in the future.

Consequently, the study has several additional limitations. First, the convenience method of selecting the research sample for this study prohibits one from generalizing the findings from this study to gay and lesbian patients in other hospitals, or even to other gay and lesbian patients on 7B at SFGH. It also resulted in an all-male sample, so that the views of lesbians are not included.

Second, the small sample size (and, again, the convenience sample) does not provide sufficient information on frequency to determine how often other gay and lesbian psychiatric patients at SFGH share the subjects' views. Third, while every effort was made to inform subjects about the research questions, the content and direction of the phenomenological interview is, by design, determined by the subject: The interviews may not have obtained as much information relevant to the research questions as the investigator might have wished.

A key intent of the research has been to generate a list of concerns, expressed by a few patients, that can be incorporated into a questionnaire for a larger group of patients on 7B. This is consistent with a method for survey development described by Hayes (1992). However, the development and pilot-testing of the questionnaire and the administration of the survey are additional activities beyond the scope of this project.

Significance of the Study

This study is significant in that it ties together several threads of current thinking about health care delivery and occupational therapy treatment. The current trend toward improved customer service in health care has generated renewed interest in the cultural appropriateness of care for the diverse U.S. population and in the need for reliable methods for polling customers about their satisfaction with health services. The study is also consistent with the holistic and client-centered approaches to health care advocated by most occupational therapy theorists, including the developers of the model of human occupation and the Canadian Occupational Performance Model (Kielhofner, 1995a; Canadian Association of Occupational Therapists, CAOT, 1993).

Culturally Appropriate Health Care

The importance of culturally appropriate health care has been described by Dillard et al. (1992), Jessop (1993), Peloquin (1990), Pizzi (1990), and Scaffa and Davis (1990). Miscommunication, stereotyping, and prejudice are viewed as barriers to accurate diagnosis, effective treatment, compliance, and stability in the community, which are all necessary for maintenance of public health and containment of health care costs (Scaffa & Davis). Recognition of sexual minorities as members of distinct subcultures with distinct mental health needs has led to the establishment of specialized acute psychiatric facilities at San Francisco General Hospital and in Belmont, California. These facilities are so new that no research on the needs of their patient population has yet been published. Mental health professionals, including occupational therapists, working in these facilities therefore currently have little research on which to base program planning.

Customer Satisfaction with Health Care Services

Moreover, Marszalek-Gaucher and Coffey (1990) state that the quality of a service (including the quality of care delivered by a health care institution) is defined by how well it meets the needs of its customers. The authors describe a three-step method for determining customer needs that includes asking customers what they perceive to be

their requirements, through direct communication (p. 107). This project is intended to complement traditional program planning in psychiatry based on case study research and, ultimately, help make SFGH more responsive to patient needs. Hinton and Stout (1993) assert that health care treatment compliance increases when patients' subjective perceptions of treatment are positive (p. 45).

Previous research on the needs perceived by sexual minority patients in acute psychiatry could inform the development of a questionnaire to assess the needs of lesbian, gay, and bisexual patients on 7B, but a review of the literature found no studies of this population (Ford, Young, Perez, Obermeyer, & Rohner, 1992; Mallon, 1992; Rabin, Keefe, & Burton, 1986; Solomon & Beck, 1989). A broader survey, which would be much more generalizable than this study, could therefore not be conducted until one or more qualitative studies like this one have been conducted.

Occupational Therapy

This study is highly relevant to occupational therapy treatment and theory development. The model of human occupation (Kielhofner, 1995a) offers a structure for organizing and relating information gathered on clients' beliefs, motivations, sense of personal efficacy, roles, values, habits, and skills. Kielhofner and Burke (1985) describe how internalized

personal-sexual, familial-social, and occupational roles are related (p. 25). These relationships may be reflected in the occupational behavior of sexual minority people and should therefore be considered by occupational therapists treating them. For example, in a survey of non-institutionalized male homosexuals, Weinberg and Williams (1974) find conflicts between personal-sexual and occupational roles, with subjects concealing their homosexuality for fear of job discrimination. This concealment is viewed as affecting social relationships as well (Weinberg & Williams).

Similarly, Eldridge and Gilbert (1990) find that conflicts among personal, family, and work roles in lesbian couples are negatively correlated to relationship satisfaction and life satisfaction. Occupational therapists need to examine the intimate link between one's sexual orientation and one's ability to accomplish meaningful activities, if sexual minority patients are to receive appropriate and satisfactory occupational therapy services. Jackson (1995) recently completed important work in this area.

This study is also relevant to the movement for client-centered care. Pollock (1993) states that patients should be involved in identifying the goals of OT treatment because, "if the person is no longer the problem definer, it is unlikely that he or she will be the problem solver either" (pp. 298-299). The Canadian Occupational Performance Measure

(COPM), which Pollock helped develop, is explicitly designed to build client participation into the process of goal-setting for OT treatment (Law et al., 1994). Clients' satisfaction with their progress is also quantified and used as a key outcome measure in the COPM (Law et al., 1994).

CHAPTER 2

REVIEW OF THE LITERATURE

Several areas of previous research seemed relevant to a needs assessment of sexual minority patients in acute psychiatry and were consulted during the design phase of this study. First, the literature on patient needs assessment in mental health was consulted for information on the views of acute psychiatric patients and sexual minorities. Second, the literature on psychiatric disorders of gay, lesbian, and bisexual patients and psychiatric treatment issues (including the development of orientation and identity, as well as patients' views of themselves, relationships with others, and stressors) is relevant to treatment and discharge planning.

Third, literature on the cultural competency of therapists and the nature of therapeutic relationships appeared likely to shed light on the cultural appropriateness of treatment for this population. Fourth, and finally, research on patterns of occupational and role behaviors preferred by gay men and lesbians could be relevant to occupational therapy. This chapter presents the key findings from a review of this literature.

Literature relevant to additional topics brought up during the interviews will be discussed in Chapter 5.

Patient Needs Assessment in Mental Health

A review of the literature found numerous needs assessments for mental-health services, but few studies that have polled gay, lesbian, or bisexual patients about their perceived needs. In general, mental health needs assessments appear to have focused on outpatient or adolescent populations or to have collected data on parents' or health professionals' views of patient, rather than the views of patients themselves (Ford et al., 1992; Mallon, 1992; Rabin et al., 1986; Solomon & Beck, 1989).

Nonetheless, Hinton and Stout (1993) describe the views of patients as critical to the success of health care quality improvement (p. 45) and assert that patient satisfaction increases patient cooperation with and acceptance of recommendations from physicians and therapists (p. 42). Hinton and Stout adopt Petersen's definition of patient satisfaction: "a subjective perception from a patient's point of view that care givers, however, must view as reality" (as cited in Hinton & Stout p. 42). This suggests an approach to research that identifies patient's perceptions of their needs.

Study of Psychiatric Emergency Patients

Solomon and Beck (1989) interviewed 52 chronic psychiatric patients who sought treatment in a Cleveland hospital psychiatric emergency room, but were not admitted to the hospital, during a 17-day

period in 1987. Subjects were asked about their service needs during the previous month. Seventy-one percent of the subjects had at least one previous psychiatric hospitalization (p. 218). About half (48%) were diagnosed with a substance-abuse disorder, and about one-fifth (21%) with a “schizophrenic disorder” (Solomon & Beck, p. 218).

The investigators compiled a list of 23 areas of need identified by all the subjects. Most frequently mentioned (that is, identified by one-half to two-thirds of the subjects) were the need for information and advice, financial assistance, counseling, and assistance in controlling emotions (Solomon & Beck, 1989, p. 219). One-quarter or less of the respondents identified the following needs: developing leisure-time activities, meeting people, budgeting, managing or obtaining medications, and getting along with others (p. 215). The number of needs identified by each subject ranged from 1 to 18, with a median of 7 and an average of 7.25, indicating that the subjects generally had a multiplicity of needs (Solomon & Beck, p. 222).

In general, subjects reported that they sought help from formal service providers, family, and friends to meet the needs they identified, except in the areas of dressing and hygiene, budgeting, and meeting people (Solomon & Beck, 1989, p. 223). If the gay, lesbian, and bisexual clients on 7B share the needs and service utilization patterns of the

subjects in Solomon and Beck's study, 7B might consider focusing staff resources on programming to address personal care, budgeting, and social skills.

Study of Psychiatric Day Treatment Patients

Perez, Mortimer, and Russell (1987) surveyed 71 patients in a psychiatric day hospital in Ottawa to determine their use of services, problems encountered, satisfaction, and aftercare needs (p. 85). About one-quarter of respondents were employed, about three-quarters of the unemployed respondents wanted a job, and about two-thirds of the unemployed had looked for work in the previous two years (Perez et al., p. 88). Respondents cited lack of experience and inconsistent work histories due to illness as the two main barriers to finding work. Respondents tended to express interest in job training and education, with a strong preference for vocational programs over educational programs (Perez et al., p. 90). The subjects of this study did not feel that vocational programs were unavailable in their Canadian community (Perez et al., p. 89). Three-quarters of respondents identified "comfort with others attending" (Perez et al., p. 88) as the most important determinant of their satisfaction with vocational programs, while only half cited "taught necessary job skills" (p. 88). Comfort with others was

also an important element of patient satisfaction with social-recreational programs (Perez et al., p. 88).

Study of Psychiatric Outpatients in Pennsylvania

Lynch and Kruzich (1986) interviewed mental health professionals serving a probability sample of 286 chronically mentally ill outpatients in 30 agencies (e.g., hospitals and social service agencies) to determine patients' needs in one Pennsylvania county. The authors also conducted group interviews with a non-random sample of 45 clients to obtain their views and compare them to the views of the professionals.

Lynch and Kruzich (1986) found that professional and client perspectives on service needs and barriers to service use differ, and that both professionals and clients tend to attribute inadequacies in treatment to the shortcomings of others. The professionals viewed medication checks and individual therapy as the two interventions required by at least half their clients, and identified client resistance as the biggest obstacle to mental health service utilization (Lynch & Kruzich, p. 243).

The clients, unlike their case managers, felt that needed services were unavailable (Lynch & Kruzich, 1986, p. 244). Clients described the need for more activities programs (both in the community and in hospitals), improved daily living skills, services on weekends and

evenings, and more information on services available in the community (Lynch & Kruzich, p. 244). Moreover, the clients viewed a lack of finances and inadequate case management as the main barriers to their utilization of services (Lynch & Kruzich, p. 244).

Lynch and Kruzich (1986) assert that outcome research does not support the emphasis that professionals in their study place on medications and individual therapy (p. 244). Instead, outcome research indicates that medications, aggressive case management, and rehabilitative services are the key components of successful programs (Lynch & Kruzich, p. 244). Lynch and Kruzich further imply that biases exist in professionals' views of patients' needs, that these biases may lead to treatments of unproved effectiveness, and that patients' views may offer clues about which treatments may be most effective.

Study of Psychiatric Outpatients in Ohio

Through a survey of 90 community mental health agency case managers, Ford et al. (1992) conducted a needs assessment of 1,470 mental health outpatients in Hamilton County, Ohio, which includes Cincinnati. Questionnaires were completed for 86.2% of a randomly-selected pool of 1,706 clients (Ford et al., 1992, pp. 495-496). Case-manager respondents were asked not only what kinds of assistance they believed their clients needed, but also what they believed their clients

wanted. The authors cite their desire to include clients' responses in the survey, but state that resource limitations prevented this (Ford et al., 1992).

Housing options were a primary focus of the survey (Ford et al., 1992). The case managers felt that more clients needed structured residential settings than were willing to accept them. Male clients were judged more likely than female clients to need structured residential settings and substance abuse treatment (Ford et al., pp. 497-499). Clients aged 18-25 were assessed as needing assistance setting limits on their behavior, keeping appointments, budgeting household expenses, and taking their medications (Ford et al., p. 499). The data show the need for assistance in fewer areas as clients get older, but older clients appear to require more frequent and intensive interventions (Ford et al., p. 499).

A high proportion of clients aged 26-35 are described as needing one-on-one assistance to get out of bed and follow a daily routine; use transportation; keep appointments; shop for household supplies, food, and clothing; plan and prepare meals; and monitor psychotropic medications (Ford et al., 1992, p.499). Socialization was listed as a problem for 40% of clients, and respondents identified substance-abuse treatment, counseling, group therapy, social opportunities, and

vocational training as needed services (Ford et al., p. 499). Some of these needs may be shared by sexual minority inpatients on 7B.

Implications of the Psychiatric Needs Assessment Literature

The studies cited above focused neither on a hospitalized population nor on gay, lesbian, or bisexual clients. However, several aspects of this research are worth noting. First, the research suggests that chronic mentally ill persons may have perspectives on their needs that studies of mental health practitioners alone do not capture. Second, some of the same services that clients have identified as important appear to have been found effective by program outcome research. Third, many of the unmet service needs identified by clients are in areas that occupational therapists are qualified to address. Patients should therefore be asked to identify their own needs and the implications of the findings for occupational therapy programming ought to be analyzed.

Psychiatric Disorders of Gay Men and Lesbians

Very little information is available on the incidence of psychiatric disorders among gay, lesbian, and bisexual people as compared to heterosexuals. Unfortunately, the difficulties of obtaining a random sample of gay men, lesbians, or bisexuals complicate research to determine whether negative views of homosexuality affect the psychological adjustment of individuals (and if so, to what degree).

Bieber, et al. (1988) based their research on a self-selected sample of psychotherapy patients. Large-scale studies supported by the National Institute of Mental Health (NIMH), notably research by the Alfred C. Kinsey Institute for Sex Research¹ (Bell & Weinberg, 1978; Bell, Weinberg, & Hammersmith, 1981; Weinberg & Williams, 1974) and the National Lesbian Health Care Survey² (Falco, 1991), also suffer from self-selection bias: Sample members for these studies were recruited from public advertisements; gay, lesbian, and other organizations; mailing lists; businesses; and social networks.

The Kinsey Institute researchers' findings, which compare data on homosexual and heterosexual respondents, are further clouded by the matched comparison group research design (Bell & Weinberg, 1978; Bell et al., 1981; Weinberg & Williams, 1974). Even the proportion of sexual minority people in the United States population is a matter of considerable dispute in research circles, due to methodological problems (Barringer, 1993; Dynes, 1987).

¹The Kinsey Institute studies were based on interviews, conducted in 1969 and 1970, of 979 homosexual men and women and a comparison group of 477 heterosexual men and women in the San Francisco Bay Area (Bell et al., 1981).

²The National Lesbian Health Care Survey included a mental health survey of 1,917 lesbians in 1984 and 1985; the results of which were published in the 1987 report National Lesbian Health Care Survey: Mental Health Implications (Falco, 1991).

The political sensitivity of directing public resources to obtain accurate data on sexual behavior in the United States (Rich, 1991; Suplee, 1991) suggests that methodological problems will not soon be resolved. Methodological limitations can be viewed as having prevented quantitative research on sexual minority populations from overtaking qualitative research as a basis for theory and program development.

Gender Non-conformity and Depression

In one of the few quantitative studies on the subject, Harry (1983/1992) found that childhood gender nonconformity was related to increased depression in male adolescents and increased suicidal ideation and suicide attempts in adult men, with weaker effects in women. Harry reanalyzed data from the Kinsey Institute, comparing the recalled experience of 686 homosexual men and 293 homosexual women with matched groups of 337 heterosexual men and 140 heterosexual women. Harry found gender nonconformity to be predictive of suicidality in heterosexuals as well as homosexuals, but stated that “such departures are much more common among gays and lesbians” (p. 140), a view supported by Green (1987) and by Bailey and Zucker (1995).

Homophobia and Psychiatric Symptomatology

Gonsiorek (1982) cites the well-established link between increases in environmental stressors and psychiatric decompensation as special

concerns for gay, lesbian, and bisexual patients, who may experience unusual stress in confronting unwanted homosexual feelings or discrimination. Gonsiorek's work is descriptive rather than quantitative, and he suggests strategies to avoid misdiagnosis. Both Cabaj (1992) and Gonsiorek describe how dissociation and the "splitting of affect and behavior" (Cabaj, p. 856) can arise when positive sexual feelings are combined with powerfully negative feelings of guilt and recrimination, to form a borderline-appearing personality. Cabaj asserts that this process contributes to the high incidence of substance abuse in the gay and lesbian population (estimated to be about 30%, as opposed to 10% to 12% for the general population; p. 852). Cabaj further speculates that the difference results from the bar-centered element of gay culture and internalized homophobia, combined with genetic and biological factors. Several specialized services are described for gay and lesbian patients, including social skills groups for gay people with schizophrenia (Gonsiorek) and gay-affirmative substance-abuse treatment programs (Cabaj).

Sexual Minorities and Environmental Stress

The hypothesis that gay men, lesbians, and bisexuals experience environmental stressors that other populations do not suffuses much of the psychological literature on homosexuality. The National Lesbian

Health Care Survey surveyed 1,442 women who reported rates of physical abuse, rape, childhood incest, and eating disorders similar to the rates experienced by all United States women (Falco, 1991). However, in addition, survey participants reported being verbally and physically attacked, losing their jobs, losing their health insurance, and being discharged from military service due to their status as lesbians (Falco). In a 1989 report on youth suicide, the U. S. Department of Health and Human Services stated that gay youth are two to three times more likely than non-gay youth to attempt suicide (Alcohol, Drug Abuse, and Mental Health Administration, pp. 3-110), and described 40 risk factors that placed them at greater risk (pp. 3-138, 3-139).

Gay Men and Acquired Immune Deficiency Syndrome (AIDS)

No discussion of stressors common among gay men would be complete without addressing the human immunodeficiency virus (HIV), the virus believed to cause acquired immune deficiency syndrome (AIDS). The San Francisco Department of Public Health AIDS Office (SFDPH; 1993) reports that gay and bisexual men comprise 90% of the city's total HIV-infected population, and that 43% of the estimated 58,000 gay and bisexual men in San Francisco are thought to be infected with HIV. Bonck and MacRae (1990) note that the combined neurological and physical involvement of HIV illness may generate multiple psychosocial

issues, behavioral issues, and changes in roles. Changes in sexual behaviors, body image, and loss of basic survival skills are significant stressors for many (Bonck & MacRae). Increased dependency on others may coincide with reduced frustration tolerance and attention span, taxing support networks (usually friendship networks among gay men) to the limit (Bonck & MacRae; Scaffa & Davis, 1990).

Scaffa and Davis (1990) note that an AIDS diagnosis may force a person to tell family members, friends, and co-workers about his homosexuality for the first time. Williams (1990) writes about her clients' difficulty coping with a life threatening condition; fear of death, isolation, and illness; guilt about acquiring the disease and leaving others behind; and anger at being infected. Schaffner (1990) points out that HIV illness "represents the end of the illusion of mastery and control over one's life" (p. 10) due to the frustrating course of the illness. Schaffner also describes the severe strain the disease puts on relationships with partners. Okoneski (1990) recounts how caretakers and survivors of gay men have few legal rights in relation to their loved one, and offers a case study of the devoted partner who cares for his lover throughout his long decline and death, only to become sick himself. These effects of HIV illness are no doubt part of the everyday experience of some of the sexual minority people on 7B.

Psychiatric Treatment of Gay Men, Lesbians, and Bisexuals

What Malyon (1993) calls “gay-affirmative” (p. 81) mental health care³ is a fairly recent phenomenon in the United States. Until 1973, when the American Psychiatric Association officially deleted it from the Diagnostic and Statistical Manual, and perhaps afterward as well, homosexuality was viewed and treated by most mental health professionals, including researchers, as a disease to be cured (Bieber et al., 1988; Cabaj, 1992; Krajeski, 1986). The conceptualization of homosexuality as a sickness dates as far back as the second century writings of Soranus of Ephesus (Dynes, 1987, p. 725), and was reiterated in Krafft-Ebing’s 1898 Psychopathia Sexualis, in which the term “homosexual” was first used (as cited in Dynes & Donaldson, 1992). Sigmund Freud, who is widely viewed as introducing a concern for sexual matters into psychiatry, took a humane approach to homosexuals, viewing homosexuality as neither a disease nor a crime, but his approach was supplanted by the more “harshly negative” views of “latter-day psychoanalysts” (Dynes, 1987, p. 561).

In 1975, the American Psychological Association issued a policy statement urging “all mental health professionals to take the lead in

³“Gay-affirmative strategies regard fixed homoerotic predilections as sexual and affectional capacities that are to be valued and facilitated” (Malyon, 1993, p. 81).

removing the stigma of mental illness that has long been associated with homosexual orientations" (Conger, as cited in Morin, 1977/1992). While much of the literature on homosexuality published in the past several decades has focused on revising theory accordingly (especially psychoanalytic theory), a number of writings have addressed issues relevant to providing gay, lesbian, and bisexual people with mental health services that accept their sexual orientation and support their functioning in desired social roles. Two sets of recent writings in particular may be helpful to mental health professionals interested in understanding the needs of their sexual minority patients.

Psychoanalytic Treatment of Sexual Minorities

One body of recent literature attempts to expand and rework psychoanalytic theories of development to include the possibility of a non-pathological process of development leading to a healthy gay, lesbian, or bisexual orientation (Friedman, 1986/1992; Isay, 1987; Malyon, 1993; Mills, 1990/1992, Reiter, 1991). In the psychoanalytic tradition, these writings are based on case studies of patients typically functioning at a much higher level than most patients on 7B, and emphasize a form of intensive, long-term, individualized treatment impractical in an acute-care public hospital. However, the emphasis of revisionist psychoanalytic writers on internal conflict and subjective

aspects of family relations may sensitize mental health professionals to issues of potential concern to patients, especially as they relate to functioning in family and social roles.

Gay and Lesbian Identity Formation

A second body of research attempts to describe stages in the formation of a gay, lesbian, or bisexual identity (Falco, 1991). Commitment to a gay identity was found to be positively correlated with psychological adjustment and reported support from significant others, in a study of 2,497 gay men in the United States, Netherlands, and Denmark, by Hammersmith and Weinberg (1973/1992). Hammersmith and Weinberg had a non-random sample of subjects fill out a 145-item questionnaire that contained questions about (a) commitment to homosexual identity, (b) psychological adjustment (as indicated by signs of stability of self concept and self esteem), (c) maladjustment (as indicated by signs of anxiety and depression), and (d) perceived support from significant others about one's homosexual identity. No direct relationship was found in this study between positive social support and adjustment, independent of commitment to a gay identity (Hammersmith & Weinberg).

Hammersmith and Weinberg's (1973/1992) findings, which are widely cited by other authors, suggest that psychiatric and occupational

therapy treatment should pay attention to the strength of gay identity described by male patients, and should help reinforce the gay identity of these patients wherever appropriate. Hammersmith and Weinberg's paper (like Bell & Weinberg, 1978; Bell et al., 1981; and Weinberg & Williams, 1974) is notable in the field of research on gay and lesbian issues for its thoroughness and logic in describing the research design, sampling techniques, validity testing, and statistical data, though the non-random sample recruited for their study and questionable validity of the survey instrument weaken their conclusions.

Falco (1991) reviews five descriptive models of lesbian identity development (also known as the "coming out" process) based on psychotherapy with gay and lesbian clients. Three models describe linear series of developmental stages and focus on internal psychological processes (Coleman, 1982; Falco). A fourth model, proposed by Gramick, differs in that it emphasizes key social interactions (as cited in Falco). These interactions may occur in any order, but their importance is determined by the subjective meaning each woman gives to them as she interacts with others (Falco).

Troiden (1979/1992) describes a model of gay male identity formation based on interviews with 150 non-patient gay men. Like Gramick, Troiden found that respondents invested past events with

homosexual meanings (Falco, 1991). Troiden states that “it is not so much childhood experiences themselves . . . but the meanings which later came to be attributed to them that are important in the acquisition of gay identities” (p. 289). The qualitative research method employed by Troiden revealed common themes in the responses of sample members to open-ended questions. Though Troiden’s non-random sample cannot be viewed as representative of all gay men, his study, grounded in his background in anthropology and sociology, brings richness, nuance, and a refreshing ideological restraint to the literature on the complex phenomenon of coming out. His methodology has parallels to a phenomenological approach (though on a larger scale and with a different population), and offers the mental health professional many clues about client concerns.

The Importance of Culturally Appropriate Care

Five descriptive articles in the occupational therapy literature discuss the need for culturally appropriate care, and some of these (Pizzi, 1990; Scaffa & Davis, 1990) describe sexual minority clients as members of distinct cultural groups. Dillard et al. (1992), in their article describing the focus programs at SFGH, state that culture is relevant to diagnosis, evaluation, and treatment of psychiatric disorders. Dillard et al. assert that patients respond with relief and calmness when the staff is able to

speak to them in their language. This facilitates information gathering and builds trust (Dillard et al.).

Culture and AIDS

Several occupational therapists have written about cultural considerations in the treatment of AIDS. In a discussion of professional-patient relations in AIDS treatment, Peloquin (1990) states that occupational therapists must acknowledge personal attitudes that may interfere with their treatment. Pizzi (1990) stresses the importance of honest communication between therapists and patients with HIV about each others' personal, social, and cultural values. Scaffa and Davis (1990) summarize key cultural differences between the minority populations most affected by HIV and state that cultural issues can facilitate or impede efforts toward successful treatment. According to Scaffa and Davis, cultural insensitivity in health care institutions can result in (a) policies contrary to the values of specific groups; (b) misunderstandings due to different expectations, norms of behavior, and communication styles; and (c) distrust of the medical system by cultural minorities following negative experiences.

Culture and Client-centered Treatment of a Transsexual Client

In a case study of occupational therapy with a male-to-female transsexual, Jessop (1993) describes employing many of the principles

and concerns outlined by Dillard et al. (1992), Peloquin (1990), Pizzi (1990), and Scaffa and Davis (1990). Jessop describes using a pragmatic, client-led approach to goal-setting and treatment to overcome differences she had with her client's cultural and role expectations.

Client-therapist Similarity

A substantial amount of the psychology literature on therapeutic relationships discusses the related issue of whether gay, lesbian, or heterosexual therapists are better for gay or lesbian mental health clients (Anthony, 1982; Atkinson et al., 1981/1992; de Monteflores, 1993; Falco, 1991; Gonsiorek, 1982; Krajeski, 1986; Rochlin, 1982; Sang, 1977/1992). None of this literature involves research with acute psychiatric patients. Writings on the topic of therapist-patient relations appears to fall into three categories: (a) descriptions of negative experiences that gay, lesbian, and bisexual people have had with heterosexual therapists; (b) rationales for promoting therapist similarity, based largely on theory and case study research, and (c) experimental research. Because much of the information on negative experiences is dated, this review will focus on rationales and experimental research.

Rochlin (1982) reviews writings on client-therapist similarity from object-relations theorists; client-centered therapists; and investigations of relationships among Anglo-Saxon, Jewish, African American, and

Latino patients and therapists. Rochlin concludes that “the intuitive and accurate understanding of an individual characterized by a stigmatized minority status requires more than just a shared humanity. It requires considerable commonality of the cultural context in which the basic human feelings are experienced and expressed” (p. 23). Rochlin further suggests that a gay or lesbian therapist is better able than a heterosexual therapist to serve as a role model for gay clients.

Kohut’s developmental model of self-psychology provides the framework for de Monteflores’s (1993) examination of client-therapist relationships. Like the child who creates an “omnipotent union” with the idealized mother to assimilate the parent’s qualities and experience power, the client forges an empowering union with the therapist through “idealizing transference” (de Monteflores). In de Monteflores’ view, the idealizing transference between a client and a therapist who share a particular minority trait, such as ethnic identity or sexual preference, is likely to be stronger than the transference between a minority client and non-minority therapist. Empowered by identification with the therapist, the client is able to integrate an individual identity and develop self-esteem (de Monteflores).

Anthony (1982), by contrast, acknowledges the therapeutic benefit of shared cultural experience, but draws attention to the difficulty of

maintaining an “uncontaminated transference” in a small, minority community where therapists and their clients often run into each other socially. Anthony also describes the challenge to therapists (gay and non-gay alike) of dealing with erotic transference.

These rationales for linking gay, lesbian, and bisexual patients with gay, lesbian, and bisexual therapists haul a heavy load of preconceived notions into the therapeutic relationship, and seem to leave wide room for the misinterpretation of clients’ needs. Krajeski (1986) criticizes the short shrift given to countertransference in psychoanalytic literature and, while he refers primarily to psychotherapists holding the traditional pathological view of homosexuality, his condemnation of therapists who bring “unwarranted certitude and dogmatism” (p. 22) into the therapeutic relationship apply equally well to psychoanalytic revisionists and gay-affirmative therapists. Gonsiorek (1982) describes a disturbing incident in which a misguided group leader, believing schizophrenia to be “medical model garbage,” placed such pressure on a schizophrenic group member to “accept his gayness” that he decompensated, became suicidal, and required hospitalization. Research is needed that allows gay, lesbian, and bisexual people in acute psychiatry to express their needs without the distorting lens of the therapist’s theory.

The few quantitative studies of client-therapist relationships that have been attempted deserve attention. Unfortunately, sampling biases skewed the results of a survey conducted by Brooks (cited in Falco, 1991) and the National Lesbian Health Care Survey. In a review of these surveys, Falco concluded that many lesbians appear to prefer lesbian therapists, and that some may be more successful with lesbian therapists than with male therapists, but that evidence supporting these trends is not clear-cut.

By contrast, Atkinson et al. (1981/1992) conducted a clever and revealing experiment in which group of 84 gay male volunteers were asked to evaluate audiotaped excerpts from a mock therapy session. On the tape, a male client tells a male therapist about his anxiety about being gay. The six versions of the tape were identical except in two spots: one in which the therapist is asked to disclose his sexual orientation (homosexual, heterosexual, or not stated) and one in which he is asked to take a stand (activist or nonactivist) on an issue of concern to the patient.

Subjects were classified as activists or nonactivists based on a baseline questionnaire, randomly assigned to listen to one of the six tapes, and asked to rate the therapists' expertness, trustworthiness, and attractiveness (Atkinson et al., 1981/1992). Subjects rated the "gay

therapist” more expert, trustworthy, and attractive than the “heterosexual” or “non-disclosing therapist” (indicating a preference for membership similarity). The attitude similarity (activist vs. nonactivist) between the subject and the “therapist” was also related to perceived therapist attractiveness, but was less important than membership similarity. The sample was small, the subjects’ views may not reflect the views of other gay men, and the constructs of expertness, trust, and attractiveness may not be related to therapy success. However, the results are consistent with earlier studies of attitude similarity and appear to support the experience of therapists that membership similarity is a significant factor in the therapeutic relationship.

Occupational and Role Behavior of Gay Men and Lesbians

Childhood Gender Non-conformity and Play

As mentioned earlier, Harry (1983/1992) and Green (1987) describe gender-role non-conformity to be more common in homosexuals than in heterosexuals, based on recalled data. In a recent review of 48 studies of early signs of homosexuality, Bailey and Zucker (1995) concur. They employ a classification system for behaviors that includes categories such as rough-and-tumble play and competitive athletics; toy and activity preference; imagined roles, careers, or role models; cross-dressing; preferences for affiliation with boys versus girls; social

reputation (as sissy, tomboy, or loner); and gender identity (p. 47). Bailey and Zucker report that 81% of adult lesbians and 89% of adult gay men reported rates of cross-gender behavior in childhood that exceeded the medians for heterosexual men and women (p. 48). Bell et al. (1981) also obtained recalled data supporting the idea that gay men and lesbians are more likely than heterosexuals to report childhood gender nonconformity, including boys' participation in "feminine" play activities (pp. 74-76) and girls' participation in "masculine" play activities (pp. 147-149).

The accuracy of recalled data to determine rates of gender nonconformity is questionable, according to Krajeski (1986), and attempts to determine relative rates of effeminacy among gay men and "butchness" among lesbians meet with considerable suspicion in the gay and lesbian community. Professionals working with gay, lesbian, and bisexual psychiatric patients should nonetheless be aware that patients may view gender nonconformity as a significant aspect of their childhood experience that may influence their self-esteem, social functioning, and mental health as adults.

Adult Sexual Orientation and Occupational Choice

Considerably less research appears to have been devoted to the relationship of sexual orientation to occupational choice. Jackson (1995)

proposes that “one’s lesbian, gay, or bisexual orientation may work as a symbolic theme of meaning in that person’s identity that affects occupations” (p. 676). Kielhofner and Burke (1985) assert that internalized personal-sexual, familial-social, and occupational roles are related (p. 25). Kielhofner (1995c) states that role behaviors are ambiguous for same-sex couples, and that “the constraints and expectations given by society, interwoven with occupational choices, determine the succession of roles that make up a person’s life” (p. 78). Neither author describes specific role behaviors or occupational choices of sexual minority people.

In their comparison-group study of homosexual and heterosexual adults conducted for the Kinsey Institute for Sex Research, Bell and Weinberg (1978) and Bell et al. (1981) suggest that gender-role nonconformity among homosexuals may persist in adulthood. Data from Bell and Weinberg (1978) indicate that homosexual women are employed in “typically masculine fields” (p. 278) such as skilled crafts, technical jobs, and engineering, in greater numbers than heterosexual women, and that heterosexual men may also be employed in traditionally male jobs more often than homosexual men. Since non-random samples were employed in Bell and Weinberg’s (1978) research, homosexual/heterosexual relationships drawn from it may be illusory. Moreover,

interview excerpts illuminate other factors that may affect occupational choices: Some respondents describe being fired following disclosure of their homosexuality, being afraid of job discrimination, and deciding to limit job searches to fields in which homosexuality is accepted or even expected (Bell & Weinberg, p. 144). White men were more likely to report that their homosexuality had a detrimental effect on their careers, while black men reported that the connections and support of other homosexuals in the workplace had a beneficial effect on their careers (Bell & Weinberg, p. 146).

Bell and Weinberg (1978) also present data on self-care and leisure activities from the Kinsey Institute research. Two thirds of male and a majority of female homosexuals in couple relationships equally shared responsibility for completing household chores such as shopping, cooking, home repair, and household bookkeeping (Bell & Weinberg, pp. 91, 100). Social activities popular among homosexual respondents in the study included going to bars; staying at home; socializing with friends; and attending movies, theater, and concerts (Bell & Weinberg, pp. 404-412). A majority of black homosexual respondents attended sporting events, while a majority of white homosexual respondents did not (Bell & Weinberg, p. 410). While a slight majority of homosexual respondents stated that they did not attend religious services or functions, twice as many black as white homosexual respondents

regularly attended religious activities (Bell & Weinberg, p. 364). If these patterns reflect actual activity patterns in the gay, lesbian, and bisexual community in San Francisco, they may be relevant to the development of meaningful occupational therapy programming for gay, lesbian, and bisexual patients on 7B.

CHAPTER 3

DESIGN AND METHODOLOGY

Study Design

The study is intended to examine how lesbian, gay, and bisexual patients admitted to the Gay and Lesbian Focus Unit (Unit 7B) in the Department of Psychiatry at San Francisco General Hospital experience their needs. The theoretical framework underlying the methodology of the research is phenomenology.

The Appropriateness of Qualitative Research

Descriptive research is appropriate for the study because no research to date has examined how lesbian, gay, or bisexual inpatients in acute psychiatry perceive their own needs during acute psychiatric hospitalization. Krefting (1989) describes qualitative research as the preferred method for obtaining the “insider’s perspective” (p. 68). Case study research has focused on relatively high-functioning, voluntary, gay and lesbian therapy clients, rather than involuntarily hospitalized gay and lesbian inpatients (Anthony, 1982; Atkinson et al., 1981/1992; de Monteflores, 1993; Falco, 1991; Gonsiorek, 1982; Krajeski, 1986; Rochlin, 1982; Sang, 1977/1992). As mentioned in the literature review, previous needs assessments of mental health clients have focused on outpatient or adolescent populations, or have collected data on parents’ or health professionals’ views of patient needs (Ford et al., 1992; Mallon,

1992; Rabin et al., 1986; Solomon & Beck, 1989). Obtaining information directly from patients is essential if we are to understand how they experience hospitalization, and how treatment works (or does not work) for them.

Small-scale qualitative research is typically viewed as a precursor to large-scale experimental research. When little is known about a population or phenomenon of interest, qualitative research projects are conducted to generate data that can be used to form the basis for experimental hypotheses (DePoy & Gitlin, 1994). However, Spencer, Krefting, and Mattingly (1993) assert that “many constructs of interest to occupational therapists,” including the illness experience and the meaning of an activity for a patient, “can be studied only through qualitative methods” (p. 303).

The reliability of the data gathered from small-scale qualitative research has been controversial, and needs to be discussed. The general consensus appears to be that reliability in qualitative research is derived from the richness and specificity of the data, not sample size or statistical power, as in survey or experimental research. Guba and Lincoln (1982) assert that the notion of reliability as understood in quantitative research is simply not applicable to qualitative studies. Instead, qualitative studies should be judged based on the credibility and

trustworthiness of the findings (Guba & Lincoln, 1982; Marshall & Rossman, 1989).

Last, but not least, a qualitative approach to this study is consistent with the recommendations of a number of authors on questionnaire development and survey research, including Hayes (1992), who suggests conducting qualitative interviews with a small number of customers before developing large-scale customer-oriented questionnaires. Hayes views this approach as one that greatly reduces the danger of asking the wrong questions.

The Philosophy of Phenomenology

The aim of phenomenology is “to understand the experiences of a small set of individuals from their own perspective” (DePoy & Gitlin, 1994, p. 179) and “to describe experience as it is lived by people” (Munhall & Oiler, 1986, p. 70). Phenomenological philosophers, including Husserl and Merleau-Ponty, take the position that we perceive the world of objects, events, and people through the instrument of our body, rendering irrelevant the distinction between subjective and objective truth (as cited in van Manen, 1990; Munhall & Oiler).

Phenomenology attempts to make sense of the essence of events or objects by studying them as they are encountered in lived experience (van Manen, 1990). To understand the subject of interest, the

investigator is expected to employ a technique called “reduction,” which is characterized by the following four steps: (a) reawakening a sense of astonishment and wonder at the world, (b) overcoming personal feelings about the world, (c) stripping away theories or scientific schema of the world, (d) identifying and setting aside (“bracketing”) feelings and theories so that one can look beyond them and see the essence of the phenomenon of interest (Munhall & Oiler; van Manen). MacRae (1993) describes bracketing as “a pre-theoretical state which helps prevent prior knowledge from biasing the analysis of the descriptive data” (p. 27). Reduction helps the researcher to receive an understanding of (but not to influence) the subject’s view of the phenomenon of interest.

Rationale for a Phenomenological Study

Phenomenology appears to be the most appropriate philosophical and methodological framework for approaching this study for two reasons. First, it provides for the suspension of theoretical biases that have permeated much of case-study research on the lesbian, gay, and bisexual population in mental health. Second, the phenomenological interview is structured in a way that is less likely than other methods to impose the interviewer’s priorities for organizing information on the data collected in the interview.

In a phenomenological interview, an initial question is asked and subsequent interview questions, which are formulated as the interview progresses, are derived from material contained in the subject's responses to the previous questions. In a structured interview, by contrast, the interviewer returns again and again to a list of prepared interview questions based on preconceived notions of the phenomenon of interest. The emphasis of the content (i.e., the weight given to specific facts or themes) in a phenomenological interview therefore matches more closely the priorities of the subject, while the data from a structured interview invariably emphasize the concerns of the interviewer.

An example will help to illustrate why phenomenology is appropriate for this study. It is possible to imagine a subject in the study who considers her lesbianism to be an issue of little importance during her acute psychiatric hospitalizations. In this example, a structured interview asking 37 questions about the relationship of the patient's lesbianism to her needs during her hospitalization might cause her to elaborate on that subject but would likely fail to capture issues of genuine importance to her. A phenomenological interview, on the other hand, would permit the patient to emphasize the concerns she considers most important, and would provide mental health professionals with a clearer picture of the issues that she might wish to address.

Theoretical Biases of the Investigator

Several of the investigators' assumptions and theories needed to be bracketed in the study in order to meet the requirements of phenomenological research. First, the medical model assumes that people in psychiatric hospitals have mental disorders that (a) sometimes result in inaccurate perceptions of the world and (b) have distinct characteristics and predictable courses. Second, underlying the creation of the Gay and Lesbian Focus Program is the assumption that sexual minority patients have needs different from those of heterosexual patients and will benefit from the expertise of a culturally competent staff. Third, any assumptions about the behavior or psychological processes of sexual minority people, whether based on experience or stereotype, needed to be bracketed.

Finally, all occupational therapy frames of reference, which view the person in the context of his or her interaction with the physical, task, and social environment, need to be set aside. The purpose of this is not to deny that relationships exist between the person and the environment; on the contrary, one of the key reasons for conducting this study is to determine how therapists can optimally manage these relationships for a specific group of patients in a specific setting. This study requires the bracketing of occupational therapy frames of reference to avoid imposing

mechanistic interpretations of person-environment interactions on the experiences of the subjects.

The model of human occupation as described by Kielhofner (1995a) is the primary occupational therapy frame of reference used by the investigator. Consequently, the investigator's assumptions about the usefulness of the model of human occupation make it the most important theoretical framework to bracket while conducting this study. The investigator's tendency to employ the model of human occupation to understand occupational behavior needed to be set aside during interviews with the subjects, to place on the subjects the greatest possible responsibility for guiding the content of the interviews and describing the essential experience of need.

Sample Population

A convenience sample of five self-identified gay or bisexual patients admitted to SFGH unit 7B were interviewed to obtain information on actual programs and treatment conditions at SFGH. The criteria for selection were that subjects 1) be admitted to SFGH unit 7B; 2) self-identify as gay, lesbian, or bisexual; 3) not be conserved; 4) consent to be interviewed; and 5) tolerate an interview of at least 30 minutes duration.

Five male subjects that met the selection criteria were recruited for the sample and interviewed during August and September 1995. Four of

the subjects self-identified as gay men, and one self-identified as bisexual. The subjects' ages ranged from early 20s to late 60s. One subject was African-American, one was Latino, and the remaining three were European-American. Three subjects stated that depression had led to their admission into the hospital, a fourth subject stated that he had "fifteen thoughts to your one," and the fifth subject did not state the reason for his admission, but talked softly to himself and stated "I'm not really here" during his interview. Two subjects said that they had never before been admitted to a psychiatric hospital, another subject described two admissions, and yet another subject stated that he had been admitted to psychiatric hospitals 25 to 30 times prior to the time of his interview. No women meeting the selection criteria were admitted to Unit 7B during this period, so women's views could not be included in this study.

Procedures

Subject Recruitment

Subject recruitment began after the investigator obtained approval to conduct this research from the Department of Psychiatry at San Francisco General Hospital and the Human Subjects-Institutional Review Boards of San Jose State University and the University of California at San Francisco (see Appendices B and C). Lynne Andonian, the

occupational therapist on unit 7B at SFGH, reviewed prospective subjects' charts in the normal course of her duties and identified prospective subjects according to the selection criteria. Ms. Andonian described the research to these prospective subjects, and asked them whether they were willing to be interviewed for this study. I then contacted prospective subjects to describe the research, explain informed consent procedures, and give subjects the opportunity to read and sign (or refuse to sign) the consent form.

Data Collection

Data collection via interviews followed procedures for phenomenological research consistent with Giorgi (1985), MacRae (1993), Munhall and Oiler (1986), and van Manen (1990). Since I had not previously conducted phenomenological interviews, I conducted two practice interviews to develop phenomenological interview skills. A recording of one of these practice interviews was presented to Elizabeth Cara, OTR, MA, MFCC; and Anne MacRae, Ph.D., OTR; on the faculty of the Occupational Therapy Department at San Jose State University for evaluation and approval.

Interviews took place at San Francisco General Hospital (1001 Potrero Avenue, San Francisco, CA, 94110) in the conference room of ward 7B. Interviews were recorded on audiotape.

Confidentiality

To protect the confidentiality of the subjects, recorded tapes were stored in a locked box in an apartment three miles from San Francisco General Hospital. Tapes were marked with a code to prevent them from being linked with the subjects' names, and were erased after their transcription by the investigator. False names were given to each subject, and names mentioned during interviews were altered in the transcripts to protect the confidentiality of the subjects and their fellow patients. The investigator also informed subjects about the research and obtained their written consent to participate before including them in the research, in accordance with the guidelines of the institutions involved (see Appendix D).

Data Analysis

Data analysis was performed based on methods described by Giorgi (1985) and MacRae (1993). Giorgi sketches out a method for phenomenology in psychology research that MacRae explicates and adapts for use in occupational therapy research. As described earlier, phenomenological reduction was employed to minimize the biases of the investigator and determine as closely as possible each subject's experience as he experienced it.

Step 1: Sense of the Whole

Following transcription of the data, multiple readings of each interview transcript were undertaken to obtain a sense of the whole (Giorgi, 1985; MacRae, 1993).

Step 2: Discrimination of Meaning Units

This step consisted of breaking each interview transcript down into manageable “meaning units” (Giorgi, 1985, p. 11), defined by shifts in the content of the text. Giorgi describes a process for determining where such content shifts occur. In his phenomenological approach to psychological research, Giorgi proposes taking the vantage point, or “attitude” (Giorgi, 1985, p. 11), of psychology and marking the text based on shifts in psychological meaning. MacRae (1993) adapts this approach by taking the attitude (or perspective) of occupational therapy towards the data (p. 30).

MacRae (1993) states that the adoption of an appropriate perspective is essential to the discrimination of meaning units and their transformation (p. 30). Though the occupational therapy perspective itself is not fully articulated (p. 31), there is a “lived sense” of the perspective that operates spontaneously and enables the investigator to identify shifts in meaning (MacRae, p. 32).

To increase the manageability of the data, Giorgi (1985) describes the need to “adopt a set” (p. 12), in other words, “to set some limits or controls on the analysis and to thematize only a particular aspect of a more complex reality” (p. 12). For this study, each text was read with the “set” that it was concerned with the experience of need.

Step 3: Transformation into the Language of Occupational Therapy

Through a “process of reflection and imaginative variation” (Giorgi, 1985, p. 17), the subjects’ everyday expressions were transformed into the language of the discipline of occupational therapy. First, each meaning unit was reread to determine its essential meaning, relevant to occupational therapy and the experience of need. Then, each meaning unit was condensed, preserving all its constituents and, as much as possible, the subject’s own words. Finally, each meaning unit was rewritten to capture its essential meaning.

Examples will illustrate this three-step process better than further description. Appendix E contains five tables, each of which presents a single meaning unit from an interview with one of the subjects, followed by a condensed summary of all the constituents present in the meaning unit and by the transformation of the meaning unit. Each transformation captures the essence of the subject’s statement from the perspective of occupational therapy and the analysis of his need experience.

Step 4: Synthesis of Transformed Meaning Units

The final step in the phenomenological method outlined by Giorgi (1985) and demonstrated by MacRae (1993) is the synthesis of the transformed meaning units into consistent statements about the phenomenon of interest. First, specific descriptions of the experience of need for each subject were written, based on the transformations created in the previous step. Then, the specific descriptions were synthesized into a general description intended to capture the essence of the experience of need for all the subjects. The product of this step can be found in Chapter 4.

CHAPTER 4

DATA AND RESULTS

This chapter presents specific descriptions of the structure of each subject's experience of need, and a general description summarizing the essential general structure of the experience of need, based on the methodology described in the previous chapter.

Specific Descriptions of the Experience of Need

Robert⁴

Robert experiences need as a sense of isolation from other gay men. When he arrived on 7B, Robert saw a rainbow flag, symbolizing gay pride, and a schedule board indicating that gay and lesbian support groups would take place. Robert expected to work on his problems (depression, isolation, adapting problems, and gay identity issues) in the gay and lesbian support groups on 7B. But Robert was disappointed to learn that these groups were not taking place. He would like to learn who other gay patients on the unit are, reduce his social isolation, develop social relationships, and participate in group discussions about issues such as AIDS. Robert needs the kind of feedback from other patients that

⁴Not his real name. All names in this document (other than references) are pseudonyms.

discussion groups can provide, and finds these groups more helpful than one-on-one discussions with staff.

Robert thinks that it isn't safe for gay and lesbian patients to make telephone to obtain information on HIV, sexuality, sexual orientation, or homophobia, because the phones are located in a hallway and phone calls can easily be overheard. Gay and lesbian patients' safety is endangered by the lack of privacy and the social ostracism that may follow disclosure of their sexual orientation. Robert believes that gay and lesbian focus groups, run by nurses or occupational therapists, would offer patients a forum to discuss issues of concern in a safe environment and without fear of disclosure.

Robert needs to feel safe on 7B, but does not feel safe when patients use derogatory terms, such as "faggot." He is afraid to confront other patients when they use offensive language because he has been gay-bashed. Robert believes that efforts to educate the general patient population about gay and lesbian people will make him feel safer.

Robert describes an incident on 7B that underlines his safety concerns. One day, a non-gay patient who understood the rainbow flag's symbolic value to gay and lesbian people ripped the flag off the wall. Robert viewed this action itself as a symbolic one, intended as a put-down of gay and lesbian people in general. Nurses immediately put the

rainbow flag back up on the wall, but Robert was not satisfied by the mere restoration of the symbol to its appointed place in the environment. He felt that the act of pulling the flag off the wall revealed a social division among patients on 7B that demanded a response in programming. Robert suggested that the whole community of patients be assembled to discuss the issues brought up by the symbolic act of ripping down the rainbow flag.

In general, Robert feels that he is better able to communicate with gay nurses than with straight nurses, especially about personal medical problems common among gay men. He also feels that he could relate better to a gay or lesbian doctor than to a straight doctor. Robert seems to relate to gay staff better because he considers them part of his social group. In other situations, however, the power and authority of nurses over patients can get in the way of communication between them, regardless of their sexual orientation. Robert would like access to a gay or lesbian staff member seven days a week or, failing that, a gay and lesbian support group once or twice a week.

Twice recently, Robert has expected to go to a place where he can address gay issues, and twice he has been disappointed. First, he came to 7B and the Gay and Lesbian Focus Program, then discovered that the support groups he was expecting were not taking place. The rainbow flag

and schedule board had reinforced his expectations. Second, Robert expected to go to a halfway house for gay men, but the arrangements fell through.

The following paragraphs summarize Robert's views on group activities:

1. 7B offers an inadequate number of meaningful tasks for Robert during the day, and very few evening activities other than TV-watching.
2. Educational groups would be interesting and helpful for Robert. Representatives from community agencies could be brought in to discuss their services and provide information. Robert suggests asking the San Francisco AIDS Foundation or the halfway house for gay men (which Robert didn't get into) to send a representative. Robert would be interested in seeing presentations scheduled on support groups for HIV-negative men, women and AIDS, sexuality, and breast cancer.
3. Robert would like access to grooming supplies on the grooming cart in the late morning, after he takes his shower. This would more closely approximate his morning routine.
4. Occupational therapy groups on 7B do not meet the needs of patients at Robert's relatively high functional level, but they do meet the needs of patients at lower functional levels. Robert would like more discussion groups and fewer craft groups (e.g., making calendars).

Painting and drawing per se are not meaningful activities for Robert. However, Robert found painting meaningful in one occupational therapy (OT) group, when he painted a design relevant to his culture and gay identity on a T-shirt that he was able to keep. When another patient encouraged Robert to wear the T-shirt, Robert obtained social support for his creativity and successful task performance.

5. Robert enjoys watching videotaped movies on weekends. He prefers reading magazines and doing crossword puzzles to the activities available in occupational therapy.

6. Peer counseling is not meaningful for Robert because he does not feel that peer counselors are part of his social group, and does not communicate effectively with them. Peer counseling is also inadequately structured for Robert.

7. Outdoor leisure activities on the patio, such as volleyball and basketball, are beneficial, but they depend on the availability of equipment. Volleyball-playing ended recently when 7B's ball got stuck on the roof.

Robert tells a story that sheds light on his needs and activity preferences. Robert considered the retrieval of the volleyball to be important, and voluntarily initiated and organized a task for himself: obtaining assistance from hospital staff to get the ball off the roof and

back in the hands of the patients on 7B. Robert used the telephone and spoke with thirteen different people in the hospital before reaching the security office and obtaining an agreement from a security staff member to reach Robert's goal. He derived satisfaction from having successfully negotiated the hospital bureaucracy.

Unfortunately, the security staff member became angry with Robert when he revealed his status as a patient, and asked the nursing staff on 7B to assert its authority over him. The ball was left on the roof and a nurse rebuked Robert. Robert felt somewhat successful in performing short-term, process-oriented steps toward his goal, but felt unsuccessful in achieving the end product: the return of the ball. He felt punished for performing a task that would be considered highly functional outside the hospital culture and setting.

Robert is interested in seeing more current informational gay- and lesbian-oriented magazines on 7B. The book cart that is brought around to all the psychiatric units should include books on gay and lesbian themes. The presence of this gay and lesbian literature on 7B would have a positive effect on patients.

Robert needs interactions with his social group, which he identifies as gay men. He values the development of social skills and supportive relationships with other gay patients and gay staff, and considers it

important to his recovery process for the director of the facility to identify himself as gay to gay and lesbian patients. Robert envisions a room in the hospital where educational materials would be made available and where gay and lesbian patients would feel safe to talk freely, separated from non-gay patients. Robert would be interested in participating in a gay and lesbian support group that draws high-functioning patients by invitation from all the psychiatric wards at SFGH.

James

James experiences need as an overwhelming inability to cope with the stresses of his day-to-day life. James came to 7B because his increasing difficulty caring for his lover of 12 years precipitated a crisis and James became suicidal. James's lover, Doug, has AIDS, and his behavior became disorganized, disrupted their home environment, and placed increasing demands on James's physical strength and coping skills. James has a physical disability that prevented him from meeting his lover's demands.

When James came to 7B, he sought relief from the increasing stress of caring for Doug. He also sought to rebuild himself and increase his energy so that he could function in the community. Doug was admitted to a medical ward at SFGH at the same time that James was admitted to 7B. Now that Doug is being taken care of, James's goal is to

find a workable living situation for himself and Doug—preferably together but most likely apart—in which both men receive appropriate care and support.

James has been hospitalized 25 to 30 times for depression, about once a year starting in his teens. He is now in his sixties. However, in the 12 years that James and Doug have been together, James has needed to be hospitalized only twice. James credits his relationship with improving his ability to function in the community for longer periods. Those two hospitalizations have occurred within the past year, for the same reasons as his current hospitalization.

James's daily life activities are narrowly focused on his caregiver role, and Doug and he do everything together—a situation James views as problematic. Group discussions are meaningful for James because they enable him to throw his feelings out to others and, in return, receive ideas about prospective courses of action that he might not have considered on his own. However, James faces a dilemma. He finds discussion groups meaningful, but seldom participates in them because he is reluctant to come out as a gay man to other patients and risk taxing his already fragile coping skills. If patients are to provide James with support and assistance, they must learn about his relationship with Doug, thus his sexual orientation. Yet James is afraid that, by coming

out to other patients, he will not only fail to obtain the assistance and support he seeks, but will also be ostracized. James feels this way despite the fact that he has experienced no anti-gay prejudice on 7B from patients, and has never experienced prejudice from staff at any psychiatric institution. James therefore isolates himself from the social milieu, but does not believe his isolation to be a good thing.

During most of his previous hospitalizations, James was not an openly gay man. Intolerance among patients was rare and quickly resolved by separation of the individual from the group. When James talks about the act of coming out as a gay man, he invariably does so in terms of potential confrontations it may generate with other patients. James describes coping assertively with such confrontations using a direct statement like, "Let's get off the subject."

James experiences 7B as a safe place that meets his needs for comfort and stress relief over the short term. The environment on 7B allows him to rest and still work on his problems. When James and Doug both became patients at SFGH, James was able to pass his caregiver duties on to the SFGH medical staff. James has been hospitalized before, and relies on habits established during previous hospitalizations that he believes will help him achieve his desired goal—improved coping skills—in anywhere from two weeks to two months.

James has the following to say about groups on 7B:

1. James is satisfied with the number and frequency of structured group activities on 7B. He highly values the free time built into the schedule on 7B. James spends much of his free time sleeping.

2. James would like to develop a grooming routine, but he does not currently value grooming enough to put the energy into it.

3. James values discussion groups, but does not attend many of them. One meaningful group he did attend was an informational group on free activities in the community.

4. James finds OT groups meaningful because they help him concentrate and simulate real life, in microcosm. OT groups can be uplifting one day or just the opposite another day. They offer creative, structured tasks with beginning, middle, and completion phases. James derives self-satisfaction from the progress he makes through each phase of the structured task—until something goes awry. Then James must exercise his problem-solving and coping skills, just as he would have to do in the community. James tends to retreat when things aren't going well, but sees this as dysfunctional, especially in a work situation. James needs opportunities to learn to cope with challenges to his progress—opportunities that OT provides. That's what hospitalization is for, according to James. For this reason, James finds OT groups involving

the hands-on creation of a finished product more beneficial than discussion groups.

One of James's most important emotional needs on 7B was met without him even having to ask. The staff on 7B learned of the circumstances surrounding James's and Doug's admission to SFGH and arranged for James to visit Doug for an hour every day. James appreciates the fact that the staff on 7B designed a treatment program for him that built in regular contact with his main source of social support.

James thinks constantly about Doug, and his moods rise and fall on the tides of Doug's health. Yet James articulates an imbalance in his daily life activities. James feels that his thoughts and activities are focused too much on his work with Doug and not enough on his own self-care. This is bad for James and doesn't help Doug, either. James wants to figure out how to take care of himself, as he has in the past, by exploring his activity interests and reorganizing his time. James is not yet prepared to do this, but 7B offers him what he needs to do it. As James says, "The ball is in my court now."

Michael

For Michael, the experience of need is the feeling that he has lost his mind. Michael, who has AIDS and lives in a hotel, experienced a

burglary in his hotel room and sought help from the community-based organization that placed him in the hotel. They brought him to the SFGH psychiatric emergency service (PES) and he was admitted to 7B, feeling afraid and abandoned in an unfamiliar environment. One of Michael's goals was to return to an apartment from which he was being evicted, and he was unsure how or whether SFGH would help him meet that goal.

Michael felt emotionally lost and needed emotional support when he came to SFGH. Michael had also experienced a functional decline, which he describes in terms of his inability to balance a checkbook, despite having majored in finance in college. Michael listens to others around him when they tell him he is better, and feels that hospitalization has been good for him.

Michael needs medication for debilitating headaches and HIV disease. His headaches are "at least 1000 times worse than a normal headache" and interfere with his sleep-wake cycles. He especially needs the staff on 7B to listen to him when he tells them which medications work to combat his headaches, and to provide him with these medications in a timely way.

Michael confesses to being difficult to communicate with when he has headaches. However, he attributes an argument he had with his

doctor to miscommunication between a gay person and a non-gay person. The doctor would not communicate with Michael when “the queen came out” of him. The result was that Michael did not get the medication he needed for a severe headache, and he “just went ahead and went through the pain.” He was sent to his room by the staff because he yelled at his doctor and called her an unflattering name.

Two days after Michael’s argument with his doctor, he continued to have trouble communicating with and trusting her. Michael’s mother served as an intermediary between them. Michael believes that if 7B had more gay staff, communication problems like this one would be reduced, and patients would receive better care. He also suggests that medical identification bracelets be required for people with AIDS so that medical professionals will have the information they need to expedite proper treatment without having to rely on patient reports or medical records.

Michael has received treatment at Ralph K. Davies Medical Center and St. Mary’s Medical Center in San Francisco. He is satisfied with the knowledge of the SFGH staff, but believes that 7B is understaffed and needs better accommodations. Michael felt accepted by staff on 7B when he arrived on the unit, but less so by patients. The environment on 7B needs to change and the staff needs to be more compassionate towards patients. From people in his environment, Michael needs guidance,

support, encouragement, a pat on the back and a kind word. He also needs to develop the skills and judgment to ask for help and develop trusting relationships.

Michael says that patients need to work with staff members they can look up to—people who are professional, can relate to patients, and are flexible. He believes that when patients and staff members share a common racial identity or sexual orientation, they can relate to one another better than if they do not have this in common. Michael does not believe that training or reading can substitute for shared cultural experience. In his view, a facility that purports to have a gay and lesbian focus should have more gay and lesbian staff, representing a cross-section of the gay community. Michael does not expect staff members to disclose their sexual orientation unless a rapport has already been established. He needs staff to be professional in behavior and appearance, and respects their privacy.

Michael, who is African American, describes how he quickly established a trusting relationship with a black staff member on 7B after the man communicated with Michael in a culturally appropriate way. In their first conversation, this staff member began by complimenting Michael, established rapport, revealed events from his personal experience, acknowledged Michael's homosexuality discreetly, and did

not shy away from providing another patient with physical comfort. This staff member is friendly and asks after Michael's mother. Michael feels that he can tell this staff member anything.

Michael mentions only one group activity he has been involved in, and only in terms of its product: He helped make pizza in an OT cooking group and wanted to taste it. Michael likes listening to music (but not rock and roll). He is familiar with the way hotel managers, police reports, and BART work. He used to attend the annual gay and lesbian parade in San Francisco and, this year, watched it on TV.

Michael says he needs to get his mind back. He is in the hospital because he lost it somewhere along the line, during his hard life. He needs a strong mind to endure the trials of facing systematic discrimination without the support of a partner. Michael acknowledges that his thoughts have slowed down since he came to 7B and that this is a good thing. He credits medications and support from his family with helping to accomplish this. Michael has had troubled relationships with his mother, stepfather, and brother in the past, related in part to Michael's sexual orientation. However, Michael's family has visited him in the hospital and provided him with needed social support.

Michael feels stigmatized for being gay and for having AIDS, which is a huge source of stress for him. Because AIDS makes him feel

poisonous towards others—a feeling that impedes his ability to establish supportive social relationships—he needs long-term psychiatric help. Others' attitudes towards AIDS also pose physical dangers: For example, Michael's landlord refused to fix a gas leak in Michael's apartment because he was not going into an "AIDS-infected place."

Michael is mistrustful of the government and social-service systems. Michael lived in a hotel that was unsafe, but typical of the housing provided by social service agencies for people with AIDS in San Francisco. Michael attributes the poor quality of this housing to the general public's lack of respect for people with AIDS. He needs a safe place to live and feels that people with AIDS deserve more respect from society.

Dave

Dave experiences need as anger at the failure of other people to help him. A suicide attempt resulted in Dave's admission to 7B. Some nurses permit Dave to shave without supervision, while others stand by to make sure he doesn't cut himself. The latter approach insults Dave and treats him like a child. Dave sets himself apart from the other patients on 7B, whom he refers to as "vegetables." He needs exceptional treatment because he is able to function at a higher level than the other

patients. There should be two levels of programming: one for low-functioning patients and one for high-functioning patients like Dave.

Dave's status as a college graduate and professional make him sensitive to the personal appearance of staff members on 7B. The staff does not look professional enough, considering that they have authority over him. He needs them to wear uniforms and improve their grooming. He needs staff to be older professionals rather than young interns, so that they can relate better to him. Dave needs to be treated in a facility with a clinical, professional air.

Dave is not able to describe what "professional" help on 7B might be. He had no knowledge or expectations of SFGH before his admission. Dave understands that he is being kept against his will to prevent him from killing himself, but is unsatisfied with this limited objective. He is angry about the possibility that he may be released in 7 to 14 days without the guidance and professional counseling that he feels he needs. He is unsatisfied by the care he is receiving on 7B and has set a goal for himself: to write letters criticizing SFGH to senators and governors. Dave's high level of anger motivates him to do this.

Dave could accept being held against his will if he were learning things of value to him. But the only thing Dave has learned on 7B is that he is in a high risk group for suicide—unemployed single white males

over 50—and that there are others like him. Dave derives comfort from this knowledge. Dave needs to receive guidance, help, input, suggestions, and ideas from a professional. He needs for someone to tell him things rather than let him develop solutions for himself.

Dave views the patient role as a passive one, in which professionals seek him out and provide him with information and answers to his problems. Dave needs staff members to follow through on their commitments to “get back to him” within a specified time frame. Breakdowns in communication are attributable to poor communication skills on the part of the staff. Dave’s time is wasted on 7B due to the staff’s neglect of his needs. He cannot help himself because this is all new to him.

Dave needs to find a \$40,000-a-year job. Unemployment caused him to attempt suicide, so searching for a job would be the most effective activity for him to engage in. He already knows how to look for jobs in the want ads, sign up with employment agencies, and knock on doors. Dave needs individualized, professional career counseling and job-search information.

Dave has the following to say about group activities:

1. Group activities on 7B are a waste of time for him. He has difficulty identifying activities that are meaningful for him. The projects

available in OT should be more interesting and adult. The OT staff should trust patients with materials, rather than treating them like children.

2. Dave has attended OT goal-setting groups, but the experiences of other patients are not helpful to him. He needs groups that are not patient-fed (i.e., patients think of their goals and there is a group discussion about them). Dave needed to apologize to a patient recently because he rudely interrupted her useless feedback about his employment goals.

The staff on 7B need not address gay and lesbian issues with most patients because of their low cognitive and functional levels. In fact, most of the patients on 7B are so profoundly dysfunctional that they cannot even acknowledge whether they are straight or gay or bisexual, and would not know whether they were being ostracized for it or not. Programming that deals with sexual orientation issues is a waste of time. Dave does not feel ostracized at all as a gay man on 7B.

Stephen

Stephen experiences need as sitting and “going crazy.” He needs peace of mind, and he has it on 7B. The staff on 7B provides Stephen with structure and sets limits by telling him what he can and cannot do on the unit. He gets his medications when he needs them.

Stephen needs staff members to help him solve problems, talk on his behalf, provide him with support, and counsel him. He highly values staff members' willingness to listen and offer alternative ways of thinking about his concerns and behaviors (e.g., Stephen's drug use). Stephen also says that he needs to be a friend to others.

At the time of the interview, Stephen is preparing for a visit from his mother, whom he has not seen in five years. He is concerned about being able to bathe and shave before this meeting.

Stephen has the same routine every day on 7B. He usually attends OT and symptom management groups. After he attends groups, he gets a second cigarette as a reward. He has the following to say about groups:

1. Stephen finds all the groups on 7B to be useful because they give him alternative ways to look at his environment.
2. Stephen performs whatever task the other patients do in groups on 7B. He likes task groups, especially crafts, because they keep his mind occupied. Moreover, doing something with his hands in OT groups keeps his mind focused on one thing. At other times, Stephen just sits, sees nothing, and feels like he's going crazy.
3. Stephen finds symptom management group interesting, particularly other patients' descriptions of what they are doing.

Stephen has heard of the Gay and Lesbian Focus Program, but does not know anything about it.

General Description of the Essential Experience of Need

Need, as experienced by the subjects, is a phenomenon arising from the individual's desires, fears, and expectations about himself, other people, and the world around him. The subjects typically trace their needs back to negative feelings or perceived dysfunctions in areas important to them. For example, a subject may recognize that he has a need when he feels profoundly isolated, or overwhelmed by everyday activities, or angry at others' neglect of him. Alternatively, he may think that he is going crazy, or has lost his mind because he can no longer perform a day-to-day task that was once easy for him. By monitoring his feelings and functional performance, either alone or with the help of others, the subject can determine whether or not his needs are being met. Rarely do the subjects in this study directly touch on what it is like to need something (i.e., the abstract experience of needing), but their individual experience of need can be inferred from the data. For the most part, the subjects focus on specific needs, in the following wide range of areas:

1. Subjects express the need to work on specific, practical, skills of daily living, such as bathing, shaving, balancing a checkbook, and finding housing or employment.

2. Physical objects in the environment may be needed. These may include decorative objects, symbols, informational materials, medications, uniforms, or objects used for leisure activities.

3. Various types of social support are important to subjects, including discussion groups with other patients, visits with partners and family members, and informal conversations with patients and staff.

4. Several subjects describe needs related to intangible environmental qualities, such as safety, professionalism, and organization.

5. Interactions with other people are another category of need. Relating well to and communicating effectively with staff members and other patients are important to four of the five subjects in the study. Trusting others is also an issue. One subject relies on monitoring and feedback from other people to mark improvements in his mental status. One-on-one career counseling is sought by another subject, and yet another expresses a need to bond with other gay men.

6. The way that the subjects' time is organized is an issue of concern. Some subjects need large blocks of free time, while others need

additional activities to relieve boredom, or need adjustments in the scheduling of group activities.

7. Group activities need to meet the needs of both highly functional and severely impaired patients on 7B. Hands-on activities should be engaging and adult. Separate groups may be needed for patients functioning at different levels. Some subjects require hands-on projects, while others need more discussion groups.

8. Subjects need assistance with their interactions with the environment. They describe needing to improve their concentration and to focus on one thing at a time. They need to cope with environmental stressors and solve problems they encounter in their daily lives.

9. Information of various kinds is needed, including information on AIDS, reasonably priced housing options, inexpensive activities in the community, employment opportunities, psychiatric diagnoses, and health and social services. One subject needs information about rules for appropriate behavior.

The complex and highly individual paths that each of the subjects has taken to 7B assures that no two of them can experience their needs in the same way. However, recurring themes are present in the subjects' descriptions of their needs. These themes, with their implications for further research and patient treatment, are discussed in the following chapter.

CHAPTER 5

SUMMARY AND RECOMMENDATIONS

The intent of this chapter is to compare the essential experience of need, described in Chapter 4, to relevant literature in occupational therapy and related fields, some of which is discussed in Chapter 2. This chapter will be organized around the themes, or categories of need, presented in the final section of Chapter 4 (General Description of the Essential Experience of Need). Excerpts from the interviews are presented to clarify and deepen the reader's understanding of each theme. Following the treatment of each theme and its relevance to the literature are recommendations for further research and treatment.

Summary of Themes in the Data

Need for Practical Daily Living Skills

Bathing and Grooming

I haven't been personally taking care of my grooming. I just let everything fall aside and I'm trying to get back on track, make these things important enough to put the energy into it. (James)

Balancing a checkbook

I majored in finances, I couldn't even balance a checkbook. That's how far gone I was. (Michael)

Finding housing

Most of the board and care [sic] will not take couples. So that means we're going to have to split up, as far as our living conditions go. That's a pretty difficult issue to deal with. And there

just isn't any answer to that right now. I'm working on that though right now, trying to get residential housing. . . . (James)

Finding employment

My situation is that I want a job. I want a job. There's nothing wrong with me that a \$40,000-a-year job wouldn't cure. . . . Help me find a job! (Dave)

The subjects describe practical difficulties they are having with daily living activities. One of the core domains of occupational therapy is to address dysfunctions in everyday self-care, work/productivity, and play/leisure activities (Law et al., 1994; Pedretti & Pasquinelli, 1990).

Need for Physical Objects in the Environment

Uniforms for staff

They do not look professional here at all. And I think this needs to be . . . have a little spiffier look to it. More clinical look to it. And there should be some kind of uniform out there that people are wearing. (Dave)

Rainbow flag and gay literature

When I was brought to this ward, I was with the idea that it was a ward with a gay and lesbian focus. And this is where I got familiar: I saw the banners on the walls and a couple of gay newspapers, a couple of magazines, a couple of support groups on the schedule board, you know, of activities for patients. . . . I felt some relief, actually. Because I thought that was going to help me with some of the problems I was having. (Robert)

Earhart (1985) describes how the placement of objects in the environment influences behavior. Kielhofner (1995b) writes that "we imbue objects with meaning so that they become symbols of power,

prestige, independence, and connection to others” (p. 98). For Dave, the clothing of the staff on 7B lacks the power and prestige appropriate for people with authority over him. Robert, by contrast, views the rainbow flag as a symbol of connecting with other gay men.

In their interview transcripts, both Michael and Stephen discuss the importance of obtaining medications that meet their needs on 7B. Medications took on symbolic value for Michael when he brought his 24 pill bottles to SFGH with him, so that the staff would know how sick he was. However, medications most often influence behavior chemically, rather than symbolically. Medications in this sense are objects that afford Michael and Stephen the potential to engage in tasks (Kielhofner, 1995b, p. 92).

Need for Social Support

Discussion groups

Any time you can throw out your feelings and let them come back, there are some other outside factors involved that gives you . . . prospects because otherwise you're looking at it in just your very narrow . . . tone. (James)

I'm not here to listen to all these other people babble! This is not going to help me, all their babbling and rambling and incoherent conversation. This is not going to help me. . . . What I know about you ain't going to put bread on my table. What I know about her, you know, clerk work at Macy's or whatever ain't going to help me being a credit manager. (Dave)

Family support

I generally used to stay out of the hospital about a year. But since my lover and I have been together [12 years], I've only had two periods of hospitalization, so that's been great. Real great. We've been good for each other. It's too bad that now we're going through a rough period that makes it real difficult. (James)

I don't have that full support [from my family]. See when you come out, honey you get bashed! And I don't mean physically bashed, you get mentally bashed. And it starts from inside your family, all out. Because I'm not going to sit up here, and paint no pretty picture that "Oh, my family just loves me because I'm so gay." No, sweetheart. (Michael)

One-on-one support

The counselors are always helpful. They always will give you a helping hand to do something. They're always willing to talk on your behalf. They're always willing to just be there for you, as a human being, you know. Where if you need someone to talk to, they're always there to lend an ear. And just help support or, you know, "Well, look at it this way," instead of having such a one-mind focus one way. . . .You know, many thoughts. (Stephen)

Both the Model of Human Occupation (Barris, Kielhofner, Levine, & Neville, 1985; Kielhofner, 1995b) and the Canadian Occupational Performance Model (CAOT, 1993) regard the social environment as having a substantial influence over a person's ability to function. For the most part, however, the subjects of this study appear to value social support for reasons other than its potential impact on their ability to perform tasks.

The need for social support expressed by all five subjects appears to be consistent with the findings from a Cleveland-based survey of 52 chronic psychiatric patients in 1989, in which the issue of sexual orientation was not addressed (Solomon & Beck, 1989). The most frequently mentioned areas of need identified by the subjects of the Cleveland study were information and advice, financial assistance, counseling, and assistance in controlling emotions (p. 219). The respondents tended to seek help from formal service providers, family, and friends to meet these needs (p. 223).

James's and Michael's statements merit further discussion in light of the Cleveland findings. Both men sought help from formal service providers after losing support from informal service providers for reasons related to their sexual orientation: James, because of his lover's AIDS-related disability, and Michael, because of his family's rejection of his gay identity. Further research is needed to determine whether gay men are, in fact, less likely than non-gay men to rely on formal service providers.

Need for Intangible Environmental Qualities

Safety

Having lunch together with a person, you know, you can have a nice conversation and then something happens, you know, and they start with "faggots," and this and that. . . . The person I am talking to, she sees somebody doing something and she starts saying, "You faggot," or that kind of thing. Not necessarily to me, because she doesn't know that I'm gay. So in that case, I'm not actually afraid of confronting him [sic] . . . saying "No, don't use

that word, you're offending me, blah, blah, blah." But, at the same time, because I have other problems, I just take it as "I don't have to disclose that." And in a way it's bad. I want to be myself, but I can't do that in an unsafe environment. Because I've been gay-bashed before. And that's one of the reasons that I'm here. (Robert)

[In] groups, I am able to . . . get some ideas, and there again, that's an issue because I haven't really came out [sic] that I was gay. . . . I've been a little reluctant to do that. Because . . . I felt there might be prejudice involved. It just might be more unhelpful than helpful. (James)

Professionalism

I'm a college graduate, I'm a professional. . . . [7B] needs to have a more, a clinical, professional air. . . . When am I going to get some professional guidance and help that's going to talk to me? (Dave)

Organization

Downstairs is a different joke than it was upstairs, and the reason I say that is because everybody is crazy and you don't know who's who! When I was down there, it wasn't as organized as it is up here. . . . Okay? But honey, they couldn't have given a care or less about you downstairs. But up here, it's more relaxed. (Michael)

Much of the occupational therapy literature concerns itself with the nature of the interaction between a person and the environment during task performance. The character of the environment is relevant to Allen's (1982, 1985) discussions of methods for structuring the environment to facilitate successful task performance by people with cognitive disabilities.

However, the intangible qualities that some individual subjects feel they need on 7B pose special programming challenges, because they are

inherently elusive and subjective. These qualities may be cultural artifacts relevant to occupational performance (Barris et al., 1985; Kielhofner, 1995b; Law et al., 1991). Further research is needed to understand how the environment can be manipulated to address patients' concerns in these areas.

Need for Interactions with Other People

Relating

It would be good to have somebody, you know, to talk about these issues. Besides my doctor. I know he's very understanding, and this and that. You know, I'd rather talk to a gay man. Even a lesbian. Somebody that can relate to how I feel. . . . I mean, talking to straight guys, you know. (Robert)

Everybody needs an example. Somebody to look up to. Okay. I would imagine the setting would be gay professionals, because this is a field that's very professional. But then again, you got to be professional, and you got to know what it's about. . . . This is what it's about. Relating to different people on different levels. And if you can't do that, you can't be that flexible. Or even try to cross-train over to see what it is actually about, then there's no way. Because you can't learn this shit in a textbook. (Michael)

The medical doctors are so young, they're interns, I don't think they can relate to an age situation, that I'm in. (Dave)

Communicating

I had a conversation with a gay man that is a nurse, and I had a conversation with a nurse that isn't gay. The one that isn't gay was very supportive. But still, it's hard for me to express what . . . uh . . . even medical problems that are common for gay men. You know, his reaction, although he said he was very supportive, it was hard to explain it to him because of the way he responded. (Robert)

[The doctor] said, "I can't talk to you when you're like this." I said, "Look, God damn it! . . . What part of 'I need morphine' don't you

understand?" That's that queen coming out of me. And she walked off talking about, "Well, I can't talk to you!". . . . Two days it took her to talk to me. And then when she did, I told her. I said, well, you know, I said, "It may have been my medication." I said, "But you know, when I have these headaches and stuff," I said, "I know you don't have access to my medical records." I said, "You ought to listen to somebody that knows what they've been through. . . ." I just went ahead and went through the pain. (Michael)

Trusting

It's the hardest trial that I've had to go through, is asking and trusting people. . . . Which people are the ones that you're going to trust? (Michael)

Monitoring

They knew that I had a problem, that I was not unaware of. And that is, is my mind travels quicker than the average person. And I didn't see it, but when I hear a lot of people telling me that, "Michael, oh, you sound 100% better, 100 . . ." maybe there might be some truth to it. (Michael)

Fein (1990) and Miller (1983) assert that people interpret events, interact, and communicate based on internal scripts that help us make sense of social situations and expectations. These scripts help us figure out how to behave and meet our needs (Kielhofner, 1995c, p. 73). They also help us fulfill roles within a larger social group that meet the needs of the group (Kielhofner, p. 73).

When the subjects talk about their need to relate to gay staff members or patients on 7B, they seem to be conveying the notion that they need to talk with someone who shares the same script. This is especially important when Robert and Michael are trying to discuss their

treatments with their doctors and nurses. Michael, for example, thinks that his doctor “pushed” him to the point where “the queen came out” in him, then reacted inappropriately by cutting off communication with him. He felt confused and suffered unnecessary pain as a result.

Crepeau (1991) discusses the need for therapists to avoid letting their power over patients hinder communication and become an obstacle to treatment.

Need for Organization of Time

Free time vs. boredom

Going to the groups . . . they’re spaced out enough so that you do have some free time. You’re not bombarded constantly. (James)

After lunch. . . we don’t have nothing to do. So you can either watch TV, or listen to the radio. . . . During the day, a counselor, a social worker, may come over and talk to you. Or your nurse may . . . ask you questions, take your blood pressure. . . . But it’s very, you know, very, very boring, the whole thing. (Robert)

Timing of groups

By the time we’re in the shower, the OT person is running around with a cart with deodorant. You know, actually I think that that should be later, so they can allow you to get out of the shower, dry and then. . . . Because, you know, I haven’t been able to do that for a while. (Robert)

James is satisfied with the timing and variety of activity choices on 7B, while Robert is not. This difference can be attributed to differences in habits or personal rhythms of alternating behaviors (e.g., eating and

sleeping, working and resting) that one typically develops to fulfill

biological, psychological, and social needs (Kielhofner, 1995c, p. 69).

Need for Group Activities

Discussion groups vs. hands-on activities

[Groups] just focus your mind, on one thing, by doing something. With your hands. . . . Rather than sitting and just seeing nothing, they give you something to think about. You know, rather than sitting there and just going “ding, ding, ding, ding, ding,” dinging off the walls You just sit back and you say, “Yeah, I can do that,” or “No, I can’t do that.” Or you just sit and you . . . go crazy, pretty much. That’s really what it feels like, that you’re going nuts. (Stephen)

Occupational therapy. . . . Some of them actually suck. You know, as I said, for different people, at different levels, it helps. You know, I’d rather have a group to discuss issues, you know, that are out there, and very real. . . . than making a calendar for the month of August. (Robert)

Higher-level and lower-level groups

The program here is geared for the lowest common denominator. . . . Well can’t there exceptions be made? When you finally get somebody in here that has an IQ of over 75, isn’t there somebody out there that has the intellect to be able to deal with that? . . . There should be two levels here. There should be the vegetable level, and there should be the level that could deal with me. (Dave)

Meaningfulness of activities

I work on crossword puzzles, read a magazine. Actually boring, you know, it’s totally boring. Or go to OT and start painting, or drawing, or things like that. You know, things I don’t care much about, to tell you the truth. I had fun in one group, though, because I got to paint one T-shirt. So I put “Latino Queer” on it. But I haven’t gotten to wear it yet, you know? Somebody asked me “When are you going to wear that?” One older man. And I told him, “In church.” (Robert)

The subjects describe a diversity of needs related to group activities. Volumes of occupational therapy literature have been devoted to addressing the challenge of meeting the diverse needs of patients and finding activities that are meaningful for them (Allen, 1982, 1985, 1986; Christiansen & Baum, 1991; Fidler & Fidler, 1963; Hopkins & Smith, 1993; Kielhofner, 1995a; Pedretti & Zoltan, 1990). A core tenet of occupational therapy is that “purposeful activities” (i.e., activities that engage and have meaning for the patient; American Occupational Therapy Association, 1993, p. V.9) be used to evaluate, maintain, and restore patient function.

The subjects’ statements can be taken to indicate that purposeful activities need to be provided on 7B, and that this need is being met for some patients, but not for others. Cole (1993) proposes offering verbal activity groups for patients functioning at higher cognitive levels, and hands-on activity groups for patients functioning at lower levels (p. 134; see also Allen, 1985).

Need for Interactions with the Environment

Problem-solving

It’s kind of like you see a problem, you want it solved, they help you solve it, and you sit back and go “thank you.” (Stephen)

Coping

My lover and I for twelve years, he has AIDS, he’s gay, and more severely ill. So we’ve reached a crisis point where I feel I can’t really

take care of him properly. . . . So the issue was, for me, how to cope with this, and that's why I became suicidal. And I just couldn't cope, so that's why I'm here. (James)

Concentration

[OT groups] are beneficial, because concentration is a problem, and I find that some days it's really uplifting and other days it's just the opposite. I find OT very beneficial. . . . I can relate to that easier [than discussion groups] because you're creating something, normally. So there's a period of starting it, working on it, and the completion. And this gives you self-satisfaction, along the line, unless something goes arrear [sic], and then you get hung up, and so it's really very close to living, overall. (James)

In these statements and in Stephen's earlier statement about achieving focus through hands-on activities (in the group activities section of this chapter), the subjects express the need to interact more satisfactorily with their physical environment. Fisher and Kielhofner (1995) discuss a range of skills needed to process and act on information from the environment to accomplish important tasks, including maintaining attention, accommodating one's actions to the environment, and adapting the environment (pp. 120-123). Accommodation and adaptation are concepts borrowed from Jean Piaget (Allen, 1985).

Chapter 2 briefly summarizes some of the literature on the coping difficulties experienced by the caregivers of people with AIDS (Bonck & MacRae, 1990; Okoneski, 1990; Scaffa & Davis, 1990; Schaffner, 1990). This experience is uniquely common among gay and bisexual men in San

Francisco, who comprise 90% of the city's total HIV-infected population (SFDPH AIDS Office, 1993).

Need for Information

AIDS information

Maybe somebody from the San Francisco AIDS Foundation, coming and making a presentation about their services. Maybe about . . . I don't know, who to consult for a support group for men who are HIV-negative. Because that's a big issue in the community, because they don't have much support. What about information about women and AIDS, sexuality, and breast cancer . . . you know, I don't know. Something like that will make the time, the hour of the group, worthwhile for people who don't know where to go when they leave the hospital. (Robert)

Rules

The groups I go to help me immensely. . . . They keep varying my outlook on things. . . . From the counselors . . . their input into my views. Their input into what I do. Their "No, you can't do this. Yes, you can to that." Stuff like that. (Stephen)

Employment

This is what I need. I need to talk to a professional person who can give me some suggestions in where to go look for a job. Maybe explore other avenues that I haven't thought of. (Dave)

Suicide rate

I thought it was an interesting statistic—that I am in one of the highest suicide-rate categories. I am a single white male, unemployed, over 50. . . . I'm glad to know that there are others in my category. (Dave)

Free things to do in the city

I did go to one [group] the other day that was finding things inexpensive or free to do in the city. And I learned a little bit about

things that I hadn't thought of. . . . There was a lot of other areas to find this information out that I didn't know. (James)

The information needs of patients are varied and self-explanatory. They appear to relate to other needs expressed during the interviews, such as interacting with others, coping, finding a job, and organizing one's time. They also relate to patients' interests. AIDS is more likely to be an issue of concern to gay male patients than non-gay patients, for the reasons stated in the previous section.

Recommendations

The results from this study could be seen to indicate the need for substantial changes in policies regulating hiring, communications between patients and staff, dress codes, and the structure and content of group therapies on 7B. However, no study of five people can provide any institution with a solid enough base of information to develop new policies affecting large numbers of patients. The phenomenological method is designed to reflect the priorities of subjects more closely than other methods, including the structured interactions that normally take place in the hospital and are naturally influenced by the priorities set by the hospital. The staff on 7B may find the concerns raised by the subjects in this study quite familiar or quite surprising, and may decide to keep or change policies and programs accordingly. They should do so with the understanding that the results complement the clinical

observations of the staff on 7B and other data gathering performed by the SFGH Department of Psychiatry.

Even though the findings from this study are not generalizable, the staff on 7B can make use of them. The Department of Psychiatry provides individualized treatment for its patients: Knowledge of how individual patients experience their care is therefore very important. For example, the fact that even one subject feels unsafe and fearful on 7B makes safety a concern for staff, whether other patients share his fears or not. In this example, the subject's fear is an obstacle to recompensation that the staff must help him overcome. Even if 7B admits only two patients a year with safety concerns, a therapist on 7B may be able to treat those patients better if she understands another patient's experience of feeling unsafe.

Two sets of recommendations can therefore be made: clinical recommendations aimed at informing patient treatment, and recommendations for further research.

Clinical Recommendations

Clinical recommendations can be made based on specific issues and themes emerging from the research. Clinicians should be aware that some of their patients may perceive the following concerns to be of major importance during their treatment on 7B:

1. Patients on 7B may be concerned about improving their daily living skills, such as maintaining personal hygiene, managing money, obtaining housing, and finding employment. Like Michael, they may identify one or more of these skills as a concrete indicator of their overall level of function.

2. Like Dave, patients may be highly sensitive to the personal appearance of staff members on 7B. Personal appearance may take on a symbolic meaning for some patients, and may be seen as a source of agitation or comfort. Patients may communicate with certain staff members in unexpected ways based on these perceptions, and the staff may have to develop a repertoire of responses.

3. Patients seeing the rainbow flag and the schedule board may develop high expectations of their ability to bond with sexual minority patients like themselves. The staff on 7B may need to evaluate whether the mission of the Gay and Lesbian Focus Program is clear to staff and patients, and whether the expectations that its trappings elicit can reasonably be met.

4. The subjects in this study have complex relationships with family members, and seldom obtain social and emotional support from them. All five subjects describe a need for and reliance upon friendships and sexual relationships as important or desired sources of social and

emotional support outside the hospital. The staff on 7B may encounter other patients who are estranged from their families and rely instead on existing or hypothetical friendship networks. If possible, the staff on 7B may need to involve the patient's friends in the transition to community living.

5. Some patients may prefer discussion groups, while others may prefer hands-on activities. Both should be offered on 7B.

6. Some patients may be afraid to disclose their sexual orientation to other patients. This fear may cause the patient to avoid a discussion group even if he considers the group to be beneficial.

7. Patients may attribute difficulties relating to and communicating with staff members on 7B to differences in sexual orientation, race, age, or professional status. Patients may also consider their own relative powerlessness in the hospital setting to be an obstacle to effective communication with the staff. The staff should be aware that patients may view common group membership or common cultural experience as a prerequisite to effective communication and trust-building. Gay patients may expect gay staff members to declare their sexual orientation (in a professional manner) and may be frustrated, offended, or put off when non-gay staff members do not share the same communication style.

8. Some patients feel the need to improve their problem-solving skills, coping skills, and concentration. Patients may also feel the need to learn more about mental and physical illnesses (especially AIDS), job-search strategies, and inexpensive activities in the community. Occupational therapy groups could address these concerns, if they do not already do so.

Research Recommendations

The results also have significant implications for further research. One of the limitations of this study is the absence of lesbians and bisexual women in the research sample. The literature review found no research on sexual-minority women in acute psychiatry. The need experience of this population therefore remains to be studied.

Moreover, a needs-assessment survey of a larger group of patients in the Department of Psychiatry can help determine the extent to which others share the concerns voiced by the subjects. The themes outlined in the first part of this chapter correspond to what Hayes (1992) describes as “quality dimensions” (p. 7) on which customers (in this case, patients) typically base their judgments about the quality of a service. The subjects’ describe significant contacts with the staff on 7B, which constitute “critical incidents” (Hayes, p. 13) that are used to measure quality. According to Hayes, quality dimensions and critical incidents are

the essential raw materials for a questionnaire that can provide high-quality information on the frequency and magnitude of customer concerns. Such a survey would provide generalizable findings on patient needs that can inform departmental policies affecting large numbers of patients.

Whether a survey is conducted or not, this study offers insights that previous research does not. No previous study could be found that asks gay men in acute psychiatry about their needs. Few previous studies of gay people in mental health have tried to break free of theoretical bias to understand patients' concerns on their own terms. The five men who participated in this study were remarkably articulate and offered complex and highly personal information. Their manner of self-expression alone can tell health care providers much about how to communicate with gay male patients. This study gives voice to their insights—a small achievement, perhaps, but, as Michael said at the close of his interview,

I've been through a lot of shit. And it's just the ignorance of people. And I want to leave on that note, because . . . that's just, that's just it. I mean, I've been living with this for so long. Hopefully, out of your research and stuff, something positive will come out of it.

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Appendix A

Multidisciplinary Assessment Data Base Form

**SAN FRANCISCO GENERAL HOSPITAL
MEDICAL CENTER
DEPARTMENT OF PSYCHIATRY
MULTIDISCIPLINARY ASSESSMENT DATA BASE**

Addressograph

Nursing (shift of admission)

Date

Time

Unit

Primary Language

ORIENTATION TO UNIT

PATIENT PROPERTY

- ☐ Introduction ☐ Smoking
☐ Telephone ☐ ID Band On
☐ Visiting Hours ☐ Personal Space
☐ Unit Routine ☐ Unable to Orient

- VALUABLES: ☐ N ☐ Y: ☐ Prop Office
CLOTHING: ☐ N ☐ Y: ☐ Clothing Rm
MEDICATIONS: ☐ N ☐ Y: ☐ Prop Office
PROTHESES: ☐ N ☐ Y: ☐ Full Dentures
☐ Eye Glasses ☐ Contact Lens

- ☐ Ward Privy Rm ☐ Home w/
☐ Ward Privy Rm ☐ Home w/
☐ Home w/
☐ Partial Dentures ☐ Hearing Aid R/L
☐ Contact Lens ☐ Other

Patient Rights

Admission: ☐ Yes ☐ No, reason: _____

Booklet Given: ☐ Yes ☐ No, reason: _____

CURRENT HEALTH STATUS

- PHYSICAL ILLNESSES/CONDITIONS: ☐ None known ☐ See PES intake ☐ See physical exam ☐ See consult report
☐ Other: _____
☐ Treatments: _____
☐ Pain/Discomfort/Location: _____

ALLERGIES: Medications: _____

Hx. of EPS ☐ No ☐ Yes: _____

Foods: _____

Dietary Restrictions: _____

- AMBULATORY STATUS: ☐ Indep ☐ Needs Assist* ☐ Needs Device* *Complete Falls Assessment
HEARING: ☐ Non-Impaired ☐ Hard of Hearing ☐ Deaf R/L
VISION: ☐ Non-Impaired ☐ Impaired: _____
HYGIENE: ☐ Good ☐ Fair ☐ Poor ☐ Head/Body Lice
CURRENT SLEEP PATTERN: _____
CURRENT SUBSTANCE USE: ☐ see PES intake ☐ add info: _____ ☐ Withdrawal Potential: _____

CIRCUMSTANCES OF ADMISSION

- ☐ See PES/JFS intake ☐ See Consult Report ☐ Add info: _____

MENTAL STATUS EXAM (on admission)

(Check all that apply in each category)

ORIENTATION:	☐ Time	☐ Place	☐ Person	☐ Event	
APPEARANCE:	☐ Neat	☐ Disheveled	☐ Dirty		
BEHAVIOR:	☐ Cooperative	☐ Anxious	☐ Uncooperative	☐ Irritable	☐ Angry ☐ Suspicious
THOUGHT PROCESS:	☐ Clear	☐ Tangential	☐ Circumstantial	☐ Loose	☐ Grandiose ☐ Depressive
THOUGHT CONTENT:	☐ Suicidal	☐ Homicidal	☐ Delusional	☐ Paranoid	☐ Mute
SPEECH:	☐ Slow	☐ Pressured	☐ Loud	☐ Slurred	☐ Euphoric ☐ Irritable
AFFECT:	☐ Normal	☐ Hostile	☐ Inappropriate	☐ Full Range	
MOOD:	☐ Flat	☐ Depressed	☐ Anxious	☐ Other: _____	
LEVEL OF CONSCIOUSNESS:	☐ Normal	☐ Drowsy	☐ Unresponsive		
INSIGHT/JUDGEMENT:	☐ Alert	☐ Fair	☐ Poor		
MEMORY: Immediate	☐ Good	☐ Fair	☐ Poor	☐ Cannot assess	
Recent	☐ Good	☐ Fair	☐ Poor	☐ Cannot assess	
Remote	☐ Good	☐ Fair	☐ Poor	☐ Cannot assess	

POTENTIAL FOR VIOLENCE

TOWARD SELF:

Ideation: ☐ No ☐ Yes, Plan: _____

History of Attempt: ☐ No ☐ Yes, Date(s): _____

TOWARD OTHERS:

Ideation: ☐ No ☐ Yes, Plan: _____

History of Violence: ☐ No ☐ Yes, Precipitant: _____

Signature

Date

Time

SOCIAL WORK (72 Hour Note)

IDENTIFYING INFORMATION

☐ Male ☐ Female
 Date of Birth: _____
 Age: _____
 Ethnicity: _____
 Primary language: _____
 Religion: _____

SEXUAL ORIENTATION

☐ Heterosexual
☐ Bisexual
☐ Lesbian
☐ Gay
☐ Patient refuses

MARITAL STATUS

☐ Now married
☐ Never married
☐ Divorced
☐ Separated
☐ Widowed
☐ Other: _____

CHILDREN: Name and Age

REASON FOR HOSPITALIZATION

☐ Danger to self. Describe: _____

☐ Danger to others. Describe: _____

☐ Gravely disabled. Describe: _____

REFERRAL SOURCE: Check primary source

☐ Police
☐ Family
☐ Self
☐ Mental health personnel
☐ Other: _____

PSYCHIATRIC/SUBSTANCE ABUSE TREATMENT

DSM III-R Axis I: _____

HOSPITALIZATIONS: _____ DAY TREATMENT: _____

INCARCERATIONS: _____ OUTPATIENT: _____

RESIDENTIAL CARE: _____ TREATMENT COMPLIANCE: _____

SUBSTANCE USE	Daily	Weekly	Other	Amount		Daily	Weekly	Monthly	Other	Amount
Alcohol	—	—	—	—	Amphetamines	—	—	—	—	—
Cocaine	—	—	—	—	Heroin	—	—	—	—	—
Marijuana	—	—	—	—	Inhalants	—	—	—	—	—
LSD	—	—	—	—	Methadone	—	—	—	—	—
PCP	—	—	—	—	Other	—	—	—	—	—

CRIMINAL CHARGES: (Court dates)

SUPPORT SYSTEM

LIVING SITUATION: ☐ ADU ☐ Hotel ☐ Family-Friends ☐ Residential Care ☐ L-facility ☐ Shelter ☐ Homeless ☐ Jail

INCOME (ENTITLEMENTS): ☐ GA ☐ SSI ☐ SSD ☐ SDI ☐ Unemployed ☐ Payee ☐ Other: _____

SUPPORT SYSTEM: (name, telephone): _____

MENTAL HEALTH SYSTEM SUPPORTS: _____

STRENGTHS:

TENTATIVE DISCHARGE PLAN

DISPOSITION: _____

Signature
 MLF:ks/proj13

Date

Time

INITIAL PSYCHIATRIC ASSESSMENT (24 Hour Note)

HISTORY OF PRESENT ILLNESS

☐ See PES/IPS Intake

☐ See Consult Report

☐ Additional Information: _____

MEDICAL HISTORY

☐ See PES/IPS Intake

☐ See Consult Report

☐ See Permanent Data Base: (Add additional information permanent data base)

PSYCHIATRIC HISTORY

☐ See PES/IPS Intake

☐ See Consult Report

☐ See Permanent Data Base: (Add additional information to permanent data base)

EXAMINATION

IMPRESSION

PLAN

Attending Medical Staff Signature

Date

Time

MLF:ks/proj13

PATIENT/FAMILY EDUCATION: each discipline to complete assessment by 72 hours

NURSING ASSESSMENT:

SELF CARE: Assessment of Capabilities (I=Independent, A=Assistance Needed, D=Dependent)				
Bathing	Oral Hygiene	Bladder Management	Eating	
Dressing	Bowel Movement	Participation in Program	Sleeping	

Patient's Self Care Goal: _____

Patient's Goal for Hospitalization: _____

EDUCATIONAL NEEDS: (Check all that apply to current hospitalization)

- ☐ ILLNESS IMPACT: ☐ on self care ☐ on treatment follow-up ☐ on interaction with others ☐ on safety
☐ MEDICATION: ☐ basic information ☐ follow-up ☐ side effect management
☐ SAFE SEX: ☐ HIV/AIDS ☐ SUBSTANCE ABUSE: _____ ☐ SPECIAL DIET: _____

ATTENDING ASSESSMENT (Check all that apply to current hospitalization)

- ☐ Knowledge of psychiatric illness: _____ ☐ Medication information: _____
☐ Knowledge of medical conditions: _____ ☐ Medication information: _____
☐ Knowledge of psychiatric/medical follow-up: _____

SOCIAL WORK ASSESSMENT: (Check all that apply to current hospitalization)

- ☐ COMMUNITY SERVICES: _____
☐ HOUSING/INCOME: _____
☐ FAMILY/SOCIAL RELATIONSHIPS: _____
☐ FOLLOW-UP FOR TREATMENT: _____
☐ SUBSTANCE ABUSE: _____

OCCUPATIONAL THERAPY ASSESSMENT Not assessed due to: ☐ refusal ☐ not able to participate

LEARNING STYLE: Check all that apply

- ☐ visual cues ☐ written instruction ☐ modeling ☐ distraction
☐ verbal cues ☐ hands on practice ☐ trial and error ☐ non-threatening environment
☐ group instruction ☐ familiar environment ☐ 3 plus step instructions ☐ individual step instructions
☐ demonstration ☐ explorative ☐ 1-2 step instructions * ☐ other _____

LIVING SKILLS - Check all areas in which assistance is needed

- ___ Dressing ___ Hygiene ___ Washing Clothes ___ General Appearance ___ Parenting
 ___ Cooking ___ Budgeting ___ Time Management ___ Safety Awareness ___ Relationships

STRENGTHS/GOALS: _____

WORK CAPABILITIES: _____

LEISURE INTERESTS: _____

SIGNATURES:
(by 72 hours)

Nursing: _____ Date: _____ Time: _____
 Attending: _____ Date: _____ Time: _____
 Social Worker: _____ Date: _____ Time: _____
 O.T.: _____ Date: _____ Time: _____

Appendix B

**Letter of Support from the Department of Psychiatry,
San Francisco General Hospital**

City and County of San Francisco

**Department of
Public Health**

**San Francisco General Hospital
Medical Center**

April 24, 1995

Reese Jones, MD
Chair, Committee on Human Research
University of California at San Francisco
Office of Research Affairs
3333 California Street, Suite 11
San Francisco, CA 94118

Dear Dr. Jones:

I am writing to acknowledge and endorse the research project entitled "A Phenomenological Needs Assessment of Sexual Minority Patients in an Acute Psychiatric Setting." I understand that Richard Bookwalter, occupational therapy student at San Jose State University, will be the co-principal investigator of this study along with his advisor Orren Perlman, M.D., Clinical Instructor in Psychiatry at San Francisco General Hospital (SFGH). Lynne Andonian, OTR, Occupational Therapist in the Department of Psychiatry at SFGH, will assist with subject selection for this project and will serve on the graduate research committee advising Mr. Bookwalter on this project. I urge the Committee on Human Research to approve this study, the results of which are expected to enhance services for gay, lesbian, and bisexual patients admitted to the Department of Psychiatry at San Francisco General Hospital.

Sincerely,

A handwritten signature in cursive script that reads "Mark Leary".

Mark Leary, MD
Unit Chief, 7B
Department of Psychiatry

ML:rb

Appendix C

**Human Subjects-Institutional Review Board Approval from
San Jose State University and the
University of California at San Francisco**

Office of the Academic Vice President • Associate Academic Vice President • Graduate Studies and Research
One Washington Square • San Jose, California 95192-0025 • 408/924-2480

TO: Richard Bookwalter
250 Douglass Street, #15
San Francisco, CA 94114-2453

FROM: Serena W. Stanford *Serena W. Stanford*
AAVP, Graduate Studies & Research

DATE: August 1, 1995

The Human Subjects-Institutional Review Board has approved your request to use human subjects in the study entitled:

"A Phenomenological Needs Assessment of Sexual Minority Patients in an Acute Psychiatric Setting"

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Serena Stanford, Ph.D., immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that each subject needs to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate, or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have any questions, please contact me at (408) 924-2480.

COMMITTEE ON HUMAN RESEARCH
OFFICE OF RESEARCH AFFAIRS, Box 0962
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

CHR APPROVAL LETTER

TO: Orrert Perlman, M.D.
SFGH, 7M

✓ Richard Bookwalter, B.A.
c/o L. Andonian
OTR, SFGH, 7B

RE: A Phenomenological Needs Assessment of Sexual Minority Patients in an Acute Psychiatric Setting

The Committee on Human Research, the UCSF Institutional Review Board holding Department of Health and Human Services Multiple Assurance #M-1169, has reviewed and approved this application to involve humans as research subjects.

APPROVAL NUMBER: H8720-11665-01. This number is a UCSF CHR number and should be used on all consent forms, correspondence and patient charts.

APPROVAL DATE: June 28, 1995.

Full Committee Review

EXPIRATION DATE: July 1, 1996. If the project is to continue, it must be renewed *by the expiration date*. See reverse side for details.

ADVERSE REACTIONS/COMPLICATIONS: All problems having to do with subject safety must be reported to the CHR within ten working days.

MODIFICATIONS: All protocol changes involving subjects must have prior CHR approval.

QUESTIONS: Please contact the office of the Committee on Human Research at (415) 476-1814 or campus mail stop, Box 0962.

Sincerely,

Reese T. Jones, M.D.
Chairman
Committee on Human Research

cc: SFGH

Project # 95011665

Appendix D

Consent Form

College of Applied Sciences and Arts • Department of Occupational Therapy
One Washington Square • San José, California 95192-0059
Main Office: 408/924-3070 • Fieldwork Office: 408/924-3078 • FAX: 408/924-3088

**UNIVERSITY OF CALIFORNIA, SAN FRANCISCO (UCSF)
AND
SAN FRANCISCO GENERAL HOSPITAL (SFGH)**

CONSENT TO BE A RESEARCH SUBJECT

A. PURPOSE AND BACKGROUND

Richard Bookwalter, Occupational Therapy Student, of San Jose State University (SJSU) and Orren Perlman, MD and Lynne Andonian, OTR of the San Francisco General Hospital (SFGH) Department of Psychiatry are conducting a research study to find out what gay men, lesbians and bisexual people need when they are in the hospital. You are being asked to participate in this study because you are a gay man, lesbian, or bisexual person currently admitted to Unit 7B.

B. PROCEDURES

If you agree to be in the study, the following will occur: Mr. Bookwalter will interview you one-on-one. He will ask you to tell him about *your needs on Unit 7B* and the two of you will discuss them. The first interview will take 30 minutes or more, depending on how long you want to talk. You may schedule additional interviews with Mr. Bookwalter if you need more time. Mr. Bookwalter will tape-record the interview(s) on Unit 7B.

C. RISKS/DISCOMFORTS

1. Some of the interview questions may make you feel uncomfortable or upset, but you will be able to decline to answer any questions you do not wish to answer or stop the discussion at any time.
2. Confidentiality: Participation in research may involve a loss of privacy; however, your records will be handled as confidentially as possible. Only Mr. Bookwalter, Ms. Andonian, and Dr. Perlman will have access to your audiotapes. After the interview has been transcribed from the tapes, the tapes will be destroyed. No names or individual identities will be used in any reports or publications that may result from this study.

D. BENEFITS

There will be no direct benefit to you from participating in this study. However, the information that you provide may help improve programs for gay, lesbian, and bisexual patients on 7B in the future.

E. COSTS

There will be no costs to you as a result of taking part in this study.

F. PAYMENT

You will not be paid for your participation in this study.

G. QUESTIONS

You have talked to Mr. Bookwalter, Ms. Andonian, or Dr. Periman about this study and have had your questions answered. If you have further questions, you may call Mr. Bookwalter at (415) 241-1579 and leave a voice mail message. He will call you back.

If you have any comments or concerns about participation in this study, you should first talk with call Mr. Bookwalter. If for some reason you do not wish to do this, you may contact one of the following:

1. The UCSF Committee on Human Research, which is concerned with the protection of volunteers in research projects. You may reach the committee office between 8:00 a.m. and 5:00 p.m., Monday through Friday, by calling (415) 476-1814, or by writing: Committee on Human Research, Box 0962, University of California, San Francisco, San Francisco, CA 94143.
2. Amy Killingsworth, Acting Chairperson of the Department of Occupational Therapy at San Jose State University, at (408) 924-3070, or Serena Stanford, Associate Academic Vice President for Graduate Studies and Research at SJSU, at (408) 924-2480.

H. CONSENT

You will be given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You are free to decline to be in this study, or to withdraw from it at any point. Your decision as to whether or not to participate in this study will have no influence on your present or future status as a patient at San Francisco General Hospital.

If you agree to participate, you should sign below.

_____	_____
Date	Signature of Study Participant
_____	_____
Date	Signature of Person Obtaining Consent

Appendix E

Sample Meaning Unit Transformations from Interviews with the Subjects

Appendix E

Table E1

Sample Meaning Unit Transformation from Interview with Robert

Meaning unit
<i>Yeah. You mentioned something about homophobia on the unit, or just hearing comments.</i>
<p>Yeah. That's homophobia, yeah definitely. That's what I say, that maybe it's helpful to bring up the issues here. I mean, come on. They advertise this unit as the Gay, Lesbian, Bisexual, you know, unit. So let's have ACT UP come on [chuckling] . . . no. Because, there's a nurse, you know, he's gay, and sometimes, he was kind of loud, you know, calling people loud for the patio. Like an opera singer. You know, it's fun. But then, you can hear patients walking around. They don't actually say it to the nurse because they don't get to go out, probably. But they start with "faggot," and "frigging homosexual," and "goddamn this" and "goddamn that." I mean, these people need to be educated, you know, who we are. And as long as this is the Gay, Lesbian, Bisexual ward, all of that should be addressed. I mean, I don't think that there'll be any problem because we're all adults. I don't expect to change anybody's mind, but at least to . . . to feel safe. To feel safe, you know, because of my sexuality. And that isn't happening.</p>
<i>You don't feel safe?</i>

table continues

Table E1

Sample Meaning Unit Transformation from Interview with Robert

No, no. That's why I'm telling you that, I mean, yes, maybe a couple of people know that I'm gay. Because, sometimes, you're in the, I mean, having lunch together with a person, you know, you can have a nice conversation and then something happens, you know, and they start with "faggots," and this and that . . .

That happened?:

That happened.

Can you give an example . . . it happened to you here? You were talking to someone . . .

Yeah, to someone and, actually, the person I am talking to, she sees somebody doing something and she starts saying, "You faggot," or that kind of thing. Not necessarily to me. because she doesn't know that I'm gay. So in that case, I'm not actually afraid of confronting him . . . saying "No, don't use that word, you're offending me, blah, blah, blah." But, at the same time, because I have other problems, I just take it as "I don't have to disclose that." And in a way it's bad. I want to be myself, but I can't do that in an unsafe environment. Because I've been gay-bashed before. And that's one of the reasons that I'm here. So as long as

table continues

Table E1

Sample Meaning Unit Transformation from Interview with Robert

somebody's offering me a safe environment, and doing it based on my sexual orientation, don't just . . . seduce me! [Laughter]

Constituents present in meaning unit

Patients on 7B use homophobic language such as "faggot," and "frigging homosexual." This makes Robert feel unsafe and unable to be himself. Because Robert has been gay-bashed in the past and has other problems, he avoids one-on-one confrontations. However, Robert wants to educate patients about "who we are," to increase his feeling of safety.

Transformation

Robert needs to feel safe on 7B, and he does not feel safe when patients use derogatory terms, such as "faggot." Robert is afraid to confront other patients when they use offensive language because he has been gay-bashed. Robert believes that his feelings of safety will be increased by efforts to educate the general patient population on 7B about gay and lesbian people.

Note. Robert is not the subject's real name.

Table E2

Sample Meaning Unit Transformation from Interview with James

Meaning unit
<p><i>When you talk about "it might be helpful or unhelpful," could you talk more about that?</i></p> <p>Well, I think any time you can throw out your feelings and let them come back, there are some other outside factors involved that gives you . . . prospects because otherwise you're looking at it in just your very narrow . . . tone. Because one of our major problems between us, my lover and I, is we are very codependent. This is making the situation extremely more difficult, because there is nothing that we do not do together. We're never apart. So that's a roughy. The other thing is just the backing off from having to deal with the everyday stresses is giving me an opportunity hopefully to rebuild myself, enough so that I'll have a little more energy to come back and start playing again.</p> <p><i>So, okay. Do you feel like you're backing off from everyday stresses while you're here?</i></p> <p>Yeah. I don't have to deal with . . . you know, Doug's being taken care of, he's on Ward 5, so . . .</p> <p><i>What are some of the other stresses?</i></p> <p>Uh . . .</p>

table continues

Sample Meaning Unit Transformation from Interview with James

Is that the main one?

That's the main one.

Constituents present in meaning unit

James thinks that throwing feelings out to others and letting them come back gives him more "prospects" and gets him out of his "narrow tone." There is nothing he and his lover do not do together. This is "codependent," a problem, and "a roughy." James's hospitalization is an opportunity to reduce the stress of caring for his lover (who is being taken care of on a medical floor of SFGH while James is on 7B), rebuild himself, and gather more energy to "come back and start playing again."

Transformation

Group discussions are meaningful for James because they enable him to throw his feelings out to others and, in return, receive ideas about prospective courses of action that he might not have considered on his own. James's daily life activities are narrowly focused on his caregiver role, and his lover and he do everything together—a situation James views as problematic. On 7B, James needs relief from the stress of caring for his lover and an opportunity to rebuild himself and increase his energy so that he can function in the community. The first of James's needs is being met because his lover is being taken care of on a

table continues

Sample Meaning Unit Transformation from Interview with James

medical ward at SFGH. When James and his lover both became patients at SFGH, James was able to pass his caregiver duties on to the SFGH medical staff.

Note. James is not the subject's real name.

Table E3

Sample Meaning Unit Transformation from Interview with Michael

Meaning unit
<p>Because you look at . . . everybody needs an example. Somebody to look up to. Okay. I would imagine the setting would be gay professionals, because this is a field that's very professional. But then again, you got to be professional, and you got to know what it's about. You know what I'm saying? It's that between thing that kind of screws up a lot of people and a lot of things within our lifestyle.</p> <p><i>So "knowing what it's about." Can you talk more about that?</i></p> <p>What you mean?</p> <p><i>Well, you said . . .</i></p> <p>Okay, let me use this as an example. Okay. It's just like, you're white, I'm black. I'm gay, you're straight. This is just my example. I'm gay and you're straight, okay. You were raised probably in a nice home, a foundation. I probably was raised in the ghetto. This is what it's about. Relating to different people on different levels. And if you can't do that, you can't be that flexible. Or even try to cross-train over to see what it is actually about, then there's no way. Because you can't learn this shit in a textbook. You cannot learn it in no textbook. Ain't nobody . . . Langston Hughes can't do it in a poem. There ain't no way. Until you've been in that other person's shoes—somebody said that—until</p>
<u>table continues</u>

Table E3

Sample Meaning Unit Transformation from Interview with Michael

you've been in that other person's shoes, then you'll see the path they walked through. Somebody said it! It may not have come out like that, but shit, I did my own version. Shit, I did! But yeah. That's the honest-to-God truth. That's what I mean. That's what I mean. That's what I mean.

Constituents present in meaning unit

Everybody needs an example. Somebody to look up to. You've got to be professional, and you've got to know what it's about. It's that between thing that kind of screws up a lot of people and a lot of things within the gay lifestyle. . It's just like, you're white, I'm black. I'm gay, you're straight. This is what it's about: relating to different people on different levels. And if you can't do that, you can't be flexible. Even if you try to cross-train over to see what gay life is about, there's no way. Because you can't learn it in a textbook. Langston Hughes can't do it in a poem. Only when you've been in that other person's shoes, will you see the path they walked through.

Transformation

Michael needs staff members he can look up to who are professional, can relate to patients, and are flexible. Michael believes that when patients and staff members share a common racial identity or sexual orientation, they can relate to

table continues

Table E3**Sample Meaning Unit Transformation from Interview with Michael**

one another better than if they do not have this in common. Michael does not believe that training or reading can substitute for shared experience.

Note. Michael is not the subject's real name.

Table E4

Sample Meaning Unit Transformation from Interview with Dave

Meaning unit

You talked about your experiences with other staff members. What has your experience been? Can you tell me a story about an interaction with one of the other staff members that you had personally?

I haven't, you know, I haven't attempted really any . . . in consultation with any of them. So consequently I don't really have anything to report. Other than the fact that the Chris that was on . . . a nurse or whatever—I don't know what her job title is—that was working yesterday. When I wanted to shave, she said, "Promise me you won't hurt yourself." And I said, "Sweetheart, if you knew anything at all about me, you would know that I can't stand the sight of blood. If and when I decide to kill my self, it ain't going to be . . . where blood is exposed. Trust me." And so, she says, "Okay, fine." And so she gave me a shaver, a razor and some shaving cream and I went off to my bathroom to shave. Okay, when I asked to shave today, it was a different person on. She stood and watched me while I shaved. "Well, I don't know you like Chris did." Fine. But, you know, this is all and insult to my intelligence. So, what else?

Well, so how would you like to be treated?

Well, you know, from their viewpoint, and if I've been told once, I've been told a dozen times, by a dozen different people, that "The act that you

table continues

Table E4

Sample Meaning Unit Transformation from Interview with Dave

committed and the note that you wrote, there was no, there was no doubt that you were sincere about this. You just weren't trying to get attention. You were definitely going through this. That's very serious. Very serious." Fuck! Don't you think I know that was serious? Then they have to keep have to keep hounding it into me? I'm not a five-year-old. "That was very serious. Very serious. Very serious." If I've heard that once, I've heard that 25 times. "That was very serious." Shit, I know that! They talk down to me. They're so used to working with these vegetables that when they get somebody that's got an IQ of over 75, they don't know how to deal with it. They talk down to everybody.

So they should deal with you . . .

Well, it was explained to me that, yes, the program here is geared for the lowest common denominator. Somebody finally admitted that to me yesterday. Well can't there exceptions be made? When you finally get somebody in here that has an IQ of over 75, isn't there somebody out there that has the intellect to be able to deal with that?

Constituents present in meaning unit

Dave hasn't attempted to consult with staff members. But when Dave wanted to shave one day, Chris, his nurse, asked him to promise he wouldn't

table continues

Table E4

Sample Meaning Unit Transformation from Interview with Dave

hurt himself. Dave replied that he couldn't stand the sight of blood and asked her to trust him. So she gave Dave a razor and let him shave. Today, another nurse stood and watched Dave shave, saying, "Well, I don't know you like Chris did." Dave thinks this is an insult to his intelligence. The staff has told him many times that his suicide attempt was very serious. Dave is not a five-year-old, but the staff members talk down to him because they're so used to working with vegetables that when they get somebody that's got an IQ of over 75, they don't know how to deal with it. They talk down to everybody. Yesterday somebody admitted to Dave that the program on 7B is geared for the lowest common denominator. But when a patient on 7B has an IQ of over 75, can't exceptions be made?

Transformation

Some nurses permit Dave to shave without supervision, while others stand by to make sure he doesn't cut himself. Dave regards the latter approach as infantilizing. Dave sets himself apart from the other patients on 7B, whom he refers to as "vegetables." He needs exceptional treatment because he is able to function at a higher level than the other patients on 7B.

Note. Dave is not the subject's real name.

Table E5

Sample Meaning Unit Transformation from Interview with Stephen

Meaning unit
<i>I'll make sure you have time to do that. So, keeping your mind occupied.</i>
<i>How is that?</i>
It's . . . [affecting a British accent] "a feeling of an almost human nature."
<i>Oh, yeah? Can you say more about that?</i>
[pause]
<i>Keeping your mind occupied. Why is it a feeling of an almost human nature?</i>
[pause]
<i>Hey, Stephen.</i>
Yeah?
<i>Keeping your mind occupied. Like, through groups. What is that like, again?</i>
It's just like, they just focus your mind, on one thing, by doing something.
With your hands. You know what I'm saying?
<i>And what's that like?</i>
It's interesting. Keeps your mind occupied.
<u>table continues</u>

Table E5

Sample Meaning Unit Transformation from Interview with Stephen

When you say "interesting," could you elaborate a little? [pause] Can you tell me some more?

Um, it's like, rather than sitting and just seeing nothing, they give you something to think about. You know, rather than sitting there and just going "ding, ding, ding, ding, ding," dinging off the walls, you know what I'm saying? You just sit back and you say, "Yeah, I can do that," or "No, I can't do that." Or you just sit and you . . . go crazy, pretty much. That's really what it feels like, that you're going nuts. But you're not really going crazy because . . . what is crazy, you know? Crazy is in the mind. If you know where you are, you know who you are, you're not crazy. How can you say I'm crazy?

Constituents present in meaning unit

Keeping his mind occupied is a feeling of an almost human nature for Stephen. In groups, he focuses his mind on one thing, by doing something with his hands. It keeps Stephen's mind occupied, rather than sitting and just seeing nothing. Groups give Stephen something to think about, rather than sitting there and dinging off the walls. Stephen just sits back and says, "Yeah, I can do that," or "No, I can't do that." Or he just sits and goes crazy. That's really what it feels like, that he's going nuts. But he's not really going crazy because . . . what is

table continues

Table E5

Sample Meaning Unit Transformation from Interview with Stephen

Transformation
<p>Stephen finds task groups meaningful, because they enable him to focus his mind on one thing by doing something with his hands. At other times, Stephen just sits, sees nothing, and feels like he's going crazy.</p>

Note. Stephen is not the subject's real name.